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 1-866-846-2682 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 1-866-846-2682 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 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. **$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 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 **$2,000** person / **$4,000** 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 1-866-846-2682.	You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. 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 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	None.
	Specialist visit	$20 copayment, deductible does not apply	$50 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)	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.	Preferred Generic Drugs (Tier 1)	$15 copayment retail $30 copayment mail order		Not covered retail Not covered 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. One copayment or coinsurance amount covers up to a 30-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 Tier 3 are available in a
	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%2F2024%2FEOCCOI-For-SBC%2F2024_MMLGHMOEOC_DIR.pdf

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		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-day supply through mail order. Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy and are limited to a 30-day supply (retail and mail order).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copayment, deductible does not apply		Not covered	Pre-authorization required.
	Physician/surgeon fees	No charge, deductible does not apply		Not covered	None.
If you need immediate medical attention	Emergency room care	$200 copayment, deductible does not apply		$200 copayment, deductible does not apply	None.
	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-authorization required for non-emergent transport.
	Urgent care	$60 copayment, deductible does not apply		Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment, deductible does not apply		Not covered	Pre-authorization required.
	Physician/surgeon fees	No charge, deductible does not apply		Not covered	None.
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 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

* 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_DIR.pdf

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		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 by the Plan's EAV providers only.
	Inpatient services	$500 copayment, deductible does not apply		Not covered	Pre-authorization required for all inpatient services.
If you are pregnant	Office visits	$150 Global copayment for all prenatal services, deductible does not apply		Not covered	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	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-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, deductible does not apply		Not covered	Pre-authorization required. 90 days/plan year.
	Durable medical equipment	20% coinsurance		Not covered	Pre-authorization required for single items over $750, all rental items, and repair and replacement.

* 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_DIR.pdf

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		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)	
	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	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	Coverage limited to one exam/plan year from participating VSP providers.
	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	Coverage limited to one frame and lenses or contact lenses/plan year from participating VSP providers.
	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	Coverage limited to two exams, two cleanings, one emergency exam, one topical fluoride (up to age 16), two bitewing x-rays/plan year; one diagnostic x-ray/60 months; and one sealant per tooth (up to age 16)/lifetime.

* 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_DIR.pdf

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	• Long-term care	• Routine foot care unless medically necessary
• Cosmetic Surgery	• Non-emergency care when traveling outside the U.S.	• 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.)		
• Bariatric Surgery	• Dental Care (Pediatric)	• Infertility Treatment
• Chiropractic Care	• Glasses	• Private-duty nursing
• Dental Care (Adult)	• Hearing aids (Adult)	• Routine eye care (Adult)
	• Hearing aids (Pediatric)	

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 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. 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.

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.

* 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_DIR.pdf

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.——————————

* 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_DIR.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 plan's overall deductible	$200
Specialist copayment	$150
Hospital (facility) copayment	$500
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	$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**

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

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) copayment	$500
Other copayment	$25

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	$200
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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