Sentara Health Plans

BusinessEDGE® Guide

2027 Plan Guide

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Sentara® Health Plans

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This plan guide is for Business***EDGE*** plans. If you are looking for information about other plans, such as fully insured plans, or information about group sizes, contact your local Sentara Health Plans sales team. Learn more at **sentarahealthplans.com/brokers**.

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Group sizes

Business*EDGE*, our level-funded health plans, are eligible to groups that include:

5-250 enrolled employees

Business*EDGE* offers fixed premium costs, tax savings, and more for 12 months.

To learn more about our provider network and value-added services scan this **QR code**.



2027 Sentara Business***EDGE*** **Vantage Plans**

Plan Name	Sentara Vantage 0/25/20%	Sentara Vantage 500/25/20%	Sentara Vantage 1000/25/20%	Sentara Vantage 1000/25/30%	Sentara Vantage 1500/25/20%	Sentara Vantage 2000/25/30%	Sentara Vantage 2500/30/20%
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	$0/$0	$500/$1,000	$1,000/$2,000	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000
In-network out-of-pocket max (individual/family)	$2,500/$5,000	$7,500/$15,000	$5,000/$10,000	$6,200/$12,400	$6,500/$13,000	$6,500/$13,000	$6,500/$13,000
Physician services							
Primary care physician office visit	$25	$25	$25	$25	$25	$25	$30
Virtual consult	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Specialist office visit	$50	$50	$50	$50	$50	$50	$60
Outpatient services							
Outpatient surgery	$300	20% AD	20% AD	30% AD	$300 AD	30% AD	$350 AD
Outpatient diagnostic procedures and tests	20%	$50	20% AD	30% AD	$60 AD	30% AD	$60
Outpatient lab work	20%	$50	20% AD	30% AD	$30 AD	30% AD	$30
Advanced imaging and testing procedures	$150	20% AD	20% AD	30% AD	$400 AD	30% AD	$300
Inpatient services							
Inpatient hospital services	$300/day ($1,200 max)	20% AD	20% AD	30% AD	$400 AD	30% AD	20% AD
Emergency and urgent care services							
Emergency services (in- and out-of-network)	30%	30% AD	30% AD	40% AD	$350 AD	40% AD	30% AD
Urgent care center services	$50	$50	$50	$50	$50	$50	$60
Mental/behavioral health and substance use disorder services							
Inpatient services	$300/day ($1,200 max)	20% AD	20% AD	30% AD	$400 AD	30% AD	20% AD
Outpatient office visits (PCP, specialist or virtual consults)	$35	$35	$35	$35	$35	$35	$40
Other outpatient services	$60	20% AD	20% AD	30% AD	$60	30% AD	$70
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment							
Insulin pumps, pump infusion sets and supplies	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Testing supplies◇ (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services							
Preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation)§	20%	20% AD	20% AD	30% AD	20% AD	30% AD	20% AD
Maternity care	$300	20% AD	20% AD	30% AD	$400 AD	30% AD	20% AD
Hearing aid (Available for dependent children up to age 18)	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy							
Prescription drug coverage -deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*$400 max-out-of-pocket, per prescription)	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*

◇Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer.
§Plan visit limits apply. | AD: After Deductible | p/p: Per Person

This is a summary of the standard covered expenses. Exclusions and limitations apply. Additional benefits may be available.
Please see plan-specific summary for more information. Most values reflect in-network coverage. Coinsurance amounts represent the percentage the member pays.

2027 Sentara Business***EDGE*** **Vantage Plans** *(continued)*

Plan Name	Sentara Vantage 3000/30/0%	Sentara Vantage 4000/30/0%	Sentara Vantage 4000/40/20%	Sentara Vantage 4500/45/30%	Sentara Vantage 5000/25/0%
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	$3,000/$6,000	$4,000/$8,000	$4,000/$8,000	$4,500/$9,000	$5,000/$10,000
In-network out-of-pocket max (individual/family)	$6,500/$13,000	$6,500/$13,000	$8,650/$17,300	$9,000/$18,000	$9,000/$18,000
Physician services					
Primary care physician office visit	$30	$30	$40	$45	$25
Virtual consult	No charge	No charge	No charge	No charge	No charge
Specialist office visit	$60	$60	$80	$90	$60
Outpatient services					
Outpatient surgery	No charge AD	No charge AD	20% AD	30% AD	No charge AD
Outpatient diagnostic procedures and tests	No charge AD	No charge AD	$80 AD	30% AD	No charge AD
Outpatient lab work	No charge AD	No charge AD	$80 AD	30% AD	No charge AD
Advanced imaging and testing procedures	No charge AD	No charge AD	20% AD	30% AD	No charge AD
Inpatient services					
Inpatient hospital services	No charge AD	No charge AD	20% AD	30% AD	No charge AD
Emergency and urgent care services					
Emergency services (in- and out-of-network)	$350 AD	$350 AD	30% AD	40% AD	20% AD
Urgent care center services	$75	$75	$80	$90	$75
Mental/behavioral health and substance use disorder services					
Inpatient services	No charge AD	No charge AD	20% AD	30% AD	No charge AD
Outpatient office visits (PCP, specialist or virtual consults)	$40	$40	$50	$45	$25
Other outpatient services	No charge AD	No charge AD	20% AD	30% AD	No charge AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment					
Insulin pumps, pump infusion sets and supplies	No charge	No charge	No charge	No charge	No charge
Testing supplies◇ (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services					
Preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation)§	No charge AD	No charge AD	20% AD	30% AD	No charge AD
Maternity care	No charge AD	No charge AD	20% AD	30% AD	No charge AD
Hearing aid (Available for dependent children up to age 18)	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy					
Prescription drug coverage -deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*$400 max-out-of-pocket, per prescription)	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*

