Sentara Health Plans
Sentara Vantage Equity 3200/10% Direct
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Plan Effective Date: Beginning on or after 01/01/2024
Large Group Benefit Summary

This document is not a contract or health plan policy from Sentara Health Plans. If there are any differences between this benefit summary and the Sentara Health Plans 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. The first column lists cost sharing amounts You will pay for In-Network Tier 1 benefits from Plan Providers. The other column lists cost sharing amounts You will pay for In-Network Tier 2 benefits from Plan Providers. This Plan has tiered Copayment or Coinsurance amounts listed for In-Network benefits. For some services You will pay less out-of-pocket when You use Tier 1 Physicians, Hospitals or other Facilities or 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 not be Covered under Your Plan unless:

1. The Covered Service is an Emergency Service or an air ambulance 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.

For the services above, Members are only responsible for applicable In-Network Copayments, Coinsurance and Deductibles which will be applied to In-Network Maximum Out-of-Pocket Amounts. Members are protected from balance billing for these services.

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 a Coinsurance, but not both, for a Covered

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

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, or that are paid on their behalf, 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 Tier 1	**In-Network Tier 2**	**Out-of-Network**
Deductible Plan Year	$3,200/Individual; $6,400/Family		Not Covered

The Plan has one combined Deductible for Tier 1 and Tier 2 In-Network Covered Services. Tier 1 and Tier 2 In-Network Covered Services will count toward meeting the In-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 Tier 1	**In-Network Tier 2**	**Out-of-Network**
Maximum Out-of-Pocket Plan Year	$5,000/Individual; $10,000/Family		Not Covered

