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Summary of Benefits & Coverage

Medical $0 Deductible
CoreChoice Bronze Plan

Anthem BlueCard PPO In-Network

Rates effective as of January 1, 2026

*This plan is offered through the Amalgamated Local 426 S.W. Workers Union, and not Anthem BCBS.

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Network: Anthem PPO	In Network	Out of Network
In Network Provider: To search for in-network providers, click *here*. **Visit anthem.com/find-care → Search as Guest → Select:** **Medical Plan or Network | Your State | Employer-Sponsored | National PPO (BlueCard PPO) → Continue**		
Lifetime Maximum Benefit	Unlimited	NOT COVERED
Deductible The amount the Covered Person pays each benefit year for Covered Services before the Coinsurance is payable. . Individual . Family	 $0 $0	NOT COVERED
Co-Insurance The percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met.	40% (Plan Pays 60%)	NOT COVERED
Out of Pocket Maximum Includes deductible, copayments and co-insurance. Once reached the plan pays 100% of covered in-network services for the rest of the year. . Individual . Family	 $7,350 $14.700	NOT COVERED
Copays: Please note that after your deductible has been met, you will still be responsible for paying copayments for your medical services.		
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care • Routine Eye Care (Adult)	• Dental Care (Adult)	• Private-Duty Nursing
Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Hearing Aids • Non-Emergency Care Outside of U.S.	• Infertility Treatment • Routine Foot Care • Cosmetic Surgery	• Long-Term Care • Weight Loss Programs
This illustration describes the plan in an easily understood manner and is presented as a matter of general information only.		
Services may require preauthorization. Failure to obtain the required preauthorization may result in denial of benefit coverage.		
The contents are not to be accepted or construed as a substitute for the provisions of the plan document or summary plan description, which contains more exact terms and detailed provisions of the plan, and it is not to be considered a policy of insurance.		

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Covered Services - Preventive, Health Care Provider or Clinic		
• **Primary Care Physician** • **Specialist Office Visit** ◦ No Referral Needed	40% Co-Insurance	NOT COVERED
Annual Preventive Care, Screenings, Immunizations	No Charge	NOT COVERED

• **Diagnostic Test**
  ◦ X-Rays, Blood Work
• **Imaging**
  ◦ CT/PET Scans, MRI
	40% Co-Insurance	NOT COVERED

Covered Services - Emergency Services, Hospitalization and Surgeries		
• **Urgent Care** • **Emergency Room Care** • **Emergency Medical Transportation**	40% Co-Insurance	Deductible, 40% Co-Insurance
Outpatient Services (Preauthorization May Be Required) • Outpatient Surgical Facility Services • Physician / Surgeon Fee	40% Co-Insurance	NOT COVERED
Inpatient Services (Preauthorization Required) • Inpatient Hospital Care Facility and Intensive Care Unit ◦ 30 days per plan year • Inpatient Hospital Surgical Services • Physician / Surgeon Fee	40% Co-Insurance	NOT COVERED
Covered Services - Maternity		
Pregnancy/Maternity • Prenatal/Postnatal Office Visits • Childbirth/Delivery Facility Services • Childbirth/Delivery Professional Services Does not cover maternity services for child dependents.	40% Co-Insurance	NOT COVERED

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Covered Services - Mental Health and Other		
Mental Health, Behavioral Health or Substance Abuse Services • Outpatient Services • Inpatient Services	40% Co-Insurance	NOT COVERED
Home Health Care (Pre-Authorization Required) 200 visits per plan year	40% Co-Insurance	NOT COVERED
Rehabilitation Services (Pre-Authorization Required) 30 visits per plan year	40% Co-Insurance	NOT COVERED
Skilled Nursing Care (Pre-Authorization Required) 60 days per plan year	40% Co-Insurance	NOT COVERED
Durable Medical Equipment (DME)	40% Co-Insurance	NOT COVERED
Hospice Services (Pre-Authorization Required) In Home Only	40% Co-Insurance	NOT COVERED
Children's Eye Exam and Glasses Maximum $150 benefit every 24 months. Only for dependents under age 19	No Charge	NOT COVERED
Children's Dental Check-Up	No Charge	NOT COVERED
Habilitation Services	NOT COVERED	NOT COVERED

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Network: Anthem PPO		In Network	Out of Network
Covered Services - Prescriptions			
Retail Pharmacy Copayments 30-Day Supply at Retail Pharmacies. Mail Order Required for Medication After 30-Day Initial Supply.	Generic Drugs	40% Co-Insurance	NOT COVERED
	Brand Name Drugs	40% Co-Insurance	NOT COVERED
	Non-Preferred Brand Name Drugs	40% Co-Insurance	NOT COVERED
	Specialty Drugs	NOT COVERED. PIP and PAP Eligible	
Mail Order Pharmacy Copayments 90-Day Supply at Retail Pharmacies.	Generic Drugs	40% Co-Insurance	NOT COVERED
	Brand Name Drugs	40% Co-Insurance	NOT COVERED
	Non-Preferred Brand Name Drugs	40% Co-Insurance	NOT COVERED
	Specialty Drugs	NOT COVERED. PIP and PAP Eligible	
Prescription coverage is initally limited to $3,000 per calendar year. Then charges between $3,000 and $6,000 are not covered, and charges in excess of $6,000 per calendar year are covered at 60% and you will pay 40%.			
Prescription Benefit Highlights			
RX Company		HealthCare Advantage	
Formulary		Select Formulary	
Supplemental Plan Information			
Plan SBC		SBC	

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