




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.Anthemblue.com/eocdps/aso>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (800) 496-6132 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0/individual or \$0/family Catholic Health <a href="#">Providers</a> . \$1,250/individual or \$2,500/family for In- <a href="#">Network Facilities</a>	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , Primary Care visit, <a href="#">Specialist</a> visit, and Vision exam for Anthem Tier In- <a href="#">Network Providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$50/individual or \$100/family for Prescription Drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,200/individual or \$14,400/family for Catholic Health/Anthem Tier In- <a href="#">Network Providers</a> . Rx: \$2,000/individual or \$4,000/family for In- <a href="#">Network Providers</a> for <a href="#">Prescription Drugs</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, EPO. See <a href="http://www.Anthemblue.com">www.Anthemblue.com</a> or call (800) 496-6132 for a list of <a href="#">network providers</a> .	You pay the least if you use a Catholic Health <a href="#">provider</a> .. You pay more if you use a <a href="#">provider</a> in the Anthem Network. This plan does not provide out of network benefits.. Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work).

		Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Catholic Health Provider (You will pay the least)	Anthem Tier In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	No charge	\$45/visit <a href="#">deductible</a> does not apply	Not covered	-----none-----
	<a href="#">Specialist</a> visit	No charge	\$70/visit <a href="#">deductible</a> does not apply	Not covered	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	Not covered	Well child care covered up to age 19 for CHS <a href="#">Providers</a> and Anthem In- <a href="#">Network Providers</a> . You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	30% <a href="#">coinsurance</a>	Not covered	Covered 100% at in- <a href="#">network</a> lab provider setting.
	Imaging (CT/PET scans, MRIs)	No charge	30% <a href="#">coinsurance</a>	Not covered	Covered 100% after \$60 Copay at in- <a href="#">network</a> provider office setting.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> .	Generic	\$10 copay	\$20 copay	Not covered	Clinical rules may apply; Copays are up to 30 day supply; Up to 90 day supply maintenance drugs available at 2x the MyCHSRx copay (MyCHSRx) or 2x retail copay (OptumRx Mail Order). For more information contact the MyCHSRx Pharmacy at 516-207-7007 or OptumRx at 1-844-642-9089.
	<a href="#">Preferred</a> Brand	20% coinsurance \$25 min/\$50 max	25% coinsurance \$50 min/\$100 max	Not covered	
	Non- <a href="#">Preferred</a> Brand	40% coinsurance \$40 min/\$80max	50% coinsurance \$75 min/\$175 max	Not covered	

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.Anthemblue.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Catholic Health Provider (You will pay the least)	Anthem Tier In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Cardiology and Orthopedic Services: 50% coinsurance  All other: 30% <a href="#">coinsurance</a>	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fees	No charge	No charge	Not covered	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50/visit	\$200/visit	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Emergency medical transportation</a>	No charge	No charge	Not covered	-----none-----
	<a href="#">Urgent care</a>	\$25/visit at CH and NY Excel Urgent Care  \$55/visit at CityMD	\$75/visit	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Cardiology and Orthopedic Services: 50% coinsurance  All other: 30% <a href="#">coinsurance</a>	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fees	No charge	No charge	Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$25/visit	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Inpatient services	No charge	No charge	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Office visits	No charge	\$45/visit first 1 visit	Not covered	<a href="#">Cost sharing</a> does not apply for preventive services. Maternity care

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.Anthemblue.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Catholic Health Provider (You will pay the least)	Anthem Tier In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	No charge	No charge	Not covered	may include tests and services described elsewhere in the SBC (i.e. ultrasound). Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Childbirth/delivery facility services	No charge	30% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	No charge	Not covered	200 days limit/benefit period for Catholic Health <a href="#">Providers</a> and In- <a href="#">Network Providers</a> combined.
	<a href="#">Rehabilitation services</a>	No charge	\$45/visit	Not covered	*See Therapy Services section
	<a href="#">Habilitation services</a>	No charge	\$45/visit	Not covered	
	<a href="#">Skilled nursing care</a>	No charge	30% <a href="#">coinsurance</a>	Not covered	60 days limit/benefit period for Catholic Health <a href="#">Providers</a> and In- <a href="#">Network Providers</a> combined. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	<a href="#">Durable medical equipment</a>	No charge	No charge	Not covered	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	No charge	No charge	Not covered	210 days limit/lifetime for Catholic Health <a href="#">Providers</a> and In- <a href="#">Network Providers</a> combined. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If your child needs dental or eye care	Children's eye exam	\$5/exam	\$5/exam	Not covered	*See Vision Services section \$5 copay for 1 exam every 24 months plus discount on frames and lenses
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	*See Dental Services section

