Medical Insurance Options

Optima Health is changing its name to Sentara Health Plans! Sentara Health Plans provide national program coverage for all plans offered by NNPS. This coverage allows you to use medical services or see in-network specialists within the PHCS network anywhere in the country without a referral from a primary care physician (PCP). Sentara provides access to network benefits for dependent students away at school and retirees who leave the area after retirement.

All Sentara Health Plans offer the following preventative benefits

- Wellness exams are at no cost to participants
- No cost for Well Baby Care
- No cost for Well Women Care
- Provides one eye exam per year

	Sentara Health Plans Equity 3500/0%		Sentara Health Plans Vantage 35/50	Sentara Health Plans POS 1000/40/30%	
Benefits Coverage	In-Network Benefits	Out-of-Network Benefits	In-Network Only	In-Network Benefits	Out-of-Network Benefits
Annual Deductible					
Individual	$3,500	$3,500	$0	$1,000	$3,000
Family	$7,000	$7,000	$0	$2,000	$6,000
Coinsurance	0%	30%	10% (complex radiology)	30%	40%
Maximum Out-of-Pocket*					
Individual	$4,500	$6,500	$4,750	$4,750	$6,000
Family	$9,000	$13,000	$9,000	$9,000	$12,000
Physician Office Visit					
Primary Care	0% after deductible	30% after deductible	$35 copay	$40 copay	40% after deductible
Specialty Care	0% after deductible	30% after deductible	$50 copay	$60 copay	40% after deductible
Preventive Care					
Adult Periodic Exams	Covered at 100%	30% after deductible	Covered at 100%	Covered at 100%	40% after deductible
Well-Child Care	Covered at 100%	30% after deductible	Covered at 100%	Covered at 100%	40% after deductible
Diagnostic Services					
X-ray and Lab Tests	0% after deductible	30% after deductible	$50 copay	30% after deductible	40% after deductible
Complex Radiology	0% after deductible	30% after deductible	10% after deductible	30% after deductible	40% after deductible
Urgent Care Facility	0% after deductible	30% after deductible	$50 copay	$60 copay	40% after deductible
Emergency Room Facility Charges	0% after deductible	0% after deductible	$300 copay	30% after deductible	30% after deductible
Facility Charges					
Inpatient Facility Charges	0% after deductible	30% after deductible	$350 copay per day	30% after deductible	40% after deductible
Outpatient Facility and Surgical Charges	0% after deductible	30% after deductible	$500 copay	30% after deductible	40% after deductible

	Sentara Health Plans Equity 3500/0%		Sentara Health Plans Vantage 35/50	Sentara Health Plans POS 1000/40/30%	
Benefits Coverage	In-Network Benefits	Out-of-Network Benefits	In-Network Only	In-Network Benefits	Out-of-Network Benefits
Skilled Nursing	0% after deductible, limit 100 days	30% after deductible	20% coinsurance, limited to 100 days per year	30% after deductible, limited to 100 days per yr.	40% after deductible
Maternity Care					
Pre/Post Natal Care	0% after deductible	30% after deductible	$400 copay global	$500 copay global	40% after deductible
Inpatient Hospital Delivery Charges	0% after deductible	30% after deductible	$350 copay per day	30% after deductible	50% after deductible
Mental Health & Substance Abuse					
Inpatient	0% after deductible	30% after deductible	$350 copay per day	30% after deductible	50% after deductible
Outpatient	0% after deductible	30% after deductible	$35 copay	$40 copay	50% after deductible
Other Services					
Ambulance	0% after deductible	30% after deductible	$100 per transport	30% after deductible	40% after deductible
Vision Benefits (exam only) every 12 months through VSP	No charge	Reimbursed up to $30	No charge	No charge	Reimbursed up to $30
Durable Medical Equipment	30% after deductible	30% after deductible	No charge	30% after deductible	40% after deductible
Chiropractic	0% after deductible; 30 visits per year	30% after deductible; 30 visits per year	$35 copay	30% after deductible; 30 visits per year	40% after deductible; 30 visits per year
Retail Pharmacy (30 Day Supply) – Administered by Elixir now MedImpact					
Prescription Deductible	Suject to Annual Deductible, Certain Preventive Medications are paid at 100% by the plan before Annual Deductible		$150 per calendar year, Tier 2 & 3 only	$150 per calendar year, Tier 2 & 3 only	
Generic (Tier 1)	$10 copay	$10 copay	$15 copay	$15 copay	$15 copay
Preferred (Tier 2)	$30 copay	$30 copay	$40 copay	$40 copay	$40 copay
Non-Preferred (Tier 3)	$50 copay	$50 copay	$75 copay	$75 copay	$75 copay
Mail Order Pharmacy (90 Day Supply) – Administered by Elixir now MedImpact					
Generic (Tier 1)	$20 copay	Not covered	$30 copay	$30 copay	Not covered
Preferred (Tier 2)	$60 copay	Not covered	$80 copay	$80 copay	Not covered
Non-Preferred (Tier 3)	$100 copay	Not covered	$150 copay	$150 copay	Not covered

Sentara Health Plans

https://www.sentarahealthplans.com/

757-552-7110 or 1-800-229-1199

Sentara Health Administration, Inc.

Sentara POS 1000/30%

10301VA000400200

Newport News Public Schools

72821

Plan Effective Date: 01/01/2024

Large Group Schedule of Benefits

This document is not a contract or health plan policy from Sentara. If there are any differences between this benefit summary and the Plan coverage documents issued when You are enrolled, the provisions of the coverage documents will prevail for all benefits, conditions, cost sharing, and limitations and exclusions.

