

Benefit Information Guide

POS/Plus PPO Self-Funded
Administered By Sentara Health Administration, Inc.



Contact Us

If you are a new member to the plan and do not have a member ID card, please call us toll-free at **1-877-552-7401**.

Visit sentarahealthplans.com/members or download the **Sentara Health Plans mobile app** to access your secure member information and to:

- view a list of Plan providers
- change your Plan primary care physician (PCP)
- update your home address, phone number, or email address
- order a new member ID card or print a temporary member ID card
- view your claims history
- view your benefits
- view your authorizations
- get important preventive care notifications
- learn about member discounts
- manage your pharmacy benefit (if administered by Sentara Health Plans)
- research drug options and pricing
- choose to receive your Explanation of Benefits (EOB) electronically
- research conditions, treatment options, and hospital quality

Member Services

Call the number listed on the back of your member ID card

1-877-552-7401

Office hours:

Mon. – Fri. 8 a.m. to 6 p.m.

After business hours, please leave a message

24/7 Nurse Advice Line

Call the number listed on the back of your member ID card

1-800-394-2237

Behavioral Health Services

1-800-648-8420

24/7 Behavioral Health Crisis Line

1-833-717-2310

Language Assistance Services

Call **1-855-687-6260** for assistance for visually impaired and non-English speaking members

TTY/TDD line for the hearing impaired

Sentara Health Plans uses the Virginia Relay Service **1-800-828-1140** or 711

Sentara Health Plans Individual & Family Plans

Member Services for current members
1-866-514-5916

New sales inquiries and quotes
1-800-741-4825

sentarahealthplans.com/individual

Email

members@sentarahealthplans.com

Please note: Members who register and sign in to sentarahealthplans.com or the mobile app can contact Member Services securely using the Contact Us form.

Mail

Sentara Health Plans Member Services
PO Box 66189
Virginia Beach, VA 23466



Sentara[®]
Health Plans

Benefit Information Guide

Prepared exclusively for:

Group Name:

Portsmouth Public Schools

POS Plan

Effective Date:

1/1/2024

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Welcome to Sentara Health Plans



Within the pages of this Benefit Information Guide you will find answers to frequently asked questions about pre-authorization, emergencies, urgent care, and more. Information specific to services your plan covers, as well as plan deductibles, copayments, and other cost-share amounts can be found in the Uniform Summary of Benefits and Coverage (SBC) and the Benefit Summary in the following two sections of this Guide.

Our Plans

Sentara Health Plans offers several different plan options to meet our customers' needs. This Benefit Information Guide outlines basic information and answers common questions about the plans we offer. Plan information such as copayments, coinsurance, and applicable deductibles is referenced in your specific Plan benefit chosen by your employer. Refer to your Plan documents for more details.

Every individual covered by Sentara Health Plans receives a member ID card, which is designed according to your specific plan. Your card includes your name, the name of your employer, group number, member ID number, the name of your plan, and important phone numbers. Depending on your plan, it will also include copayment and coinsurance amounts for prescription drugs, office visits, emergency room, and other services. Always show your member ID card whenever you receive services or get a prescription drug filled to ensure you are charged the correct amount.

POS and Plus PPO Plans

Sentara POS and Sentara Plus PPO

Sentara POS is a point-of-service plan and Sentara Plus PPO is a preferred provider organization (PPO) plan, which are designed to give members more freedom and flexibility when choosing providers for care.

Sentara POS Design/HRA and Sentara Plus PPO Design/HRA

Sentara POS Design/HRA and Plus PPO Design/HRA are consumer-directed health plans (CDHP) coupled with a Health Reimbursement Arrangement (HRA). Employer groups offer tax-free HRA funds to help offset medical expenses, like the deductible. Unused funds are returned to the employer at the end of the plan year.

Sentara POS Equity/HSA and Sentara Plus PPO Equity/HSA

Sentara POS Equity/HSA and Plus PPO Equity/HSA are consumer-directed health plans (CDHP) combined with a Health Savings Account (HSA). Employees are eligible to make tax-deductible contributions to their HSA account. Funds added to an HSA account belong to the individual and roll over every year.





POS and PPO Basics

All Sentara POS and Plus PPO plans feature in-network and out-of-network benefits. You choose the coverage you want to use each time you seek care. Below are characteristics of in-network and out-of-network coverage options:

In-Network Coverage

- To receive benefits at the in-network level, you must receive your care from Plan providers, including, but not limited to, doctors, facilities, and laboratories.
- Generally, you pay a set copayment and/or coinsurance for services. Depending on your plan, you may have to meet a deductible before coinsurance will apply.
- Your out-of-pocket costs, or copayments/coinsurance amounts, are generally lower, and you do not need to file for reimbursement.
- Payments applied to the in-network, out-of-pocket maximum only apply toward the in-network maximum.

Any exceptions are noted on the Benefit Summary, included with your plan documents.

