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, please visit www.virginiapremier.com/individual-family. 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 833-672-8075 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$700/individual or $1,400/family	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. Preventive care and eye exam/glasses/contacts for children 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 https://www.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?	$2,600 individual / $5,200 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 out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization for services and healthcare services not covered by this plan.	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 www.virginiapremier.com/individual-family or call 1-833-672-8075 for a list of network providers.	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 may 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
		Network Provider (You will pay the least)	Out-of-Network Provider (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 Copay	Not Covered	The deductible does not apply.
	Specialist visit	15% Coinsurance	Not Covered	None
	Preventive care/screening/ immunization	0% Coinsurance	Not Covered	You may have to pay for services that aren't preventive. Ask you provider if the services you need are preventive, then check what your plan will pay for. The deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	15% Coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	15% Coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.virginiapremier.com/individual-family	Preferred generic drugs	$3 Copay – Retail $6 Copay – Mail Order	Not Covered	Retail = 30-day supply Mail Order = 90-day supply
	Non-preferred generic drugs	$12 Copay – Retail $24 Copay – Mail Order	Not Covered	
	Preferred brand drugs	$45 Copay – Retail $90 Copay – Mail Order	Not Covered	
	Non-preferred brand drugs	50% Coinsurance	Not Covered	
	Specialty drugs	50% Coinsurance	Not Covered	
	Zero Cost Share preventive drugs	0% Coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% Coinsurance	Not Covered	None
	Physician/surgeon fees	15% Coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	15% Coinsurance	15% Coinsurance	You pay the same level as in-network if it is an emergency as defined in your plan, otherwise Not Covered.
	Emergency medical transportation	15% Coinsurance	15% Coinsurance	You pay the same level as in-network if it is an emergency as defined in your plan, otherwise Not Covered.
	Urgent care	$35 Copay	Not Covered	None

[* For more information about limitations and exceptions, see the plan or policy document at www.virginiapremier.com/individual-family]

If you have a hospital stay	Facility fee (e.g., hospital room)	15% Coinsurance	Not Covered	None
	Physician/surgeon fees	15% Coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% Coinsurance	Not Covered	None
	Inpatient services	15% Coinsurance	Not Covered	None
If you are pregnant	Office visits	15% Coinsurance	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	15% Coinsurance	Not Covered	
	Childbirth/delivery facility services	15% Coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	15% Coinsurance	Not Covered	Limited to 100 visits per member per calendar year. The limit does not apply to home infusion therapy or home dialysis. Private duty nursing care provided in the home setting is limited to a maximum of 16 hours per member, per calendar year.
	Rehabilitation services	15% Coinsurance	Not Covered	Includes rehabilitative occupational therapy, physical therapy, speech therapy, and speech language pathology. The limits will not apply if you receive the care as part of the hospice benefit. Limited to 30 visits, per member, per calendar year.
	Habilitation services	15% Coinsurance	Not Covered	Includes habilitative occupational therapy, physical therapy, speech therapy, and speech language pathology. The limits will not apply if you receive the care as part of the hospice benefit. Limited to 30 visits, per member, per calendar year.
	Skilled nursing care	15% Coinsurance	Not Covered	Limited to a maximum of 100 days per stay.
	Durable medical equipment	15% Coinsurance	Not Covered	Wig after cancer treatment limited to 1 wig per member, per calendar year.
	Hospice services	15% Coinsurance	Not Covered	No therapy visit maximum applies to occupational, physical, or speech therapy services under this benefit.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Applies to children up to age 21. Coverage is limited to one exam per member per year. The deductible does not apply.

[* For more information about limitations and exceptions, see the plan or policy document at www.virginiapremier.com/individual-family]

	Children's glasses	No Charge	Not Covered	Applies to children up to age 21. Coverage is limited to one pair of glasses per member per year. The deductible does not apply.
	Children's dental check-up	Not Covered	Not Covered	Coverage is available through a stand-alone dental policy (SADP).

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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care (When travelling outside the U.S.)
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Chiropractic Care
- Private Duty Nursing – Benefits are limited to 16 hours per benefit period.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the Virginia Bureau of Insurance at 1-800-552-7945 or you may contact the issuer at 1-833-672-8075. 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 the Virginia Bureau of Insurance at 1-800-552-7945.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? N/A.
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 1-833-672-8075]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-672-8075]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-672-8075]

[* For more information about limitations and exceptions, see the plan or policy document at www.virginiapremier.com/individual-family]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-672-8075]

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

[* For more information about limitations and exceptions, see the plan or policy document at www.virginiapremier.com/individual-family]

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	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$700
Copayments	$30
Coinsurance	$1,770
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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 coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$700
Copayments	$760
Coinsurance	$750
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,270**

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

The plan's overall deductible	$700
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$0
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$880**

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

Notice of Non-Discrimination

Virginia Premier Health Plan, Inc. (Virginia Premier) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Virginia Premier does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Virginia Premier:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Member Services 1-833-672-8075, TTY: 711.

If you believe that Virginia Premier has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a complaint with:

Virginia Premier Individual Plans
Attn: Complaints & Appeals Manager
P.O. Box 5547
Richmond, VA 23220-0547
1-833-672-8075, TTY: 711
Fax: 1-877-240-4214
complaintsandappeals@vapremier.com

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, the Complaints & Appeals Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Insert
Multi-Language Interpreter Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-833-672-8075 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-672-8075 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-833-672-8075 (TTY: 711) 번으로 전화해주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Xin gọi số 1-833-672-8075 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-833-672-8075 (TTY: 711)。

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-833-672-8075 < (الهاتف النصي (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may mga magagamit kang libreng serbisyo ng tulong sa wika. Tumawag sa 1-833-672-8075 (TTY: 711).

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره 1-833-672-8075 (TTY: 711) تماس بگیرید.

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-833-672-8075 > (መስማት ለተሳናቸው: 711).

توجہ دیں: اگر آپ اردو بولتے ہیں تو، زبان سے متعلق اعانت کی خدمات، آپ کے لیے مفت دستیاب ہے۔ 1-833-672-8075 (TTY: 711) پر کال کریں۔

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-833-672-8075 (ATS: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-833-672-8075 (линия TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-833-672-8075 (TTY: 711) पर कॉल करें।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-833-672-8075 (TTY: 711).

মনোযোগ দিনঃ আপনি যদি বাংলাতে কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-877-739-1370 (TTY: 711)।

YI LE: I balè u pot tila hop won ngim bod i kobol mahop i la hola wè ni hop won, u saa béé to yom. Sébél 1-833-672-8075 (TTY: 711).

GENU NTI: Ọ buru na ina asu asusu Igbo, enyemaka na-ahazi asusu, bu n'efu, diri gi mgbe niile. Kpoo nomba ndi a 1-833-672-8075 (TTY: 711).

AKIYESI: Bi o ba nsọ èdè Yorùbá, ọfé ni iranlọwọ lori èdè wa fun yin. Ẹ pe ẹrọ-ibanisọrọ yi 1-833-672-8075 (TTY: 711).