**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 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 or call 1-800-229-1199 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $1,500/Individual or $3,000/family in-network. $3,000/Individual or $6,000/family out-of-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, preventive vision, and most services that require a copayment 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 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 individual / $12,000 family. For out-of-network providers, $10,000 individual / $20,000 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 limits 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, healthcare this plan 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 out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See sentarahealthplans.com or call 1-800-229-1199 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 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 Provider (You will pay the least) | Out-of-Network Provider (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 | $25 copayment/visit<br>Deductible does not apply | 40% coinsurance | --none-- |
| | Specialist visit | $50 copayment/visit<br>Deductible does not apply | 40% coinsurance | --none-- |
| | Preventive care/screening/ immunization | No charge<br>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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | --none-- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | Pre-authorization required. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at sentarahealthplans.com | Preferred Generic drugs (Tier 1) | $15 copayment preferred network/$25 copayment retail /$15 copayment mail order | $15 copayment preferred network/$25 copayment retail /$15 copayment mail order | 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) | $40 copayment preferred network/$50 copayment retail /$80 copayment mail order | $40 copayment preferred network/$50 copayment retail /$80 copayment mail order | |
| | Non-Preferred brand drugs (Tier 3) | $75 copayment preferred network/$85 copayment retail /$225 copayment mail order | $75 copayment preferred network/$85 copayment retail /$225 copayment mail order | |
| | Specialty drugs (Tier 4) | 20% coinsurance retail $125 max/ mail order not covered | 20% coinsurance retail $125 max/ mail order not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | Pre-authorization required. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | --none-- |
| | Emergency room care | 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** | Emergency medical transportation | Non-emergency services: 20% coinsurance<br>Emergency services: 20% coinsurance | Non-emergency services: 20% coinsurance<br>Emergency services: 20% coinsurance | Pre-authorization required for non-emergency transport. |
| | Urgent care | $50 copayment/visit<br>Deductible does not apply | 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:<br>$25 copayment<br>Deductible does not apply<br>Other visits:<br>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** | Home health care | 20% coinsurance | 40% coinsurance | Pre-authorization required. 100 visits/plan year |
| | Rehabilitation services | Rehabilitative PT/OT: 20% coinsurance<br>Rehabilitative Speech Therapy: 20% coinsurance<br>Other Services: 20% coinsurance | Rehabilitative PT/OT: 40% coinsurance<br>Rehabilitative Speech Therapy: 40% coinsurance<br>Other Services: 40% coinsurance | Pre-authorization required. 30 visits/plan year combined for PT and OT. 30 visits/plan year for ST. |
| | Habilitation services | Not covered | Not covered | --none-- |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Pre-authorization required. 100 days/plan year |

* 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) | |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Pre-authorization required for single items over $750, all rental items, and repair and replacement. |
| | Hospice services | 20% coinsurance | 40% coinsurance | Pre-authorization required. |
| **If your child needs dental or eye care** | Children's eye exam | No charge<br>Deductible does not apply | $30 reimbursement<br>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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Glasses
- Habilitation services
- Long-term care
- Pediatric dental check-up
- Private-duty nursing
- Routine foot care unless medically necessary
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids (Adult)
- Hearing aids (Pediatric)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (under out-of-network benefit)
- Routine eye care (Adult)

## 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@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)

* For more information about limitations and exceptions, see the plan or policy document at sentarahealthplans.com.

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.*

* For more information about limitations and exceptions, see the plan or policy document at sentarahealthplans.com.

## 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** | **$1500** |
| **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 | $1,500 |
| Copayments | $70 |
| Coinsurance | $2,200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$3,770** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1500** |
| **Specialist** copayment | **$50** |
| **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 | $100 |
| Copayments | $1,000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,100** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1500** |
| **Specialist** copayment | **$50** |
| **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 | $800 |
| Copayments | $200 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,300** |

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.

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