Region 1 - 4th Quarter 2021

Small Group Health Plan Comparison

GREENE COUNTY CHAMBER OF COMMERCE
2021 4th Quarter SMALL GROUP CDPHP Rates

HMS Agency, Inc.

		2021 Option 1	2021 Option 2	2021 Option 3	2021 Option 4	2021 Option 5	2021 Option 6	2021 Option 7
Carrier		CDPHP	CDPHP	CDPHP	CDPHP	CDPHP	CDPHP	CDPHP
Product Type		EPO	EPO	EPO	HMO	EPO	EPO	EPO
Metal Tier		Gold	Gold	Gold	Gold	Silver	Silver	Bronze
Plan Name		EPO Copayment (220)	Embrace Health EPO Copayment (221) *$200 Bonus Account	HDEPO Qualified (225)	Triple Zero HMO Copay (224)	Embrace Health EPO Copayment (330) *$200 Bonus Account	Copay First ($3,000/$6,000) (425)	HDEPO Qualified (421)
Networks		National	National	National	Local	National	National	National
Aggregate: Family members must meet the Family deductible Embedded: Family members can each meet the single deductible- up to the family deductible.		Embedded	Embedded	Ded: AGG OOP: EMB	Embedded	Embedded	Embedded	Ded: AGG OOP: EMB
H.S.A. Qualified		No	No	Yes	No	No	No	Yes
Deductible (Single/Family)		$600/$1,200 (EMB)	$250/$500 (EMB)	$1,500/$3,000 (AGG)	None	$2,200/$4,400 (EMB)	Phase 1 $3,000/$6,000 (cost share/not ded) Phase 2 $6,000/$12,000 (EMB)	$6,900/$13,800 (AGG)
Coinsurance		Injectable drugs administered outpatient: Ded and/or copay + 20% of the cost of the drug	Injectable drugs administered outpatient: Ded and/or copay + 20% of the cost of the drug	Injectable drugs administered outpatient: Ded and/or copay + 20% of the cost of the drug	Injectable drugs administered outpatient: Ded and/or copay + 20% of the cost of the drug	Injectable drugs administered outpatient: Ded and/or copay + 20% of the cost of the drug	Injectable drugs administered outpatient: Ded and/or copay + 20% of the cost of the drug	Injectable drugs administered outpatient: Ded and/or copay + 20% of the cost of the drug
Out of Pocket Max (Single/Family)		$7,900/$15,800 (EMB)	$7,150/$14,300 (EMB)	$5,500/$11,000 (EMB)	$7,900/$15,800 (EMB)	$7,500/$15,000 (EMB)	$6,000/$12,000 (EMB)	$6,900/$13,800 (EMB)
Office Visit		Ded then $25	Ded then $30	Ded then $20	$0 EPC Enhanced Primary Care list of doctors $50 Non EPC	Ded then $30	Phase 1: $30 Phase 2: Ded then Covered in Full	Ded then Covered in Full
Specialist Visit		Ded then $40	Ded then $50	Ded then $20	$50	Ded then $50	Phase 1: $50 Phase 2: Ded then Covered in Full	Ded then Covered in Full
Inpatient Surgery / Hospital		Ded then $800	Ded then $1,000	Ded then $250	$1,500	Ded then $1,500	Phase 1: $500 Phase 2: Ded then Covered in Full	Ded then Covered in Full
Outpatient Surgery / Facility		Ded then $100	Ded then $100	Ded then $250	$250	Ded then $100	Phase 1: $75 Phase 2: Ded then Covered in Full	Ded then Covered in Full
Emergency Room Visit		Ded then $100	Ded then $100	Ded then $150	$500	Ded then $250	Phase 1: $75 Phase 2: Ded then Covered in Full	Ded then Covered in Full
Urgent Care		Ded then $60	Ded then $70	Ded then $65	$100	Ded then $70	Phase 1: $60 Phase 2: Ded then Covered in Full	Ded then Covered in Full
TeleMedicine		Ded then $25	Ded then $30	$0	Covered in Full	Ded then $30	Phase 1: $30 Phase 2: $49 Towards Ded then Covered in Full	Ded then Covered in Full
Lab / Radiology		Ded then $40 / Ded then $40	Ded then $50 / Ded then $50	Ded then $20 / Ded then $20	$50 / $50	Ded then $50 / Ded then $50	Phase 1: $50 / $50 Phase 2: Ded then Covered in Full	Ded then Covered in Full
Pediatric Dental		Yes - Additonal Fee Applies If Applicable - See Below	Yes - Additonal Fee Applies If Applicable - See Below	Yes - Additonal Fee Applies If Applicable - See Below	Yes - Additonal Fee Applies If Applicable - See Below	Yes - Additonal Fee Applies If Applicable - See Below	Yes - Additonal Fee Applies If Applicable - See Below	Yes - Additonal Fee Applies If Applicable - See Below
Pediatric Vision		Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Adult Vision		Exam & Hardware: Every 12 Months (after ded)	Exam & Hardware: Every 12 Months (after ded)	Exam & Hardware: Every 12 Months (after ded)	Exam & Hardware: Every 12 Months	Exam & Hardware: Every 12 Months (after ded)	Exam & Hardware - Phase 1: $30 Phase 2: Ded then Covered in Full	Exam & Hardware: Every 12 Months (after ded)
Prescription Copay		$4/$30/$60	$10/$50/$80	Ded then $10/$30/$50	$0/$50/$80	$10/$35/$70	Phase 1: $10/$30/$50 Phase 2: Ded then $10/$30/$50	Ded then Covered in Full Preventive Not Subject to Ded
Out-of-Network Benefit		No	No	No	No	No	No	No
Medical Monthly Rates		2021 Rates	2021 Rates	2021 Rates	2021 Rates	2021 Rates	2021 Rates	2021 Rates
Employee	1	$741.45	$733.30	$703.97	$645.19	$626.79	$570.31	$485.51
Employee + Spouse	1	$1,482.91	$1,466.60	$1,407.94	$1,290.38	$1,253.58	$1,140.62	$971.02
Employee + Child(ren)	1	$1,260.47	$1,246.61	$1,196.75	$1,096.82	$1,065.54	$969.53	$825.37
Family	1	$2,113.14	$2,089.90	$2,006.32	$1,838.78	$1,786.35	$1,625.38	$1,383.70
Pediatric Dental Rates		$16.46 per individual under age 19 (Up to 3 Per Family)	$16.46 per individual under age 19 (Up to 3 Per Family)	$16.46 per individual under age 19 (Up to 3 Per Family)	$16.46 per individual under age 19 (Up to 3 Per Family)	$16.46 per individual under age 19 (Up to 3 Per Family)	$16.46 per individual under age 19 (Up to 3 Per Family)	$16.46 per individual under age 19 (Up to 3 Per Family)