Out-of-Network Coverage

- You have the freedom to go out-of-network and see any provider you choose for covered services.
- Generally, an annual deductible applies. You may also pay a percentage (coinsurance) of the medical bill!
- With out-of-network coverage, your out-of-pocket costs, including out-of-pocket maximums, are generally higher.
- If your plan has a deductible, you will need to meet your deductible before your coinsurance will apply. Copayments, coinsurance, and applicable deductibles vary or may not apply depending on your plan option. Refer to your plan documents for details.

- Before you use your out-of-network benefits, ensure that any required pre-authorization has been obtained. Without pre-authorization, your coverage may be reduced or denied.

Our Provider Network

Understanding your Plan's network helps you know how your care is covered by Sentara Health Plans.

In-network:

The in-network benefit option means you can lower your out-of-pocket costs by seeing Plan primary care physicians (PCP), specialists, therapists, and other healthcare professionals who have met Sentara Health Plans' credentialing requirements and are part of the Plan network.

Sentara Direct® Network

Sentara Direct® plans have a tiered network of providers. This means that you have the freedom to choose from any healthcare provider in the network. You will have a lower cost share—copayments and coinsurance amounts—when you use a Tier 1 provider. With this network design, you have the option to also visit Tier 2 providers for a higher cost share than a Tier 1 provider. Please refer to your Plan documents for more information about the cost savings of choosing a Tier 1 provider, specific to your plan.

PHCS/MultiPlan Network

Sentara Health Plans partners with PHCS/MultiPlan to provide national coverage. Your Sentara POS and Plus PPO plans include in-network benefits for covered services when you access a PHCS/MultiPlan provider outside of the Sentara Health Plans service area². This coverage may be used for:

- out-of-area dependents
- members living outside the Sentara Health Plans service area
- coverage when traveling outside the Sentara Health Plans service area



If you need to find a PHCS/MultiPlan provider, sign in to sentarahealthplans.com/members or the mobile app. PHCS/MultiPlan providers will display their logo under "QUALITY."



Out-of-network:

If you choose to use your out-of-network benefit option for covered services, it means you can select the doctor or medical facility you want for most covered services, regardless of whether they are Plan providers. Remember, your out-of-pocket costs will be higher when you use out-of-network benefits.

Before you use your in-network benefits, verify that your provider participates in the Sentara Health Plans network. Sign in to the mobile app or sentarahealthplans.com/member, use the Find-a-Doc feature, download a Provider Directory, or call member services at the number on the back of your member ID card.

¹In accordance with the provisions in the No Surprises Act regarding balance billing, you may be responsible for paying all charges in excess of the Sentara Health Plans allowable charge, in addition to any copayment and coinsurance amounts you are required to pay.

²The Sentara Health Plans service area is defined by participating providers in the Commonwealth of Virginia and northeastern North Carolina.



Welcome to Sentara Health Plans



You and Your Primary Care Physician

A Relationship for a Healthy Life

When you have a health concern or need medical care, do you have that one “go to” doctor you can call? A primary care physician, or PCP, is your main point of contact—your first stop—to identify an illness or condition, offer methods of care, write prescriptions, and recommend specialists or facilities if additional diagnosis and follow-up are needed.

When you establish a relationship with a PCP, you develop continuity of care with someone who gets to know you and your health goals, and helps you manage your overall progress.

Benefits of a PCP

- Your PCP will provide routine and preventive care services such as annual physicals, exams, and treatment for colds and the flu.
- Your PCP can help you focus on staying healthy in addition to treating you when you are sick or hurt.
- Through routine care, your PCP can catch problems early before they become serious or lead to major illnesses.
- If you have a chronic condition like asthma or diabetes, your PCP will help you develop a self-management plan, monitor your progress, and refer you to specialized care if needed.

Get the most out of your time with your PCP

- Be honest. It's always the best policy, especially when your health could be affected.
- Come prepared. Write down your questions and be specific about what you intend to discuss.
- Prioritize your concerns. Time is limited with a provider so focus on the issues most important to you.
- Don't be afraid to request another appointment.

- Bring someone with you. A close friend or family member can help you keep track of information and make sure all your questions are answered.
- Use an online patient portal to communicate if available.
- Tell your doctor if you take over-the-counter medications, herbal supplements, and vitamins. Some of these can interact with prescribed drugs.
- Tell the doctor if you are stressed, depressed, or experiencing abuse. Doctors may not be therapists, but they've heard it all. Don't be afraid to discuss personal issues.
- Let your doctor know if you have reasons for not following orders. Does your medication cause side effects? Are you unable to follow a nutrition or activity plan? Let your doctor know!
- Tell your doctor if you can't sleep. Your doctor can evaluate the problem and provide advice on how to solve it.
- Let your doctor know if you have low energy. Fatigue is associated with many illnesses. Let your doctor know if this is a chronic problem.

FAQs

How do I choose or change a PCP?

When you enroll, if your plan requires the designation of a primary care physician (PCP) you have the right to designate any PCP who participates in your plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. Your plan may assign a PCP to you and your family until you choose a PCP. For information on how to select or change a PCP, and for a list of the participating PCPs, you can call member services. You can also find the list of participating providers on sentarahealthplans.com.