This document is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. There are two benefit columns. One column lists cost sharing amounts You will pay for In-Network benefits from Plan Providers. The other column lists cost sharing amounts You will pay for Out-of-Network benefits from Non-Plan Providers.You or Your means the Subscriber and each family member who is a Covered Person under the Plan.

Details about Covered Services are in the section “What is Covered." Details about services and treatments that are not Covered are in the section “What is Not Covered."

Some benefits require Pre-Authorization before You receive them. These services are marked with an * in this document.

Some Covered Services may have visit limits. Once a visit limit is reached, no additional services are Covered under the benefit. If a service is shown as covered under Out-of-Network benefits visit limits are combined with In-Network and Out-of-Network benefits unless otherwise stated.

Services or treatment You receive Out-of-Network or from Non-Plan Providers will be covered under the Plan’s Out-of-Network benefits unless:

1. The Covered Service is an Emergency Service;
2. During treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider; or
3. We have approved Your Covered Service in advance as an Authorized Out-of-Network Service.

If Your Plan has a Deductible that is the dollar amount that must be paid out-of-pocket by a Member for Covered Services each year before the Plan begins to pay for benefits. Your Plan may have separate Deductibles for In-Network and Out-of-Network benefits.

Copayments and Coinsurances listed in this document are amounts You pay directly to a Provider for a Covered Service. Copayments are shown as flat dollar amounts. Coinsurance is shown as a percentage of the Plan’s Allowable Charge for Your Covered Service. You will pay a Copayment or Coinsurance, but not both, for a Covered Service. For some benefits You may see the statement, “Cost sharing determined by the type and place of service.” For these services Your cost sharing will be based on where You receive a service, for example in a physician office or inpatient setting, and/or the type of service. You may also have to pay for balance billing amounts that are more than the Plan’s Allowable Charge for a Covered Service from Non-Plan Providers.

Your Plan’s Maximum Out-of-Pocket Amount means the total dollar amount Members pay out-of-pocket for most Covered Services during a year. Deductibles, Copayments and Coinsurance for most Covered Services count toward

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

the Maximum Amount. Your Plan may have separate Maximum Amounts for In-Network and Out-of-Network benefits.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	**Out-of-Network**
Deductible Plan Year	$1,000/Individual; $2,000/Family	$3,000/Individual; $6,000/Family

The In-Network and Out-of-Network Deductibles are separate. Most amounts You pay for In-Network Covered Services will count toward meeting the In-Network Deductible. Most amounts You pay for Out-of-Network Covered Services will count toward meeting the Out-of-Network Deductible.
The Deductible applies to all Covered Services except for:

- In-Network Preventive Care Services required by law;
- Other services in this document shown as Covered without a Deductible.

If You are the Subscriber, and the only Member covered under Your Plan, the Individual Deductible amount applies. If You have other Family Members on Your Plan the Family Deductible amount applies. The Plan has an embedded Individual Deductible within the Family Deductible. If one Family Member meets the Individual Deductible his or her benefits will begin. Once the total Family coverage Deductible is met benefits are available for all Family Members. No one Member can contribute more than their Individual Deductible amount to the Family Deductible. Copayment or Coinsurance amounts a Member pays for services shown as covered without a Deductible will not count toward meeting the Individual or Family Deductible.

	In-Network	**Out-of-Network**
Maximum Out-of-Pocket Plan Year	$4,750/Individual; $9,000/Family	$6,000/Individual; $12,000/Family

The In-Network and the Out-of-Network Maximum Out-of-Pocket Amounts are separate. Most amounts You pay, or that are paid on Your behalf, for In-Network Covered Services will count toward meeting the In-Network Maximum. Most amounts You pay, or that are paid on Your behalf, for Covered Services Out-of-Network will count toward meeting the Out-of-Network Maximum.
The following will not count toward the Plan Maximum Amount(s):

- Amounts You pay for services not covered under Your Plan;
- Amounts You pay for any services after a benefit limit has been reached;
- Balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers;
- Premium amounts;
- Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits;
- Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available;
- Other services in this document that are shown as excluded from the Maximum Amount.

If You are the Subscriber, and the only Member Covered under Your Plan, the Individual Maximum applies. If You have other Family Members on Your Plan the Family Maximum applies. Under Family coverage the Individual Maximum applies separately to each covered Family Member. Once the total Family coverage Maximum is met the Family Maximum Amount is satisfied. No one Member can contribute more than their Individual Maximum Amount to the Family limit.

