BETHLEHEM CHAMBER OF COMMERCE

2020 MVP Health Small Group Medical Plan Options

		PLATINUM 1	GOLD 3	GOLD 4	SILVER 1	SILVER 3	BRONZE 5
	Network Type	**EPO**	**EPO**	**EPO**	**EPO**	**EPO - HAS Eligible**	**EPO - HAS Eligible**
	Abbreviations use below:	N/A=Non applicable / INN=In Network / OON=Out of network / AD=After deductible / S=Single / F=Family / Cov=Coverage / Covd=Covered / CIF=Covered in full					
IN NETWORK (INN)	**Annual Deductible**	$0	$800 S/$1,600 F (Embedded)	$0	$2,100S/$4,200F (Embedded)	$2,200S/$4,400F *(Aggregate)*	$5,350S/$10,700F (Embedded)
	Out of Pocket Max	$2,450S/$4,900F (Embedded)	$5,000 S/$10,000 F (Embedded)	$6,750S/$13,500F (Embedded)	$7,050S/$14,100F (Embedded)	$5,200S/$10,400F (Embedded)	$6,750S/$13,500F (Embedded)
	Co-insurance split	N/A	N/A	N/A	20%	N/A	50% AD
OUT of NETWORK (OON)	**Annual Deductible**	N/A	N/A	N/A	N/A	N/A	N/A
	Out of Pocket Max	N/A	N/A	N/A	N/A	N/A	N/A
	Co-insurance split	N/A	N/A	N/A	N/A	N/A	N/A
MEDICAL SERVICES	**Office Visit PCP/Spec**	INN:$5 / $45	INN:$20 AD/$40 AD	INN:$40/$60	INN:$30 PCP No DD/$50 AD	INN:$25 AD/$50 AD	INN:$5 AD/OON:50% AD
	Note:	PLATINUM 1 ONLY: first three (3) visits for Adults and Pediatrics covered at $0 then $5 thereafter.					
	Preventive Services	INN: $0	INN: $0	INN: $0	INN: $0	INN: $0	INN: $0
	Laboratory	INN: $0	INN:$40 AD	INN:$10/$40 AD	INN:$30 No DD/$50 NDD	INN:$25 AD/$50 AD	INN:$5 AD/50% AD
	Chiropractic Care	INN:$45 AD	INN:$40 AD	INN:$60 AD	INN:$50 AD	INN:50$ AD	INN:50% AD
	Maternity-Dr	INN: Office-CIF/$50 Delivery	INN: Office-CIF/$50 Delivery	INN:Office-CIF/Delivery 20% AD	INN: Office-CIF/$100 AD Delivery	INN:Office-CIF/Delivery 50% AD	INN:Office-CIF/Delivery 50% AD
	Imaging, X-rays*	INN:$10/$50/ $150* NDD	INN:$10/$50/ $150* NDD	INN:$30 No DD/$125 AD/$225 AD*	INN:$25 AD/$50 AD/$150 AD*	INN:50% AD *	INN:50% AD *
	Therapies: PT/OT/ST **	INN:$45 AD	INN:$40 AD	INN:$50 AD	INN:$50 AD	INN:50% AD **	INN:50% AD **
PEDIATRIC DENTAL		Pediatric Dental Benefits are included with ALL MVP NY Small Group Plans. Preventive: $25 co-pay / Routine Care: 20% AD / Major Services: 50% AD / Medically-Necessary Orthodontia: 50% AD. See flyer for complete details.					
HOSPITAL SERVICES	**Hospital Inpatient**	INN:$300	INN:$800 AD	INN:$750 AD	INN:20% AD	INN:$500 AD	INN:50% AD
	OutPatient Surgery	INN:$100	INN:$100 AD	INN:$300 AD	INN:$300 AD	INN:$200 AD	INN:50% AD
	Emergency Room	INN:$100	INN:$300 AD	INN:$500 AD	INN:$350 AD	INN: $300 AD	INN:$100 AD
	Urgent Care	INN:$45	INN:$40 AD	INN:$60 AD	INN:$50 AD	INN:$50 AD	INN:50% AD
VISION	**Pediatric**	1 Exam/yr-$40/hardware covd	1 Exam/yr-$40/hardware covd	1 Exam/yr-$40/hardware covd	1 Exam/yr-$40/hardware covd	1 Exam/yr-$40/hardware covd	1 Exam/yr-$40/hardware covd
	Note:	APPLIES TO ALL PLANS: OOP pediatric vision costs now apply to OOP maximum totals.					
	Adult	Medical Necessity Only	Medical Necessity Only	Medical Necessity Only	Medical Necessity Only	Medical Necessity Only	Medical Necessity Only
PRESCRIPTION MEDICATIONS	**In network**	$5G/$30NB/$50NF	$10G/$35NB/50%NF	$10G/$40NB/$60NF	$15G NDD/$35NB AD/$70NF AD ($100S/$200F Ded NB Meds ONLY)	$15G/$40NB/$60NF AD (Preventive durugs NDD)	$5G/$30NB/$50NF AD (Preventive durugs NDD)
	Mail Order Meds:	APPLIES TO ALL PLANS: Mail Order option available at 2.5 co-pays for 90-day supply.					
	Telemedicine	$5	$20	$40	$30 NDD	$25	$5
ADDITIONAL BENEFITS	**Wellness Benefits**	Up to $600 in Benefits/Contract	Up to $600 in Benefits/Contract	Up to $600 in Benefits/Contract	Up to $600 in Benefits/Contract	Up to $600 in Benefits/Contract	Up to $600 in Benefits/Contract
	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 Covd	Deps to 26/DP Covd	Deps to 26/DP Covd	Deps to 26/DP Covd	Deps to 26/DP Covd	Deps to 26/DP Covd
MONTHLY PREMIUMS	Single	$840.51	$698.17	$734.41	$603.82	$586.79	$479.13
	Employee/Child (ren)	$1,428.87	$1,186.89	$1,248.50	$1,026.49	$997.54	$814.52
	Employee/Spouse	$1,681.02	$1,396.34	$1,468.82	$1,207.64	$1,173.58	$958.26
	Family	$2,395.45	$1,989.78	$2,093.07	$1,720.89	$1,672.35	$1,365.52

IMPORTANT NOTES

ALL plans include routine preventive care covered in full IN NETWORK ONLY: examples; routine annual physical, routine lab tests, routine annual well woman exam /cytology, etc.

Aggregate deductible: In policies insuring more than one person, one or more persons must meet the full FAMILY deductible amount before co-pays/co-insurance goes into effect for any insured person.

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

*** Higher co-pay applies to Advanced Imaging Services (CT/PET scans and MRI's) in all plans.**

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