**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 | *If using a Non-Preferred Lab facility- charges will be higher |
| | 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) | ***Enhanced Preventive RX List covered at 100%, deductible does not apply.*** *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/<br><br>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 (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. |

* 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** | 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<br>No charge<br>Other Outpatient<br>No charge | Office Visit<br>No charge<br>Other Outpatient<br>No charge | Office Visit<br>30% coinsurance<br>Other Outpatient<br>30% coinsurance | Office Visit<br>--------none--------<br>Other Outpatient<br>--------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. |

* 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** | 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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Dental Check-up
- Glasses for a child
- Hearing aids
- Infertility treatment
- Long- term care
- Private-duty nursing
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

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

- Chiropractic care
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- 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 |
| *What isn't covered* | |
| 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 |
| *What isn't covered* | |
| 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 |
| *What isn't covered* | |
| 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:

**(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)**: ከዚህ ሰነድ ጋር በተያያዘ ጥያቄ ካለዎት፣ ያለምንም ክፍያ በቋንቋዎ መረጃ እና እገዛ የማግኘት መብት አለዎት። አስተርጓሚ ለመነጋገር (833) 592-9956 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 (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 (Bàsɔ̀ɔ̀ Wùdù):** Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bé m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùŭn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (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 အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (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。

**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 (833) 592-9956.

**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 (833) 592-9956.

**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 (833) 592-9956 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 (833) 592-9956.

## 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 (ગજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહહતી મેળવવાનો તમને અહિકાર છે. દુભાહષયા 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 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 (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:

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