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by Optima Health approved providers. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits. ***Pre-Authorization is required for in-office surgery.**		
Primary Care Visit	You Pay $40	After Deductible You Pay 40%
Virtual Consult	No Charge	Not Covered
Specialist Visit	You Pay $60	After Deductible You Pay 40%
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of $250 per dose. This does not include routine immunizations covered under Preventive Care.	After Deductible You Pay 30%	After Deductible You Pay 40%
Preventive Care Recommended Preventive Care Services are Covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.		
Recommended exams, screenings, tests, immunizations, and other services	No Charge	After Deductible You Pay 40%
Outpatient Therapies and Services You Pay a Copayment or Coinsurance amount for each visit for services done in a Physician's office, a free-standing outpatient Facility, a Hospital outpatient Facility, or at home as part of Your Skilled Home Health Care Services benefit. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of a treatment plan for Autism Spectrum Disorder. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Occupational and Physical Therapy* Services limited to 30 combined visits per Plan year.	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	After Deductible You Pay 40%
Speech Therapy* Services limited to 30 visits per Plan year.	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Cardiac Rehabilitation*	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	After Deductible You Pay 40%
Pulmonary Rehabilitation*	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	After Deductible You Pay 40%
Vascular Rehabilitation*	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	After Deductible You Pay 40%
Vestibular Rehabilitation*	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	After Deductible You Pay 40%
IV Infusion Therapy	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	After Deductible You Pay 40%
Respiratory/Inhalation Therapy	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	After Deductible You Pay 40%
Chemotherapy and Chemotherapy Drugs*	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Radiation Therapy*	**PCP Office Visit** After Deductible You Pay 30% **Specialist Office Visit** After Deductible You Pay 30% **Outpatient Facility** After Deductible You Pay 30%	After Deductible You Pay 40%
Pre-Authorized Injectable and Infused Medications* Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient Facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs.	After Deductible You Pay 30%	After Deductible You Pay 40%
Outpatient Dialysis You Pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.		
Dialysis Services	After Deductible You Pay 30%	After Deductible You Pay 40%
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free-standing ambulatory surgery center or Hospital outpatient surgical facility.		
Surgery Services*	After Deductible You Pay 30%	After Deductible You Pay 40%
Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient Facility or lab or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Diagnostic Procedures	After Deductible You Pay 30%	After Deductible You Pay 40%
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You Pay 30%	After Deductible You Pay 40%
Lab Work	After Deductible You Pay 30%	After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a freestanding outpatient Facility or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Magnetic Resonance Imaging (MRI)* **Magnetic Resonance Angiography (MRA)*** **Positron Emission Tomography (PET)*** **Computerized Axial Tomography (CT)*** **Computerized Axial Tomography Angiogram (CTA)*** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Sleep Studies***	After Deductible You Pay 30%	After Deductible You Pay 40%
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are covered under preventive benefits.		
Maternity Care ***Pre-Authorization is required for prenatal services**	You Pay $500 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	After Deductible You Pay 40%
Inpatient Services		
Inpatient Hospital Services*	After Deductible You Pay 30%	After Deductible You Pay 40%
Transplants*	After Deductible You Pay 30%	After Deductible You Pay 40%
Skilled Nursing Facility Services* Limited to a maximum of 100 days per Plan year.	After Deductible You Pay 30%	After Deductible You Pay 40%
Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Air, Water, Ground Services*	After Deductible You Pay 30%	After Deductible You Pay 40%
Air Ambulance Services Non-Emergent Transportation*	After Deductible You Pay 30%	After Deductible You Pay 30%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Emergency Services Includes medical and mental health and substance use disorder Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other facility charges, such as diagnostic x-ray and lab services and medical supplies provided in an Emergency Department, including and independent freestanding Emergency Department, In-Network or Out-of-Network.		
Emergency Services	After Deductible You Pay 30%	After Deductible You Pay 30%
Emergency Ambulance	After Deductible You Pay 30%	After Deductible You Pay 30%
Urgent Care Services Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care Facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Urgent Care Services	You Pay $60	After Deductible You Pay 40%
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Virtual Consults must be furnished by approved Optima Health providers. ***Pre-Authorization is required for Inpatient Hospital Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.**		
Inpatient Hospital Services*	After Deductible You Pay 30%	After Deductible You Pay 40%
Residential Treatment Services*	After Deductible You Pay 30%	After Deductible You Pay 40%
Outpatient Office Visits (PCP or Specialist)	You Pay $40	After Deductible You Pay 40%
Virtual Consults	No Charge	Not Covered
Partial Hospitalization/Intensive Outpatient Program Facility Services*	After Deductible You Pay 30%	After Deductible You Pay 40%
Other Outpatient Services	After Deductible You Pay 30%	After Deductible You Pay 40%
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is Covered from an In-Network Plan Provider or a participating VSP Vision Care provider at the office visit Copayment or Coinsurance amount.		
Insulin Pumps*	After Deductible You Pay 30%	After Deductible You Pay 40%
Pump Infusion Sets and Supplies*	After Deductible You Pay 30%	After Deductible You Pay 40%
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution, and continuous glucose monitors, sensors and supplies. ***Pre-Authorization is required for talking blood glucose monitors**	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Insulin, and Needles and Syringes for Injection	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit
Outpatient Self-Management Training, Education, Nutritional Therapy	After Deductible You Pay 30%	After Deductible You Pay 40%
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	After Deductible You Pay 30%	After Deductible You Pay 40%
Durable Medical Equipment (DME) and Supplies		
DME, Orthopedic Devices, Prosthetic Appliances, Devices ***Pre-Authorization is required for items over $750** ***Pre-Authorization is required for repair, replacement and rental items.**	After Deductible You Pay 30%	After Deductible You Pay 40%
Early Intervention Services For Dependent children from birth to age three.		
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices.*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Home Health Care Includes skilled home health care services for home bound Members. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home.		
Home Health Care*	After Deductible You Pay 30%	After Deductible You Pay 40%
Hospice Care		
Hospice Care*	After Deductible You Pay 30%	After Deductible You Pay 40%
Vision Care Optima Health contracts with VSP Vision Care to administer this benefit. Services must be received from VSP Vision Care providers.		
Vision Exams Limited to one routine eye exam every 12 months from a VSP provider.	No Charge Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost.	Members will be reimbursed up to $30 for one routine eye exam only

