




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 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>What is the overall deductible?</p>	<p>\$0/Individual or \$0/family In-Network</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Prescription drugs, most services that require a copayment, preventive care, and a routine eye exam are covered before you meet your deductible.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. \$150 person for Prescription drugs Tiers 2, 3</p>	<p>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.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For In-Network \$4,750 person / \$9,000 family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billed charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See sentarahealthplans.com or call 1-800-229-1199.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 copayment	Not covered	None.
	Specialist visit	\$50 copayment	Not covered	None.
	Preventive care/screening/immunization	No charge	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)	\$50 copayment	Not covered	None.
	Imaging (CT/PET scans, MRIs)	10% 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 Envision Rx	Selected Generic drugs (Tier 1)	\$15 retail Copayment/\$30 mail order Copayment Deductible does not apply	\$15 copayment retail/ mail order not covered Deductible does not apply	Prescription drugs are administered by Envision Rx and are not covered through Sentara Health Plans.
	Selected brand and other generic drugs (Tier 2)	\$40 retail Copayment/\$80 mail order Copayment	\$40 Copayment retail/ mail order not covered	
	Non-selected brand drugs (Tier 3)	\$75 retail Copayment/ \$150 mail order Copayment	\$75 Copayment retail/ mail order not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 copayment ,	Not covered	Pre-authorization required.
	Physician/surgeon fees	No charge	Not covered	None.
	Emergency room care	\$300 copayment	\$300 copayment	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_MMLGHMOEOC.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)	
If you need immediate medical attention	Emergency medical transportation	Non-emergency services: \$100 copayment Emergency services: \$300 copayment	Non-emergency services: Not covered Emergency services: \$300 copayment	Pre-authorization required for non-emergent transport.
	Urgent care	\$50 copayment	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 copayment	Not covered	Pre-authorization required.
	Physician/surgeon fees	No charge	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$35 copayment , deductible does not apply Other visits: \$35 copayment , deductible does not apply	Office visits: Not covered Other visits: Not covered	Pre-authorization required for partial hospitalization, intensive outpatient program, electro-convulsive therapy, and Transcranial Magnetic Stimulation.
	Inpatient services	\$350 copayment	Not covered	Pre-authorization required for all inpatient services.
If you are pregnant	Office visits	\$400 Global copayment	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	No charge	Not covered	
	Childbirth/delivery facility services	\$350 copayment	Not covered	
If you need help recovering or have other special health needs	Home health care	\$50 copayment	Not covered	Pre-authorization required. 100 visits/plan year.
	Rehabilitation services	Rehabilitative PT/OT: \$35 copayment Rehabilitative Speech Therapy: \$35 copayment Other Services: \$50 copayment	Rehabilitative PT/OT: Not covered Rehabilitative Speech Therapy: Not covered Other Services: Not covered	Pre-authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST.

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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)	
	Habilitation services	Habilitative PT/OT: \$35 copayment Habilitative Speech Therapy: \$35 copayment	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	20% coinsurance	Not covered	Pre-authorization required. 100 days/plan year. \$1,500 maximum copayment per Admission.
	Durable medical equipment	No charge	Not covered	Pre-authorization required for single items over \$750, all rental items, and repair and replacement.
	Hospice services	No charge	Not covered	Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	\$30 Reimbursement	Coverage limited to one exam/ plan year from participating VSP 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 .)		
<ul style="list-style-type: none"> Acupuncture Bariatric Surgery Cosmetic Surgery Dental Care (Adult) 	<ul style="list-style-type: none"> Dental Care (Pediatric) Glasses Long-term care 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Routine foot care unless medically necessary 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.)		
<ul style="list-style-type: none"> Chiropractic Care Hearing aids (Adult) 	<ul style="list-style-type: none"> Hearing aids (Pediatric) Infertility Treatment 	<ul style="list-style-type: none"> Private-duty nursing Routine eye care (Adult)

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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 dol.gov/ebsa/healthreform; or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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 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](#).

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.—————

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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 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	\$0
■ Specialist copayment	\$400
■ Hospital (facility) copayment	\$300
■ Other copayment	\$50

This EXAMPLE event includes services like:

[Specialist](#) 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,300
Coinsurance	\$30
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$1,330

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ PCP copayment	\$35
■ Hospital (facility) copayment	\$300
■ Other copayment	\$50

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,200

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$50
■ Hospital (facility) copayment	\$350
■ Other copayment	\$25

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$10
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,110