




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 1-800-229-1199 or visit [sentarahealthplans.com](https://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 1-800-229-1199 to request a copy.

Important Questions	Answers	Why This Matters
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p><b>\$3,300/Individual or \$6,600/family In-<a href="#">Network</a></b>  <b>\$3,300/Individual or \$6,600/family Out-of-<a href="#">Network</a></b></p>	<p>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>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Prescription drugs</a>, most services that require a <a href="#">copayment</a>, <a href="#">preventive care</a>, and a routine eye exam are covered before you meet your <a href="#">deductible</a>.</p>	<p>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 preventive services without cost sharing and before you meet your <a href="#">deductible</a>. See a list of covered preventive services at <a href="https://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific <a href="#">services</a>.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>For In-<a href="#">Network</a> <b>\$3,500</b> person / <b>\$7,000</b> family and out-of-<a href="#">network providers</a> <b>\$6,000</b> person / <b>\$12,000</b> family</p>	<p>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 limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Premiums</a>, balance-billed charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="https://sentarahealthplans.com">sentarahealthplans.com</a> or call 1-800-229-1199.</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider 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.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>

 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)	
<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	No charge	30% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	No charge	30% <a href="#">coinsurance</a>	None.
	<a href="#">Preventive care/ screening/ immunization</a>	No charge, <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	30% <a href="#">coinsurance</a>	None.
	Imaging (CT/PET scans, MRIs)	No charge	30% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> 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 Express Scripts, phone 1-877-476-9269 or <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Preferred Generic Drugs (Tier 1)	\$10 copayment retail/\$25 copayment mail order	\$10 copayment retail/\$25 copayment mail order	Coverage is limited to FDA approved prescription drugs. If brand drugs are chosen by you when a generic is available, you must pay the difference in cost plus the copayment or coinsurance amount. One copayment covers up to a 31-day supply (retail); 31-90 day supply (mail order).
	Preferred Brand and Other Generic Drugs (Tier 2)	\$30 copayment retail/\$75 copayment mail order	\$30 copayment retail/\$75 copayment mail order	
	Non-Preferred Brand Drugs (Tier 3)	\$50 copayment retail/ \$125 copayment mail order	\$50 copayment retail/ \$125 copayment mail order	
	<a href="#">Specialty drugs</a> (Tier 4)	\$100 copayment retail/ mail order	\$100 copayment retail/ mail order	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	30% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	Physician/surgeon fees	No charge	30% <a href="#">coinsurance</a>	None.
	<a href="#">Emergency room care</a>	No charge	No charge	None.

\* 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\\_MMLGPPCOI\\_HSA.pdf](https://apps.sentarahealthplans.com/public/ViewCorePlanSOB/CorePlanFilter/DownloadAzureFile?sobFile=%2Fpresales%2F2024%2FEOCCOI-For-SBC%2F2024_MMLGPPCOI_HSA.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)	
<b>If you need immediate medical attention</b>	<a href="#">Emergency medical transportation</a>	Non-emergency services: No charge Emergency services: No charge	Non-emergency services: 30% <a href="#">coinsurance</a> Emergency services: No charge	Pre-authorization required for non-emergent transport.
	<a href="#">Urgent care</a>	No charge	30% <a href="#">coinsurance</a>	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	30% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	Physician/surgeon fees	No charge	30% <a href="#">coinsurance</a>	None.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office visits: No charge Other visits: No charge	Office visits: 30% <a href="#">coinsurance</a> Other visits: 30% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required for partial hospitalization, intensive outpatient program, electro-convulsive therapy, and Transcranial Magnetic Stimulation.
	Inpatient services	No charge	30% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required for all inpatient services.
	Emergency Services (Ambulance and ER)	No charge	No charge	None.
<b>If you are pregnant</b>	Office visits	No charge	30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> 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	No charge	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge	30% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	30% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required. 100 visits/plan year.
	<a href="#">Rehabilitation services</a>	Rehabilitative PT/OT: No charge Rehabilitative Speech Therapy: No charge Other Services: No charge	Rehabilitative PT/OT: 30% <a href="#">coinsurance</a> Rehabilitative Speech Therapy: 30% <a href="#">coinsurance</a> Other Services: 30% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> 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.

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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)	
	<a href="#">Habilitation services</a>	Not covered	Not covered	None.
	<a href="#">Skilled nursing care</a>	No charge	30% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required. 90 days/plan year.
	<a href="#">Durable medical equipment</a>	No charge	30% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required for single items over \$750, all rental items, and repair and replacement.
	<a href="#">Hospice services</a>	No charge	30% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
If your child needs dental or eye care	Children's eye exam	No charge, <a href="#">deductible</a> does not apply	\$30 Reimbursement, <a href="#">deductible</a> does not apply	Coverage limited to one exam/ <a href="#">plan</a> year from participating VSP <a href="#">providers</a> .
	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>• Bariatric Surgery</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental Care (Pediatric)</li> <li>• Glasses</li> <li>• Infertility Treatment</li> <li>• Long-term care</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care unless medically necessary</li> <li>• Weight Loss Programs and Medications</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>• Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (Adult)</li> <li>• Non-emergency care when traveling outside the U.S. (under out-of-network benefit)</li> <li>• Hearing aids (Pediatric)</li> </ul>	<ul style="list-style-type: none"> <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 1-800-229-1199. 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](mailto:bureauofinsurance@scc.virginia.gov); the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [dol.gov/ebsa/healthreform](https://dol.gov/ebsa/healthreform); or the

\* 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\\_MMLGPPCOI\\_HSA.pdf](https://apps.sentarahealthplans.com/public/ViewCorePlanSOB/CorePlanFilter/DownloadAzureFile?sobFile=%2Fpresales%2F2024%2FEOCCOI-For-SBC%2F2024_MMLGPPCOI_HSA.pdf)

U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [ccio.cms.gov](https://www.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](https://www.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](https://www.healthcare.gov). For more information about the [Marketplace](https://www.healthcare.gov), visit [www.healthcare.gov](https://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 [dol.gov/ebsa/healthreform](https://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](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 [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.

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

\* 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\\_MMLGPPOCOI\\_HSA.pdf](https://apps.sentarahealthplans.com/public/ViewCorePlanSOB/CorePlanFilter/DownloadAzureFile?sobFile=%2Fpresales%2F2024%2FEOCCOI-For-SBC%2F2024_MMLGPPOCOI_HSA.pdf)

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,300
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
Deductibles	\$3,300
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,310</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,300
■ <a href="#">PCP coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
Deductibles	\$3,300
Copayments	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$3,400</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,300
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

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

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