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.		
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Infertility Services Includes limited services, for Members only, to diagnose and treat underlying medical conditions resulting in Infertility.		
Endometrial biopsies Limited to 2 per lifetime **Semen analysis** Limited to 2 per lifetime **Hysterosalpingography** Limited to 2 per lifetime **Sims-Huhner test (smear)** Limited to 4 per lifetime **Diagnostic laparoscopy** Limited to 1 per lifetime	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Clinical Trials Includes "routine patient costs" for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.		
Clinical Trial Services*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Allergy Care		
Allergy Care, Testing, and Serum	No Charge	Cost sharing determined by the type and place of service.
Hearing Aid Services for Children Age 18 and Younger Includes hearing aids and related services (earmolds, initial batteries, other necessary equipment, maintenance, and adaption training.) Benefits for hearing aids and related services are limited to a combined benefit for In-Network benefits and Out-of-Network benefits of $1500 per hearing impaired ear every 24 months.		
Hearing Aids and Related Services*	After Deductible You Pay 30%	After Deductible You Pay 40%
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.		
Telemedicine Services	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Chiropractic Care Rider Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit.		
Chiropractic Care Rider Maximum number of visits 30 per Calendar year. This benefit also includes coverage of Chiropractic appliances up to a maximum benefit of 1 appliance per Person per Calendar year when medically necessary.	After Deductible You Pay 30%	After Deductible You Pay 40%
Hearing Aid Rider		
Hearing Aid Services* Covered Services include the following up to the annual maximum benefit of $1,200 per ear: • the hearing aid(s); • audiometric specialist office visits for fitting, including molds and dispensing; • repair, replacement or refurbishment of the hearing aid(s) Replacement is covered only every 48 months from date of acquisition. Batteries and supplies are not covered.	After Deductible You Pay 30%	After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Notice/Notes/Terms & Conditions:

Dependent Children enrolled in the Plan are Covered until the end of month they turn 26.

This Plan does not have pre-existing condition exclusions.

This Plan does not have annual or lifetime dollar limits on Essential Health Benefits.

This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

Need help in another language? Call us.

需要以其他语言获得帮助？ 联系我们。

다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

Quý vị cần được giúp đỡ bằng một ngôn ngữ khác? Hãy gọi cho chúng tôi.

Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

1-855-687-6260

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Sentara Health Administration, Inc.

Sentara POS Equity 3500/0%

10311VA000400200

Newport News Public Schools

72822

Plan Effective Date: 01/01/2024

Large Group Schedule of Benefits

This document is not a contract or health plan policy from Sentara. If there are any differences between this benefit summary and the Plan coverage documents issued when You are enrolled, the provisions of the coverage documents will prevail for all benefits, conditions, cost sharing, and limitations and exclusions.

This document is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. There are two benefit columns. One column lists cost sharing amounts You will pay for In-Network benefits from Plan Providers. The other column lists cost sharing amounts You will pay for Out-of-Network benefits from Non-Plan Providers.You or Your means the Subscriber and each family member who is a Covered Person under the Plan.

Details about Covered Services are in the section “What is Covered." Details about services and treatments that are not Covered are in the section “What is Not Covered."

Some benefits require Pre-Authorization before You receive them. These services are marked with an * in this document.

Some Covered Services may have visit limits. Once a visit limit is reached, no additional services are Covered under the benefit. If a service is shown as covered under Out-of-Network benefits visit limits are combined with In-Network and Out-of-Network benefits unless otherwise stated.

Services or treatment You receive Out-of-Network or from Non-Plan Providers will be covered under the Plan’s Out-of-Network benefits unless:

1. The Covered Service is an Emergency Service;
2. During treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider; or
3. We have approved Your Covered Service in advance as an Authorized Out-of-Network Service.

If Your Plan has a Deductible that is the dollar amount that must be paid out-of-pocket by a Member for Covered Services each year before the Plan begins to pay for benefits. Your Plan may have separate Deductibles for In-Network and Out-of-Network benefits.

Copayments and Coinsurances listed in this document are amounts You pay directly to a Provider for a Covered Service. Copayments are shown as flat dollar amounts. Coinsurance is shown as a percentage of the Plan’s Allowable Charge for Your Covered Service. You will pay a Copayment or Coinsurance, but not both, for a Covered Service. For some benefits You may see the statement, “Cost sharing determined by the type and place of service.” For these services Your cost sharing will be based on where You receive a service, for example in a physician office or inpatient setting, and/or the type of service. You may also have to pay for balance billing amounts that are more than the Plan’s Allowable Charge for a Covered Service from Non-Plan Providers.

Your Plan’s Maximum Out-of-Pocket Amount means the total dollar amount Members pay out-of-pocket for most Covered Services during a year. Deductibles, Copayments and Coinsurance for most Covered Services count toward

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

the Maximum Amount. Your Plan may have separate Maximum Amounts for In-Network and Out-of-Network benefits.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	**Out-of-Network**
Deductible Plan Year	$3,500/Individual; $7,000/Family	$3,500/Individual; $7,000/Family

The In-Network and Out-of-Network Deductibles are separate. Most amounts You pay for In-Network Covered Services will count toward meeting the In-Network Deductible. Most amounts You pay for Out-of-Network Covered Services will count toward meeting the Out-of-Network Deductible.
The Deductible applies to all Covered Services except for:

- In-Network Preventive Care Services required by law;
- Other services in this document shown as Covered without a Deductible.

If You are the Subscriber, and the only Member covered under Your Plan, the Individual Deductible amount applies. If You have other Family Members on Your Plan the Family Deductible amount applies. Once the total Family coverage Deductible is met benefits are available for all Family Members. Copayment or Coinsurance amounts a Member pays for services shown as covered without a Deductible will not count toward meeting the Individual or Family Deductible.

