Greene County Chamber of Commerce

HMS Agency, Inc.
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Small Group Benefits/Cost Analysis 4th Qtr. 2019

Description of Coverage							
	BlueShield NENY		BlueShield NENY		BlueShield NENY		BlueShield NENY
Benefit Highlights	Platinum EX 9201	Out-of-Network	Gold EX 6501	Out-of-Network	Gold Standard POS 1101	Out-of-Network	Silver EPO 8000 3601
Deductible	$0/$0	$2,000 single/ $4,000 family	$750 single/ $1,500 family *	$5,000 single/ $10,000 family *	$600 single / $1,200 family *	$5,000 single / $10,000 family *	$3,450 single / $6,900 family *
Coinsurance	N/A	20%	20%	50%	N/A	50%	N/A
Out-of-Pocket Max	$5,000 single/ $10,000 family*	$10,000 single / $20,000 family	$7,900 single/ $15,800 family	$10,000 single / $20,000 family	$4,000 single / $8,000 family	$10,000 single / $20,000 family	$6,650 single / $13,300 family
PCP Office Visits/Sick Child Visits	$0 pediatric PCP visits; $0 for first three adult PCP visits then $15 copay	Deductible then 20% coinsurance	$0 pediatric PCP visits, $25 copay adult PCP Visits	Deductible then 50% coinsurance	Deductible then $25 copay	Deductible then 50% coinsurance	Covered in Full After Deductible
Specialist Office Visits	$20 copay	Deductible then 20% coinsurance	$50 copay	Deductible then 50% coinsurance	Deductible then $40 copay	Deductible then 50% coinsurance	Covered in Full After Deductible
Chemotherapy	$20 copay	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Deductible then $25 copay	Deductible then 50% coinsurance	Covered in Full After Deductible
Inpatient Hospitalization	$250 copay	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Deductible then $1,000 copay	Deductible then 50% coinsurance	Covered in Full After Deductible
Outpatient Surgery	$100 copay	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Deductible then $100 copay	Deductible then 50% coinsurance	Covered in Full After Deductible
Laboratory	$15 copay	Deductible then 20% coinsurance	$25 copay	Deductible then 50% coinsurance	Deductible then $40 copay	Deductible then 50% coinsurance	Covered in Full After Deductible
Radiology	$20 copay	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Deductible then $40 copay	Deductible then 50% coinsurance	Covered in Full After Deductible
Urgent Care	$50 copay	$50 copay	$100 copay	$100 copay	Deductible then $60 copay	Deductible then $60 copay	Covered in Full After Deductible
Emergency Care	$100 copay	$100 copay	$200 copay	$200 copay	Deductible then $150 copay	Deductible then $150 copay	Covered in Full After Deductible
Durable Medical Equipment	50% coinsurance	Deductible then 50% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Covered in Full After Deductible
Eye Exams	One routine eye exam covered in full every year	Routine eye exam not covered; Medical eye exam deductible then 50%	One routine eye exam covered in full every year	Routine eye exam not covered; Medical eye exam deductible then 50%	Pediatric Routine Deductible then $25 copay, Adult routine not covered, Medical Deductible then $25 copay	Adult/Pediatric: Routine eye exam not covered; Medical eye exam deductible then 50%	One routine eye exam covered in full every year
Eye Wear	Affinity Discounts	Not Covered	Affinity Discounts	Not Covered	Not Covered	Not Covered	Affinity Discounts
Prescription Drugs	$10/$35/$70	Not Covered	$10/$35/$70	Not Covered	$10/$35/$70	Not Covered	Deductible then $10/$/35/$70
Mail Order (90 day)	2.5 copays = 90 day supply	Not Covered	2.5 copays = 90 day supply	Not Covered	2.5 copays = 90 day supply	Not Covered	2.5 copays = 90 day supply
Rates	10/1/2019-9/30/2020		10/1/2019-9/30/2020		10/1/2019-9/30/2020		10/1/2019-9/30/2020
Single	$792.16		$686.67		$670.68		$610.24
Employee/Spouse	$1,584.33		$1,373.34		$1,341.35		$1,220.49
Employee/Child(ren)	$1,346.69		$1,167.33		$1,140.15		$1,037.41
Family	$2,257.68		$1,957.03		$1,911.43		$1,739.19