

BETHLEHEM CHAMBER OF COMMERCE

2020 BlueShied NENY Small Group Medical Plan Options



Network Type		PLATINUM EX	GOLD RADIUS HIGH	GOLD RADIUS	SILVER POS CLASSIC	SILVER EX 8000	BRONZE VALUE
Abbreviations use below:		POS	POS	HYBRID	POS	PREFERRED/PARTICIPATING HAS Eligible	POS-HSA Eligible
N/A=Non applicable / INN=In Network / OON=Out of network / AD=After deductible / S=Single / F=Family / Cov=Coverage / Cvd=Covered / CIF=Covered in full							
IN NETWORK (INN)	Annual Deductible	\$0	\$0	\$750 S / \$1,500 F	\$1,700 S / \$3,400 F	\$3,700 S / \$7,400 F	\$6,900 S / \$13,800 F
	Out of Pocket Max	\$5,000 S / \$10,000 F	\$8,150S / \$16,300 F	\$8,150 S / \$16,300 F	\$7,900 S / \$15,800 F	\$6,900S / \$13,800 F	\$6,900 S / \$13,800 F
	Co-insurance split	N/A	N/A	30%	N/A	0% AD	CIF AD
OUT of NETWORK (OON)	Annual Deductible	\$5,000 S / \$10,000 F	\$5,000S / \$10,000 F	\$5,000 S / \$10,000 F	\$5,000 S / \$10,000 F	\$6,900S / \$13,800 F	Not Covered
	Out of Pocket Max	\$10,000 S / \$20,000 F	\$10,000S / \$20,000 F	\$10,000 S / \$20,000 F	\$10,000 S / \$20,000 F	\$10,000 S / \$20,000 F	Not Covered
	Co-insurance split	50%AD	50% AD	50% AD	50% AD	0% AD	Not Covered
MEDICAL SERVICES	Office Visit PCP/Spec	INN: \$15 / \$20 / OON: 50% AD	INN: \$25 / \$40 / OON: 50% AD	INN: \$25 / \$50 NDD / OON: 50% AD	INN: \$30 PCP / \$50 AD / OON: 50% AD	INN: 0% AD / OON: 50% AD	INN: \$0 AD / OON: N/A
	<i>Note:</i>	THREE (3) \$0 co-pay ADULT visits to PCP in Platinum & Gold Radius High INN ONLY. // \$0 co-pay for PEDIATRIC visits (sick & well) to PCP in Platinum & Gold Plans IN NETWORK ONLY.					
	Preventive Services	INN ONLY: \$0 Co-pay / OON: 50% AD	INN ONLY: \$0 Co-pay / OON: 50% AD	INN ONLY: \$0 Co-pay / OON: 50% AD	INN ONLY: \$0 Co-pay	INN ONLY: \$0 Co-pay NDD	INN: \$0 CIF / OON: Not covered
	Laboratory	INN: \$15 / OON: 50% AD	INN: \$25 / OON: 50% AD	INN: \$25 NDD / OON: 50% AD	INN: \$30 AD / OON: 50% AD	INN: \$0 AD / OON: 50% AD	INN: \$0 AD / OON: Not covered
	Chiropractic Care	INN: \$15 / OON: 50% AD	INN: \$25 / OON: 50% AD	INN: \$25 NDD / OON: 50% AD	INN: \$50 AD / OON: 50% AD	INN: \$0 AD / OON: 50% AD	INN: \$0 AD / OON: Not covered
	Maternity-Dr	INN: \$15 1st Visit then CIF / OON: 50% AD	INN: \$25 1st Visit then CIF / OON: 50% AD	INN: \$25 NDD 1st Visit then CIF / OON: 50% AD	INN: \$30 visit AD / OON: 50% AD	INN: \$0 AD / OON: 50% AD	INN: \$0 AD / OON: Not covered
	Imaging, X-rays	INN: \$20 / OON: 50%AD	INN: \$40 / OON: 50%AD	INN: 30% AD / OON: 50% AD	INN: \$50 AD / OON: 50% AD	INN: \$0 AD / OON: 50% AD	INN: \$0 AD / OON: Not covered
Therapies: PT/OT/ST **	INN: \$15 / OON: 50% AD	INN: \$25 / OON: 50% AD	INN: \$25 / OON: 50% AD	INN: \$30AD / OON: 50% AD	INN: \$0 AD / OON: 50% AD	INN: \$0 AD / OON: Not covered	
PEDIATRIC DENTAL	Pediatric Dental	INN Cov ONLY; see dental flyer	INN Cov ONLY; see dental flyer	INN Cov ONLY; see dental flyer	INN Cov ONLY; see dental flyer	INN Cov ONLY; see dental flyer	INN Cov ONLY; see dental flyer
	<i>Note:</i>	APPLIES TO ALL PLANS: The ACA REQUIRES Pediatric Dental. If you insure children under age 19 & DO NOT provide a dental waiver, an add'l \$22.19/mo/child will be billed to you.					
HOSPITAL SERVICES	Hospital Inpatient	INN: \$250 / OON: 50% AD	INN: \$1,000 / OON: 50% AD	INN: 30% AD / OON: 50% AD	INN: \$1,500 AD / OON: 50% AD	INN: \$0 AD / OON: 50% AD	INN: \$0 AD / OON: covered as in-network
