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

Region 1 - 4th Quarter 2021

Small Group Health Plan Comparison

		2021 Option 1	2021 Option 2	2021 Option 3	2021 Option 4	2021 Option 5	2021 Option 1	2021 Option 7	2021 Option 8
Carrier		MVP	MVP	MVP	MVP	MVP	MVP	MVP	MVP
Product Type		EPO	EPO	EPO	HMO	EPO	EPO	HMO	HMO
Metal Tier		Gold	Gold	Gold	Gold	Silver	Silver	Silver	Bronze
Plan Name		Gold 4	Gold 1 EPO	Gold 3	Gold 2 HMO HDHP	Silver 1	Silver 4 HRA *Mandatory HRA w/Min of $85 Annual ER Contrib	Silver 12 HMO	Bronze 2 HMO
Networks		Cigna	Cigna	Cigna	Local	Cigna	Cigna	Local	Local
Aggregate: Family members must meet the Family deductible Embedded: Family members can each meet the single deductible- up to the family deductible.		Embedded	Embedded	Embedded	Ded: AGG OOP: EMB	Embedded	Embedded	Embedded	Embedded
H.S.A. Qualified		No	No	No	Yes	No	No	No	No
Deductible (Single/Family)		None	$850/$1,700 (EMB)	$1,000/$2,000 (EMB)	$1,600/$3.200 (AGG)	$2,100/$4,200 (EMB)	$2,500/$5,000 (EMB)	$1,700/$3,400 (EMB)	$6,000/$12,000 (EMB)
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	Injectable drugs administered outpatient: Ded and/or copay + 20% of the cost of the drug
Out of Pocket Max (Single/Family)		$6,750/$13,500 (EMB)	$7,000/$14,000 (EMB)	$5,000/$10,000 (EMB)	$5,000/$10,000 (EMB)	$7,800/$15,600 (EMB)	$6,350/$12,700 (EMB)	$7,900/$15,800 (EMB)	$8,400/$16,800 (EMB)
Office Visit		$40	3 Visits @ $0 then $15	Ded then $20	Ded then $10	$30	Ded then $20	Ded then $30	3 Visits @ $0 then Ded then $35
Specialist Visit		$60	Ded then $50	Ded then $40	Ded then $20	Ded then $50	Ded then $50	Ded then $50	Ded then $60
Inpatient Surgery / Hospital		$750	Ded then $500	Ded then $800	Ded then $200	Ded then 20% Coins	Ded then $800	Ded then $1,500	Ded then 30% Coins
Outpatient Surgery / Facility		Facility: $300	Facility: Ded then $200	Facility: Ded then $100	Facility: Ded then $200	Facility: Ded then $300	Facility: Ded then $200	Facility: Ded then $200	Facility: Ded then $300
		Physician: Covered in Full	Physician: Ded then $100	Physician: Ded then $50	Physician: Ded then $25	Physician: Ded then $200	Physician: Ded then $100	Physician: Ded then $100	Physician: Ded then Covered in Full
Emergency Room Visit		$500	$300	Ded then $300	Ded then $75	Ded then $350	Ded then $300	Ded then $250	Ded then $350
Urgent Care		$60	$50	Ded then $40	Ded then $20	$50	Ded then $50	Ded then $50	Ded then $60
TeleMedicine		Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Lab / Radiology		Ded then $60 / Ded then $60	$50 / Ded then $50	Ded then $40 / Ded then $40	Ded then $20 / Ded then $20	$50 / Ded then $50	Ded then $50 / Ded then $50	Ded then $50 / Ded then $50	Ded then $60 / Ded then $60
Pediatric Dental		Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Pediatric Vision		Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Adult Vision		Exam & Hardware:	Exam & Hardware:	Exam & Hardware:	Exam & Hardware:	Exam & Hardware:	Exam & Hardware:	Exam & Hardware:	Exam & Hardware:
		Every 24 Months	Every 24 Months (after ded)	Every 24 Months (after ded)	Every 24 Months (after ded)	Every 24 Months	Every 24 Months (after ded)	Every 24 Months (after ded)	Every 24 Months (after ded)
Prescription Copay		$10/$40/$60	$200/$400 Ded (Non Generic Only) then $10/Ded then $35/Ded then $70	$10/$35/50%	Ded then $10/$30/$50 Preventive Not Subject to Ded	$100/$200 Ded (Non Generic Only) then $15/Ded then $35/Ded then $70	$10/$35/50%	$10/$35/$70	Ded then $10/$40/$60
Out-of-Network Benefit		No	No	No	No	No	No	No	No
Medical Monthly Rates		2021 Rates	2021 Rates	2021 Rates	2021 Rates	2021 Rates	2021 Rates	2021 Rates	2021 Rates
Employee	1	$805.82	$775.18	$752.46	$670.21	$659.44	$634.87	$597.17	$458.61
Employee + Spouse	1	$1,611.64	$1,550.36	$1,504.92	$1,340.42	$1,318.88	$1,269.74	$1,194.34	$917.22
Employee + Child(ren)	1	$1,369.89	$1,317.81	$1,279.18	$1,139.36	$1,121.05	$1,079.28	$1,015.19	$779.64
Family	1	$2,296.59	$2,209.26	$2,144.51	$1,910.10	$1,879.40	$1,809.38	$1,701.93	$1,307.04
Pediatric Dental Rates		with medical rates.	with medical rates.	with medical rates.	with medical rates.	with medical rates.	with medical rates.	with medical rates.	with medical rates.