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/ or call (800) 496-6132 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**/individual or **$0**/family for Catholic Health Providers. **$1,250**/individual or **$2,500**/family for In-Network Providers. **$2,500**/individual or **$5,000**/family for Out-of-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.,.
Are there services covered before you meet your deductible?	Yes. Primary Care visit, Specialist visit, Preventive care, and Vision exam for Catholic Health and In-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles 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 out-of-pocket limit for this plan?	Medical: **$8,600**/individual or **$17,200**/family for Catholic Health/ In-Network Providers. **$12,000**/individual or **$24,000**/family for Out-of-Network Providers. Rx: **$2,000**/individual or **$4,000**/family for In-Network Providers for Prescription Drugs.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met..

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, PPO. See www.Anthemblue.com or call (800) 496-6132 for a list of network providers. For elective (non-emergency) procedures performed at an in-network facility, services provided by an out-of-network provider are covered only if you complete a federal "Notice and Consent" form before receiving care. Without a valid form, those services will not be covered.	You pay the least if you use a Catholic Health provider. You pay more if you use a provider in In-Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$40/visit deductible does not apply	40% coinsurance	--------none--------
	Specialist visit	No charge	$65/visit deductible does not apply	40% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance	Well child care covered up to age 19. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

* 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)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	40% coinsurance	Covered 100% after $65 Copay at in-network provider office setting.
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	40% coinsurance	Covered 100% after $65 Copay at in-network provider office setting.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com.	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.
	Preferred Brand	20% coinsurance $25 min/$50 max	25% coinsurance $50 min/$100 max	Not covered	
	Non-Preferred Brand	40% coinsurance $40 min/$80 max	50% coinsurance $75 min/$175 max	Not covered	
	Specialty	50% coinsurance $50 min/$100 max	60% coinsurance $80 min/$200 max	Not covered	Specialty Rx is limited to the MyCHSRx pharmacy. For certain specialty drugs not available through MyCHSRx pharmacy (i.e., limited distribution drugs), members will have access to OptumRx Specialty.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Cardiology and Orthopedic Services: 50% coinsurance All other: 30% coinsurance	Cardiology and Orthopedic Services: 50% coinsurance All other: 40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage. See above Notice and Consent requirement for elective services furnished by out-of-network providers at in-network facilities.
	Physician/surgeon fees	No charge	No charge	40% coinsurance	See above Notice and Consent requirement for elective services furnished by out-of-network providers at in-network facilities.
f you need immediate	Emergency room care	$50/visit	$200/visit	Covered as In-Network	--------none--------

* 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)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
medical attention	Emergency medical transportation	No charge	No charge	Not covered	--------none--------
	Urgent care	$30/visit at CH Urgent Care $55 /visit at NY Excel and CityMD Urgent Care	$75/visit	40% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Cardiology and Orthopedic Services: 50% coinsurance All other: 30% coinsurance	Cardiology and Orthopedic Services: 50% coinsurance All other: 40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage. See above Notice and Consent requirement for elective services furnished by out-of-network providers at in-network facilities.
	Physician/surgeon fees	No charge	No charge	40% coinsurance	See above Notice and Consent requirement for elective services furnished by out-of-network providers at in-network facilities.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$25/visit	40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Inpatient services	No charge	No charge	40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Office visits	No charge	$40/visit first 1 visit	40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services
	Childbirth/delivery professional services	No charge	No charge	40% coinsurance	

* 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)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	No charge	30% coinsurance	40% coinsurance	described elsewhere in the SBC (i.e. ultrasound). Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you need help recovering or have other special health needs	Home health care	No charge	No charge	40% coinsurance deductible does not apply	200 days limit/benefit period. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Rehabilitation services	No charge	$40/visit	Not covered	*See Therapy Services section
	Habilitation services	No charge	$40/visit	Not covered	
	Skilled nursing care	No charge	30% coinsurance	Not covered	120 days limit/benefit period for Catholic Health Providers and In-Network Providers combined. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Durable medical equipment	No charge	No charge	Not covered	*See Durable Medical Equipment Section.
	Hospice services	No charge	No charge	Not covered	210 days limit/lifetime for Catholic Health Providers and In-Network Providers 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.)

- Contraceptive Services
- Cosmetic surgery
- Dental care (adult)
- Elective Termination of Pregnancy
- Hearing aids
- Long- term care
- Other services related to gender affirmation or transition
- Private-duty nursing
- Routine foot care unless you have been diagnosed with diabetes
- Sterilization
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- 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)
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Routine eye care (adult) 1 exam every 24 months

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. Other coverage options may be available to you too, including buying individual insurance coverage through the Heath Insurance Marketplace. For more information about the Marketplace, visit 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

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? Yes

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.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.Anthemblue.com/eocdps/aso.

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 plan's overall deductible	$1,250
Specialist *copayment*	$65
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$800
Copayments	$110
Coinsurance	$2,000
What isn't covered	
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 plan's overall deductible	$1,250
Specialist *copayment*	$65
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$110
Copayments	$765
Coinsurance	$920
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,855**

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

The plan's overall deductible	$1,250
Specialist *copayment*	$65
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$25
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5
The total Mia would pay is	**$250**

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 (Bǎsɔ́ɔ̀ Wùdù): Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nià kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dɛ́ m̀ bídí-wùdùǔn bó pídyi. Bɛ́ m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (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 အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (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 nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (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 (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای 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): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (800) 496-6132.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (800) 496-6132.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (800) 496-6132.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 496-6132

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(800) 496-6132 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (800) 496-6132 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (800) 496-6132.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (800) 496-6132 로 문의하십시오.

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

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