	OutPatient Surgery	INN: \$15/\$20 in office / OON: 50% AD	INN: \$20/\$40 in office / OON: 50% AD	INN: 30% AD / OON: 50% AD	INN: \$150 AD / OON: 50% AD	INN: \$0 AD / OON: 50% AD	INN: \$0 AD / OON: Not covered
	ER & Ambulance	INN: \$100 / OON: \$100	INN: \$300 / OON: \$300	INN: \$350 / OON: \$350 NDD	ER - INN: \$250 AD / OON: \$250 AD Ambulance - INN: \$150 AD / OON: \$150 AD	INN: \$0 AD / OON: \$0 AD	INN: \$0 AD / OON: covered as in-network
	Urgent Care	INN: \$50 / OON: \$50	INN: \$75 / OON: \$75	INN: \$100 / OON: \$100 NDD	INN: \$70 AD / OON: \$70 AD	INN: \$0 AD / OON: \$0 AD	INN: \$0 AD / covered as in-network
VISION	Vision	1 Exam/yr CIF / hardware covd	1 Exam/yr CIF / hardware covd	1 Exam/yr CIF / hardware covd NDD	1 Exam/yr CIF / hardware covd	1 Exam/yr-CIF/hardware cov \$0AD	1 Exam/yr CIF / hardware covd
	Adult	1 Exam/yr CIF / OON: N/A (hardware discount program, see flyer)	1 Exam/yr CIF / OON: N/A (hardware discount program, see flyer)	1 Exam/yr CIF / OON: N/A (hardware discount program, see flyer)	1 Exam/yr CIF / OON: N/A (hardware discount program, see flyer)	1 Exam/yr-CIF/ hardware disc pgm	1 Exam/yr-CIF/ hardware disc pgm
PRESCRIPTION	Medications	INN: \$10G / \$35NB / \$70NF / OON: N/A	INN: \$10G / \$35NB / \$70NF / OON: N/A	INN: \$10G / \$35NB / \$70NF / OON: N/A	INN: \$10G / \$35NB / \$70NF NDD / OON: N/A	INN: AD: \$10G / \$35NB / \$70NF AD / OON:N/A	INN CIF AD & OON: N/A
	Telemedicine	INN:CIF/OON: N/A	INN:CIF/OON: N/A	INN:CIF/OON: N/A	INN:CIF NDD/OON: N/A	INN:CIF AD/OON: N/A	INN:CIF AD/OON: N/A
ADDITIONAL BENEFITS	Wellness	\$250 Wellness Card	\$250 Wellness Card	\$250 Wellness Card	\$250 Wellness Card	\$250 Wellness Card	\$250 Wellness Card
	Benefits	\$50 Incentive for HRA	\$50 Incentive for HRA	\$50 Incentive for HRA	\$50 Incentive for HRA	\$50 Incentive for HRA	\$50 Incentive for HRA
	Worldwide Coverage	Urgent & emergency care only	Urgent & emergency care only	Urgent & emergency care only	Urgent & emergency care only	Urgent & emergency care only	Urgent & emergency care only
	Deps/Domestic Ptnrs	Deps to 26 / DP Cvd	Deps to 26 / DP Cvd	Deps to 26 / DP Cvd	Deps to 26 / DP Cvd	Deps to 26 / DP Cvd	Deps to 26 / DP Cvd
MONTHLY PREMIUMS	Single	\$803.40	\$706.75	\$651.65	\$604.93	\$576.19	\$480.20
	Employee/Child (ren)	\$1,365.78	\$1,201.48	\$1,107.81	\$1,028.38	\$979.52	\$816.34
	Employee/Spouse	\$1,606.80	\$1,413.50	\$1,303.30	\$1,209.86	\$1,152.38	\$960.40
	Family	\$2,289.69	\$2,014.24	\$1,857.20	\$1,724.05	\$1,642.14	\$1,368.57

IMPORTANT NOTES

ALL plans include IN NETWORK preventive care covered in full. Examples: routine annual physical, routine lab tests, routine annual well woman exam /cytology, etc. Please refer to plan info for details.

Embedded Deductible: A deductible where each person must satisfy the *individual* deductible amount, *not the full family deductible amount*, before co-pays and co-insurance will be in effect.

****PT/OT/ST = 60 visits combined per condition for the plan year on all plans EXCEPT the Silver Standard. On that plan it is 60 visits combined per condition for a lifetime.**

*****Eyewear benefit administered by Davis Vision**

PLEASE READ GLOSSARY



This is a general overview of benefits available under these plans; it is not a contract.