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, call 1-800-543-3359 or visit sentarahealthplans.com and sign into the Member Portal. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-543-3359 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	**$250**/Individual or **$500**/family In-Network	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. Prescription drugs, most services that require a copayment, preventive care, and a routine eye exam are covered before you meet your deductible.	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 healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$150** per person or **$300** per family for prescription drugs. There are no other deductibles.	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?	For In-Network **$5,000** person / **$10,000** family	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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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. See sentarahealthplans.com or call 1-800-543-3359.	This plan uses a provider network. You will pay less if you use a provider in the plan'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.	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
		In-Network (You will pay the least)	Out-of-Network (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	$30 copayment, deductible does not apply	Not covered	None.
	Specialist visit	$60 copayment, deductible does not apply	Not covered	None.
	Preventive care/ screening/ immunization	No charge, deductible does not apply	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	$60 copayment, deductible does not apply	Not covered	None.
	Imaging (CT/PET scans, MRIs)	$350 copayment	Not covered	Pre-authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at sentarahealthplans.com.	Preferred Generic Drugs (Tier 1)	$15 copayment, deductible does not apply retail $30 copayment, deductible does not apply mail order	$15 copayment, deductible does not apply retail Not covered mail order	Deductible applies except to tier 1 prescription drugs.Coverage is limited to FDA-approved prescription drugs. For specialty drugs, the out-of-pocket amount is limited to $200 copayment per retail prescription and $200 copayment per mail order prescription. If brand drugs are used when a generic is available, you must pay the difference in cost plus the copayment or coinsurance amount. One copayment or coinsurance amount covers up to a 31-day supply; two copayments or coinsurance amounts cover a 31- to 60-day supply; and three copayments or coinsurance amounts cover a 61- to 90-day supply (retail). Some outpatient prescription drugs in Tier 1, Tier 2, and
	Preferred Brand and Other Generic Drugs (Tier 2)	$40 copayment retail $80 copayment mail order	$40 copayment retail Not covered mail order	
	Non-Preferred Brand Drugs (Tier 3)	$50 copayment retail $100 copayment mail order	$50 copayment retail Not covered mail order	
	Specialty drugs (Tier 4)	20% coinsurance retail 20% coinsurance mail order	20% coinsurance retail Not covered mail order	

* For more information about limitations and exceptions, see the plan or policy document at https://apps.sentarahealthplans.com/public/ViewCorePlanSOB/CorePlanFilter/DownloadAzureFile?sobFile=%2Fpresales%2F2024%2FEOCCOI-For-SBC%2F2024_MMLGHMOEOC.pdf

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
				Tier 3 are available in a 90-day supply through mail order. Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy and are limited to a 31-day supply (retail and mail order).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copayment	Not covered	Pre-authorization required.
	Physician/surgeon fees	No charge	Not covered	None.
If you need immediate medical attention	Emergency room care	$350 copayment, deductible does not apply	$350 copayment, deductible does not apply	None.
	Emergency medical transportation	Non-emergency services: $350 copayment, deductible does not apply Emergency services: $350 copayment, deductible does not apply	Non-emergency services: Not covered Emergency services: $350 copayment, deductible does not apply	Pre-authorization required for non-emergent transport.
	Urgent care	$50 copayment, deductible does not apply	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Pre-authorization required.
	Physician/surgeon fees	20% coinsurance	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $30 copayment, deductible does not apply Other visits: $30 copayment, deductible does not apply EAV: No charge, deductible does not apply	Office visits: Not covered Other visits: Not covered EAV: Not covered	Pre-authorization required for partial hospitalization, intensive outpatient program, electro-convulsive therapy, and Transcranial Magnetic Stimulation. EAV: 5 visits/presenting issue by the Plan's EAV providers only.

* For more information about limitations and exceptions, see the plan or policy document at https://apps.sentarahealthplans.com/public/ViewCorePlanSOB/CorePlanFilter/DownloadAzureFile?sobFile=%2Fpresales%2F2024%2FEOCCOI-For-SBC%2F2024_MMLGHMOEOC.pdf

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
	Inpatient services	20% coinsurance, deductible does not apply	Not covered	Pre-authorization required for all inpatient services.
If you are pregnant	Office visits	$200 Global copayment, deductible does not apply	Not covered	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	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	$30 copayment, deductible does not apply	Not covered	Pre-authorization required. 100 visits/plan year.
	Rehabilitation services	Rehabilitative PT/OT: $30 copayment, deductible does not apply Rehabilitative Speech Therapy: $30 copayment, deductible does not apply Other Services: $30 copayment, deductible does not apply	Rehabilitative PT/OT: Not covered Rehabilitative Speech Therapy: Not covered Other Services: Not covered	Pre-authorization required. 30 combined visits/plan year for physical and occupational therapies. 30 visits/plan year each for speech therapy; and cardiac, pulmonary, vascular, and vestibular rehabilitation.
	Habilitation services	Habilitative PT/OT: $30 copayment, deductible does not apply Habilitative Speech Therapy: $30 copayment, deductible does not apply	Habilitative PT/OT: Not covered Habilitative Speech Therapy: Not covered	Pre-authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST.
	Skilled nursing care	No charge after inpatient copayment met	Not covered	Pre-authorization required. 100 days/plan year.
	Durable medical equipment	30% coinsurance, deductible does not apply	Not covered	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 (You will pay the least)	Out-of-Network (You will pay the most)	
	Hospice services	No charge, deductible does not apply	Not covered	Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	$30 Reimbursement	Coverage limited to one exam/plan year from participating VSP 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 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)
- Hearing aids (Pediatric)
- Dental Care (Pediatric)
- Glasses
- Hearing aids (Adult)
- Long-term care
- Infertility Treatment
- Chiropractic Care
- Non-emergency care when traveling outside the U.S.
- Routine foot care unless medically necessary
- Weight Loss Programs and Medications

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

- Routine eye care (Adult)
- Private-duty nursing

Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the plan at 1-800-543-3359. 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@scc.virginia.gov; the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform; or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 HealthCare.gov or call 1-800-318-2596. 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 the plan or policy document at https://apps.sentarahealthplans.com/public/ViewCorePlanSOB/CorePlanFilter/DownloadAzureFile?sobFile=%2Fpresales%2F2024%2FEOCCOI-For-SBC%2F2024_MMLGHMOEOC.pdf

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 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@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 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, kwiijigo holne' 1-855-687-6260.

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

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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	$250
Specialist copayment	$200
Hospital (facility) coinsurance	20%
Other copayment	$50

This EXAMPLE event includes services like:
Specialist 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	$250
Copayments	$1,100
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,950**

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

The plan's overall deductible	$250
PCP copayment	$60
Hospital (facility) coinsurance	20%
Other copayment	$50

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	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$800**

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

The plan's overall deductible	$250
Specialist copayment	$60
Hospital (facility) copayment	$350
Other copayment	$50

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$1,200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,650**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.