If you are new to the Sentara Health Plans community, you can often continue your relationship with your current physician, or select a new one from our extensive list of participating providers. If you have children, you may choose a participating pediatrician as their PCP.

What about my spouse and children? Do we all have to have the same PCP?

Adult members have the right to choose a general family practice or an internal medicine doctor as their PCP, and a family practice doctor or a pediatrician for their children.

What if my doctor leaves the Sentara Health Plans network?

If your plan doctor leaves the network, Sentara Health Plans will notify and assist you in finding a new doctor or facility. If you are in active treatment with a doctor who leaves the network, you can request to continue receiving healthcare services from the doctor for at least 90 days. If you are beyond the first trimester of pregnancy, you may be able to remain with that doctor through the provision of postpartum care directly related to the delivery. For a terminal illness, treatment may continue for the remainder of the member's life for care directly related to the terminal illness.

Specialist Care

What if I need to see a specialist?

You do not need a referral from your PCP for specialist care. If you and your PCP make the decision for you to see a plan specialist, your PCP will coordinate your care, and you can make your own appointment. Before you see a specialist, you should confirm that the specialist is in the Sentara Health Plans network.

What if my plan doctor directs my care to a non-plan provider?

It is your responsibility to ensure that you are using in-network or plan doctors and facilities. If you have

a Vantage HMO plan and your plan doctor directs you to a non-plan provider, you will be responsible for payment of these services. If you have a POS or Plus (PPO) plan, you have the option of using plan providers or non-plan providers. Claims from non-plan providers will be paid at a reduced benefit level and you will usually pay a higher deductible, copayment, and/or coinsurance amount. You may also be balance billed for any charges in excess of the Plan's allowable charges. Information on balance billing is located in The Fine Print section of this guide.

Is my plan specialist authorized to order diagnostic or X-ray tests for me?

Yes. However, some tests may require pre-authorization by the Plan.

Do I need a referral for my annual OB/GYN exam?

No. Your plan does not require referrals. Members may schedule an appointment for a routine annual exam with any OB/GYN in the Sentara Health Plans network.

Can an obstetrician (OB) serve as PCP while I am pregnant?

Yes. During your pregnancy, your OB can serve as your PCP. As a plan member, you are automatically eligible for the Sentara Health Plans Partners in Pregnancy program. This program is designed to provide education and support to pregnant women. If you would like more information about the program, please call **1-866-239-0618**, option 2.





Member Services

When do I receive my member ID card?

You should receive your card(s) in the mail within 10 days of your plan effective date, depending on when you enroll. You can also view, download, and print a temporary card when you sign in to sentarahealthplans.com/members and create an account, or download the Sentara Health Plans mobile app. If you do not receive your member ID card, please contact your group benefits administrator.

What does Sentara Health Plans do to assist members with communication disabilities?

Sentara Health Plans uses various means to facilitate healthcare services for members with physical, mental, language, and cultural barriers. For members who may be hearing impaired, Sentara Health Plans uses the Virginia Relay Service at TTY 711 or **1-800-828-1140**. Members who are non-English speaking can connect to a language interpretation service by calling 1-855-687-6260. Additionally, members may request documents that contain benefit, plan, premium, and appeals information in languages other than English.

Who can make changes or update my membership information?

No one can make changes or view your information without your consent. In accordance with privacy laws, we require an Authorization of Designated Agent form whenever anyone other than the Sentara Health Plans member needs to obtain and/or change health information. This form must be signed and returned to Sentara Health Plans. Visit sentarahealthplans.com/members to download a Designated Agent form or contact member services at the number on the back of your member ID card to request a form.

When and how can I add a newborn or adopted child?

You must add newborns or adopted children to the plan within 31 days of birth or placement for adoption.

The application and supporting documents for these additions must be submitted directly to your employer for processing. Failure to provide information requested by Sentara Health Plans within 31 days from the birth or adoption will result in your dependent being ineligible for coverage until the next open enrollment period or qualifying event.

When and how can I enroll my dependent up to age 26?

Dependents up to age 26 can be enrolled during the month of the group's renewal regardless of the dependent's student status. The subscriber has 30 days to add the dependent. If the child is added within the 30-day period, coverage will begin on the plan renewal date. If the child is not added within the 30-day period, the child will have to wait until the next open enrollment or a qualifying event.

How can I ensure my enrollment in the health plan is processed in a timely manner?

Respond to each item listed on the application in its entirety. Also, pay close attention to areas requiring you to provide information about other health insurance carriers that you or your family may have. If you do not have additional health insurance, please state so in the areas indicated. If your application is incomplete or if you have failed to complete the coordination of benefits section, this may delay processing your enrollment and your effective date of coverage.

Do I have to present any additional information to have my application processed?

You may need to provide additional information if you have dependents with a last name different from your own, you may need to produce legal documentation to support your relationship (e.g. birth certificate, marriage certificate, court order, adoption papers), or if you have dependents that exceed the maximum dependent age, you will be asked to provide current documentation to support their disabled status. Contact member services to see if dependents are eligible for coverage. Failure to provide information



requested by Sentara Health Plans may result in your dependent being ineligible for coverage.

