# DIOCESE OF BETHLEHEM PLAN YEAR 2024

| Plan | Anthem BCBS BlueCard PPO 100 | | Anthem BCBS BlueCard PPO 90 | | Anthem BCBS CDHP 15/HSA | | Anthem BCBS CDHP 20/HSA | |
|---|---|---|---|---|---|---|---|---|
| | **Network** | **Out-of-Network** | **Network** | **Out-of-Network** | **Network** | **Out-of-Network** | **Network** | **Out-of-Network** |
| Annual Medical Deductible (CDHPs have a combined medical & RX deductible) | $0 per person<br>$0 per family | $500 per person<br>$1,000 per family | $500 per person<br>$1,000 per family | $1,000 per person<br>$2,000 per family | $1,600 per person<br>$3,200 per family (deductible is non-embedded) | $3,200 per person<br>$6,400 per family (deductible is non-embedded) | $3,200 per person<br>$5,450 per family (deductible is non-embedded) | $3,200 per person<br>$6,000 per family (deductible is non-embedded) |
| Annual Out-of-Pocket Limit | $2,000 per person<br>$4,000 per family | $4,000 per person<br>$8,000 per family | $2,500 per person<br>$5,000 per family | $5,000 per person<br>$10,000 per family | $2,400 per person<br>$4,800 per family (out-of-pocket is non-embedded) | $4,800 per person<br>$9,600 per family (out-of-pocket is non-embedded) | $4,200 per person<br>$8,450 per family (out-of-pocket is non-embedded) | $7,000 per person<br>$13,000 per family (out-of-pocket is non-embedded) |
| **Preventive Care** | | | | | | | | |
| Preventive Services & Well-Child Care | $0 copay | 50% coinsurance plus any balance billing | $0 copay | 50% coinsurance plus any balance billing | $0 copay | 40% coinsurance plus any balance billing | $0 copay | 45% coinsurance plus any balance billing |
| **Physician Services** | | | | | | | | |
| Office Visit | $30 copay | 50% coinsurance plus any balance billing | $30 copay | 50% coinsurance plus any balance billing | 15% coinsurance | 40% coinsurance plus any balance billing | 20% coinsurance | 45% coinsurance plus any balance billing |
| Diagnostic Services (outpatient) | $0 copay | 50% coinsurance plus any balance billing | 10% coinsurance | 50% coinsurance plus any balance billing | 15% coinsurance | 40% coinsurance plus any balance billing | 20% coinsurance | 45% coinsurance plus any balance billing |
| Specialist Care | $45 copay | 50% coinsurance plus any balance billing | $45 copay | 50% coinsurance plus any balance billing | 15% coinsurance | 40% coinsurance plus any balance billing | 20% coinsurance | 45% coinsurance plus any balance billing |
| **Hospital Services** | | | | | | | | |
| Inpatient Services (including inpatient maternity services) | $250 copay | 50% coinsurance plus any balance billing | 10% coinsurance | 50% coinsurance plus any balance billing | 15% coinsurance | 40% coinsurance plus any balance billing | 20% coinsurance | 45% coinsurance plus any balance billing |
| Outpatient Surgery | $200 copay | 50% coinsurance plus any balance billing | 10% coinsurance | 50% coinsurance plus any balance billing | 15% coinsurance | 40% coinsurance plus any balance billing | 20% coinsurance | 45% coinsurance plus any balance billing |
| Emergency Room Care | $250 copay | Covered at in-network benefit level | $250 copay | Covered at in-network benefit level | 15% coinsurance | Covered at in-network benefit level | 20% coinsurance | Covered at in-network benefit level |
| Ambulance Services | $0 copay | Covered at in-network benefit level for emergency transport | 10% coinsurance | Covered at in-network benefit level for emergency transport | 15% coinsurance | Covered at in-network benefit level for emergency transport | 20% coinsurance | Covered at in-network benefit level for emergency transport |
| **Behavioral Health** | | | | | | | | |
| Outpatient Services | $0 copay | 30% coinsurance plus any balance billing | $30 copay | 30% coinsurance plus any balance billing | 15% coinsurance | 40% coinsurance plus any balance billing | 20% coinsurance | 45% coinsurance plus any balance billing |
| Inpatient Services | $250 copay | 50% coinsurance plus any balance billing | 10% coinsurance | 50% coinsurance plus any balance billing | 15% coinsurance | 40% coinsurance plus any balance billing | 20% coinsurance | 45% coinsurance plus any balance billing |
| **Other Medical Services** | | | | | | | | |
| Durable Medical Equipment | $0 copay | 50% coinsurance plus any balance billing | 10% coinsurance | 50% coinsurance plus any balance billing | 15% coinsurance | 40% coinsurance plus any balance billing | 20% coinsurance | 45% coinsurance plus any balance billing |
| Home Health Care (210 visits per calendar year, combined network & out-of-network) | $0 copay | 50% coinsurance plus any balance billing | 10% coinsurance | 50% coinsurance plus any balance billing | 15% coinsurance | 40% coinsurance plus any balance billing | 20% coinsurance | 45% coinsurance plus any balance billing |
| Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network & out-of-network) | $30 copay PCP<br>$45 copay specialist (includes speech, physical, and occupational) | 50% coinsurance plus any balance billing (includes speech, physical, and occupational) | $30 copay PCP $45 copay specialist (includes speech, physical, and occupational) | 50% coinsurance plus any balance billing (includes speech, physical, and occupational) | 15% coinsurance (includes speech, physical, and occupational) | 40% coinsurance plus any balance billing (includes speech, physical, and occupational) | 20% coinsurance (includes speech, physical, and occupational) | 45% coinsurance plus any balance billing (includes speech, physical, and occupational) |
| Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network & out-of-network | $0 copay | 50% coinsurance plus any balance billing | 10% coinsurance | 50% coinsurance plus any balance billing | 15% coinsurance | 40% coinsurance plus any balance billing | 20% coinsurance | 45% coinsurance plus any balance billing |
| Urgent Care Services | $50 copay | 50% coinsurance plus any balance billing | $50 copay | 50% coinsurance plus any balance billing | 15% coinsurance | 15% coinsurance plus any balance billing | 20% coinsurance | 20% coinsurance plus any balance billing |

