




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 1-800-275-3755 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 1-800-275-3755 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	This <a href="#">plan</a> covers items and services even if you haven't yet met the <a href="#">deductible</a> amount.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific <a href="#">services</a> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For In- <a href="#">Network</a> \$3,000 person / \$6,000 family	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , balance-billed charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://sentarahealthplans.com">sentarahealthplans.com</a> or call 1-800-275-3755.	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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copayment</a>	Not covered	None.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment</a>	Not covered	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	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)	\$50 <a href="#">copayment</a>	Not covered	None.
	Imaging (CT/PET scans, MRIs)	\$150 <a href="#">copayment</a>	Not covered	<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 <a href="https://sentarahealthplans.com">sentarahealthplans.com</a> .	Preferred Generic Drugs (Tier 1)	\$15 <a href="#">copayment, deductible</a> does not apply retail \$38 <a href="#">copayment, deductible</a> does not apply mail order	Not covered retail Not covered mail order	Coverage is limited to FDA-approved <a href="#">prescription drugs</a> . For specialty drugs, the out-of-pocket amount is limited to \$300 <a href="#">copayment</a> per retail prescription and \$300 <a href="#">copayment</a> per mail order prescription. If brand drugs are used when a generic is available, you must pay the difference in cost plus the <a href="#">copayment</a> or <a href="#">coinsurance</a> amount. One <a href="#">copayment</a> or <a href="#">coinsurance</a> amount covers up to a 30-day supply; two <a href="#">copayments</a> or <a href="#">coinsurance</a> amounts cover a 31- to 60-day supply; and three <a href="#">copayments</a> or <a href="#">coinsurance</a> 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 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).
	Preferred Brand and Other Generic Drugs (Tier 2)	\$40 <a href="#">copayment, deductible</a> does not apply retail \$100 <a href="#">copayment, deductible</a> does not apply mail order	Not covered retail Not covered mail order	
	Non-Preferred Brand Drugs (Tier 3)	\$75 <a href="#">copayment, deductible</a> does not apply retail \$225 <a href="#">copayment, deductible</a> does not apply mail order	Not covered retail Not covered mail order	
	<a href="#">Specialty drugs</a> (Tier 4)	20% <a href="#">coinsurance, deductible</a> does not apply retail 20% <a href="#">coinsurance, deductible</a> does not apply 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.pdf](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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 <a href="#">copayment</a>	Not covered	<a href="#">Pre-authorization</a> required.
	Physician/surgeon fees	No charge; <a href="#">deductible</a> does not apply	Not covered	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$350 <a href="#">copayment</a>	\$350 <a href="#">copayment</a>	None.
	<a href="#">Emergency medical transportation</a>	Non-emergency services: \$35 <a href="#">copayment</a> Emergency services: \$350 <a href="#">copayment</a>	Non-emergency services: Not covered Emergency services: \$350 <a href="#">copayment</a>	Pre-authorization required for non-emergent transport.
	<a href="#">Urgent care</a>	\$50 <a href="#">copayment</a>	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 <a href="#">copayment</a> /Day	Not covered	<a href="#">Pre-authorization</a> required. \$1,500 maximum <a href="#">copayment</a> per admission.
	Physician/surgeon fees	\$300 <a href="#">copayment</a> /Day, <a href="#">deductible</a> does not apply	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$35 <a href="#">copayment</a> Other visits: \$35 <a href="#">copayment</a> EAV: No charge	Office visits: Not covered Other visits: Not covered EAV: Not covered	<a href="#">Pre-authorization</a> required for partial hospitalization, intensive outpatient program, electro-convulsive therapy, and Transcranial Magnetic Stimulation. EAV: 3 visits/presenting issue by the Plan's EAV providers only.
	Inpatient services	\$300 <a href="#">copayment</a> /Day	Not covered	<a href="#">Pre-authorization</a> required for all inpatient services. \$1,500 maximum <a href="#">copayment</a> per admission.
If you are pregnant	Office visits	\$500 Global <a href="#">copayment</a>	Not covered	<a href="#">Pre-authorization</a> required for prenatal services. <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). \$1,500 maximum <a href="#">copayment</a> per admission for delivery.
	Childbirth/delivery professional services	\$300 <a href="#">copayment</a> /Day, <a href="#">deductible</a> does not apply	Not covered	
	Childbirth/delivery facility services	\$300 <a href="#">copayment</a> /Day	Not covered	
If you need help recovering or have	<a href="#">Home health care</a>	\$25 <a href="#">copayment</a>	Not covered	<a href="#">Pre-authorization</a> required. 100 visits/plan year.
	<a href="#">Rehabilitation</a>	Rehabilitative PT/OT: \$25	Rehabilitative PT/OT: Not	<a href="#">Pre-authorization</a> required. 30 combined visits/plan year

\* 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](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)	
<b>other special health needs</b>	<a href="#">services</a>	<a href="#">copayment</a> Rehabilitative Speech Therapy: \$25 <a href="#">copayment</a> Other Services: \$25 <a href="#">copayment</a>	covered Rehabilitative Speech Therapy: Not covered Other Services: Not covered	for physical and occupational therapies. 30 visits/plan year each for speech therapy; and cardiac, pulmonary, vascular, and vestibular rehabilitation.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None.
	<a href="#">Skilled nursing care</a>	\$300 <a href="#">copayment</a> /Day	Not covered	<a href="#">Pre-authorization</a> required. 90 days/plan year. \$1,500 maximum <a href="#">copayment</a> per Admission.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	Not covered	<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	Not covered	<a href="#">Pre-authorization</a> required.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge, <a href="#">deductible</a> does not apply	\$30 Reimbursement	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>• Bariatric Surgery</li> <li>• Chiropractic Care</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> <li>• Dental Care (Pediatric)</li> </ul>	<ul style="list-style-type: none"> <li>• Glasses</li> <li>• Habilitative services</li> <li>• Hearing aids (Adult)</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care unless medically necessary</li> <li>• Weight Loss Programs</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>• Hearing aids (Pediatric)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> </ul>

### Your Rights to Continue Coverage:

\* 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](https://apps.sentarahealthplans.com/public/ViewCorePlanSOB/CorePlanFilter/DownloadAzureFile?sobFile=%2Fpresales%2F2024%2FEOCCOI-For-SBC%2F2024_MMLGHMOEOC.pdf)

For more information on your rights to continue coverage, contact the plan at 1-800-275-3755. 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 [www.dol.gov/ebsa/healthreform](http://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](http://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](http://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](http://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](http://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](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.—————

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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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$500	■ <a href="#">Specialist copayment</a>	\$25	■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$300	■ Hospital (facility) <a href="#">copayment</a>	\$300	■ Hospital (facility) <a href="#">copayment</a>	\$350
■ Other <a href="#">copayment</a>	\$50	■ Other <a href="#">copayment</a>	\$50	■ Other <a href="#">copayment</a>	\$25
<b>This EXAMPLE event includes services like:</b> Specialist office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests ( <i>ultrasounds and blood work</i> ) Specialist visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> Primary care physician office visits ( <i>including disease education</i> ) Diagnostic tests ( <i>blood work</i> ) Prescription drugs Durable medical equipment ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> Emergency room care ( <i>including medical supplies</i> ) Diagnostic test ( <i>x-ray</i> ) Durable medical equipment ( <i>crutches</i> ) Rehabilitation services ( <i>physical therapy</i> )	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$2,200	Copayments	\$700	Copayments	\$1,800
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$70
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,200</b>	<b>The total Joe would pay is</b>	<b>\$700</b>	<b>The total Mia would pay is</b>	<b>\$1,870</b>