




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.anthem.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 (833) 592-9956 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$750/member or \$1,500/family for UPG <a href="#">Network Providers</a> or for HealthKeepers <a href="#">Network Providers</a> . \$750/member or \$1,500/family for Out-of- <a href="#">Network Providers</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 <a href="#">plan</a> , 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, and <a href="#">Specialist</a> visit for UPG <a href="#">Network</a> and In- <a href="#">Network Providers</a> . Tier 1 Tier 2 Tier 3 Prescription Drugs for In- <a href="#">Network Providers</a> . Vision for In- <a href="#">Network</a> and Non- <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?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$5,000/member or \$10,000/family for UPG <a href="#">Network Providers</a> or for HealthKeepers <a href="#">Network Providers</a> . \$5,000/member or \$10,000/family for Out-of- <a href="#">Network Providers</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> .

<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes, HealthKeepers. See <a href="http://www.anthem.com">www.anthem.com</a> or call (833) 592-9956 for a list of <a href="#">network providers</a> .	You pay the least if you use a <a href="#">provider</a> in UPG <a href="#">Network</a> . You pay more if you use a <a href="#">provider</a> that is In- <a href="#">Network</a> , but not part of UPG's network. You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). 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.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</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
		UPG/UVA Network (You will pay the least)	In-Network Provider (You will pay more)	Non-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	\$15/visit <a href="#">deductible</a> does not apply	\$20/visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	\$30/visit <a href="#">deductible</a> does not apply	\$35/visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No charge	No charge	30% <a href="#">coinsurance</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)	Lab – Office No charge X-Ray – Office 0% <a href="#">coinsurance</a>	Lab – Office No charge X-Ray – Office 20% <a href="#">coinsurance</a>	Lab – Office 30% <a href="#">coinsurance</a> X-Ray – Office 30% <a href="#">coinsurance</a>	Lab – Office -----none----- X-Ray – Office -----none-----
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
If you need drugs to treat your illness or condition	Tier 1 - Typically Generic	\$15/prescription <a href="#">deductible</a> does not apply (retail) and \$38/prescription <a href="#">deductible</a> does not	\$15/prescription <a href="#">deductible</a> does not apply (retail) and \$38/prescription <a href="#">deductible</a> does not	30% <a href="#">coinsurance</a> (retail) and 30% <a href="#">coinsurance</a> (home delivery)	*See Prescription Drug section

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UPG/UVA Network (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
More information about <a href="http://www.anthem.com/pharmacyinformation/">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>  Essential		apply (home delivery)	apply (home delivery)		
	Tier 2 - Typically <a href="#">Preferred</a> / Brand	\$50/prescription <a href="#">deductible</a> does not apply (retail) and \$125/prescription <a href="#">deductible</a> does not apply (home delivery)	\$50/prescription <a href="#">deductible</a> does not apply (retail) and \$125/prescription <a href="#">deductible</a> does not apply (home delivery)	30% <a href="#">coinsurance</a> (retail) and 30% <a href="#">coinsurance</a> (home delivery)	
	Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a>	\$85/prescription <a href="#">deductible</a> does not apply (retail) and \$213/prescription <a href="#">deductible</a> does not apply (home delivery)	\$85/prescription <a href="#">deductible</a> does not apply (retail) and \$213/prescription <a href="#">deductible</a> does not apply (home delivery)	30% <a href="#">coinsurance</a> (retail) and 30% <a href="#">coinsurance</a> (home delivery)	
	Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)	20% <a href="#">coinsurance</a> up to \$250 maximum /prescription (retail) and 20% <a href="#">coinsurance</a> up to \$250 maximum /prescription (home delivery)	20% <a href="#">coinsurance</a> up to \$250 maximum /prescription (retail) and 20% <a href="#">coinsurance</a> up to \$250 maximum /prescription (home delivery)	30% <a href="#">coinsurance</a> (retail) and 30% <a href="#">coinsurance</a> (home delivery)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	\$30/visit <a href="#">deductible</a> does not apply	\$35/visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	-----none-----
<b>If you need immediate</b>	<a href="#">Emergency room care</a>	\$300/visit <a href="#">deductible</a> does not apply	\$300/visit <a href="#">deductible</a> does not apply	Covered as In- <a href="#">Network</a>	Copay waived if admitted.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UPG/UVA Network (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
medical attention	<a href="#">Emergency medical transportation</a>	\$100/transport <a href="#">deductible</a> does not apply	\$100/transport <a href="#">deductible</a> does not apply	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	\$15 (PCP)/\$30 (specialist) per visit <a href="#">deductible</a> does not apply	\$20 (PCP)/\$35 (specialist) per visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300/admission <a href="#">deductible</a> does not apply	\$600/admission <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	If you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived. <b>150 days/benefit period</b> for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit No charge Other Outpatient No charge	Office Visit No charge Other Outpatient No charge	Office Visit 30% <a href="#">coinsurance</a> Other Outpatient 30% <a href="#">coinsurance</a>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	\$300/admission <a href="#">deductible</a> does not apply	\$300/admission <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	If you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
If you are pregnant	Office visits	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	If you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	\$300/admission <a href="#">deductible</a> does not apply	\$600/admission <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	
If you need help recovering or have other	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	100 visits/benefit period for In- <a href="#">Network Providers</a> and Non- <a href="#">Network Providers</a> combined.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UPG/UVA Network (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
special health needs	<a href="#">Rehabilitation services</a>	\$30/visit <a href="#">deductible</a> does not apply	\$35/visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	*See Therapy Services section
	<a href="#">Habilitation services</a>	\$30/visit <a href="#">deductible</a> does not apply	\$35/visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	150 days limit/admission for In-Network Providers and Non-Network Providers combined.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
If your child needs dental or eye care	Children's eye exam	No charge	No charge	\$30 reimbursement	*See Vision Services section
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	*See Dental Services section

**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>• Acupuncture</li> <li>• Dental care (adult)</li> <li>• Hearing aids</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Dental Check-up</li> <li>• Infertility treatment</li> <li>• Routine foot care unless you have been diagnosed with diabetes.</li> </ul> | <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Glasses for a child</li> <li>• Long- term care</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>• Chiropractic care</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> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (adult) 1 exam/benefit period.</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.

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

**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 27401, Richmond, VA 23279

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

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

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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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.anthem.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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">copayment</a>	\$300
■ 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	\$12,800
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$400</b>

### 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>	\$750
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">copayment</a>	\$300
■ 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	\$7,400
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$6,000
<b>The total Joe would pay is</b>	<b>\$6,200</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">copayment</a>	\$300
■ 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	\$1,900
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,420</b>

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 (833) 592-9956

**Amharic (አማርኛ):** ለሰነድ ይህን ጽሑፍ ላይ ጥያቄዎች ለማሟላት ወይንም ለተጨማሪ መረጃ ለማግኘት፣ እባክዎ ወደ (833) 592-9956 ይግኙ።

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 592-9956.

**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՝ (833) 592-9956:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ n̄à kɛ dyí ní, ɔ̀ m̀ò n̄ì dyí-bɛ̀dɛ̀n̄-dɛ̀ bɛ̀ m̄ kɛ gbo-kpá-kpá kè b̄́ kp̄́ dɛ̀ m̄ bídí-wùdùùn b́ó pídyi. Bɛ̀ m̄ kɛ wuɖu-ziīn-nyò d̀ò gbo wùdù kɛ, d́á (833) 592-9956.

**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 (833) 592-9956 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (833) 592-9956 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 (833) 592-9956。

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