Why do you need social security numbers for me and my dependents?

Social Security numbers (SSN) are required for all individuals, including children, to comply with federal law related to coordination of benefits. If you do not have a SSN or do not wish to provide one, a refusal form must be completed annually for each family member not providing a social security number. New enrolling members who do not provide their SSN and do not send a refusal form will not be enrolled and will be ineligible for coverage until your employer's next open enrollment period. If you are the subscriber and do not provide the documentation, then none of your dependents will be enrolled.

Will I ever need to file a claim?

If you use an out-of-network provider who does not file on your behalf, you will need to mail originals of your medical bills for reimbursement to: MEDICAL CLAIMS, P.O. Box 5028, Troy, MI 48007-5028.

The itemized bill should contain the name, address, tax ID number, and NPI number of the provider; the name of the member receiving services; the date, diagnosis, and type of services the member received, and the charge for each type of service. Your claim will be processed in accordance with out-of-network benefits. Instructions on how to file a claim can be found at sentarahealthplans.com.

24/7 Nurse Advice Line

What should I do if I get sick or hurt after business hours or during the weekend?

If you have an illness, injury, or condition that occurs during an evening or weekend, you should call your PCP or doctor's office, or the Sentara Health Plans 24/7 Nurse Advice Line number located on the back of your member ID card.

When you call the 24/7 Nurse Advice Line, a registered

nurse will ask you to describe your medical situation in as much detail as possible. Be sure to mention any other medical conditions you have, such as diabetes or hypertension.

Depending on the situation, you may be advised about appropriate home treatments, or advised to visit your doctor. If necessary, the nurse may direct you to an urgent care center or Emergency Department.

The nurses for our 24/7 Nurse Advice Line have training in emergency medicine, acute care, OB/GYN, and pediatric care. They are well prepared to answer your medical questions. However, since they are unable to access medical records, they cannot diagnose or medically treat conditions, order labs, write prescriptions, order home health services, or initiate hospital admissions or discharges.

Sentara Health Plans also offers a 24/7 Behavioral Health Crisis Line that is staffed by professionals who can triage and assist members going through a crisis. If you need help, you should call the number located on the back of your member ID card. Remember if you have thoughts of harming yourself or someone else, you should get help right away by calling 911 or go to the closest hospital for emergency care.

Emergency Care

What should I do if I have an emergency?

In any life-threatening emergency, always go to the closest Emergency Department or call 911. If you receive emergency care and are admitted, you or a family member should contact Sentara Health Plans within 48 hours (two business days), or as soon as medically possible. This enables Sentara Health Plans to arrange for appropriate follow-up care, if necessary.

How can I tell if it is an emergency?

An emergency is the sudden onset of a medical condition resulting in severe symptoms or pain that an average person with average knowledge of health and medicine (prudent layperson) would seek medical care immediately because there may be serious risk to your



physical or mental health, or that of your unborn child. Some examples of situations that would require the use of an Emergency Department include, but are not limited to:

- heart attack/severe chest pain
- stroke
- loss of consciousness
- loss of pulse or breathing
- poisoning
- convulsions

Sentara Health Plans may review all Emergency Department care retrospectively to determine if a medical emergency did exist. If an emergency did not exist, you could be responsible for payment for all services.

What conditions generally do not require emergency department treatment?

The following conditions do not ordinarily require Emergency Department treatment, and may be more appropriately treated in your doctor's office, or at an urgent care center:

- sprains or strains
- chronic conditions such as arthritis, bursitis, or backaches
- minor injuries and puncture wounds of the skin

What is the difference between an Emergency Department and an Urgent Care Center?

An Emergency Department is designed, staffed, and equipped to treat life-threatening conditions. An urgent care center is a more appropriate place to seek treatment for sudden acute illness and minor injuries when your doctor's office is closed or not available. Copayments and coinsurance amounts for Emergency Department visits are generally higher than copayments for urgent care visits. If you are transferred to an Emergency Department from an urgent care center, you will be charged an Emergency Department copayment/coinsurance.

Do I need to contact Sentara Health Plans or my PCP before going to the Emergency Department/Urgent Care Center?

If you are experiencing a life-threatening emergency, you do not need to call Sentara Health Plans or your PCP, you can proceed to nearest emergency room. If you are unsure whether to visit an Emergency Department or urgent care center, you can call your PCP office or the Sentara Health Plans 24/7 Nurse Advice Line at the number on the back of your member ID card.

Are there any special emergency care policies I should know about?

Yes. Sentara Health Plans may review all emergency care retrospectively, or after the fact, to determine if a true medical emergency did exist. This retrospective review policy is designed to protect you and all other Sentara Health Plans members from the high costs associated with unnecessary use of Emergency Departments and urgent care centers. If you handle non-emergencies as if they are emergencies by seeking treatment at an Emergency Department or urgent care center when a visit to your doctor's office would suffice, you could be responsible for paying a greater portion or all of the charges.





