




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 1-866-514-5916 or visit [sentarahealthplans.com](http://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 1-866-514-5916 to request a copy.

Important Questions	Answers	Why This Matters
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p><b>\$700/Individual or \$1,400/family In-<a href="#">Network</a></b></p>	<p>Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. Most <a href="#">preventive care</a> services and <a href="#">screenings</a> are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example this <a href="#">plan</a> covers certain preventive services without cost sharing and before you meet your <a href="#">deductible</a>. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-carebenefits/">https://www.healthcare.gov/coverage/preventive-carebenefits/</a>.</p>
<p><b>Are there other <a href="#">deductible</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific <a href="#">services</a>.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>For In-<a href="#">Network</a> <b>\$3,000</b> person / <b>\$6,000</b> family</p>	<p>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>, the overall family <a href="#">out-of-pocket limit</a> must be met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Premiums</a>, balance-billed charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="http://www.sentarahealthplans.com">http://www.sentarahealthplans.com</a> or call 1-866-514-5916.</p>	<p>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.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copayment</a> /Visit, <a href="#">deductible</a> does not apply	Not covered	None.
	<a href="#">Specialist</a> visit	\$40 <a href="#">copayment</a> /Visit, <a href="#">deductible</a> does not apply	Not covered	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge, <a href="#">deductible</a> does not apply	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)	30% <a href="#">coinsurance</a>	Not covered	None.
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-authorization</a> required. See also other outpatient services copayment or coinsurance amounts under mental health/substance use benefits.
<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="#">optimahealth.com</a> .	Preferred Generic Drugs (Tier 1)	\$10 <a href="#">copayment</a> , <a href="#">deductible</a> does not apply retail \$30 <a href="#">copayment</a> , <a href="#">deductible</a> does not apply mail order	Not covered retail Not covered mail order	Medical <a href="#">deductible</a> applies to tier 3 and tier 4 prescription drugs. Coverage is limited to FDA-approved <a href="#">prescription drugs</a> . 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)	\$20 <a href="#">copayment</a> , <a href="#">deductible</a> does not apply retail \$60 <a href="#">copayment</a> , <a href="#">deductible</a> does not apply mail order	Not covered retail Not covered mail order	
	Non-Preferred Brand Drugs (Tier 3)	\$60 <a href="#">copayment</a> retail \$180 <a href="#">copayment</a> mail order	Not covered retail Not covered mail order	
	<a href="#">Specialty drugs</a> (Tier 4)	\$250 <a href="#">copayment</a> retail \$250 <a href="#">copayment</a> mail order	Not covered retail Not covered mail order	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-authorization</a> required.
	Physician/surgeon	30% <a href="#">coinsurance</a>	Not covered	None.

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

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)	
	fees			
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.
	<a href="#">Emergency medical transportation</a>	Non-emergency services: 30% <a href="#">coinsurance</a> Emergency services: 30% <a href="#">coinsurance</a>	Non-emergency services: Not covered Emergency services: 30% <a href="#">coinsurance</a>	Pre-authorization required for non-emergent transport.
	<a href="#">Urgent care</a>	\$30 <a href="#">copayment</a> /Visit, <a href="#">deductible</a> does not apply	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-authorization</a> required.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$20 <a href="#">copayment</a> /Visit, <a href="#">deductible</a> does not apply Other visits: 30% <a href="#">coinsurance</a>	Office visits: Not covered Other visits: Not covered	<a href="#">Pre-authorization</a> required for partial hospitalization, intensive outpatient program, electro-convulsive therapy, and Transcranial Magnetic Stimulation.
	Inpatient services	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-authorization</a> required for all inpatient services.
If you are pregnant	Office visits	30% <a href="#">coinsurance</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).
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-authorization</a> required. 100 visits/year.
	<a href="#">Rehabilitation services</a>	Rehabilitative PT/OT: \$20 <a href="#">copayment</a> /Visit, <a href="#">deductible</a> does not apply Rehabilitative Speech Therapy: \$20 <a href="#">copayment</a> /Visit, <a href="#">deductible</a>	Rehabilitative PT/OT: Not covered Rehabilitative Speech Therapy: Not covered Other Services: Not covered	<a href="#">Pre-authorization</a> 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)	
		does not apply Other Services: 30% <a href="#">coinsurance</a>		
	<a href="#">Habilitation services</a>	Habilitative PT/OT: \$20 <a href="#">copayment</a> /Visit, <a href="#">deductible</a> does not apply Habilitative Speech Therapy: \$20 <a href="#">copayment</a> /Visit, <a href="#">deductible</a> does not apply Other Services: 30% <a href="#">coinsurance</a>	Habilitative PT/OT: Not covered Habilitative Speech Therapy: Not covered Other Services: Not covered	<a href="#">Pre-authorization</a> required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-authorization</a> required. 100 days/stay.
	<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>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-authorization</a> required.
If your child needs dental or eye care	Children's eye exam	No charge, <a href="#">deductible</a> does not apply	Not covered	Coverage limited to one exam/ <a href="#">plan</a> year from participating VSP <a href="#">providers</a> .
	Children's glasses	No charge, <a href="#">deductible</a> does not apply	Not covered	Coverage limited to one pair/ <a href="#">plan</a> year from participating VSP <a href="#">providers</a> .
	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>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li><li>• Acupuncture</li><li>• Bariatric Surgery</li><li>• Cosmetic Surgery</li></ul>	<ul style="list-style-type: none"><li>• Dental Care (Adult)</li><li>• Dental Care (Pediatric)</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>• Routine eye care (Adult)</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>• Chiropractic Care</li><li>• Hearing aids</li></ul>	<ul style="list-style-type: none"><li>• Infertility Treatment</li><li>• Private-duty nursing</li></ul>	

### Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the plan at 1-866-514-5916. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is your state insurance department at Bureau of Insurance at 1-877-310-6560 or [bureauofinsurance@scc.virginia.gov](mailto:bureauofinsurance@scc.virginia.gov); or [www.HealthCare.gov](http://www.HealthCare.gov) at 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). 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](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.

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

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, kwijjigo holne' 1-855-687-6260.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

## 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](#) \$700
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$700
Copayments	\$40
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,000</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$700
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$700</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$700
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 30%
- Other [copayment](#) \$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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$700
Copayments	\$100
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>