◇Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer.
§Plan visit limits apply. | AD: After Deductible | p/p: Per Person

This is a summary of the standard covered expenses. Exclusions and limitations apply. Additional benefits may be available. Please see plan-specific summary for more information. Most values reflect in-network coverage. Coinsurance amounts represent the percentage the member pays.



2027 Sentara Business***EDGE*** **Vantage Plans** *(continued)*

Plan Name	Sentara Vantage 5000/30/30%	Sentara Vantage 5500/40/20%
Embedded/non-embedded	Embedded	Embedded
In-network deductible (individual/family)	$5,000/$10,000	$5,500/$11,000
In-network out-of-pocket max (individual/family)	$9,000/$18,000	$7,000/$14,000
Physician services		
Primary care physician office visit	$30	$40
Virtual consult	No charge	No charge
Specialist office visit	$50	$80
Outpatient services		
Outpatient surgery	30% AD	20% AD
Outpatient diagnostic procedures and tests	30% AD	$80 AD
Outpatient lab work	30% AD	$80 AD
Advanced imaging and testing procedures	30% AD	20% AD
Inpatient services		
Inpatient hospital services	30% AD	20% AD
Emergency and urgent care services		
Emergency services (in- and out-of-network)	40% AD	30% AD
Urgent care center services	$50	$80
Mental/behavioral health and substance use disorder services		
Inpatient services	30% AD	20% AD
Outpatient office visits (PCP, specialist or virtual consults)	$40	$50
Other outpatient services	30% AD	20% AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment		
Insulin pumps, pump infusion sets and supplies	No charge	No charge
Testing supplies◊ (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services		
Preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation)§	30% AD	20% AD
Maternity care	30% AD	20% AD
Hearing aid (Available for dependent children up to age 18)	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy		
Prescription drug coverage -deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*$400 max-out-of-pocket, per prescription)	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*

◊Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer. | §Plan visit limits apply.
AD: After Deductible | p/p: Per Person This is a summary of the standard covered expenses. Exclusions and limitations apply. Additional benefits may be available. Please see plan-specific summary for more information. Most values reflect in-network coverage. Coinsurance amounts represent the percentage the member pays.

2027 Sentara Business***EDGE*** **Vantage HSA Plans**

Plan Name	Sentara Vantage HSA 2500/20%	Sentara Vantage HSA 3500/10%	Sentara Vantage HSA 4000/20%	Sentara Vantage HSA 5000/0%	Sentara Vantage HSA 5000/30%
Embedded/non-embedded	Non-embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)[¥]	$2,500/$5,000	$3,500/$7,000	$4,000/$8,000	$5,000/$10,000	$5,000/$10,000
In-network out-of-pocket max (individual/family)	$6,500/$13,000	$5,000/$10,000	$6,750/$13,500	$7,000/$14,000	$7,000/$14,000
Physician services					
Primary care physician office visit	20% AD	10% AD	20% AD	No charge AD	30% AD
Virtual consult	No charge AD	No charge AD	No charge AD	No charge AD	No charge AD
Specialist office visit	20% AD	10% AD	20% AD	No charge AD	30% AD
Outpatient services					
Outpatient surgery	20% AD	10% AD	20% AD	No charge AD	30% AD
Outpatient diagnostic procedures and tests	20% AD	10% AD	20% AD	No charge AD	30% AD
Outpatient lab work	20% AD	10% AD	20% AD	No charge AD	30% AD
Advanced imaging and testing procedures	20% AD	10% AD	20% AD	No charge AD	30% AD
Inpatient services					
Inpatient hospital services	20% AD	10% AD	20% AD	No charge AD	30% AD
Emergency and urgent care services					
Emergency services (in- and out-of-network)	30% AD	20% AD	30% AD	20% AD	40% AD
Urgent care center services	20% AD	10% AD	20% AD	No charge AD	30% AD
Mental/behavioral health and substance use disorder services					
Inpatient services	20% AD	10% AD	20% AD	No charge AD	30% AD
Outpatient office visits (PCP, specialist or virtual consults)	20% AD	10% AD	20% AD	No charge AD	30% AD
Other outpatient services	20% AD	10% AD	20% AD	No charge AD	30% AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment					
Insulin pumps, pump infusion sets and supplies	No charge	No charge	No charge	No charge	No charge
Testing supplies[◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services					
Preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation)[§]	20% AD	10% AD	20% AD	No charge AD	30% AD
Maternity care	20% AD	10% AD	20% AD	No charge AD	30% AD
Hearing aid (Available for dependent children up to age 18)	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy					
[‡]Prescription drug coverage -deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*$400 max-out-of-pocket, per prescription)	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*

