The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you h share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, ca sentarahealthplans.com and sign into the Member Portal. For general definitions of common terms, such as allowed amount copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.heal 866-846-2682 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	**$200**/Individual or **$400**/family In-Network	Generally, you must pay all of the costs from p amount before this plan begins to pay. If you h the plan, each family member must meet their the total amount of deductible expenses paid overall family deductible.
Are there services covered before you meet your deductible?	Yes. Most preventive care services and screenings and a routine eye exam are covered before you meet your deductible.	This plan covers some items and services eve deductible amount. But a copayment or coinsu this plan covers certain preventive services wi you meet your deductible. See a list of covere healthcare.gov/coverage/preventive-care-ben
Are there other deductibles for specific services?	Yes. **$50** per person/**$150** per family for Dental Care (Adult). There are no other specific deductibles.	You must pay all of the costs for these service amount before this plan begins to pay for thes
What is the out-of-pocket limit for this plan?	For In-Network **$2,000** person / **$4,000** family	The out-of-pocket limit is the most you could p services. If you have other family members in own out-of-pocket limit until the overall family
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 do pocket limit.
Will you pay less if you use a network provider?	Yes. See sentarahealthplans.com or call 1-866-846-2682.	You pay the least if you use a provider in Tier provider in Tier 2. You will pay the most if you and you might receive a bill from a provider fo provider's charge and what your plan pays (ba network provider might use an out-of-network as lab work). Check with your provider before
Do you need a referral to see a specialist?	No.	You can see the specialist you choose withou

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			Lim
		In-Network Tier 1 (You will pay the least)	In-Network Tier 2 (You will pay less)	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	$10 copayment, deductible does not apply	$30 copayment, deductible does not apply	Not covered	Non
	Specialist visit	$20 copayment, deductible does not apply	$50 copayment, deductible does not apply	Not covered	Non
	Preventive care/ screening/ immunization	No charge, deductible does not apply		Not covered	You that prov prev plan
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance		Not covered	Non
	Imaging (CT/PET scans, MRIs)	20% coinsurance		Not covered	Pre-
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 retail $30 copayment mail order		Not covered retail Not covered mail order	Cove pres used mus the amo coins 30-d coins 60-d or co to 90 outp 1, Ti
	Preferred Brand and Other Generic Drugs (Tier 2)	$30 copayment retail $60 copayment mail order		Not covered retail Not covered mail order	
	Non-Preferred Brand Drugs (Tier 3)	$45 copayment retail $90 copayment mail order		Not covered retail Not covered mail order	
	Specialty drugs (Tier 4)	$55 copayment retail $55 copayment mail order		Not covered 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%2F2026%OI-For-SBC%2F2026_MMLGHMOEOC.pdf

Common Medical Event	Services You May Need	What You Will Pay			Lim
		In-Network Tier 1 (You will pay the least)	In-Network Tier 2 (You will pay less)	Out-of-Network (You will pay the most)	
					90-d Tier avail Phar supp
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copayment, deductible does not apply		Not covered	Pre-
	Physician/surgeon fees	No charge, deductible does not apply		Not covered	Non
If you need immediate medical attention	Emergency room care	$200 copayment, deductible does not apply		$200 copayment, deductible does not apply	Non
	Emergency medical transportation	Non-emergency services: 20% coinsurance Emergency services: $200 copayment, deductible does not apply		Non-emergency services: Not covered Emergency services: $200 copayment, deductible does not apply	Pre- eme
	Urgent care	$60 copayment, deductible does not apply		Not covered	Non
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment, deductible does not apply		Not covered	Pre-
	Physician/surgeon fees	No charge, deductible does not apply		Not covered	Non
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $10 copayment, deductible does not apply Other visits: $200 copayment, deductible does not apply EAP: No charge, deductible does not apply		Office visits: Not covered Other visits: Not covered EAP: Not covered	Pre- hosp prog and Stim