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.Anthemblue.com/eocdps/aso>.

## Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"><li>• Contraceptive Services</li><li>• Cosmetic surgery</li><li>• Dental care (adult)</li><li>• Elective Termination of Pregnancy</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids</li><li>• Long- term care</li><li>• Other services related to gender affirmation or transition</li><li>• Private-duty nursing</li></ul> | <ul style="list-style-type: none"><li>• Routine foot care unless you have been diagnosed with diabetes</li><li>• Sterilization</li><li>• Weight loss programs</li></ul> |
|---|--|---|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Chiropractic care</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment (except artificial insemination and advanced reproductive technologies such as in-vitro fertilization, ZIFT, GIFT, and ICSI, in accordance with Ethical and Religious Directives of the Catholic Church)</li></ul> | <ul style="list-style-type: none"><li>• Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a></li><li>• Routine eye care (adult) 1 exam every 24 months</li></ul> |
|---|--|--|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: [Grievances](#) and [Appeals](#), P.O. Box 1407, Church Street Station, New York, NY 10008-1407

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? No**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.Anthemblue.com/eocdps/aso>.

————— To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section. —————

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	0%

This EXAMPLE event includes services like:  
[Specialist](#) office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:	
<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$110
<a href="#">Coinsurance</a>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,970

**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	0%

This EXAMPLE event includes services like:  
[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:	
<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$110
<a href="#">Copayments</a>	\$765
<a href="#">Coinsurance</a>	\$920
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,850

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	0%

This EXAMPLE event includes services like:  
[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:	
<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$25
<a href="#">Copayments</a>	\$250
<a href="#">Coinsurance</a>	\$5
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$280

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (800) 496-6132

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 496-6132 ይደውሉ።

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 496-6132.

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 496-6132:

**Bassa (Bàsɔ̀ Wùdù):** M̐ dyi dyi-diè-djé b̐é b̐édjé b̐á céè-djé nià k̐e dyí ní, ɔ̀ m̐ò nì dyí-b̐édjèìn-djé b̐é m̐ k̐é gbo-kpá-kpá k̐è b̐ŋ kp̐ɔ̀ djé m̐ bídjí-wùdùùn b̐ó pídyi. B̐é m̐ k̐é wuɖu-zìin-nyò d̐ò gbo wùdù k̐e, d̐á (800) 496-6132.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (800) 496-6132 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (800) 496-6132 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (800) 496-6132。

**Dinka (Dinka):** Na naŋ thiëc nē ke de yā thorē, ke yin naŋ loŋ bē yi kuony ku wēr alēu bē gēer yic yin ne thoŋ du ke cin wēu tāäuē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin cōl (800) 496-6132.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (800) 496-6132.

**Farsi (فارسی):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 496-6132 تماس بگیرید.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 496-6132.



## Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (800) 496-6132.

**Greek (Ελληνικά):** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (800) 496-6132.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (800) 496-6132.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (800) 496-6132.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (800) 496-6132 ।

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (800) 496-6132.

**Igbo (Igbo):** O bür ü na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo (800) 496-6132.

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**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໂອ້ນລັກກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (800) 496-6132.

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Ata' halne'ígíí la' bich'ı́' hadeesdzih nínízingo koǵı́' hodiílnih (800) 496-6132.

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दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (800) 496-6132

**Oromo (Oromifaa):** Sanadi kanaa wajiin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (800) 496-6132 bilbilla.

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