1099WORKERS.COM

Summary of Benefits & Coverage

Medical $1,000 Deductible
CoreChoice 1000 Gold 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	Unlimited
Deductible The amount the Covered Person pays each benefit year for Covered Services before the Coinsurance is payable. . Individual . Family	 $1,000 $2,000	 $7,500 $15,000
Co-Insurance The percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met.	20% (Plan Pays 80%)	50% (Plan Pays 50%)
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	 $9,100 $18,200	 $15,000 $30,000
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		
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 • Bariatric Surgery • Cosmetic Surgery • Dental Care	• Eye Exam • Habilitation Services • Infertility Treatment • Long Term Care	• Medical Care Outside the U.S. • Private Duty Nursing • 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	$40 Copay $40 Copay	Deductible, 50% Co-Insurance
Annual Preventive Care, Screenings, Immunizations	No Charge	Deductible, 50% Co-Insurance

• **Diagnostic Test**
  ◦ X-Rays, Blood Work
• **Imaging**
  ◦ CT/PET Scans, MRI
	Deductible, 20% Co-Insurance	Deductible, 50% Co-Insurance

Covered Services - Emergency Services, Hospitalization and Surgeries		
• **Urgent Care** • **Emergency Room Care** • **Emergency Medical Transportation**	$40 Copay $350 Copay Deductible, 20% Co-Insurance	$40 Copay $350 Copay Deductible, 20% Co-Insurance
Outpatient Services (Preauthorization Required) • Outpatient Surgical Facility Services • Physician / Surgeon Fee	Deductible, 20% Co-Insurance $40 Copay	Deductible, 50% Co-Insurance
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, 20% Co-Insurance	Deductible, 50% Co-Insurance
Covered Services - Maternity		
Pregnancy/Maternity (Preauthorization May Be Required) • Prenatal/Postnatal Office Visits • Childbirth/Delivery Facility Services • Childbirth/Delivery Professional Services Does not cover maternity services for child dependents.	$40 Copay Deductible, 20% Co-Insurance Deductible, 20% Co-Insurance	Deductible, 50% Co-Insurance

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Covered Services - Mental Health and Other		
Mental Health, Behavioral Health or Substance Abuse Services • Outpatient Services • Inpatient Services	$40 Copay Deductible, 20% Co-Insurance	Deductible, 50% Co-Insurance
Home Health Care and Rehabilitation Services (Pre-Authorization Required) 60 visits per plan year	Deductible, 20% Co-Insurance	Deductible, 50% Co-Insurance
Skilled Nursing Care (Pre-Authorization Required) 30 visits per calendar year	Deductible, 20% Co-Insurance	Deductible, 50% Co-Insurance
Durable Medical Equipment (DME)	Deductible, 20% Co-Insurance	Deductible, 50% Co-Insurance
Hospice Services (Pre-Authorization Required) 30 visits per calendar year	Deductible, 20% Co-Insurance	Deductible, 50% Co-Insurance
Children's Eye Exam Only for dependents under age 19	No Charge	Deductible, 50% Co-Insurance
Children's Glasses	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			
Retail Pharmacy Copayments 30-Day Supply at Retail Pharmacies. Mail Order Required for Medication After 30-Day Initial Supply.	Generic Drugs	$10 Copay	NOT COVERED
	Brand Name Drugs	$35 Copay	NOT COVERED
	Non-Preferred Brand Name Drugs	$75 Copay	NOT COVERED
	Specialty Drugs	NOT COVERED. PIP and PAP Eligible	
Mail Order Pharmacy Copayments 90-Day Supply at Retail Pharmacies.	Generic Drugs	$25 Copay	NOT COVERED
	Brand Name Drugs	$87 Copay	NOT COVERED
	Non-Preferred Brand Name Drugs	$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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