The Plan has one combined Maximum Out of Pocket Amount for Tier 1 and Tier 2 In-Network Covered Services. Most amounts You pay, or that are paid on Your behalf, for Tier 1 and Tier 2 In-Network Covered Services will count toward meeting the In-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 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 Tier 1	In-Network Tier 2	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 approved Plan 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 You Pay 10%	After Deductible You Pay 50%	Not Covered
Virtual Consult	After Deductible No Charge	After Deductible No Charge	Not Covered
Specialist Visit	After Deductible You Pay 10%	After Deductible You Pay 50%	Not Covered
Vaccines and Immunotherapeutic Agents This does not include routine immunizations Covered under Preventive Care.	After Deductible You Pay 10%	After Deductible You Pay 10%	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. (See Your EOC under "OFFICE VISIT COPAYMENTS FOR 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	No Charge	Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Outpatient Therapies and Services You pay a Copayment or Coinsurance amount for each visit at a Physician's office, a free-standing outpatient Facility, a Hospital outpatient Facility, or at home. For home visits the Home Health Visit limit will apply instead of the Therapy Services limits listed below. Visit limits do not apply to outpatient habilitative or rehabilitative therapy services if You get that care as part of the Hospice or Early Intervention benefit, or as part of a treatment plan for Autism Spectrum Disorder. Visit limits do not apply to outpatient or home health habilitative or rehabilitative therapy services for mental health conditions or substance use disorders. 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.			
Occupational and Physical Therapy* Services limited to 30 combined visits per Plan year.	**PCP Office Visit** After Deductible You Pay 10% **Specialist Office Visit** After Deductible You Pay 10% **Outpatient Facility** After Deductible You Pay 10%	**PCP Office Visit** After Deductible You Pay 50% **Specialist Office Visit** After Deductible You Pay 50% **Outpatient Facility** After Deductible You Pay 50%	Not Covered
Speech Therapy* Services limited to 30 visits per Plan year.	**PCP Office Visit** After Deductible You Pay 10% **Specialist Office Visit** After Deductible You Pay 10% **Outpatient Facility** After Deductible You Pay 10%	**PCP Office Visit** After Deductible You Pay 50% **Specialist Office Visit** After Deductible You Pay 50% **Outpatient Facility** After Deductible You Pay 50%	Not Covered
Cardiac Rehabilitation* Services limited to 30 visits per Plan year.	**PCP Office Visit** After Deductible You Pay 10% **Specialist Office Visit** After Deductible You Pay 10% **Outpatient Facility** After Deductible You Pay 10%	**PCP Office Visit** After Deductible You Pay 50% **Specialist Office Visit** After Deductible You Pay 50% **Outpatient Facility** After Deductible You Pay 50%	Not Covered
Pulmonary Rehabilitation* Services limited to 30 visits per Plan year.	**PCP Office Visit** After Deductible You Pay 10% **Specialist Office Visit** After Deductible You Pay 10% **Outpatient Facility** After Deductible You Pay 10%	**PCP Office Visit** After Deductible You Pay 50% **Specialist Office Visit** After Deductible You Pay 50% **Outpatient Facility** After Deductible 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 Tier 1	In-Network Tier 2	Out-of-Network
Vascular Rehabilitation* Services limited to 30 visits per Plan year.	**PCP Office Visit** After Deductible You Pay 10% **Specialist Office Visit** After Deductible You Pay 10% **Outpatient Facility** After Deductible You Pay 10%	**PCP Office Visit** After Deductible You Pay 50% **Specialist Office Visit** After Deductible You Pay 50% **Outpatient Facility** After Deductible You Pay 50%	Not Covered
Vestibular Rehabilitation* Services limited to 30 visits per Plan year.	**PCP Office Visit** After Deductible You Pay 10% **Specialist Office Visit** After Deductible You Pay 10% **Outpatient Facility** After Deductible You Pay 10%	**PCP Office Visit** After Deductible You Pay 50% **Specialist Office Visit** After Deductible You Pay 50% **Outpatient Facility** After Deductible You Pay 50%	Not Covered
IV Infusion Therapy	**PCP Office Visit** After Deductible You Pay 10% **Specialist Office Visit** After Deductible You Pay 10% **Outpatient Facility** After Deductible You Pay 10%	**PCP Office Visit** After Deductible You Pay 50% **Specialist Office Visit** After Deductible You Pay 50% **Outpatient Facility** After Deductible You Pay 50%	Not Covered
Respiratory/Inhalation Therapy	**PCP Office Visit** After Deductible You Pay 10% **Specialist Office Visit** After Deductible You Pay 10% **Outpatient Facility** After Deductible You Pay 10%	**PCP Office Visit** After Deductible You Pay 50% **Specialist Office Visit** After Deductible You Pay 50% **Outpatient Facility** After Deductible You Pay 50%	Not Covered
Chemotherapy and Chemotherapy Drugs*	**PCP Office Visit** After Deductible You Pay 10% **Specialist Office Visit** After Deductible You Pay 10% **Outpatient Facility** After Deductible You Pay 10%	**PCP Office Visit** After Deductible You Pay 50% **Specialist Office Visit** After Deductible You Pay 50% **Outpatient Facility** After Deductible 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 Tier 1	In-Network Tier 2	Out-of-Network
Radiation Therapy*	**PCP Office Visit** After Deductible You Pay 10% **Specialist Office Visit** After Deductible You Pay 10% **Outpatient Facility** After Deductible You Pay 10%	**PCP Office Visit** After Deductible You Pay 50% **Specialist Office Visit** After Deductible You Pay 50% **Outpatient Facility** After Deductible 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.	After Deductible You Pay 10%	After Deductible You Pay 10%	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	After Deductible You Pay 10%	After Deductible You Pay 10%	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*	After Deductible You Pay 10%	After Deductible You Pay 50%	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	After Deductible You Pay 10%	After Deductible You Pay 50%	Not Covered
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You Pay 10%	After Deductible You Pay 50%	Not Covered
Lab Work	After Deductible You Pay 10%	After Deductible 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 Tier 1	In-Network Tier 2	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 10%	After Deductible You Pay 50%	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**	After Deductible You Pay 10%	After Deductible You Pay 50%	Not Covered
