

Greene County Chamber of Commerce
 Nicholas J. Marino & Co., Inc.
 Karen Landau- Vice President Employee Benefits
 Small Group Medical Benefits/Cost Analysis **2nd Qtr 2017**

Description of Coverage	BlueShield NENY		BlueShield NENY	BlueShield NENY	
	Silver Standard POS (5601)	Out-of-Network	Bronze Value EPO (4301)	Bronze Standard POS (7001)	Out-of-Network
Benefit Highlights					
Deductible	\$2,000 single/ \$4,000 family *	\$5,000 single/ \$10,000 family *	\$6,450 single/ \$12,900 family *	\$4,000 single/ \$8,000 family*	\$5,000 single/ \$10,000 family *
Coinsurance	0%	50%	0%	50%	50%
In Network Out-of-Pocket Max	\$6,750 single/ \$13,500 family	\$10,000 single/ \$20,000 family	\$6,450 single/ \$12,900 family	\$7,150 single/ \$14,300 family	\$10,000 single/ \$20,000 family
PCP Office Visits	Deductible then \$30 copay	Deductible then 50%	Covered in Full after Deductible	Deductible then 50%	Deductible then 50%
Specialist Office Visits	Deductible then \$50 copay	Deductible then 50%	Covered in Full after Deductible	Deductible then 50%	Deductible then 50%
Lab	Deductible then \$50 copay	Deductible then 50%	Covered in Full after Deductible	Deductible then 50%	Deductible then 50%
Radiology	Deductible then \$50 copay	Deductible then 50%	Covered in Full after Deductible	Deductible then 50%	Deductible then 50%
Inpatient Hospitalization	Deductible then \$1,500 copay	Deductible then 50%	Covered in Full after Deductible	Deductible then 50%	Deductible then 50%
Outpatient Surgery	Deductible then \$100 copay	Deductible then 50%	Covered in Full after Deductible	Deductible then 50%	Deductible then 50%
Urgent Care	Deductible then \$70 copay	Deductible then \$70 copay	Covered in Full after Deductible	Deductible then 50%	Deductible then 50%
Emergency Care	Deductible then \$250 copay	Deductible then \$150 copay	Covered in Full after Deductible	Deductible then 50%	Deductible then 50%
Durable Medical Equipment	Deductible then 30%	Deductible then 50%	Covered in Full after Deductible	Deductible then 50%	Deductible then 50%
Eye Exams	One routine eye exam covered in full every other year (Adult & Pediatric)	Routine eye exam not covered; Medical eye exam deductible then 50%	One routine eye exam covered in full every other year (Adult & Pediatric)	One routine eye exam covered in full every other year (Adult & Pediatric)	Routine eye exam not covered; Medical eye exam deductible then 50%
Eye Wear	Affinity Discounts	Not Covered	Affinity Discounts	Affinity Discounts	Not Covered
Prescription Drugs	\$10/\$35/\$70	Not Covered	Covered in Full after Deductible	Deductible then \$10/\$35/\$70	Not Covered
Mail Order (90 day supply)	2.5 copays = 90 day supply	Not Covered	2.5 copays = 90 day supply	2.5 copays = 90 day supply	Not Covered
Dependent/Student	26/26	26/26	26/26	26/26	26/26
Rates	04/01/2017-06/30/2017		04/01/2017-06/30/2017	04/01/2017-06/30/2017	
Single	\$484.47		\$412.68	\$411.44	
Employee/Spouse	\$968.94		\$825.36	\$822.88	
Employee/Child(ren)	\$823.60		\$701.56	\$699.45	
Family	\$1,380.74		\$1,176.14	\$1,172.60	

