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/federal or call 1-800-206-1060. 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 or call 1-800-206-1060 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000/Self Only $4,000/Self Plus One or Self and 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. Preventive care is 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 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?	For in-network providers $6,000 Self Only/$12,000 Self Plus One or Self and 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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, IVF and infertility drugs, and healthcare 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/federal or call 1-800-206-1060 for a list of network providers.	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 for covered services 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not covered	--none--
	Specialist visit	20% coinsurance	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)	20% coinsurance	Not covered	--none--
	Imaging (CT/PET scans, MRIs)	20% coinsurance	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/federal	Generic drugs	$15 copayment retail/$30 copayment mail order	$15 copayment retail/$30 Copayment mail order	The medical deductible applies except 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); 30-to 90-day supply (mail order). Not all drugs are available through a mail order program.
	Preferred brand drugs	$50 copayment retail/$100 copayment mail order	$50 copayment retail/$100 copayment mail order	
	Non-preferred brand drugs	20% not to exceed $85 copayment retail/20% not to exceed $170 copayment mail order	20% not to exceed $85 copayment retail /20% not to exceed $170 copayment mail order	
	Specialty drugs	20% coinsurance retail	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Pre-authorization required
	Physician/surgeon fees	20% coinsurance	Not covered	--none--
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	--none--
	Emergency medical transportation	Non-emergency services: 20% coinsurance Emergency services: 20% coinsurance	Non-emergency services: Not covered Emergency services: 20% coinsurance	Pre-authorization required for non-emergency transport.
	Urgent care	20% coinsurance	Not covered	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Pre-authorization required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
	Physician/surgeon fees	20% coinsurance	Not covered	--none--
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not covered	Pre-authorization required for intensive outpatient program, partial hospitalization services, electroconvulsive therapy, and Transcranial Magnetic Stimulation
	Inpatient services	20% coinsurance	Not covered	Pre-authorization required for all inpatient services
If you are pregnant	Office visits	20% coinsurance	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	20% coinsurance	Not covered	Coverage limited to care ordered by a plan physician and provided by a R.N, L.P.N., L.V.N., or home health aide. Therapy applicable to applicable copayments and limits.
	Rehabilitation services	20% coinsurance	Not covered	Pre-authorization required.
	Habilitation services	20% coinsurance	Not covered	Pre-authorization required.
	Skilled nursing care	20% coinsurance	Not covered	Pre-authorization required. 100 days/plan year
	Durable medical equipment	20% coinsurance	Not covered	Pre-authorization required
	Hospice services	20% coinsurance	Not covered	Pre-authorization required
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply	Not covered	One exam/plan year from participating VSP Vision Care providers only
	Children's glasses	$200 allowance/glasses or contact lenses for ocular injury or intraocular surgery Not covered/all other	Not covered	One pair/plan year from participating VSP Vision Care providers only
	Children's dental check-up	Not covered	Not covered	--none--

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other excluded services.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental check-up

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

- Bariatric surgery
- Certain weight loss programs
- Hearing aids (Pediatric)
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care when under active treatment for metabolic disease

Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the plan at 1-800-229-1199. 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 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. 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.

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; 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.

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.

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

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

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** **$2,000**
- **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,170**

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

- **The plan's overall deductible** **$2,000**
- **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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$200
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,300**

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

- **The plan's overall deductible** **$2,000**
- **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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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