	In-Network	**Out-of-Network**
Maximum Out-of-Pocket Plan Year	$4,500/Individual; $9,000/Family	$6,500/Individual; $13,000/Family

The In-Network and the Out-of-Network Maximum Out-of-Pocket Amounts are separate. Most amounts You pay for In-Network Covered Services will count toward meeting the In-Network Maximum. Most amounts You pay for Covered Services Out-of-Network will count toward meeting the Out-of-Network Maximum.
The following will not count toward the Plan Maximum Amount(s):

- Amounts You pay for services not covered under Your Plan;
- Amounts You pay for any services after a benefit limit has been reached;
- Balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers;
- Premium amounts;
- Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits;
- Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available;
- Other services in this document that are shown as excluded from the Maximum Amount.

If You are the Subscriber, and the only Member Covered under Your Plan, the Individual Maximum applies. If You have other Family Members on Your Plan the Family Maximum applies. Once the total Family coverage Maximum is met the Family Maximum Amount is satisfied.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by Plan approved providers. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits. ***Pre-Authorization is required for in-office surgery.**		
Primary Care Visit	After Deductible No Charge	After Deductible You Pay 30%
Virtual Consult	After Deductible No Charge	Not Covered
Specialist Visit	After Deductible No Charge	After Deductible You Pay 30%
Vaccines and Immunotherapeutic Agents This does not include routine immunizations covered under Preventive Care.	After Deductible No Charge	After Deductible You Pay 30%
Preventive Care Recommended Preventive Care Services are Covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.		
Recommended exams, screenings, tests, immunizations, and other services	No Charge	After Deductible You Pay 30%
Outpatient Therapies and Services You Pay a Copayment or Coinsurance amount for each visit for services done in a Physician's office, a free-standing outpatient Facility, a Hospital outpatient Facility, or at home as part of Your Skilled Home Health Care Services benefit. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of a treatment plan for Autism Spectrum Disorder. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Occupational and Physical Therapy* Services limited to 30 combined visits per Plan year.	**PCP Office Visit** After Deductible No Charge **Specialist Office Visit** After Deductible No Charge **Outpatient Facility** After Deductible No Charge	After Deductible You Pay 30%
Speech Therapy* Services limited to 30 visits per Plan year.	**PCP Office Visit** After Deductible No Charge **Specialist Office Visit** After Deductible No Charge **Outpatient Facility** After Deductible No Charge	After Deductible You Pay 30%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Cardiac Rehabilitation*	**PCP Office Visit** After Deductible No Charge **Specialist Office Visit** After Deductible No Charge **Outpatient Facility** After Deductible No Charge	After Deductible You Pay 30%
Pulmonary Rehabilitation*	**PCP Office Visit** After Deductible No Charge **Specialist Office Visit** After Deductible No Charge **Outpatient Facility** After Deductible No Charge	After Deductible You Pay 30%
Vascular Rehabilitation*	**PCP Office Visit** After Deductible No Charge **Specialist Office Visit** After Deductible No Charge **Outpatient Facility** After Deductible No Charge	After Deductible You Pay 30%
Vestibular Rehabilitation*	**PCP Office Visit** After Deductible No Charge **Specialist Office Visit** After Deductible No Charge **Outpatient Facility** After Deductible No Charge	After Deductible You Pay 30%
IV Infusion Therapy	**PCP Office Visit** After Deductible No Charge **Specialist Office Visit** After Deductible No Charge **Outpatient Facility** After Deductible No Charge	After Deductible You Pay 30%
Respiratory/Inhalation Therapy	**PCP Office Visit** After Deductible No Charge **Specialist Office Visit** After Deductible No Charge **Outpatient Facility** After Deductible No Charge	After Deductible You Pay 30%
Chemotherapy and Chemotherapy Drugs*	**PCP Office Visit** After Deductible No Charge **Specialist Office Visit** After Deductible No Charge **Outpatient Facility** After Deductible No Charge	After Deductible You Pay 30%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Radiation Therapy*	**PCP Office Visit** After Deductible No Charge **Specialist Office Visit** After Deductible No Charge **Outpatient Facility** After Deductible No Charge	After Deductible You Pay 30%
Pre-Authorized Injectable and Infused Medications* Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient Facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs.	After Deductible No Charge	After Deductible You Pay 30%
Outpatient Dialysis You Pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.		
Dialysis Services	After Deductible No Charge	After Deductible You Pay 30%
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free-standing ambulatory surgery center or Hospital outpatient surgical facility.		
Surgery Services*	After Deductible No Charge	After Deductible You Pay 30%
Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient Facility or lab or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Diagnostic Procedures	After Deductible No Charge	After Deductible You Pay 30%
X-Ray **Ultrasound** **Doppler Studies**	After Deductible No Charge	After Deductible You Pay 30%
Lab Work	After Deductible No Charge	After Deductible You Pay 30%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a freestanding outpatient Facility or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Magnetic Resonance Imaging (MRI)* **Magnetic Resonance Angiography (MRA)*** **Positron Emission Tomography (PET)*** **Computerized Axial Tomography (CT)*** **Computerized Axial Tomography Angiogram (CTA)*** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Sleep Studies***	After Deductible No Charge	After Deductible You Pay 30%
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are covered under preventive benefits.		
Maternity Care ***Pre-Authorization is required for prenatal services**	After Deductible You Pay No Charge for delivering Obstetrician prenatal, delivery, and postpartum services	After Deductible You Pay 30%
Inpatient Services		
Inpatient Hospital Services*	After Deductible No Charge	After Deductible You Pay 30%
Transplants*	After Deductible No Charge	After Deductible You Pay 30%
Skilled Nursing Facility Services* Limited to a maximum of 100 days per Plan year.	After Deductible No Charge	After Deductible You Pay 30%
Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Air, Water, Ground Services*	After Deductible No Charge	After Deductible You Pay 30%
Air Ambulance Services Non-Emergent Transportation*	After Deductible No Charge	After Deductible No Charge