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Common Medical Event	Services You May Need	What You Will Pay			Lim
		In-Network Tier 1 (You will pay the least)	In-Network Tier 2 (You will pay less)	Out-of-Network (You will pay the most)	
					issue only.
	Inpatient services	$500 copayment, deductible does not apply		Not covered	Pre- inpa
If you are pregnant	Office visits	$150 Global copayment for all prenatal services, deductible does not apply		Not covered	Cost certa care desc ultra
	Childbirth/delivery professional services	No charge, deductible does not apply		Not covered	
	Childbirth/delivery facility services	$500 copayment, deductible does not apply		Not covered	
If you need help recovering or have other special health needs	Home health care	No charge, deductible does not apply		Not covered	Pre- visits
	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- com and visits thera vasc reha
	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- visits visits
	Skilled nursing care	No charge, deductible does not apply		Not covered	Pre- days
	Durable medical equipment	20% coinsurance		Not covered	Pre-
	Hospice services	No charge, deductible does not apply		Not covered	Pre-

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Common Medical Event	Services You May Need	What You Will Pay			Lim
		In-Network Tier 1 (You will pay the least)	In-Network Tier 2 (You will pay less)	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Routine Eye Exam: $15 copayment/exam, deductible does not apply Contact Lens Exam: up to $40 copayment/standard fit & follow up 10% discount/premium fit & follow up, deductible does not apply		Routine Eye Exam: $50 Reimbursement Contact Lens Exam: Not covered	Cove year prov
	Children's glasses	$20 copayment/single, bifocal, trifocal lenses $85 copayment/ progressive lenses, deductible does not apply $100 allowance/frames and contact lenses, deductible does not apply No charge for medically necessary contact lenses, deductible does not apply		Single Lenses: $50 reimbursement Bifocal, Trifocal, and Progressive Lenses: $75 reimbursement Contact Lenses: $80 reimbursement	Cove lens from
	Children's dental check-up	No charge/diagnostic and preventive, deductible does not apply 20% coinsurance/ restorative, oral surgery, endodontics, periodontics 50% coinsurance/ crowns, implants, orthodontic		Not covered	Cove clea topic bitew diag seal 16)/I

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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 c

- Acupuncture
- Cosmetic Surgery
- Long-term care
- Routine foot care unless medically necessary
- Non-emergency care
- Weight Loss Prograr

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

- Bariatric Surgery
- Chiropractic Care
- Dental Care (Adult)
- Dental Care (Pediatric)
- Glasses
- Hearing aids (Adult)
- Hearing aids (Pediatric)
- Infertility Treatme
- Private-duty nurs
- Routine eye care

Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the plan at 1-866-846-2682. There are agencies that can help if you after it ends. The contact information for those agencies is: Virginia State Corporation Commission, Life & Health Division, Bureau of In bureauofinsurance@scc.virginia.gov; the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCar Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Mar 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 cla grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rig contact: member services at the number on the back of your member ID card. You may also contact the Department of Labor's Employ Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform; or your state department of insurance at the Virginia State Co 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 p CHIP, TRICARE, and certain other coverage. If you are eligible for Minimum Essential Coverage, you may not be eligible for the premi

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

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.

* For more information about limitations and exceptions, see the plan or policy document at https://apps.sentarahealthplans.com/public/ViewCorePlanSOB/CorePlanFilter/DownloadAzureFile?sobFile=%2Fpresales%2F2026%OI-For-SBC%2F2026_MMLGHMOEOC.pdf

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 ca different depending on the actual care you receive, the prices your providers charge, and many other factors amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this inform costs you might pay under different health plans. Please note these coverage examples are based on self-c

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$200
Specialist copayment	$450
Hospital (facility) copayment	$500
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialistvisits (*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	$200
Copayments	$700
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,200**

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

The plan's overall deductible	$200
PCP copayment	$10
Hospital (facility) copayment	$500
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	$100
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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(in-network emerge

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Other coinsura	

This EXAMPLE ev
Emergency room c
Diagnostic tests *(x-*
Durable medical eq
Rehabilitation servi

Total Example Co	

In this example, M

Deductibles	
Copayments	
Coinsurance	
W	
Limits or exclusions	
The total Mia wou	

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

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