[¥]No 4th quarter deductible carryover on HSA plans. | [◇]Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer.
[§]Plan visit limits apply. | [‡]Some preventive drugs are available before the deductible for HSA plans. | Prev BD: Preventive drugs before deductible.
AD: After Deductible | p/p: Per Person

This is a summary of the standard covered expenses. Exclusions and limitations apply. Additional benefits may be available. Please see plan-specific summary for more information.
Most values reflect in-network coverage. Coinsurance amounts represent the percentage the member pays.

2027 Sentara Business***EDGE*** **Vantage HSA Plans** *(continued)*

Plan Name	Sentara Vantage HSA 6000/30%	Sentara Vantage HSA 6500/0%
Embedded/non-embedded	Embedded	Embedded
In-network deductible (individual/family)[¥]	$6,000/$12,000	$6,500/$13,000
In-network out-of-pocket max (individual/family)	$7,000/$14,000	$7,500/$15,000
Physician services		
Primary care physician office visit	30% AD	No charge AD
Virtual consult	No charge AD	No charge AD
Specialist office visit	30% AD	No charge AD
Outpatient services		
Outpatient surgery	30% AD	No charge AD
Outpatient diagnostic procedures and tests	30% AD	No charge AD
Outpatient lab work	30% AD	No charge AD
Advanced imaging and testing procedures	30% AD	No charge AD
Inpatient services		
Inpatient hospital services	30% AD	No charge AD
Emergency and urgent care services		
Emergency services (in- and out-of-network)	40% AD	20% AD
Urgent care center services	30% AD	No charge AD
Mental/behavioral health and substance use disorder services		
Inpatient services	30% AD	No charge AD
Outpatient office visits (PCP, specialist or virtual consults)	30% AD	No charge AD
Other outpatient services	30% AD	No charge AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment		
Insulin pumps, pump infusion sets and supplies	No charge	No charge
Testing supplies[◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services		
Preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation)[§]	30% AD	No charge AD
Maternity care	30% AD	No charge AD
Hearing aid (Available for dependent children up to age 18)	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy		
[‡]Prescription drug coverage -deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*$400 max-out-of-pocket, per prescription)	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*

[¥]No 4th quarter deductible carryover on HSA plans. | [◇]Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer. [§]Plan visit limits apply. | [‡]Some preventive drugs are available before the deductible for HSA plans. | Prev BD: Preventive drugs before deductible. | AD: After Deductible | p/p: Per Person This is a summary of the standard covered expenses. Exclusions and limitations apply. Additional benefits may be available. Please see plan-specific summary for more information. Most values reflect in-network coverage. Coinsurance amounts represent the percentage the member pays.

2027 Sentara Business***EDGE*** **Vantage HRA Plan**

Plan Name	Sentara Vantage HRA 3000/20%
Embedded/non-embedded	Embedded
In-network deductible (individual/family)[¥]	$3,000/$6,000
In-network out-of-pocket max (individual/family)	$5,000/$10,000
Physician services	
Primary care physician office visit	20% AD
Virtual consult	No charge AD
Specialist office visit	20% AD
Outpatient services	
Outpatient surgery	20% AD
Outpatient diagnostic procedures and tests	20% AD
Outpatient lab work	20% AD
Advanced imaging and testing procedures	20% AD
Inpatient services	
Inpatient hospital services	20% AD
Emergency and urgent care services	
Emergency services (in- and out-of-network)	30% AD
Urgent care center services	20% AD
Mental/behavioral health and substance use disorder services	
Inpatient services	20% AD
Outpatient office visits (PCP, specialist or virtual consults)	20% AD
Other outpatient services	20% AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment	
Insulin pumps, pump infusion sets and supplies	No charge
Testing supplies[◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services	
Preventive vision exams	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation)[§]	20% AD
Maternity care	20% AD
Hearing aid (Available for dependent children up to age 18)	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy	
Prescription drug coverage -deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*$400 max-out-of-pocket, per prescription)	No deductible $10/$30/25%/30%*

[¥]No 4th quarter deductible carryover on HRA plan. | [◇]Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer. [§]Plan visit limits apply. | AD: After Deductible | p/p: Per Person This is a summary of the standard covered expenses. Exclusions and limitations apply. Additional benefits may be available. Please see plan-specific summary for more information. Most values reflect in-network coverage. Coinsurance amounts represent the percentage the member pays.

