

# 2025 Anthem POS Plan

## The POS plan covers both in-network and out-of-network services

Office Visits	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3 Out-of-Network
Office Visits <sup>1</sup> <i>primary care/specialist</i>	\$0 Primary/ \$0 Specialist Copay	\$50 Primary/ \$75 Specialist Copay	Deductible and 50% Coinsurance
Preventive Care	\$0 Copay	\$0 Copay	Deductible and 50% Coinsurance
Maternity Care <sup>1</sup>	\$0 Copay	\$50 Copay for initial visit, then covered 100%	Deductible and 50% Coinsurance
Allergy Testing and Treatment <sup>1</sup>	\$0 Copay	\$75 Specialist Copay (Copay waived for treatment)	Deductible and 50% Coinsurance
Chiropractic Care <sup>1</sup>	N/A	\$75 Specialist Copay	Deductible and 50% Coinsurance

Inpatient/Outpatient	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3 Out-of-Network
Deductible	\$0	\$1,500 Individual/\$3,000 Family	\$4,000 Individual/\$8,000 Family
Inpatient	\$0 Copay	Deductible and 35% Coinsurance	Deductible and 50% Coinsurance
Cardio and Ortho Services	\$0 Copay	50% Coinsurance (Deductible does not apply)	50% Coinsurance (Deductible does not apply)
Outpatient	\$0 Copay	Deductible and 35% Coinsurance	Deductible and 50% Coinsurance
Cardio and Ortho Services	\$0 Copay	50% Coinsurance (Deductible does not apply)	50% Coinsurance (Deductible does not apply)
Emergency Department <i>waived if admitted</i>	\$50 Copay	\$200 Copay	\$200 Copay
Urgent Care Center	\$25 at CH and NY Excel Urgent Care; \$55 Copay at CityMD	\$75 Copay	Deductible and 50% Coinsurance
Out-of-Pocket Maximum	\$7,200 Individual/\$14,400 Family		\$12,000 Individual/\$30,000 Family
Rx Out-of-Pocket Maximum	\$2,000 Individual/\$4,000 Family		N/A

Home/Office/Outpatient care	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3 Out-of-Network
Home Health Care (up to 200 visits PCY)	Covered 100%	\$75 Copay	50% Coinsurance (no deductible)
Home Infusion Therapy	Covered 100%	Covered 100%	Deductible and 50% Coinsurance
Hospice Care (up to 210 days per life time)	Covered 100%	Covered 100%	Deductible and 50% Coinsurance
Ambulatory Out-Patient Surgery	Covered 100%	Deductible and 35% Coinsurance	Deductible and 50% Coinsurance
Anesthesia	Covered 100%	Covered 100%	Deductible and 50% Coinsurance
Chemotherapy, Radiation Therapy	Covered 100%	\$50 Copay	Deductible and 50% Coinsurance
Kidney Dialysis	Covered 100%	Covered 100%	Deductible and 50% Coinsurance

Inpatient Care	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3 Out-of-Network
Physical Therapy	Covered 100%	Deductible and 35% Coinsurance	Deductible and 50% Coinsurance
Skilled Nursing Facility	Covered 100%	Deductible and 35% Coinsurance	Deductible and 50% Coinsurance
Surgery, Surgical Asst, Anesthesia	Covered 100%	Deductible and 35% Coinsurance	Deductible and 50% Coinsurance

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.

*Reimbursement for out-of-network care (PPO and POS only) is based on 175% of the National Medicare fee schedule. (Emergency room visits may be reimbursed differently.) You are responsible for the out-of-network coinsurance percentage 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.*

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	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3 Out-of-Network	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.
<b>Mental Health</b>				
Inpatient Care (as many days as medically necessary)	Covered 100%	Covered 100%	Deductible and 50% Coinsurance	
Outpatient visits to an Office or Facility (as many days as medically necessary)	Covered 100%	\$35 Copay	Deductible and 50% Coinsurance	
<b>Substance Abuse</b>				
Outpatient rehab visits to an Office or Facility	Covered 100%	\$35 Copay	Deductible and 50% Coinsurance	
Inpatient Detox (as many days as medically necessary)	Covered 100%	Covered 100%	Deductible and 50% Coinsurance	
Inpatient Rehab	Covered 100%	Covered 100%	Deductible and 50% Coinsurance	
<b>Office/Outpatient care</b>				
Presurgical Testing	Covered 100%	Facility: Deductible and 35% Coinsurance Provider: Covered 100%	Deductible and 50% Coinsurance	<i>Reimbursement for out-of-network care (PPO and POS only) is based on 175% of the National Medicare fee schedule. (Emergency room visits may be reimbursed differently.) You are responsible for the out-of-network coinsurance percentage of this amount after deductible, which may be different from what a provider charges.</i>  <i>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.</i>
Laboratory Tests	Covered 100%	Facility: Deductible and 35% Coinsurance Provider: Covered 100%	Deductible and 50% Coinsurance	
X-Rays	Covered 100%	Facility: Deductible and 35% Coinsurance Provider: \$50 Copay	Deductible and 50% Coinsurance	
Radiology (MRI, MRA, CAT Scan, PET and Nuclear Cardiology)	Covered 100%	Facility: Deductible and 35% Coinsurance Provider: \$75 Copay	Deductible and 50% Coinsurance	
Physical Therapy (20 visits PCY Combined Institutional/ Professional)	Covered 100%	Facility: Deductible and 35% Coinsurance Provider: \$50 Copay	Deductible and 50% Coinsurance	
Other Short-Term Therapies - Speech/ Language, Occupational, Vision (20 visits PCY Combined Institutional/ Professional)	Covered 100%	Facility: Deductible and 35% Coinsurance Provider: \$50 Copay	Deductible and 50% Coinsurance	
<b>Other</b>		<b>In-Network</b>	<b>Out-of-Network</b>	
Medical Supplies		Covered 100%	Deductible and 50% Coinsurance	
Durable Medical Equipment		Covered 100%	Deductible and 50% Coinsurance	
Prosthetics and Orthotics		Covered 100%	Deductible and 50% Coinsurance	
Ambulance (Air Ambulance)		Covered 100%	Deductible and 50% Coinsurance	
Routine Vision Care		\$5 copay for 1 exam every 24 months plus discounts on frames and lenses	Covered In-Network Only	

<sup>1</sup> 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.