DIOCESE OF BETHLEHEM PLAN YEAR 2025

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 $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	$1,650 per person $3,300 per family (deductible is non-embedded)	$3,300 per person $6,600 per family (deductible is non-embedded)	$3,300 per person $6,600 per family (deductible is non-embedded)	$3,300 per person $6,600 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	$0 copay	50% coinsurance	$0 copay	40% coinsurance	$0 copay	45% coinsurance
Physician Services								
Office Visit	$30 copay	50% coinsurance	$30 copay	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Diagnostic Services (outpatient)	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Specialist Care	$45 copay	50% coinsurance	$45 copay	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Hospital Services								
Inpatient Services (including inpatient maternity services)	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Outpatient Surgery	$200 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance
Ambulance Services	$0 copay	$0 copay	10% coinsurance	10% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance
Behavioral Health								
Outpatient Services	$0 copay	30% coinsurance	$30 copay	30% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Inpatient Services	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Other Medical Services								
Durable Medical Equipment	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Home Health Care (210 visits per calendar year, combined network & out-of-network)	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
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 (includes speech, physical, and occupational)	$30 copay PCP $45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	15% coinsurance (includes speech, physical, and occupational)	40% coinsurance (includes speech, physical, and occupational)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network & out-of-network	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Urgent Care Services	$50 copay	$50 copay	$50 copay	$50 copay	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance

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	$1,650 per person $3,300 per family (combined with medical deductible) (non-embedded deductible)	$3,300 per person $6,600 per family (combined with medical deductible) (non-embedded deductible)
Tier 1: Generic	Up to a $10 copay	Up to a $10 copay	Up to a $10 copay	Up to a $10 copay	You pay 15% after deductible	You pay 15% after deductible
Tier 2: Preferred Brand Name	25%; up to $40 min / $80 max	25%; up to $40 min / $80 max	25%; up to $40 min / $80 max	25%; up to $40 min / $80 max	You pay 25% after deductible	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	40%; up to $80 min / $160 max	40%; up to $80 min / $160 max	40%; up to $80 min / $160 max	40%; up to $80 min / $160 max	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 $100 min / $200 max	40%: up to a $100 min / $200 max	40%: up to a $100 min / $200 max	You pay 50% after deductible	You pay 50% after deductible
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 30-day supply	Up to a 30-day supply	Up to a 30-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	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 $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
Major Services (Includes crowns, bridges, and dentures)	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance
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