2027 Sentara Business***EDGE*** **POS Plans**

Plan Name	Sentara POS 0/25/20%	Sentara POS 500/25/20%	Sentara POS 1000/25/20%	Sentara POS 1000/25/30%	Sentara POS 1500/25/20%	Sentara POS 2000/25/30%	Sentara POS 2500/30/20%
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	$0/$0	$500/$1,000	$1,000/$2,000	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000
Out-of-network deductible (individual/family)	$2,500/$5,000	$1,000/$2,000	$1,250/$2,500	$2,000/$4,000	$3,250/$6,500	$4,000/$8,000	$5,000/$10,000
In-network out-of-pocket max (individual/family)	$2,500/$5,000	$7,500/$15,000	$5,000/$10,000	$6,200/$12,400	$6,500/$13,000	$6,500/$13,000	$6,500/$13,000
Out-of-network out-of-pocket max (individual/family)	$5,000/$10,000	$15,000/$30,000	$10,000/$20,000	$12,400/$24,800	$13,000/$26,000	$13,000/$26,000	$13,000/$26,000
Out-of-network coinsurance	40% AD/AC	40% AD/AC	40% AD/AC	50% AD/AC	40% AD/AC	50% AD/AC	40% AD/AC
Physician services							
Primary care physician office visit	$25	$25	$25	$25	$25	$25	$30
Virtual consult (no out-of-network coverage)	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Specialist office visit	$50	$50	$50	$50	$50	$50	$60
Outpatient services							
Outpatient surgery	$300	20% AD	20% AD	30% AD	$300 AD	30% AD	$350 AD
Outpatient diagnostic procedures and tests	20%	$50	20% AD	30% AD	$60 AD	30% AD	$60
Outpatient lab work	20%	$50	20% AD	30% AD	$30 AD	30% AD	$30
Advanced imaging and testing procedures	$150	20% AD	20% AD	30% AD	$400 AD	30% AD	$300
Inpatient services							
Inpatient hospital services	$300/day ($1,200 max)	20% AD	20% AD	30% AD	$400 AD	30% AD	20% AD
Emergency and urgent care services							
Emergency services (in- and out-of-network)	30%	30% AD	30% AD	40% AD	$350 AD	40% AD	30% AD
Urgent care center services	$50	$50	$50	$50	$50	$50	$60
Mental/behavioral health and substance use disorder services							
Inpatient services	$300/day ($1,200 max)	20% AD	20% AD	30% AD	$400 AD	30% AD	20% AD
Outpatient office visits (PCP, specialist or virtual consults[Δ])	$35	$35	$35	$35	$35	$35	$40
Other outpatient services	$60	20% AD	20% AD	30% AD	$60	30% AD	$70
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment							
Insulin pumps, pump infusion sets and supplies	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Testing supplies[◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services							
Preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation)[§]	20%	20% AD	20% AD	30% AD	20% AD	30% AD	20% AD
Maternity care	$300	20% AD	20% AD	30% AD	$400 AD	30% AD	20% AD
Hearing aid (Available for dependent children up to age 18)	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy							
Prescription drug coverage -deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*$400 max-out-of-pocket, per prescription)	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*

[Δ] No out-of-network coverage for behavioral health virtual consults | [◇]Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer. | [§]Plan visit limits apply | AC: Allowable Charge | AD: After Deductible | p/p: Per Person

This is a summary of the standard covered expenses. Exclusions and limitations apply. Additional benefits may be available. Please see plan-specific summary for more information. Most values reflect in-network coverage. Coinsurance amounts represent the percentage the member pays.