What if I become ill when I am outside of the Sentara Health Plans service area?

Your plan includes coverage for emergency services when you are outside the service area. If you have an unexpected illness or injury when outside of the service area, you should call the 24/7 Nurse Advice Line at the number on the back of your member ID card.

In any life-threatening emergency always go to the closest Emergency Department or call 911.

Remember, Sentara Health Plans may review all Emergency Department care retrospectively, or after the fact, to determine if a medical emergency did exist. If an emergency did not exist, you could be responsible for payment for all services.

What if I need to be hospitalized?

If you received emergency care and are admitted, you or a family member should contact Sentara Health Plans within 48 hours (two business days) or as soon as medically possible. This enables Sentara Health Plans to review your care immediately and to arrange for appropriate follow-up care. Remember, all emergency care may be reviewed retrospectively to make sure it met the criteria for coverage of emergency/urgent care treatment.

If you are admitted to a hospital outside of the Sentara Health Plans service area, call member services at the number on back of your member ID card.

Be prepared to give the following information:

- member name
- reason for treatment
- hospital name
- city and state where treatment is occurring
- name of treating doctor

The doctor or hospital may also call Clinical Care Services.

What happens once I am admitted to the hospital?

As part of your Sentara Health Plans coverage, an RN case manager will follow your case from beginning to end. Your case manager will review your medical record, check your progress, and arrange for your continuing care needs after you leave the hospital.

Pre-Authorization

What is pre-authorization and when is it necessary?

Pre-authorization is a clinical review of all pertinent medical information to determine medical necessity and your Plan's benefit criteria for coverage. The provider of the service is responsible for obtaining preauthorization, when it is required. Patient service coordinators, as well as licensed medical professionals such as RNs, LPNs, social workers, and medical doctors perform the process of pre-authorization by the plan.

Medical services typically requiring pre-authorization include, but are not limited to: hospitalizations, outpatient surgeries, certain diagnostic tests, advanced imaging services (MRI, CT, PET), home health services, hospice, therapies (physical therapy, occupational therapy, speech therapy), rehabilitation services, certain durable medical equipment, prosthetics, skilled nursing facilities, certain injectable drugs, chemotherapy and radiation therapies, and scheduled ambulance transportation.

When you use your in-network benefits, your provider handles pre-authorization. Please keep in mind that this is a certification of medical necessity, not a guarantee of medical payment. Benefits are always paid according to your eligibility at the time of service and the provisions of Sentara Health Plans.

When you use your out-of-network benefits, you have a responsibility for seeing that your provider has obtained any required pre-authorization. The member should follow the plan's pre-authorization procedures and ensure that pre-authorization is obtained for medically necessary services when required.



Your provider can obtain pre-authorization by calling Medical Pre-Authorization at the number on the back of your member ID card and providing the following information:

- your member ID number
- the provider's full name, phone number, and fax number
- the diagnosis and/or procedure
- the plan of treatment
- other pertinent information such as X-rays and lab results

What happens if certain services are not pre-authorized?

If your plan provider's request for pre-authorization of a medical service is denied, Sentara Health Plans will not pay for any cost associated with the requested service. If you wish to appeal the denial, you may call member services to initiate the appeal process. Please keep in mind that if you receive medical services that Sentara Health Plans has denied, you must pay all charges for the services.

If you believe the denial of pre-authorization will result in the loss of life, limb, or permanent injury, be sure to tell the representative at the time you request an appeal. In these situations, you may request an expedited appeal.

Do I need services pre-authorized if I have primary coverage under another health plan?

Your provider must still call the plan to verify pre-authorization requirements even if you have primary coverage under another insurance plan and have Sentara Health Plans as secondary insurance.

How far in advance should my provider obtain pre-authorization?

Your provider should obtain elective pre-authorization at least 7-10 days, or as soon as you are aware, prior to the services being scheduled or provided.

How do I ensure pre-authorization has been obtained?

To ensure pre-authorization has been obtained, sign in at sentarahealthplans.com/members or the Sentara Health Plans mobile app, contact member services at the number on the back of your member ID card, or call your provider.

What if I need to be hospitalized?

If you need to be hospitalized for an elective procedure, your doctor must notify Sentara Health Plans 7-10 business days prior to your admission. If you are hospitalized due to an emergency, you or a family member should contact Optima Health within 48 hours (two business days) of admission, or as soon as medically possible.

Utilization Management

How is utilization of healthcare services determined?

The Clinical Care Services Department at Sentara Health Plans may use any or all of the following procedures to determine your healthcare services coverage:

- pre-authorization
- concurrent review or request for an extension of previously approved services including:
 - hospitalization, skilled nursing facility stays, therapies, rehabilitation, home health, and durable medical equipment
- retrospective review
- case management

Sentara Health Plans staff (nurses and doctors) make coverage decisions based on medical judgment and evidence-based criteria and policies. Our staff does not receive incentives from Sentara Health Plans based on decisions regarding coverage.