| Prescription Drug Benefits | | | | | | |
|---|---|---|---|---|---|---|
| | Pharmacy Benefits Administered by Express Scripts | | | | | |
| | Anthem BCBS PPO 100 | | Anthem BCBS PPO 90 | | CDHP-15/HSA | CDHP-20/HSA |
| | Retail | Home Delivery | Retail | Home Delivery | Retail and Home Delivery | Retail and Home Delivery |
| **Annual Prescription Deductible (in-network)** | None | None | None | None | $1,600 per person<br>$3,200 per family<br>(combined with medical deductible) (non-embedded deductible) | $3,200 per person<br>$5,450 per family<br>(combined with medical deductible) (non-embedded deductible) |
| **Tier 1: Generic** | Up to a $10 copay | Up to a $25 copay | Up to a $10 copay | Up to a $25 copay | You pay 15% after deductible | You pay 15% after deductible |
| **Tier 2: Preferred Brand Name** | Up to a $40 copay | Up to a $100 copay | Up to a $40 copay | Up to a $100 copay | You pay 25% after deductible | You pay 25% after deductible |
| **Tier 3: Non-Preferred Brand Name** | Up to an $80 copay | Up to a $200 copay | Up to an $80 copay | Up to a $200 copay | You pay 50% after deductible | You pay 50% after deductible |
| **Tier 4: Specialty Rx** | 40%: up to a $100 min / $200 max | 40%: up to a $250 min / $500 max | 40%: up to a $100 min / $200 max | 40%: up to a $250 min / $500 max | You pay 50% after deductible | You pay 50% after deductible |
| **Dispensing Limits Per Copayment** | Up to a 30-day supply | Up to a 90-day supply | Up to a 30-day supply | Up to a 90-day supply | Up to a 30-day supply (retail) or 90-day supply (mail order) | Up to a 30-day supply (retail) or 90-day supply (mail order) |

| Vision Benefits - (Tied to all above plans) | | |
|---|---|---|
| This benefit is tied into the medical benefit and is not available independently. | EyeMed | |
| | Network | Out-of-Network |
| **Eye Examinations** | $0 copay | Plan pays up to $30 for ophthalmologists or optometrists |
| **Lenses (eligible once every calendar year)** | $10 copay | Plan pays up to:<br>$32 for single vision<br>$46 for bifocal<br>$57 for trifocal |
| **Lens Options** | | |
| Standard Progressive (add-on to bifocal) | Up to $75 copay | Play pays up to $46 |
| UV Coating | up to $15 copay | You are responsible for the cost of any lens options that you elect from out-of-network providers. |
| Tint (solid and Gradient) | up to $15 copay | |
| Standard Scratch Resistance | up to $15 copay | |
| Standard Polycarbonate | $0 copay | |
| Standard Anti-Reflective Coating | up to $45 copay | |
| Disposable | 20% off retail price | |
| **Frames (eligible once every calendar year)** | $200 allowance, 20% off balance over $200 | Plan pays up to $47 |
| **Contact Lenses (eligible once every calendar year)** | | |
| Conventional | $200 allowance, 15% off balance over $200 | Plan pays up to $100 |
| Disposable | $200 allowance, then you pay balance over $200 | Plan pays up to $100 |

# Dental Benefits

| | Delta Dental Premium PPO Plan | | |
|---|---|---|---|
| | **PPO Network** | **Premier Network** | **Out-of-Network** |
| **Annual Deductible** | $0 per person / $0 per family | $0 per person<br>$0 per family | $50 per person / $150 per family |
| **Annual Benefit Maximum (Plan maximums cross-accumulate between the PPO Network, Premier Network, and out-of-network dentist)** | $3,000 | $2,500 | $2,000 |
| **Diagnostic and Preventative Services (e.g., exams, cleanings, x-rays, sealants, and space maintainers)** | You pay $0<br>(not subject to annual deductible) | | You pay $0 (not subject to annual deductible) plus any balance billing |
| **Basic Services (Includes fillings, simple extractions, root canals, oral surgery, and denture reline/repair/rebase)** | You pay 15% coinsurance | You pay 15% coinsurance | You pay 25% coinsurance plus any balance billing |
| **Major Services (Includes crowns, bridges, and dentures)** | You pay 15% coinsurance | You pay 15% coinsurance | You pay 25% coinsurance plus any balance billing |
| **Orthodontic Services** | You pay 50% coinsurance up to individual lifetime benefit limit of $2,000 | You pay 50% coinsurance up to individual lifetime benefit limit of $2,000 | You pay 60% coinsurance up to individual lifetime benefit limit of $1,500 after $50 lifetime deductible plus any balance billing |