2027 Sentara Business***EDGE*** **POS Plans** *(continued)*

Plan Name	Sentara POS 3000/30/0%	Sentara POS 4000/30/0%	Sentara POS 4000/40/20%	Sentara POS 4500/45/30%	Sentara POS 5000/25/0%	Sentara POS 5000/30/30%	Sentara POS 5500/40/20%
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	$3,000/$6,000	$4,000/$8,000	$4,000/$8,000	$4,500/$9,000	$5,000/$10,000	$5,000/$10,000	$5,500/$11,000
Out-of-network deductible (individual/family)	$6,000/$12,000	$8,000/$16,000	$8,000/$16,000	$9,000/$18,000	$10,000/$20,000	$10,000/$20,000	$11,000/$22,000
In-network out-of-pocket max (individual/family)	$6,500/$13,000	$6,500/$13,000	$8,650/$17,300	$9,000/$18,000	$9,000/$18,000	$9,000/$18,000	$7,000/$14,000
Out-of-network out-of-pocket max (individual/family)	$13,000/$26,000	$13,000/$26,000	$17,300/$34,600	$18,000/$36,000	$18,000/$36,000	$18,000/$36,000	$14,000/$28,000
Out-of-network coinsurance	30% AD/AC	30% AD/AC	40% AD/AC	50% AD/AC	30% AD/AC	50% AD/AC	40% AD/AC
Physician services							
Primary care physician office visit	$30	$30	$40	$45	$25	$30	$40
Virtual consult (no out-of-network coverage)	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Specialist office visit	$60	$60	$80	$90	$60	$50	$80
Outpatient services							
Outpatient surgery	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Outpatient diagnostic procedures and tests	No charge AD	No charge AD	$80 AD	30% AD	No charge AD	30% AD	$80 AD
Outpatient lab work	No charge AD	No charge AD	$80 AD	30% AD	No charge AD	30% AD	$80 AD
Advanced imaging and testing procedures	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Inpatient services							
Inpatient hospital services	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Emergency and urgent care services							
Emergency services (in- and out-of-network)	$350 AD	$350 AD	30% AD	40% AD	20% AD	40% AD	30% AD
Urgent care center services	$75	$75	$80	$90	$75	$50	$80
Mental/behavioral health and substance use disorder services							
Inpatient services	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Outpatient office visits (PCP, specialist or virtual consults[Δ])	$40	$40	$50	$45	$25	$40	$50
Other outpatient services	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment							
Insulin pumps, pump infusion sets and supplies	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Testing supplies[◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services							
Preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation)[§]	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Maternity care	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Hearing aid (Available for dependent children up to age 18)	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy							
Prescription drug coverage -deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*$400 max-out-of-pocket, per prescription)	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*

[Δ] No out-of-network coverage for behavioral health virtual consults | [◇] Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer. [§] Plan visit limits apply | AC: Allowable Charge | AD: After Deductible | p/p: Per Person

This is a summary of the standard covered expenses. Exclusions and limitations apply. Additional benefits may be available. Please see plan-specific summary for more information. Most values reflect in-network coverage. Coinsurance amounts represent the percentage the member pays.

2027 Sentara Business***EDGE*** **POS HSA Plans**

Plan Name	Sentara POS HSA 2500/20%	Sentara POS HSA 3500/10%	Sentara POS HSA 4000/20%	Sentara POS HSA 5000/0%	Sentara POS HSA 5000/30%	Sentara POS HSA 6000/30%	Sentara POS HSA 6500/0%
Embedded/non-embedded	Non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)[¥]	$2,500/$5,000	$3,500/$7,000	$4,000/$8,000	$5,000/$10,000	$5,000/$10,000	$6,000/$12,000	$6,500/$13,000
Out-of-network deductible (individual/family)[¥]	$5,000/$10,000	$7,000/$14,000	$5,500/$11,000	$10,000/$20,000	$10,000/$20,000	$12,000/$24,000	$13,000/$26,000
In-network out-of-pocket max (individual/family)	$6,500/$13,000	$5,000/$10,000	$6,750/$13,500	$7,000/$14,000	$7,000/$14,000	$7,000/$14,000	$7,500/$15,000
Out-of-network out-of-pocket max (individual/family)	$13,000/$26,000	$10,000/$20,000	$14,000/$28,000	$14,000/$28,000	$14,000/$28,000	$14,000/$28,000	$15,000/$30,000
Out-of-network coinsurance	40% AD/AC	30% AD/AC	40% AD/AC	30% AD/AC	50% AD/AC	50% AD/AC	30% AD/AC
Physician services							
Primary care physician office visit	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Virtual consult (no out-of-network coverage)	No charge AD	No charge AD	No charge AD	No charge AD	No charge AD	No charge AD	No charge AD
Specialist office visit	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Outpatient services							
Outpatient surgery	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Outpatient diagnostic procedures and tests	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Outpatient lab work	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Advanced imaging and testing procedures	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Inpatient services							
Inpatient hospital services	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Emergency and urgent care services							
Emergency services (in- and out-of-network)	30% AD	20% AD	30% AD	20% AD	40% AD	40% AD	20% AD
Urgent care center services	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Mental/behavioral health and substance use disorder services							
Inpatient services	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Outpatient office visits (PCP, specialist or virtual consults[Δ])	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Other outpatient services	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment							
Insulin pumps, pump infusion sets and supplies	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Testing supplies[◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services							
Preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation)[§]	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Maternity care	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Hearing aid (Available for dependent children up to age 18)	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy							
[‡]Prescription drug coverage -deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*$400 max-out-of-pocket, per prescription)	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*