How does Sentara Health Plans pay providers?

Sentara Health Plans uses a fee-for-service payment to reimburse doctors for the care they provide. Fee-for-service payment means doctors are paid for medical care each time it is delivered, whether it is for an office visit or another form of treatment. Usually, fee-for-service payments are at a discounted rate, which has been negotiated in advance. Doctors always have the right to discuss all medical care and treatment options with their patients.

What is the Sentara Health Plans Quality Improvement Program designed to do?

The Sentara Health Plans Quality Improvement Program provides a foundation for the development of programs and activities directed towards improving the health of our members. It is designed to implement, monitor, evaluate, and improve processes within the scope of the health plan. Several committees within the organization work on quality improvement (QI) issues, which includes Sentara Health Plans staff and plan providers, and may include representatives from other organizations. Each year, Sentara Health Plans develops a QI program and work plan that outlines our efforts to improve clinical care and service to our members. We identify areas for improving service by analyzing member complaint data and conducting an annual member satisfaction survey. If you would like a copy of the current QI program and work plan or information on other QI activities, please call **1-866-425-5257**.

How does Sentara Health Plans evaluate and determine coverage for new medical technologies?

Since healthcare is constantly changing, the Sentara Health Plans team of health professionals is always researching and evaluating new medical technologies and applications of existing technologies by the following:

- reviewing current medical literature and research studies
- consulting with national technology firms
- researching clinical and national state/government guidelines
- consulting with members, local doctors, and other providers in the Sentara Health Plans network

How can I learn more about health insurance? Visit sentarahealthplans.com/health-insurance-101 to find definitions of common terms and acronyms and also helpful videos to help you learn everything you need to know.





Uniform Summary of Benefits and Coverage (SBC)

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Sentara POS 1000/30/20% - Low Option

Sentara Health Administration, Inc.

Coverage Period: 01/01/2024 – 12/31/2024

Coverage for: Individual/Family | Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit sentarahealthplans.com or call 1-800-543-3359. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1-800-543-3359 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,000/Individual or \$2,000/family in-network . \$1,500/Individual or \$3,000/family out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Prescription drugs ; most services that require a copayment ; and preventive care , vision and materials are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$150/person or \$300/family for Tiers 2, 3, and 4 prescription drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers \$6,000 individual / \$12,000 family. For out-of-network providers , \$8,000 individual / \$16,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , balance-billed charges, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See sentarahealthplans.com or call 1-800-543-3359 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copayment Deductible does not apply	30% coinsurance	--none--
	Specialist visit	\$60 copayment Deductible does not apply	30% coinsurance	--none--
	Preventive care/screening/immunization	No charge Deductible does not apply	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Pre-Authorization required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at sentarahealthplans.com	Preferred Generic drugs (Tier 1)	\$15 copayment Deductible does not apply retail/ \$30 copayment Deductible does not apply mail order	\$15 copayment retail/ mail order not covered	Deductible does not apply to Tier 1 prescription drugs. Coverage is limited to FDA-approved prescription drugs . For specialty drugs, the out-of-pocket amount is limited to \$200 Copayment per retail prescription and \$200 Copayment per mail order prescription. If brand drugs are used when a generic is available, you must pay the difference in cost plus the Copayment or Coinsurance amount. One Copayment or Coinsurance amount covers up to a 31-day supply (retail). Some outpatient prescription drugs in Tier 1, Tier 2, and Tier 3 are available in a 90-day supply through mail order. Tier 4 Specialty Drugs are only available from the Plan's Specialty Pharmacy and are limited to a 31-day supply (retail and mail order).
	Preferred brand and other generic drugs (Tier 2)	\$40 copayment retail/ \$80 copayment mail order	\$40 copayment retail/ mail order not covered	
	Non-preferred brand drugs (Tier 3)	\$50 copayment retail/ \$100 copayment mail order	\$50 copayment retail/ mail order not covered	
	Specialty drugs (Tier 4)	20% coinsurance retail	20% coinsurance retail	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Pre-Authorization required
	Physician/surgeon fees	20% coinsurance	30% coinsurance	--none--

* For more information about limitations and exceptions, see the plan or policy document at [sentarahealthplans.com](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	--none--
	Emergency medical transportation	Non-emergency services: 20% coinsurance Emergency services: \$100 copayment	Non-emergency services: 40% coinsurance Emergency services: \$100 copayment	Pre-authorization required for non-emergency transport.
	Urgent care	\$50 copayment Deductible does not apply	30% coinsurance	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Pre-Authorization required
	Physician/surgeon fees	20% coinsurance	30% coinsurance	--none--
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$30 copayment Deductible does not apply Other visits: 20% coinsurance No charge for EAV Deductible does not apply	30% coinsurance EAV not covered	Pre-Authorization required for intensive outpatient program, partial hospitalization services, electroconvulsive therapy, and Transcranial Magnetic Stimulation. EAV: 3 visits/presenting issue by Sentara EAV providers only
	Inpatient services	20% coinsurance	30% coinsurance	Pre-Authorization required for all inpatient services.
If you are pregnant	Office visits	\$350 global copayment Deductible does not apply	30% coinsurance	Pre-Authorization required for prenatal services. Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	\$30 copayment Deductible does not apply	30% coinsurance	Pre-Authorization required. 100 visits/plan year
	Rehabilitation services	Rehabilitative PT/OT: 20% coinsurance Rehabilitative Speech Therapy: 20% coinsurance	Rehabilitative PT/OT: 30% coinsurance Rehabilitative Speech Therapy: 30% coinsurance	Pre-Authorization required. 30 visits/plan year for PT, OT. 30 visits/plan year for ST