Inpatient Services			
Inpatient Hospital Services*	After Deductible You Pay 10%	After Deductible You Pay 50%	Not Covered
Transplants* Covered at contracted facilities only.	After Deductible You Pay 10%	After Deductible You Pay 10%	Not Covered
Skilled Nursing Facility Services* Limited to a maximum of 90 days per Plan year.	After Deductible You Pay 10%	After Deductible You Pay 10%	Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay a Copayment or Coinsurance per transport each way. 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.			
Water and Ground Services Non-Emergent Transportation*	After Deductible You Pay 10%	After Deductible You Pay 10%	Not Covered
Air Ambulance Services Non-Emergent Transportation*	After Deductible You Pay 10%	After Deductible You Pay 10%	After Deductible You Pay 10%
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 10%	After Deductible You Pay 10%	After Deductible You Pay 10%
Emergency Ambulance	After Deductible You Pay 10%	After Deductible You Pay 10%	After Deductible You Pay 10%
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 You Pay 10%	After Deductible You Pay 10%	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*	After Deductible You Pay 10%	After Deductible You Pay 10%	Not Covered
Residential Treatment Services*	After Deductible You Pay 10%	After Deductible You Pay 10%	Not Covered
Outpatient Office Visits (PCP and Specialist)	After Deductible You Pay 10%	After Deductible You Pay 10%	Not Covered
Outpatient Office Visits (Virtual Consult)	After Deductible You Pay 10%	After Deductible You Pay 10%	Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Partial Hospitalization/Intensive Outpatient Program Facility Services*	After Deductible You Pay 10%	After Deductible You Pay 10%	Not Covered
Other Outpatient Services	After Deductible You Pay 10%	After Deductible You Pay 10%	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.	Not Covered
Employee Assistance Visits Services include short-term problem assessment by licensed behavioral health providers, and referral services for employees, and other Covered family members and household members. To use services call 757-363-6777 or 1-800-899-8174.	No Charge for up to 3 visits from Plan Employee Assistance providers per presenting issue as determined by treatment protocols.		
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is Covered from an In-Network Plan Provider or a participating Vision Services Plan (VSP) provider at the office visit Copayment or Coinsurance amount.			
Insulin Pumps*	After Deductible You Pay 10%	After Deductible You Pay 10%	Not Covered
Pump Infusion Sets and Supplies*	After Deductible You Pay 10%	After Deductible You Pay 10%	Not Covered
Testing Supplies Includes test strips, lancets, lancet devices, Blood Glucose Meters and control solution, and Continuous Blood Glucose Monitors, sensors, and supplies. ***Pre-Authorization is required for talking Blood Glucose Meters**	Covered under the Plan's Prescription Drug Benefit	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	Covered under the Plan's Prescription Drug Benefit	Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Outpatient Self-Management Training, Education, Nutritional Therapy	After Deductible You Pay 10%	After Deductible You Pay 10%	Not Covered
Prosthetic Limb Replacement			
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	After Deductible You Pay 10%	After Deductible You Pay 10%	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.**	After Deductible You Pay 10%	After Deductible You Pay 10%	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.	Cost sharing determined by the type and place of service.	Not Covered
Home Health Care Includes skilled home health care services. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home. Visit limits do not apply to outpatient habilitative or rehabilitative therapy services for mental health conditions and substance use disorders.			
Home Health Care* Limited to a maximum of 100 visits per Plan year.	After Deductible You Pay 10%	After Deductible You Pay 10%	Not Covered
Hospice Care			
Hospice Care*	After Deductible You Pay 10%	After Deductible You Pay 10%	Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Vision Care The Plan contracts with Vision Services Plan (VSP) to administer this benefit. Services must be received from Vision Services Plan (VSP) providers.			
Vision Exams Limited to one routine eye exam every 12 months from a participating VSP provider.	No Charge	No Charge	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.	Cost sharing determined by the type and place of service.	Not covered
Infertility Services Includes the services listed below to diagnose and treat conditions resulting in infertility.			
Endometrial biopsies Limited to 2 per lifetime **Semen analysis** Limited to 2 per lifetime **Hysterosalpingography** Limited to 2 per lifetime **Diagnostic laparoscopy** Limited to 1 per lifetime **Sims-Huhner test (smear)** Limited to 4 per lifetime	Cost sharing determined by the type and place of service.	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.	Not Covered
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.	Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
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.	Not Covered
Out of Area Dependent Program Dependent Children who are Covered Persons and living outside of their Plan's Service Area will receive In-Network benefits when Covered Services are received from Plan providers that participate in the Out-of-Area Program. The Plan will require eligible out-of-area Dependents to complete an annual certification form prior to being eligible for the program. Except for Emergency Services any Covered Services received outside of the service area from Out of Network Non-Plan Providers that are not included in the Out-of-Area Dependent Program will not be Covered.			
Out-of-Area Program Services ***Pre-Authorization requirements apply depending on the type and place of service.**	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service	Not Covered
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 Tier 1 and Tier 2 In-Network benefits of $1500 per hearing impaired ear every 24 months.			
Hearing Aids and Related Services*	After Deductible No Charge up to $1500 per hearing aid per hearing impaired ear every 24 months.	After Deductible No Charge up to $1500 per hearing aid per hearing impaired ear every 24 months.	Not Covered