[¥] No 4th quarter deductible carryover on HSA plans. | [Δ] No out-of-network coverage for behavioral health virtual consults | [◇] Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer. | [§] Plan visit limits apply | [‡] Some preventive drugs are available before the deductible for HSA plans.
Prev BD: Preventive drugs before deductible AC: Allowable Charge | AD: After Deductible | p/p: Per Person

This is a summary of the standard covered expenses. Exclusions and limitations apply. Additional benefits may be available. Please see plan-specific summary for more information. Most values reflect in-network coverage. Coinsurance amounts represent the percentage the member pays.

2027 Sentara Business***EDGE*** **Plus Plans**

Plan Name	Sentara Plus 0/25/20%	Sentara Plus 500/25/20%	Sentara Plus 1000/25/20%	Sentara Plus 1000/25/30%	Sentara Plus 1500/25/20%	Sentara Plus 2000/25/30%	Sentara Plus 2500/30/20%
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	$0/$0	$500/$1,000	$1,000/$2,000	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000
Out-of-network deductible (individual/family)	$2,500/$5,000	$1,000/$2,000	$1,250/$2,500	$2,000/$4,000	$3,250/$6,500	$4,000/$8,000	$5,000/$10,000
In-network out-of-pocket max (individual/family)	$2,500/$5,000	$7,500/$15,000	$5,000/$10,000	$6,200/$12,400	$6,500/$13,000	$6,500/$13,000	$6,500/$13,000
Out-of-network out-of-pocket max (individual/family)	$5,000/$10,000	$15,000/$30,000	$10,000/$20,000	$12,400/$24,800	$13,000/$26,000	$13,000/$26,000	$13,000/$26,000
Out-of-network coinsurance	40% AD/AC	40% AD/AC	40% AD/AC	50% AD/AC	40% AD/AC	50% AD/AC	40% AD/AC
Physician services							
Primary care physician office visit	$25	$25	$25	$25	$25	$25	$30
Virtual consult (no out-of-network coverage)	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Specialist office visit	$50	$50	$50	$50	$50	$50	$60
Outpatient services							
Outpatient surgery	$300	20% AD	20% AD	30% AD	$300 AD	30% AD	$350 AD
Outpatient diagnostic procedures and tests	20%	$50	20% AD	30% AD	$60 AD	30% AD	$60
Outpatient lab work	20%	$50	20% AD	30% AD	$30 AD	30% AD	$30
Advanced imaging and testing procedures	$150	20% AD	20% AD	30% AD	$400 AD	30% AD	$300
Inpatient services							
Inpatient hospital services	$300/day ($1,200 max)	20% AD	20% AD	30% AD	$400 AD	30% AD	20% AD
Emergency and urgent care services							
Emergency services (in- and out-of-network)	30%	30% AD	30% AD	40% AD	$350 AD	40% AD	30% AD
Urgent care center services	$50	$50	$50	$50	$50	$50	$60
Mental/behavioral health and substance use disorder services							
Inpatient services	$300/day ($1,200 max)	20% AD	20% AD	30% AD	$400 AD	30% AD	20% AD
Outpatient office visits (PCP, specialist or virtual consults[Δ])	$35	$35	$35	$35	$35	$35	$40
Other outpatient services	$60	20% AD	20% AD	30% AD	$60	30% AD	$70
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment							
Insulin pumps, pump infusion sets and supplies	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Testing supplies[◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services							
Preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation)[§]	20%	20% AD	20% AD	30% AD	20% AD	30% AD	20% AD
Maternity care	$300	20% AD	20% AD	30% AD	$400 AD	30% AD	20% AD
Hearing aids (Available for dependent children up to age 18)	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy							
Prescription drug coverage -deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*$400 max-out-of-pocket, per prescription)	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*

[Δ] No out-of-network coverage for behavioral health virtual consults | [◇]Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer. | [§]Plan visit limits apply. | AC: Allowable Charge | AD: After Deductible | p/p: Per Person

This is a summary of the standard covered expenses. Exclusions and limitations apply. Additional benefits may be available. Please see plan-specific summary for more information. Most values reflect in-network coverage. Coinsurance amounts represent the percentage the member pays.