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Emergency Services Includes medical and mental health and substance use disorder Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other facility charges, such as diagnostic x-ray and lab services and medical supplies provided in an Emergency Department, including and independent freestanding Emergency Department, In-Network or Out-of-Network.		
Emergency Services	After Deductible No Charge	After Deductible No Charge
Emergency Ambulance	After Deductible No Charge	After Deductible No Charge
Urgent Care Services Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care Facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Urgent Care Services	After Deductible No Charge	After Deductible You Pay 30%
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Virtual Consults must be furnished by approved Plan providers. ***Pre-Authorization is required for Inpatient Hospital Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.**		
Inpatient Hospital Services*	After Deductible No Charge	After Deductible You Pay 30%
Residential Treatment Services*	After Deductible No Charge	After Deductible You Pay 30%
Outpatient Office Visits (PCP or Specialist)	After Deductible No Charge	After Deductible You Pay 30%
Virtual Consults	After Deductible No Charge	Not Covered
Partial Hospitalization/Intensive Outpatient Program Facility Services*	After Deductible No Charge	After Deductible You Pay 30%
Other Outpatient Services	After Deductible No Charge	After Deductible You Pay 30%
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is Covered from an In-Network Plan Provider or a participating VSP Vision Care provider at the office visit Copayment or Coinsurance amount.		
Insulin Pumps*	After Deductible No Charge	After Deductible You Pay 30%
Pump Infusion Sets and Supplies*	After Deductible No Charge	After Deductible You Pay 30%
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution, and continuous glucose monitors, sensors and supplies. ***Pre-Authorization is required for talking blood glucose monitors**	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Insulin, and Needles and Syringes for Injection	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit
Outpatient Self-Management Training, Education, Nutritional Therapy	After Deductible No Charge	After Deductible You Pay 30%
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	After Deductible No Charge	After Deductible You Pay 30%
Durable Medical Equipment (DME) and Supplies		
DME, Orthopedic Devices, Prosthetic Appliances, Devices ***Pre-Authorization is required for items over $750** ***Pre-Authorization is required for repair, replacement and rental items.**	After Deductible No Charge	After Deductible You Pay 30%
Early Intervention Services For Dependent children from birth to age three.		
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices.*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Home Health Care Includes skilled home health care services for home bound Members. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home.		
Home Health Care*	After Deductible No Charge	After Deductible You Pay 30%
Hospice Care		
Hospice Care*	After Deductible No Charge	After Deductible You Pay 30%
Vision Care The Plan contracts with VSP Vision Care to administer this benefit. Services must be received from VSP Vision Care providers.		
Vision Exams Limited to one routine eye exam every 12 months from a VSP provider.	No Charge Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost.	Members will be reimbursed up to $30 for one routine eye exam only

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.		
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Infertility Services Includes limited services, for Members only, to diagnose and treat underlying medical conditions resulting in Infertility.		
Endometrial biopsies Limited to 2 per lifetime **Semen analysis** Limited to 2 per lifetime **Hysterosalpingography** Limited to 2 per lifetime **Sims-Huhner test (smear)** Limited to 4 per lifetime **Diagnostic laparoscopy** Limited to 1 per lifetime	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Clinical Trials Includes "routine patient costs" for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.		
Clinical Trial Services*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Allergy Care		
Allergy Care, Testing, and Serum	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Hearing Aid Services for Children Age 18 and Younger Includes hearing aids and related services (earmolds, initial batteries, other necessary equipment, maintenance, and adaption training.) Benefits for hearing aids and related services are limited to a combined benefit for In-Network benefits and Out-of-Network benefits of $1500 per hearing impaired ear every 24 months.		
Hearing Aids and Related Services*	After Deductible No Charge	After Deductible You Pay 30%
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.		
Telemedicine Services	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Chiropractic Care Rider The Plan contracts with American Specialty Health Group (ASH) to administer this benefit.		
Chiropractic Care Rider Maximum number of visits 30 per Calendar year. This benefit also includes coverage of Chiropractic appliances up to a maximum benefit of 1 appliance per Person per Calendar year when medically necessary.	After Deductible No Charge	After Deductible You Pay 30%
Hearing Aid Rider		
Hearing Aid Services* Covered Services include the following up to the annual maximum benefit of $1,200 per ear: • the hearing aid(s); • audiometric specialist office visits for fitting, including molds and dispensing; • repair, replacement or refurbishment of the hearing aid(s) Replacement is covered only every 48 months from date of acquisition. Batteries and supplies are not covered.	After Deductible No Charge	After Deductible You Pay 30%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Notice/Notes/Terms & Conditions:

Dependent Children enrolled in the Plan are Covered until the end of month they turn 26.

This Plan does not have pre-existing condition exclusions.

This Plan does not have annual or lifetime dollar limits on Essential Health Benefits.

Need help in another language? Call us.

需要以其他语言获得帮助？ 联系我们。

다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

Quý vị cần được giúp đỡ bằng một ngôn ngữ khác? Hãy gọi cho chúng tôi.

Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

1-855-687-6260

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Sentara Health Administration, Inc.

Sentara Vantage 35/50
10101VA000200200
Newport News Public Schools
3274
Plan Effective Date: 01/01/2024

Large Group Schedule of Benefits

This document is not a contract or health plan policy from Sentara. If there are any differences between this benefit summary and the Plan coverage documents issued when You are enrolled, the provisions of the coverage documents will prevail for all benefits, conditions, cost sharing, and limitations and exclusions.

