

DIOCESE OF BETHLEHEM PLAN YEAR 2024

Plan	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS 15/HSA		Anthem BCBS 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 \$0 per family	\$500 per person \$1,000 per family	\$500 per person \$1,000 per family	\$1,000 per person \$2,000 per family	\$1,600 per person \$3,200 per family (deductible is non-embedded)	\$3,200 per person \$6,400 per family (deductible is non-embedded)	\$3,200 per person \$5,450 per family (deductible is non-embedded)	\$3,200 per person \$6,000 per family (deductible is non-embedded)
Annual Out-of-Pocket Limit	\$2,000 per person \$4,000 per family	\$4,000 per person \$8,000 per family	\$2,500 per person \$5,000 per family	\$5,000 per person \$10,000 per family	\$2,400 per person \$4,800 per family (out-of-pocket is non-embedded)	\$4,800 per person \$9,600 per family (out-of-pocket is non-embedded)	\$4,200 per person \$8,450 per family (out-of-pocket is non-embedded)	\$7,000 per person \$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 \$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

DIOCESE OF BETHLEHEM PLAN YEAR 2024, continued

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 \$3,200 per family (combined with medical deductible) (non-embedded deductible)	\$3,200 per person \$5,450 per family (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: \$32 for single vision \$46 for bifocal \$57 for trifocal
Lens Options		
Standard Progressive (add-on to bifocal)	Up to \$75 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers.
UV Coating	up to \$15 copay	
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

	Delta Dental Premium PPO Plan		
	PPO Network	Premier Network	Out-of-Network
Annual Deductible	\$0 per person / \$0 per family	\$0 per person \$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 (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

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