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
What is the overall deductible?	/Individual or /family In-Network **$400**/Individual or **$800**/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. 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network **$2,300** person / **$4,600** family and out-of-network providers **$4,600** person / **$9,200** 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 1-800-229-1199.	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 (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	$30 copayment	30% coinsurance	None.
	Specialist visit	$45 copayment	30% coinsurance	None.
	Preventive care/ screening/ immunization	No charge	30% 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	30% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Pre-authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at optumrx.com	Tier 1	$10 copayment retail $20 copayment mail order	$10 copayment retail Not covered mail order	Your prescription drug benefit is administered by OptumRx. Please call 1-888-543-1369 or visit optumrx.com.
	Tier 2	$30 copayment retail $60 copayment mail order	$30 copayment retail Not covered mail order	
	Tier 3	$45 copayment retail $90 copayment mail order	$45 copayment retail Not covered mail order	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copayment and 20% coinsurance	30% coinsurance	Pre-authorization required.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None.
If you need immediate medical attention	Emergency room care	$100 copayment and 20% coinsurance	$100 copayment and 20% coinsurance,	None.
	Emergency medical transportation	Non-emergency services: 20% coinsurance Emergency services: $100	Non-emergency services: 20% coinsurance Emergency services: $100	Pre-authorization required for non-emergent transport.

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)	
		copayment and 20% coinsurance	copayment and 20% coinsurance	
	Urgent care	$45 copayment	30% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copayment and 20% coinsurance	30% coinsurance	Pre-authorization required. $800 maximum copayment per admission.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $30 copayment Other visits: 20% coinsurance	Office visits: 30% coinsurance Other visits: 30% coinsurance	Pre-authorization required for partial hospitalization, intensive outpatient program, electro-convulsive therapy, and Transcranial Magnetic Stimulation.
	Inpatient services	$300 copayment and 20% coinsurance	30% coinsurance	Pre-authorization required for all inpatient services. $800 maximum copayment per admission.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound). $800 maximum copayment per admission for delivery.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	$300 copayment and 20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Pre-authorization required. 90 visits/plan year.
	Rehabilitation services	Rehabilitative PT/OT: $30 copayment Rehabilitative Speech Therapy: $30 copayment Other Services: 20% coinsurance	Rehabilitative PT/OT: 30% coinsurance Rehabilitative Speech Therapy: 30% coinsurance Other Services: 30% coinsurance	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 Habilitative Speech Therapy: $30 copayment	Habilitative PT/OT: 30% coinsurance Habilitative Speech Therapy: 30% coinsurance	Pre-authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST.

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)	
	Skilled nursing care	No charge	30% coinsurance	Pre-authorization required. 100 days/plan year. $800 maximum copayment per Admission.
	Durable medical equipment	20% coinsurance	30% coinsurance	Pre-authorization required.
	Hospice services	No charge	30% coinsurance	Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None.
	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
- Dental Care (Adult)
- Cosmetic Surgery
- Dental Care (Pediatric)
- Glasses
- Long-term care
- 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.)

- Chiropractic Care
- Hearing aids (Pediatric)
- Hearing aids (Adult)
- Infertility Treatment
- Non-emergency care when traveling outside the U.S. (under out-of-network benefit)
- Private-duty nursing
- Routine eye care (Adult)
- Bariatric Surgery

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, 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.——————

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	
Specialist copayment	$350
Hospital (facility) copayment	$200
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialistvisits (*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	$0
Copayments	$1,400
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,470**

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

The plan's overall deductible	
PCP copayment	$10
Hospital (facility) copayment	$200
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	$0
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$600**

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

The plan's overall deductible	
Specialist copayment	$20
Hospital (facility) copayment	$350
Other copayment	$20

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,900
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,910**

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