




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, visit [sentarahealthplans.com](https://sentarahealthplans.com) or call 1-800-229-1199. 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 [healthcare.gov/sbc-glossary](https://healthcare.gov/sbc-glossary) or call 1-800-229-1199 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$3,200/Individual or \$6,400/family <a href="#">in-network</a> . \$6,000/Individual or \$12,000/family <a href="#">out-of-network</a>	Generally, you must pay all of the costs from providers 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , preventive vision, and prescription drugs considered by the plan to be for preventive care are covered before you meet your <a href="#">deductible</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 <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">in-network providers</a> \$5,000 individual / \$10,000 family. For <a href="#">out-of-network providers</a> , \$10,000 individual / \$20,000 family	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, healthcare this <a href="#">plan</a> doesn't cover, and cost-sharing amounts you pay for preventive vision services unless considered an Essential Health Benefit for children.	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. See <a href="https://sentarahealthplans.com">sentarahealthplans.com</a> or call 1-800-229-1199 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's 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 <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the specialist you choose without a <a href="#">referral</a> .
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 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	--none--
	<a href="#">Specialist</a> visit	20% coinsurance	40% coinsurance	--none--
	<a href="#">Preventive care/screening/immunization</a>	No charge Deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance	40% coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Pre-authorization required.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">sentarahealthplans.com</a>	Preferred Generic drugs (Tier 1)	20% coinsurance retail and mail order	20% coinsurance retail / not covered mail order	Deductible does not apply to prescription drugs considered by the plan to be for preventive care. Coverage is limited to FDA-approved prescription drugs. If brand drugs are used when a generic is available, you must pay the difference in cost plus the Copayment or Coinsurance amount. Covers up to a 30-day supply (retail); up to a 90-day supply (mail order). Not all drugs are available through a mail order program.
	Preferred brand and other generic drugs (Tier 2)	20% coinsurance retail and mail order	20% coinsurance retail / not covered mail order	
	Non-Preferred brand drugs (Tier 3)	20% coinsurance retail and mail order	20% coinsurance retail / not covered mail order	
	<a href="#">Specialty drugs</a> (Tier 4)	20% coinsurance retail/ mail order not covered	20% coinsurance retail / mail order not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Pre-authorization required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--none--
	<a href="#">Emergency room care</a>	20% coinsurance	20% coinsurance	--none--

\* For more information about limitations and exceptions, see the plan or policy document at [sentarahealthplans.com](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency medical transportation</a>	Non-emergency services: 20% coinsurance Emergency services: 20% coinsurance	Non-emergency services: 20% coinsurance Emergency services: 20% coinsurance	Pre-authorization required for non-emergency transport.
	<a href="#">Urgent care</a>	20% coinsurance	40% coinsurance	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-authorization required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--none--
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: 20% coinsurance Other visits: 20% coinsurance	40% coinsurance	Pre-authorization required for intensive outpatient program, partial hospitalization services, electroconvulsive therapy, and Transcranial Magnetic Stimulation.
	Inpatient services	20% coinsurance	40% coinsurance	Pre-authorization required for all inpatient services.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Pre-authorization required for prenatal services. Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% coinsurance	40% coinsurance	Pre-authorization required. 100 visits/plan year
	<a href="#">Rehabilitation services</a>	Rehabilitative PT/OT: 20% <a href="#">coinsurance</a> Rehabilitative Speech Therapy: 20% <a href="#">coinsurance</a> Other Services: 20% <a href="#">coinsurance</a>	Rehabilitative PT/OT: 40% <a href="#">coinsurance</a> Rehabilitative Speech Therapy: 40% <a href="#">coinsurance</a> Other Services: 40% <a href="#">coinsurance</a>	Pre-authorization required. 30 visits/plan year combined for PT and OT. 30 visits/plan year for ST.
	<a href="#">Habilitation services</a>	Not covered	Not covered	--none--
	<a href="#">Skilled nursing care</a>	20% coinsurance	40% coinsurance	Pre-authorization required. 100 days/plan year
	<a href="#">Durable medical equipment</a>	20% coinsurance	40% coinsurance	Pre-authorization required for single items over \$750, all rental items, and repair and replacement.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Hospice services</a>	20% coinsurance	40% coinsurance	Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply	\$30 reimbursement Deductible does not apply	Coverage limited to one exam/plan year from participating VSP Vision Care providers
	Children's glasses	Not covered	Not covered	--none--
	Children's dental check-up	Not covered	Not covered	--none--

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Glasses</li> </ul>	<ul style="list-style-type: none"> <li>Habilitation services</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Pediatric dental check-up</li> <li>Private-duty nursing</li> <li>Routine foot care unless medically necessary</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 <a href="#">plan</a> document.)			
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Chiropractic care</li> <li>Hearing aids (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids (Pediatric)</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S. (under out-of-network benefit)</li> <li>Routine eye care (Adult)</li> </ul>	

### Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the plan at 1-866-509-7567. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, at 1-877-310-6560 or [bureauofinsurance@scv.virginia.gov](mailto:bureauofinsurance@scv.virginia.gov); the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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: Member Services at the number on the back of your member ID card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or your state department of insurance at the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O. Box 1157, Richmond, VA, 23218, 1-877-310-6560 or [bureauofinsurance@scv.virginia.gov](mailto:bureauofinsurance@scv.virginia.gov).

\* For more information about limitations and exceptions, see the plan or policy document at [sentarahealthplans.com](http://sentarahealthplans.com).

Additionally, a consumer assistance program can help you file your appeal. Contact the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O. Box 1157, Richmond, VA, 23218, 1-877-310-6560, or [bureauofinsurance@scc.virginia.gov](mailto:bureauofinsurance@scc.virginia.gov).

**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](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-687-6260.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-687-6260.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-687-6260.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-687-6260.

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

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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](#) **\$3200**
- [Specialist](#) [coinsurance](#) **20%**
- [Hospital \(facility\)](#) [coinsurance](#) **20%**
- [Other](#) [coinsurance](#) **20%**

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,200
Copayments	\$0
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,000</b>

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

- The [plan's](#) overall [deductible](#) **\$3200**
- [Specialist](#) [coinsurance](#) **20%**
- [Hospital \(facility\)](#) [coinsurance](#) **20%**
- [Other](#) [coinsurance](#) **20%**

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,200
Copayments	\$0
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,600</b>

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

- The [plan's](#) overall [deductible](#) **\$3200**
- [Specialist](#) [coinsurance](#) **20%**
- [Hospital \(facility\)](#) [coinsurance](#) **20%**
- [Other](#) [coinsurance](#) **20%**

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-229-1199.