2027 Sentara Business***EDGE* Plus Plans** *(continued)*

Plan Name	Sentara Plus 3000/30/0%	Sentara Plus 4000/30/0%	Sentara Plus 4000/40/20%	Sentara Plus 4500/45/30%	Sentara Plus 5000/25/0%	Sentara Plus 5000/30/30%	Sentara Plus 5500/40/20%
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	$3,000/$6,000	$4,000/$8,000	$4,000/$8,000	$4,500/$9,000	$5,000/$10,000	$5,000/$10,000	$5,500/$11,000
Out-of-network deductible (individual/family)	$6,000/$12,000	$8,000/$16,000	$8,000/$16,000	$9,000/$18,000	$10,000/$20,000	$10,000/$20,000	$11,000/$22,000
In-network out-of-pocket max (individual/family)	$6,500/$13,000	$6,500/$13,000	$8,650/$17,300	$9,000/$18,000	$9,000/$18,000	$9,000/$18,000	$7,000/$14,000
Out-of-network out-of-pocket max (individual/family)	$13,000/$26,000	$13,000/$26,000	$17,300/$34,600	$18,000/$36,000	$18,000/$36,000	$18,000/$36,000	$14,000/$28,000
Out-of-network coinsurance	30% AD/AC	30% AD/AC	40% AD/AC	50% AD/AC	30% AD/AC	50% AD/AC	40% AD/AC
Physician services							
Primary care physician office visit	$30	$30	$40	$45	$25	$30	$40
Virtual consult (no out-of-network coverage)	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Specialist office visit	$60	$60	$80	$90	$60	$50	$80
Outpatient services							
Outpatient surgery	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Outpatient diagnostic procedures and tests	No charge AD	No charge AD	$80 AD	30% AD	No charge AD	30% AD	$80 AD
Outpatient lab work	No charge AD	No charge AD	$80 AD	30% AD	No charge AD	30% AD	$80 AD
Advanced imaging and testing procedures	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Inpatient services							
Inpatient hospital services	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Emergency and urgent care services							
Emergency services (in- and out-of-network)	$350 AD	$350 AD	30% AD	40% AD	20% AD	40% AD	30% AD
Urgent care center services	$75	$75	$80	$90	$75	$50	$80
Mental/behavioral health and substance use disorder services							
Inpatient services	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Outpatient office visits (PCP, specialist or virtual consults[Δ])	$40	$40	$50	$45	$25	$40	$50
Other outpatient services	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment							
Insulin pumps, pump infusion sets and supplies	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Testing supplies[◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services							
Preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation)[§]	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Maternity care	No charge AD	No charge AD	20% AD	30% AD	No charge AD	30% AD	20% AD
Hearing aids (Available for dependent children up to age 18)	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to $1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy							
Prescription drug coverage -deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*$400 max-out-of-pocket, per prescription)	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*	No deductible $10/$30/25%/30%*

[Δ] No out-of-network coverage for behavioral health virtual consults | [◇]Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer. | [§]Plan visit limits apply. | AC: Allowable Charge | AD: After Deductible | p/p: Per Person

This is a summary of the standard covered expenses. Exclusions and limitations apply. Additional benefits may be available. Please see plan-specific summary for more information. Most values reflect in-network coverage. Coinsurance amounts represent the percentage the member pays.

2027 Sentara Business***EDGE*** **Plus HSA Plans**

Plan Name	Sentara Plus HSA 2500/20%	Sentara Plus HSA 3500/10%	Sentara Plus HSA 4000/20%	Sentara Plus HSA 5000/0%	Sentara Plus HSA 5000/30%	Sentara Plus HSA 6000/30%	Sentara Plus HSA 6500/0%
Embedded/non-embedded	Non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)[¥]	$2,500/$5,000	$3,500/$7,000	$4,000/$8,000	$5,000/$10,000	$5,000/$10,000	$6,000/$12,000	$6,500/$13,000
Out-of-network deductible (individual/family)[¥]	$5,000/$10,000	$7,000/$14,000	$5,500/$11,000	$10,000/$20,000	$10,000/$20,000	$12,000/$24,000	$13,000/$26,000
In-network out-of-pocket max (individual/family)	$6,500/$13,000	$5,000/$10,000	$6,750/$13,500	$7,000/$14,000	$7,000/$14,000	$7,000/$14,000	$7,500/$15,000
Out-of-network out-of-pocket max (individual/family)	$13,000/$26,000	$10,000/$20,000	$14,000/$28,000	$14,000/$28,000	$14,000/$28,000	$14,000/$28,000	$15,000/$30,000
Out-of-network coinsurance	40% AD/AC	30% AD/AC	40% AD/AC	30% AD/AC	50% AD/AC	50% AD/AC	30% AD/AC
Physician services							
Primary care physician office visit	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Virtual consult (no out-of-network coverage)	No charge AD	No charge AD	No charge AD	No charge AD	No charge AD	No charge AD	No charge AD
Specialist office visit	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Outpatient services							
Outpatient surgery	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Outpatient diagnostic procedures and tests	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Outpatient lab work	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Advanced imaging and testing procedures	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Inpatient services							
Inpatient hospital services	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Emergency and urgent care services							
Emergency services (in- and out-of-network)	30% AD	20% AD	30% AD	20% AD	40% AD	40% AD	20% AD
Urgent care center services	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Mental/behavioral health and substance use disorder services							
Inpatient services	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Outpatient office visits (PCP, specialist or virtual consults[Δ])	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Other outpatient services	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment							
Insulin pumps, pump infusion sets and supplies	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Testing supplies[◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services							
Preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation)[§]	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Maternity care	20% AD	10% AD	20% AD	No charge AD	30% AD	30% AD	No charge AD
Hearing aid (Available for dependent children up to age 18)	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to $1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy							
[‡]Prescription drug coverage -deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*$400 max-out-of-pocket, per prescription)	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*	Prev BD, after medical deductible $10 AD/$40 AD/25% AD/30% AD*

