




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/ or call (833) 592-9956 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$750/member or \$1,500/family for UPG Network Providers or for HealthKeepers Network Providers . \$750/member or \$1,500/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 plan , 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. Preventive care , Primary Care visit, and Specialist visit for UPG Network and In- Network Providers . Tier 1 Tier 2 Tier 3 Prescription Drugs for In- Network Providers . Vision for In- Network and Non- 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? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$5,000/member or \$10,000/family for UPG Network Providers or for HealthKeepers Network Providers . \$5,000/member or \$10,000/family for Out-of- Network Providers . | 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. |
| 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, HealthKeepers. See www.anthem.com or call (833) 592-9956 for a list of network providers . | You pay the least if you use a provider in UPG Network . You pay more if you use a provider that is In- Network , but not part of UPG's 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. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist . |

 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 provider's office or clinic | Primary care visit to treat an injury or illness | \$15/visit deductible does not apply | \$20/visit deductible does not apply | 30% coinsurance | -----none----- |
| | Specialist visit | \$30/visit deductible does not apply | \$35/visit deductible does not apply | 30% coinsurance | -----none----- |
| | Preventive care / screening / immunization | No charge | No charge | 30% coinsurance | 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | Lab – Office No charge X-Ray – Office 0% coinsurance | Lab – Office 20% coinsurance X-Ray – Office 20% coinsurance | Lab – Office 30% coinsurance X-Ray – Office 30% coinsurance | Lab – Office -----none----- X-Ray – Office -----none----- |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 20% coinsurance | 30% coinsurance | -----none----- |
| If you need drugs to treat your illness or condition | Tier 1 - Typically Generic | \$15/prescription deductible does not apply (retail) and \$38/prescription deductible does not | \$15/prescription deductible does not apply (retail) and \$38/prescription deductible does not | 30% coinsurance (retail) and 30% coinsurance (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 prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/ Essential | | apply (home delivery) | apply (home delivery) | | |
| | Tier 2 - Typically Preferred / Brand | \$50/prescription deductible does not apply (retail) and \$125/prescription deductible does not apply (home delivery) | \$50/prescription deductible does not apply (retail) and \$125/prescription deductible does not apply (home delivery) | 30% coinsurance (retail) and 30% coinsurance (home delivery) | |
| | Tier 3 - Typically Non- Preferred / Specialty Drugs | \$85/prescription deductible does not apply (retail) and \$213/prescription deductible does not apply (home delivery) | \$85/prescription deductible does not apply (retail) and \$213/prescription deductible does not apply (home delivery) | 30% coinsurance (retail) and 30% coinsurance (home delivery) | |
| | Tier 4 - Typically Specialty (brand and generic) | 20% coinsurance up to \$250 maximum /prescription (retail) and 20% coinsurance up to \$250 maximum /prescription (home delivery) | 20% coinsurance up to \$250 maximum /prescription (retail) and 20% coinsurance up to \$250 maximum /prescription (home delivery) | 30% coinsurance (retail) and 30% coinsurance (home delivery) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 20% coinsurance | 30% coinsurance | -----none----- |
| | Physician/surgeon fees | \$30/visit deductible does not apply | \$35/visit deductible does not apply | 30% coinsurance | -----none----- |
| If you need immediate | Emergency room care | \$300/visit deductible does not apply | \$300/visit deductible does not apply | Covered as In- Network | Copay waived if admitted. |

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| 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 | Emergency medical transportation | \$100/transport deductible does not apply | \$100/transport deductible does not apply | Covered as In- Network | -----none----- |
| | Urgent care | \$15 (PCP)/\$30 (specialist) per visit deductible does not apply | \$20 (PCP)/\$35 (specialist) per visit deductible does not apply | 30% coinsurance | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$300/admission deductible does not apply | \$600/admission deductible does not apply | 30% coinsurance | If you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived. |
| | Physician/surgeon fees | 0% coinsurance | 20% coinsurance | 30% coinsurance | -----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% coinsurance Other Outpatient 30% coinsurance | Office Visit -----none----- Other Outpatient -----none----- |
| | Inpatient services | \$300/admission deductible does not apply | \$300/admission deductible does not apply | 30% coinsurance | 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% coinsurance | 20% coinsurance | 30% coinsurance | 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% coinsurance | 20% coinsurance | 30% coinsurance | |
| | Childbirth/delivery facility services | \$300/admission deductible does not apply | \$600/admission deductible does not apply | 30% coinsurance | |
| If you need help recovering or have other | Home health care | 20% coinsurance | 20% coinsurance | 30% coinsurance | 100 visits/benefit period for In- Network Providers and Non- Network Providers combined. |

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| 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 | Rehabilitation services | \$30/visit deductible does not apply | \$35/visit deductible does not apply | 30% coinsurance | *See Therapy Services section |
| | Habilitation services | \$30/visit deductible does not apply | \$35/visit deductible does not apply | 30% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | 30% coinsurance | 150 days limit/admission for In-Network Providers and Non-Network Providers combined. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | 30% coinsurance | -----none----- |
| | Hospice services | 20% coinsurance | 20% coinsurance | 30% coinsurance | -----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"> • Acupuncture • Dental care (adult) • Hearing aids • Private-duty nursing | <ul style="list-style-type: none"> • Bariatric surgery • Dental Check-up • Infertility treatment • Routine foot care unless you have been diagnosed with diabetes. | <ul style="list-style-type: none"> • Cosmetic surgery • Glasses for a child • Long- term care • Weight loss programs |
|--|--|--|

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"> • Chiropractic care | <ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.bcbsglobalcore.com | <ul style="list-style-type: none"> • Routine eye care (adult) 1 exam/benefit period. |
|---|--|---|

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 Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit 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

* 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 plan's overall deductible | \$750 |
| ■ Specialist copayment | \$30 |
| ■ Hospital (facility) copayment | \$300 |
| ■ 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 | \$12,800 |
|--------------------|----------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$100 |
| The total Peg would pay is | \$400 |

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$750 |
| ■ Specialist copayment | \$30 |
| ■ Hospital (facility) copayment | \$300 |
| ■ 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 | \$7,400 |
|--------------------|---------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$6,000 |
| The total Joe would pay is | \$6,200 |

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$750 |
| ■ Specialist copayment | \$30 |
| ■ Hospital (facility) copayment | \$300 |
| ■ 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 | \$1,900 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$1,400 |
| Coinsurance | \$20 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,420 |

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

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 (833) 592-9956.

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 (833) 592-9956.

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 (833) 592-9956.

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 (833) 592-9956.

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 (833) 592-9956 ।

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 (833) 592-9956.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajujụ 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 (833) 592-9956.

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 (833) 592-9956.

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 (833) 592-9956.

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 (833) 592-9956

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、(833) 592-9956 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ (833) 592-9956 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 592-9956.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (833) 592-9956 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໄດ້ຮັບກັບວ່າມແບພາສາ, ໃຫ້ໂທຫາ (833) 592-9956.

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjī bee nił hodoonih t'áadoo báąh ilinígóó.
Ata' halne'ígíí la' bich'i' hadeesdzih nínízingo kojī' hodiilnih (833) 592-9956.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (833) 592-9956

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 592-9956 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833) 592-9956 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (833) 592-9956.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (833) 592-9956.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 592-9956 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

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