This document is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.

Details about Covered Services are in the section “What is Covered." Details about services and treatments that are not Covered are in the section “What is Not Covered."

Some benefits require Pre-Authorization before You receive them. These services are marked with an * in this document.

Some Covered Services may have visit limits. Once a visit limit is reached, no additional services are Covered under the benefit. If a service is shown as covered under Out-of-Network benefits visit limits are combined with In-Network and Out-of-Network benefits unless otherwise stated.

Services or treatment You receive Out-of-Network or from Non-Plan Providers will not be Covered under Your Plan unless:

1. The Covered Service is an Emergency Service;
2. During treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider; or
3. We have approved Your Covered Service in advance as an Authorized Out-of-Network Service.

If Your Plan has a Deductible that is the dollar amount that must be paid out-of-pocket by a Member for Covered Services each year before the Plan begins to pay for benefits.

Copayments and Coinsurances listed in this document are amounts You pay directly to a Provider for a Covered Service. Copayments are shown as flat dollar amounts. Coinsurance is shown as a percentage of the Plan’s Allowable Charge for Your Covered Service. You will pay a Copayment or Coinsurance, but not both, for a Covered Service. For some benefits You may see the statement, “Cost sharing determined by the type and place of service.” For these services Your cost sharing will be based on where You receive a service, for example in a physician office or inpatient setting, and/or the type of service.

Your Plan’s Maximum Out-of-Pocket Amount means the total dollar amount Members pay out-of-pocket for most Covered Services during a year. Deductibles, Copayments and Coinsurance for most Covered Services count toward the Maximum Amount.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	**Out-of-Network**
Deductible Plan Year	Your Plan Does Not Have a Deductible	Not Covered
	In-Network	**Out-of-Network**
Maximum Out-of-Pocket Plan Year	$4,750/Individual; $9,000/Family	Not Covered

Most amounts You pay for In-Network Covered Services will count toward meeting the In-Network Maximum Out-of-Pocket Amount.

The following will not count toward the Plan Maximum Amount(s):

- Amounts You pay for services not covered under Your Plan;
- Amounts You pay for any services after a benefit limit has been reached;
- Balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers;
- Premium amounts;
- Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits;
- Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available;
- Other services in this document that are shown as excluded from the Maximum Amount.

If You are the Subscriber, and the only Member Covered under Your Plan, the Individual Maximum applies. If You have other Family Members on Your Plan the Family Maximum applies. Under Family coverage the Individual Maximum applies separately to each covered Family Member. Once the total Family coverage Maximum is met the Family Maximum Amount is satisfied. No one Member can contribute more than their Individual Maximum Amount to the Family limit.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by Plan approved providers. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits. ***Pre-Authorization is required for in-office surgery.**		
Primary Care Visit	You Pay $35	Not Covered
Virtual Consult	You Pay $25	Not Covered
Specialist Visit	You Pay $50	Not Covered
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of $250 per dose. This does not include routine immunizations covered under Preventive Care.	You Pay 50%	Not Covered
Preventive Care Recommended Preventive Care Services are Covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.		
Recommended exams, screenings, tests, immunizations, and other services	No Charge	Not Covered
Outpatient Therapies and Services You Pay a Copayment or Coinsurance amount for each visit for services done in a Physician's office, a free-standing outpatient Facility, a Hospital outpatient Facility, or at home as part of Your Skilled Home Health Care Services benefit. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of a treatment plan for Autism Spectrum Disorder. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Occupational and Physical Therapy* Services limited to 30 combined visits per Plan year.	**PCP Office Visit** You Pay $35 **Specialist Office Visit** You Pay $35 **Outpatient Facility** You Pay $35	Not Covered
Speech Therapy* Services limited to 30 visits per Plan year.	**PCP Office Visit** You Pay $35 **Specialist Office Visit** You Pay $35 **Outpatient Facility** You Pay $35	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Cardiac Rehabilitation*	**PCP Office Visit** You Pay $50 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
Pulmonary Rehabilitation*	**PCP Office Visit** You Pay $50 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
Vascular Rehabilitation*	**PCP Office Visit** You Pay $50 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
Vestibular Rehabilitation*	**PCP Office Visit** You Pay $50 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
IV Infusion Therapy	**PCP Office Visit** You Pay $35 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
Respiratory/Inhalation Therapy	**PCP Office Visit** You Pay $35 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
Chemotherapy and Chemotherapy Drugs*	**PCP Office Visit** You Pay $35 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Radiation Therapy*	**PCP Office Visit** You Pay $35 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
Pre-Authorized Injectable and Infused Medications* Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient Facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs.	You Pay $50	Not Covered
Outpatient Dialysis You Pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.		
Dialysis Services	You Pay $5	Not Covered
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free-standing ambulatory surgery center or Hospital outpatient surgical facility.		
Surgery Services*	You Pay $500	Not Covered
Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient Facility or lab or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Diagnostic Procedures	You Pay $50	Not Covered
X-Ray **Ultrasound** **Doppler Studies**	You Pay $50	Not Covered
Lab Work	You Pay $50	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a freestanding outpatient Facility or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Magnetic Resonance Imaging (MRI)* **Magnetic Resonance Angiography (MRA)*** **Positron Emission Tomography (PET)*** **Computerized Axial Tomography (CT)*** **Computerized Axial Tomography Angiogram (CTA)*** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Sleep Studies***	You Pay 10%	Not Covered
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are covered under preventive benefits.		
Maternity Care ***Pre-Authorization is required for prenatal services**	You Pay $400 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	Not Covered
Inpatient Services		
Inpatient Hospital Services*	You Pay $350 per day Copayment	Not Covered
Transplants* Covered at contracted facilities only.	You Pay $350 per day Copayment	Not Covered
Skilled Nursing Facility Services* Limited to a maximum of 100 days per Plan year.	You Pay 20%	Not Covered
Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Air, Water, Ground Services*	You Pay $100	Not Covered except for Emergency Services
Air Ambulance Services Non-Emergent Transportation*	You Pay $100	You Pay $100