[¥] No 4th quarter deductible carryover on HSA plans. | [Δ] No out-of-network coverage for behavioral health virtual consults | [◇] Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer. | [§] Plan visit limits apply | [‡] Some preventive drugs are available before the deductible for HSA plans.
AC: Allowable Charge | AD: After Deductible | p/p: Per Person | Prev BD: Preventive drugs before deductible.

This is a summary of the standard covered expenses. Exclusions and limitations apply. Additional benefits may be available. Please see plan-specific summary for more information. Most values reflect in-network coverage. Coinsurance amounts represent the percentage the member pays.

Service descriptions

Physician services

There is an additional copayment or coinsurance for outpatient habilitative and rehabilitative therapy and services, injectable and infused medications, allergy care, testing and serums, outpatient advanced imaging procedures, and sleep studies done during an office visit. Applicable to services rendered with a medical/surgical diagnosis. For treatment of mental health conditions or substance use disorder, the outpatient office visits cost sharing listed under mental health and substance use disorder services applies.

Virtual consult

Medical virtual consult

Applicable when primary diagnosis is medical. Must be provided by a Plan-approved provider.

Behavioral health virtual consult

Visits for treatment of mental health conditions or substance use disorder. Must be provided by a Plan-approved provider.

Outpatient services

Outpatient surgery

Copayment or coinsurance applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.

Outpatient diagnostic procedures and tests

Copayment or coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab. Applicable to services rendered with a medical/surgical diagnosis.

For mental health conditions or substance use disorder, the cost sharing listed under mental health and substance use disorder services/other outpatient services will apply.

Maternity care

Prenatal, delivery, postpartum services, and home health visits are included. The inpatient hospital copayment or coinsurance is also applied. ACA recommended preventive care services and screenings are covered under the Plan's Preventive Care Benefit.

Emergency services

Includes emergency services, physician services, advanced diagnostic imaging, such as MRI, and CT scans, and other facility charges, such as diagnostic X-ray and lab services, and medical supplies, provided in an emergency department in-network or out-of-network. Applicable to those with medical and mental health and substance use disorder diagnoses. Both in-and-out of network cost shares apply toward in-network accumulators. Includes mobile crisis response services and residential crisis stabilization units.

Mental/behavioral health and substance use disorder services

Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Pre-authorization is required for inpatient services, partial hospitalization services, Intensive Outpatient Program (IOP), Electro-Convulsive Therapy, and Transcranial Magnetic Stimulation (TMS).

Other outpatient services

All other outpatient services with mental health or substance use disorder diagnoses will be covered under this benefit.

Employee assistance program

Employee assistance includes short-term problem assessment by licensed behavioral health providers, referral services for employees, and other covered family members and household members.

Diabetes treatment

Coverage includes benefits for equipment, supplies, and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law.

Equipment and supplies under this benefit are not considered durable medical equipment. An annual diabetic eye exam is covered by a participating VSP Vision Care provider at the applicable office visit copayment or coinsurance amount. The following equipment and supplies are covered under this benefit:

- Insulin pumps
- Pump infusion sets and supplies
- Testing supplies–includes test strips, lancets, lancet devices, blood glucose meters, continuous blood glucose monitors, sensors, supplies, and control solution
- Insulin needles and syringes
- Outpatient self-management training and education and nutritional therapy



Vision services through VSP Vision Care

Sentara Health Plans contracts with Vision Services Plan to administer this benefit. Coverage includes one examination every 12 months when done by a participating VSP provider.

Chiropractic care

Sentara Health Plans contracts with American Specialty Health Group (ASH) to administer this benefit. Services include therapy to treat problems of the bones, joints, and back.

Hearing aid services

Available for dependent children up to age 18. Includes hearing aids and related services such as ear-molds, initial batteries, other necessary equipment, maintenance and adaption training.

Tobacco cessation

Covered Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day treatment regimens per contract year when prescribed by a healthcare provider.

For additional details on covered services, reference benefit documents.

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