1099WORKERS.COM

Summary of Benefits & Coverage

PPO $6,000 Deductible
CoreChoice 6000 HSA 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	 $6,000 $12,000	NOT COVERED
Co-Insurance The percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met.	30% (Plan Pays 70%)	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	 $8,300 $16,600	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	• Emergency Care Outside U.S.	• 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 • Dental Care (Adult and Children) • Infertility Treatment • Non-Emergency Care Outside of U.S. • Specialty Drugs	• Bariatric Surgery • Habilitation Services • Long-Term Care • Routine Eye Care (Adult and Children) • Substance Abuse Services	• Cosmetic Surgery • Hearing Aids • Mental/Behavioral Health Services • Routine Foot 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	Deductible, 30% Co-Insurance	NOT COVERED
Annual Preventive Care, Screenings, Immunizations	No Charge	NOT COVERED

• **Diagnostic Test**
  ◦ X-Rays, Blood Work
• **Imaging**
  ◦ CT/PET Scans, MRI
	Deductible, 30% Co-Insurance	NOT COVERED

Covered Services - Emergency Services, Hospitalization and Surgeries		
• **Urgent Care** • **Emergency Room Care** • **Emergency Medical Transportation**	Deductible, 30% Co-Insurance	Deductible, 30% Co-Insurance
Outpatient Services (Preauthorization May Be Required) • Outpatient Surgical Facility Services • Physician / Surgeon Fee	Deductible, 30% 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	Deductible, 30% 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.	Deductible, 30% 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	NOT COVERED	NOT COVERED
Home Health Care (Pre-Authorization Required) 40 visits per plan year	Deductible, 30% Co-Insurance	NOT COVERED
Rehabilitation Services (Pre-Authorization Required) 60 visits per condition per lifetime	Deductible, 30% Co-Insurance	NOT COVERED
Skilled Nursing Care (Pre-Authorization Required) 60 consecutive days per condition per lifetime	Deductible, 30% Co-Insurance	NOT COVERED
Durable Medical Equipment (DME)	Deductible, 30% Co-Insurance	NOT COVERED
Hospice Services (Pre-Authorization Required) 60 days per lifetime	Deductible, 30% Co-Insurance	NOT COVERED
Children's Eye Exam and Glasses Only for dependents under age 19	NOT COVERED	NOT COVERED
Children's Dental Check-Up	NOT COVERED	NOT COVERED
Habilitation Services	NOT COVERED	NOT COVERED

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Covered Services - Prescriptions			
Prescription Deductible The amount the Covered Person pays each benefit year before plan begins to cover prescription services. . Individual . Family		$2,500 $5,000	NOT COVERED
Retail Pharmacy Copayments 30-Day Supply at Retail Pharmacies. Mail Order Required for Medication After 30-Day Initial Supply.	Generic Drugs	Deductible, $10 Copay	NOT COVERED
	Brand Name Drugs	Deductible, $35 Copay	NOT COVERED
	Non-Preferred Brand Name Drugs	Deductible, $70 Copay	NOT COVERED
	Specialty Drugs	NOT COVERED. PIP and PAP Eligible	
Mail Order Pharmacy Copayments 90-Day Supply at Retail Pharmacies.	Generic Drugs	Deductible, $25 Copay	NOT COVERED
	Brand Name Drugs	Deductible, $87.50 Copay	NOT COVERED
	Non-Preferred Brand Name Drugs	Deductible, $175 Copay	NOT COVERED
	Specialty Drugs	NOT COVERED. PIP and PAP Eligible	
Prescription Benefit Highlights			
RX Company		HealthCare Advantage	
Formulary		Select Formulary	
Supplemental Plan Information			
Plan SBC		SBC	

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