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Emergency Services Includes medical and mental health and substance use disorder Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other facility charges, such as diagnostic x-ray and lab services and medical supplies provided in an Emergency Department, including and independent freestanding Emergency Department, In-Network or Out-of-Network. If You are admitted the Copayment will be waived, and You will pay the Inpatient Hospital Services Copayment or Coinsurance.		
Emergency Services	You Pay $300	You Pay $300
Emergency Ambulance	You Pay $300	You Pay $300
Urgent Care Services Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care Facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Urgent Care Services	You Pay $50	Not Covered
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Virtual Consults must be furnished by approved Plan providers. ***Pre-Authorization is required for Inpatient Hospital Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.**		
Inpatient Hospital Services*	You Pay $350 per day Copayment	Not Covered
Residential Treatment Services*	You Pay $350 per day Copayment	Not Covered
Outpatient Office Visits (PCP or Specialist)	You Pay $35	Not Covered
Virtual Consults	You Pay $25	Not Covered
Partial Hospitalization/Intensive Outpatient Program Facility Services*	You Pay $350 per day Copayment	Not Covered
Other Outpatient Services	You Pay $35	Not Covered
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is Covered from an In-Network Plan Provider or a participating VSP Vision Care provider at the office visit Copayment or Coinsurance amount.		
Insulin Pumps*	No Charge	Not Covered
Pump Infusion Sets and Supplies*	No Charge	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution, and continuous glucose monitors, sensors and supplies. ***Pre-Authorization is required for talking blood glucose monitors**	Covered under the Plan's Prescription Drug Benefit	Not Covered
Insulin, and Needles and Syringes for Injection	Covered under the Plan's Prescription Drug Benefit	Not Covered
Outpatient Self-Management Training, Education, Nutritional Therapy	No Charge	Not Covered
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	You Pay 20%	Not Covered
Durable Medical Equipment (DME) and Supplies		
DME, Orthopedic Devices, Prosthetic Appliances, Devices ***Pre-Authorization is required for items over $750** ***Pre-Authorization is required for repair, replacement and rental items.**	No Charge	Not Covered
Early Intervention Services For Dependent children from birth to age three.		
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices.*	Cost sharing determined by the type and place of service.	Not Covered
Home Health Care Includes skilled home health care services for home bound Members. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home.		
Home Health Care*	You Pay $50	Not Covered
Hospice Care		
Hospice Care*	No Charge	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Vision Care The Plan contracts with VSP Vision Care to administer this benefit. Services must be received from VSP Vision Care providers.		
Vision Exams Limited to one exam every 12 months from a VSP provider.	No Charge Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost.	Members will be reimbursed up to $30 for one routine eye exam only
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.		
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing determined by the type and place of service.	Not covered
Infertility Services Includes limited services, for Members only, to diagnose and treat underlying medical conditions resulting in Infertility.		
Endometrial biopsies Limited to 2 per lifetime **Semen analysis** Limited to 2 per lifetime **Hysterosalpingography** Limited to 2 per lifetime **Sims-Huhner test (smear)** Limited to 4 per lifetime **Diagnostic laparoscopy** Limited to 1 per lifetime	Cost sharing determined by the type and place of service.	Not Covered
Clinical Trials Includes “routine patient costs” for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.		
Clinical Trial Services*	Cost sharing determined by the type and place of service.	Not Covered
Allergy Care		
Allergy Care, Testing, and Serum	No Charge	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Hearing Aid Services for Children Age 18 and Younger Includes hearing aids and related services (earmolds, initial batteries, other necessary equipment, maintenance, and adaption training.) Benefits for hearing aids and related services are limited to a combined benefit for In-Network benefits and Out-of-Network benefits of $1500 per hearing impaired ear every 24 months.		
Hearing Aids and Related Services*	You Pay $50	Not Covered
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.		
Telemedicine Services	Cost sharing determined by the type and place of service.	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Chiropractic Care Rider The Plan contracts with American Specialty Health Group (ASH) to administer this benefit.		
Chiropractic Care Rider Maximum number of visits 30 per Calendar year. This benefit also includes coverage of Chiropractic appliances up to a maximum benefit of 1 appliance per Person per Calendar year when medically necessary.]	You Pay $35	Not Covered

Hearing Aid Rider		
Hearing Aid Services* Covered Services include the following up to the annual maximum benefit of $1,200 per ear: • the hearing aid(s); • audiometric specialist office visits for fitting, including molds and dispensing; • repair, replacement or refurbishment of the hearing aid(s) Replacement is covered only every 48 months from date of acquisition. Batteries and supplies are not covered.	You Pay $50	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Notice/Notes/Terms & Conditions:

Dependent Children enrolled in the Plan are Covered until the end of month they turn 26.

This Plan does not have pre-existing condition exclusions.

This Plan does not have annual or lifetime dollar limits on Essential Health Benefits.

Need help in another language? Call us.

需要以其他语言获得帮助？ 联系我们。

다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

Quý vị cần được giúp đỡ bằng một ngôn ngữ khác? Hãy gọi cho chúng tôi.

Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

1-855-687-6260

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.