* For more information about limitations and exceptions, see the plan or policy document at sentarahealthplans.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Other Services: 20% coinsurance	Other Services: 30% coinsurance	
	Habilitation services	Not covered	Not covered	--none--
	Skilled nursing care	20% coinsurance	30% coinsurance	Pre-Authorization required. 100 days/plan year
	Durable medical equipment	30% coinsurance	40% coinsurance	Pre-Authorization required for single items over \$750, all rental items, and repair and replacement.
	Hospice services	No charge	30% coinsurance	Pre-Authorization required.
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply	\$30 reimbursement Deductible does not apply	Coverage limited to one exam/plan year from participating VSP Vision Care providers
	Children's glasses	Not covered	Not covered	--none--
	Children's dental check-up	Not covered	Not covered	--none--

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Chiropractic care Cosmetic surgery Dental care (Adult) 	<ul style="list-style-type: none"> Glasses Hearing aids (Adult) Hearing aids (Pediatric) Habilitation services Infertility treatment 	<ul style="list-style-type: none"> Long-term care Pediatric dental check-up Private-duty nursing Routine foot care unless medically necessary Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. (under out-of-network benefit) 	<ul style="list-style-type: none"> Routine eye care (Adult) 	

Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the plan at 1-800-543-3359. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, at 1-877-310-6560 or bureauofinsurance@scc.virginia.gov; the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform; or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to

* For more information about limitations and exceptions, see the plan or policy document at sentarahealthplans.com.

submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Member Services at the number on the back of your member ID card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or your state department of insurance at the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O. Box 1157, Richmond, VA, 23218, 1-877-310-6560 or bureauofinsurance@scc.virginia.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance, P.O. Box 1157, Richmond, VA, 23218, 1-877-310-6560, or bureauofinsurance@scc.virginia.gov.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-687-6260.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-687-6260.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-687-6260.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-687-6260.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$350
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$400
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,360

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$60
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,420

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$60
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

This EXAMPLE event includes services like:

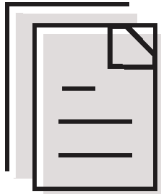
Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$300
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-877-817-3037. *Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.



Benefit Information

**2024 Portsmouth Public
Schools' POS Plan Changes**

Benefit Changes	POS Plan: <ul style="list-style-type: none">• Emergency Services: INN/OON After Deductible You Pay \$100• Mental Health Other Outpatient Services: INN After Deductible You Pay 20%

POS
Sentara Health Administration, Inc.
POS 1000/30/20%
Portsmouth Public Schools
Plan Effective Date: 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 Plan coverage documents issued when You are enrolled, the provisions of the coverage documents will prevail for all benefits, conditions, cost sharing, and limitations and exclusions.

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

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

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

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

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

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

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

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

Your Plan's Maximum Out-of-Pocket Amount means the total dollar amount Members pay, out-of-pocket for most Covered Services during a year. Deductibles, Copayments and Coinsurance for most Covered Services count toward the Maximum Amount. Your Plan may have separate Maximum Amounts for In-Network and Out-of-Network benefits.

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

Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	Out-of-Network
Deductible Plan Year	\$1,000/Individual; \$2,000/Family	\$1,500/Individual; \$3,000/Family
<p>The In-Network and Out-of-Network Deductibles are separate. Most amounts You pay for In-Network Covered Services will count toward meeting the In-Network Deductible. Most amounts You pay for Out-of-Network Covered Services will count toward meeting the Out-of-Network Deductible.</p> <p>The Deductible applies to all Covered Services except for:</p> <ul style="list-style-type: none"> • In-Network Preventive Care Services required by law; • Other services in this document shown as Covered without a Deductible. <p>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.</p> <p>Any amounts applied to the Plan Deductible during the last three months of the Plan year can be carried forward to the next year.</p>		
	In-Network	Out-of-Network
Maximum Out-of-Pocket Plan Year	\$6,000/Individual; \$12,000/Family	\$8,000/Individual; \$16,000/Family
<p>The In-Network and the Out-of-Network Maximum Out-of-Pocket Amounts are separate. Most amounts You pay, for In-Network Covered Services will count toward meeting the In-Network Maximum. Most amounts You pay, for Covered Services Out-of-Network will count toward meeting the Out-of-Network Maximum.</p> <p>The following will not count toward the Plan Maximum Amount(s):</p> <ul style="list-style-type: none"> • Amounts You pay for services not covered under Your Plan; • Amounts You pay for any services after a benefit limit has been reached; • Balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers; • Premium amounts; • Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits; • Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available; • Other services in this document that are shown as excluded from the Maximum Amount. <p>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.</p>		

