

Anthem PPO/EPO Plan

The EPO plan does not cover out-of-network services

Member cost share (deductible, coinsurance and/or copay as applicable depending on the plan) will apply to all non-Tier 1 (non-Catholic Health) facility services, including admissions through the emergency room.

Office Visits	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3: (PPO Only) (Out-of-Network) ²
Office Visits ¹ <i>primary care/specialist</i>	\$0 Primary/ \$0 Specialist Copay	\$35 Primary/ \$60 Specialist Copay	Deductible and 40% Coinsurance
Preventive Care	\$0 Copay	\$0 Copay	Deductible and 40% Coinsurance
Maternity Care ¹	\$0 Copay	\$35 Copay for initial visit, then covered 100%	Deductible and 40% Coinsurance
Allergy Testing and Treatment ¹	\$0 Copay	\$60 Specialist Copay (Copay waived for treatment)	Deductible and 40% Coinsurance
Chiropractic Care ¹	N/A	\$60 Specialist Copay	Deductible and 40% Coinsurance

Inpatient/Outpatient	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3: (PPO Only) (Out-of-Network) ²
Deductible	\$0	\$1,000 Individual/\$2,000 Family	\$2,000 Individual/\$4,000 Family
Inpatient	\$0 Copay	Deductible and 25% Coinsurance	Deductible and 40% Coinsurance
Cardio and Ortho Services	\$0 Copay	50% Coinsurance (deductible does not apply)	50% Coinsurance (deductible does not apply)
Outpatient	\$0 Copay	Deductible and 25% Coinsurance	Deductible and 40% Coinsurance
Cardio and Ortho Services	\$0 Copay	50% Coinsurance (deductible does not apply)	50% Coinsurance (deductible does not apply)
Emergency Department (Waived if admitted)	\$50 Copay	\$200 Copay	\$200 Copay
Urgent Care Center	\$25 at Excel Urgent Care; \$40 Copay at CityMD	\$75 Copay	Deductible and 40% Coinsurance
Out-of-Pocket Maximum	\$6,100 Individual/\$12,200 Family		\$10,500 Individual/\$21,000 Family (Deductible and 40% Coinsurance)
Rx Out-of-Pocket Maximum	\$3,000 Individual/\$6,000 Family		N/A

Home/Office/Outpatient care	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3: (PPO Only) (Out-of-Network) ²
Home Health Care (up to 200 visits PCY)	Covered 100%	Covered 100%	40% Coinsurance (no deductible)
Home Infusion Therapy	Covered 100%	Covered 100%	In-Network Only
Hospice Care (up to 210 days per life time)	Covered 100%	Covered 100%	In-Network Only
Ambulatory Out-Patient Surgery	Covered 100%	Deductible and 25% Coinsurance	Deductible and 40% Coinsurance
Anesthesia	Covered 100%	Covered 100%	Deductible and 40% Coinsurance
Chemotherapy, Radiation Therapy	Covered 100%	Covered 100%	Deductible and 40% Coinsurance
Kidney Dialysis	Covered 100%	Covered 100%	Deductible and 40% Coinsurance

Inpatient Care	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3: (PPO Only) (Out-of-Network) ²
Physical Therapy	Covered 100%	Deductible and 25% Coinsurance	Deductible and 40% Coinsurance
Skilled Nursing Facility	Covered 100%	Deductible and 25% Coinsurance	Covered In-Network Only
Surgery, Surgical Asst, Anesthesia	Covered 100%	Deductible and 25% Coinsurance	Deductible and 40% Coinsurance

Anthem PPO/EPO Plan

The EPO plan does not cover out-of-network services

	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3: (PPO Only) (Out-of-Network) ²	Member cost share (deductible, coinsurance and/or copay as applicable depending on the plan) will apply to all non-Tier 1 (non-Catholic Health) facility services, including admissions through the emergency room.
Mental Health				
Inpatient Care (as many days as medically necessary)	Covered 100%	Covered 100%	Deductible and 40% Coinsurance	
Outpatient visits to an Office or Facility (as many days as medically necessary)	Covered 100%	\$25 Copay	Deductible and 40% Coinsurance	
Substance Abuse				
Outpatient rehab visits to an Office or Facility	Covered 100%	\$25 Copay	Deductible and 40% Coinsurance	
Inpatient Detox (as many days as medically necessary)	Covered 100%	Covered 100%	Deductible and 40% Coinsurance	
Inpatient Rehab	Covered 100%	Covered 100%	Deductible and 40% Coinsurance	
Office/Outpatient care				
Presurgical Testing	Covered 100%	Facility: Deductible and 25% Coinsurance Provider: Covered 100%	Deductible and 40% Coinsurance	
Laboratory Tests	Covered 100%	Facility: Deductible and 25% Coinsurance Provider: Covered 100%	Deductible and 40% Coinsurance	
X-Rays	Covered 100%	Facility: Deductible and 25% Coinsurance Provider: Covered 100%	Deductible and 40% Coinsurance	
Radiology (MRI, MRA, CAT Scan, PET and Nuclear Cardiology)	Covered 100%	Facility: Deductible and 25% Coinsurance Provider: \$60 Copay	Deductible and 40% Coinsurance	
Physical Therapy (60 visits PCY Combined Institutional/ Professional)	Covered 100%	Facility: Deductible and 25% Coinsurance Provider: \$35 Copay	Covered In-Network Only	
Other Short-Term Therapies - Speech/ Language, Occupational, Vision (30 visits PCY Combined Institutional/ Professional)	Covered 100%	Facility: Deductible and 25% Coinsurance Provider: \$35 Copay	Covered In-Network Only	
Other		In-Network	Out-of-Network	
Medical Supplies		Covered 100%	Covered In-Network Only	
Durable Medical Equipment		Covered 100%	Covered In-Network Only	
Prosthetics and Orthotics		Covered 100%	Covered In-Network Only	
Ambulance (Air Ambulance)		Covered 100%	Covered In-Network Only	
Routine Vision Care		\$5 copay for 1 exam every 24 months plus discounts on frames and lenses	Covered In-Network Only	

¹ Tier 1 physician copays apply to physicians in the Catholic Health Providers directory. Coverage for other providers depends on whether or not they are in the Anthem network: consult Tier 2 to find out what your coverage is for the providers you choose.

² Reimbursement for out-of network care (PPO only) is based on 175% of the National Medicare fee schedule. (Emergency room visits may be reimbursed differently.) You are responsible for 40% of this amount after deductible, which may be different from what a provider charges. Members who use out-of-network providers and facilities may also be subject to "balance billing" by the provider or facility, which occurs when a provider requires the member to pay the difference between what the provider bills and what the plan reimburses. You can contact Anthem to learn the reimbursement schedule for a particular service.