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

Prescription Drugs
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This document describes Your Plan's outpatient prescription drug Coverage for medical and mental health and substance use disorder treatment. All drugs must be United States Food and Drug Administration (FDA) approved, and You must have a prescription. You will need to pay Your Copayment or Coinsurance when You fill your prescription at the pharmacy. If Your Plan has a Deductible, You must meet that amount before Your Coverage begins. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited.

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."

Prescriptions may be filled at a participating, In-Network Plan pharmacy or at a non-participating pharmacy or its intermediary if the non-participating pharmacy or its intermediary has agreed in writing to accept as payment in full reimbursement from the Plan or its Pharmacy Benefit Manager, including any Copayment or Coinsurance consistently imposed by the Plan or its Pharmacy Benefit Manager, at the same level as the Plan or its Pharmacy Benefit Manager gives to participating pharmacies.

Our formulary is a list of FDA-approved medications that we Cover. Prescription drugs are reviewed by the Plan's Pharmacy and Therapeutics Committee for placement onto the formulary. For a single Copayment or Coinsurance charge You may receive up to a consecutive 30-day supply of a Covered drug at a retail pharmacy. Some drugs may be available under the Plan's mail order pharmacy. Specialty Drugs are available up to a 30-day supply and can be delivered to Your home address from the Plan's specialty mail order drug pharmacy.

This formulary is organized into the following tiers which will determine what You pay out-of-pocket to fill a prescription:

Preferred Generic Drugs (Tier 1) includes commonly prescribed Generic Drugs. Other drugs may be included in Tier 1 if the Plan recognizes they show documented long-term decreases in illness.

Preferred Brand & Other Generic Drugs (Tier 2) includes brand-name drugs and some Generic Drugs with higher costs than Tier 1 Generic Drugs that are considered by the Plan to be standard therapy.

Non-Preferred Brand Drugs (Tier 3) includes brand-name drugs not included by the Plan on Tier 1 or Tier 2. These may include single source brand-name drugs that do not have a Generic Product Level equivalent or a therapeutic equivalent. Drugs on this tier may be higher in cost than equivalent drugs, or drugs determined to be no more effective than equivalent drugs on lower tiers.

Specialty Drugs (Tier 4) includes those drugs classified by the Plan as Specialty Drugs. Specialty Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty Drugs include the following:

1. Medications that treat certain patient populations including those with rare diseases;
2. Medications that require close medical and pharmacy management and monitoring;
3. Medications that require special handling and/or storage;
4. Medications derived from biotechnology and/or blood derived drugs or small molecules;
5. Medications that can be delivered via injection, infusion, inhalation, or oral administration;
6. Medications subject to restricted distribution by the U.S. Food and Drug Administration; and
7. Medications that require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

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

Specialty Drugs are only available through a Plan Specialty Pharmacy including specialty pharmacy Proprium Pharmacy at 1-855-553-3568 and are limited to a 30-day supply. Specialty Drugs will be delivered to Your home address. If You have a question or need to find out if Your drug is considered a Specialty Drug please call Pharmacy Member Services at the number on Your Plan ID Card. You can also log onto sentarahealthplans.com for a list of Specialty Drugs and specialty pharmacies.

Tier 4 also includes compound prescription medications. A compound prescription medication is used to meet the needs of a specific individual and must have at least one ingredient requiring a Physician's authorization by State or Federal Law.

Refills

Your Plan has refill limitations. You must use most of Your medication or about 75% of Your medication based on the day supply of Your prescription before You can get a refill. There are several ways to refill Your prescription. In most cases contact the retail, mail order, or specialty pharmacy where You originally filled Your prescription and request a refill. Sometimes Your doctor will prescribe a set number of refills for Your prescription. If You have run out of refills You will need a new prescription from Your doctor. In some cases, Your pharmacist may be able to call Your doctor to get more refills for You. If Your doctor increases the amount of Your dosage, you will be able to refill Your prescription at the newly prescribed dosage.

Deductibles, Maximum Out of Pocket Amount (MOOP), and Benefits	
Deductibles	You must meet the medical Deductible listed on Your Plan document before coverage for Tier 1, Tier 2, Tier 3, and Tier 4 drugs begin.
Maximum Out-of-Pocket Amount	Outpatient Prescription Drug Deductibles, Copayments or Coinsurance apply to the Plan's Maximum Medical Out-of-Pocket Limit. Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available are not Covered, do not count toward the Plan's Maximum Out-of-Pocket Amount and must continue to be paid after the Maximum Out-of-Pocket Amount has been met.
Insulin, and Needles and Syringes for Injection	You pay the cost sharing for the applicable Tier. A Member's cost sharing payment for a Covered insulin drug will not exceed $50 per 30-day supply per prescription, regardless of the amount or type of insulin needed to fill each prescription. Deductible does not apply.
Diabetic Testing Supplies including Blood Glucose Meters, test strips, lancets, lancet devices, and control solution	You pay the cost sharing for the applicable Tier. Members can pick up supplies at any network pharmacy. LifeScan products will be the preferred brand. However, the Plan reserves the right to change or add additional preferred brands. Members that request other brand name supplies will pay the applicable cost share depending on the Tier. *Pre-Authorization is required for talking Blood Glucose Meters.
Continuous Blood Glucose Monitors, Sensors and Supplies	You pay the cost sharing for the applicable Tier.
Formulary	This Plan has an open formulary. Please use the following link to see a list of drugs on the open formulary: sentarahealthplans.com. If a brand-name medication is dispensed instead of a generic equivalent, You must pay the cost difference between the dispensed brand-name drug and the Generic Drug in addition to the Copayment or Coinsurance charge, unless authorized by the Plan.

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

Retail Pharmacy Cost Sharing When You pick up Your drug at a retail pharmacy You will pay the Copayment (one Copayment for each 30-day supply) or the Coinsurance amount listed under the applicable Tier for Your Drug: • You pay one Copayment or the Coinsurance for up to a 30-day supply; • You pay two Copayments or the Coinsurance for a 31 to 60-day supply; • You pay three Copayments or the Coinsurance for a 61 to 90-day supply. Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply.	
ACA Preventive Drugs ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force. **Please use this link for a list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.**	No Charge. Deductible does not apply. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day courses of treatment per year when prescribed by a health care provider.
Other Preventive Drugs HSA Includes outpatient prescription drugs that are considered by the Plan to be preventive care. Please use this link for a list of drugs under this benefit: Equity Preventive Drug Lists - Preventive Class.	You pay the cost sharing for the applicable Tier. Deductible does not apply.
Preferred Generic Drugs **Tier 1**	After Deductible You Pay $10
Preferred Brand & Other Generic Drugs **Tier 2**	After Deductible You Pay $40
Non-Preferred Brand Drugs **Tier 3**	After Deductible You Pay $60
Specialty Drugs **Tier 4**	After Deductible You Pay 20% up to a maximum Copayment of $300.

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

Copayment and Coinsurance Mail Order (If Your Drug is available) for up to a 90-day supply Some Outpatient prescription drugs in Tier 1, Tier 2, and Tier 3 are available from the Plan's Mail Order Pharmacy Express Scripts. You may call Express Scripts at 1-888-899-2653 to find out if Your drug is available. Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply.	
ACA Preventive Drugs ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force. **Please use this link for a list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.**	No Charge. Deductible does not apply. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day courses of treatment per year when prescribed by a health care provider.
Other Preventive Drugs HSA Includes outpatient prescription drugs that are considered by the Plan to be preventive care. Please use this link for a list of drugs under this benefit: Equity Preventive Drug Lists - Preventive Class.	You pay the cost sharing for the applicable Tier. Deductible does not apply.
Preferred Generic Drugs **Tier 1**	After Deductible You Pay $25
Preferred Brand & Other Generic Drugs **Tier 2**	After Deductible You Pay $100
Non-Preferred Brand Drugs **Tier 3**	After Deductible You Pay $180
Specialty Drugs **Tier 4**	Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply.

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.