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

Benefit	In-Network	Out-of-Network
<p style="text-align: center;">Physician Office Visits</p> <p>Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by Plan approved providers. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits.</p> <p>*Pre-Authorization is required for in-office surgery.</p>		
Primary Care Visit	You Pay \$30	After Deductible You Pay 30%
Virtual Consult	No Charge	Not Covered
Specialist Visit	You Pay \$60	After Deductible You Pay 30%
<p style="text-align: center;">Preventive Care</p> <p>Recommended Preventive Care Services are Covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.</p>		
Recommended exams, screenings, tests, immunizations, and other services	No Charge	After Deductible You Pay 30%
<p style="text-align: center;">Outpatient Therapies and Services</p> <p>You Pay a Copayment or Coinsurance amount for each visit for services done in a Physician's office, a free-standing outpatient Facility, a Hospital outpatient Facility, or at home as part of Your Skilled Home Health Care Services benefit. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of a treatment plan for Autism Spectrum Disorder. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.</p>		
Occupational and Physical Therapy* Services limited to 30 combined visits per Plan year.	After Deductible You Pay 20%	After Deductible You Pay 30%
Speech Therapy* Services limited to 30 visits per Plan year.	After Deductible You Pay 20%	After Deductible You Pay 30%
Cardiac Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 20%	After Deductible You Pay 30%
Pulmonary Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 20%	After Deductible You Pay 30%
Vascular Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 20%	After Deductible You Pay 30%
Vestibular Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 20%	After Deductible You Pay 30%

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

Benefit	In-Network	Out-of-Network
IV Infusion Therapy	PCP Office Visit You Pay \$30 Specialist Office Visit You Pay \$60 Outpatient Facility After Deductible You Pay 20%	After Deductible You Pay 30%
Respiratory/Inhalation Therapy	PCP Office Visit You Pay \$30 Specialist Office Visit You Pay \$60 Outpatient Facility After Deductible You Pay 20%	After Deductible You Pay 30%
Chemotherapy and Chemotherapy Drugs*	PCP Office Visit You Pay \$30 Specialist Office Visit You Pay \$60 Outpatient Facility After Deductible You Pay 20%	After Deductible You Pay 30%
Radiation Therapy*	PCP Office Visit You Pay \$30 Specialist Office Visit You Pay \$60 Outpatient Facility After Deductible You Pay 20%	After Deductible You Pay 30%
Pre-Authorized Injectable and Infused Medications* Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient Facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs.	After Deductible You Pay 20%	After Deductible You Pay 30%
<p style="text-align: center;">Outpatient Dialysis</p> 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 20%	After Deductible You Pay 30%
<p style="text-align: center;">Outpatient Surgery</p> 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 20%	After Deductible You Pay 30%

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

Benefit	In-Network	Out-of-Network
<p align="center">Outpatient Lab, Diagnostic, Imaging and Testing</p> <p>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.</p>		
Diagnostic Procedures	After Deductible You Pay 20%	After Deductible You Pay 30%
<p align="center">X-Ray Ultrasound Doppler Studies</p>	After Deductible You Pay 20%	After Deductible You Pay 30%
Lab Work	After Deductible You Pay 20%	After Deductible You Pay 30%
<p align="center">Outpatient Advanced Imaging, Testing and Scans</p> <p>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.</p>		
<p>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</p>	After Deductible You Pay 20%	After Deductible You Pay 30%
<p align="center">Maternity Care</p> <p>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.</p>		
<p align="center">Maternity Care *Pre-Authorization is required for prenatal services</p>	You Pay \$350 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	After Deductible You Pay 30%
<p align="center">Inpatient Services</p>		
Inpatient Hospital Services*	After Deductible You Pay 20%	After Deductible You Pay 30%
Transplants*	After Deductible You Pay 20%	After Deductible You Pay 30%
<p>Skilled Nursing Facility Services* Limited to a maximum of 100 days per Plan year.</p>	After Deductible You Pay 20%	After Deductible You Pay 30%

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

Benefit	In-Network	Out-of-Network
Non-Emergent Ambulance Services		
Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Air, Water, Ground Services*	After Deductible You Pay 20%	After Deductible You Pay 40%
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 20%	After Deductible You Pay 20%
Emergency Ambulance	After Deductible You Pay \$100	After Deductible You Pay \$100
Urgent Care Services		
Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care Facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Urgent Care Services	You Pay \$50	After Deductible You Pay 30%
Mental Health and Substance Use Disorder Services		
Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Virtual Consults must be furnished by approved Plan providers.		
*Pre-Authorization is required for Inpatient Hospital Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.		
Inpatient Hospital Services*	After Deductible You Pay 20%	After Deductible You Pay 30%
Residential Treatment Services*	After Deductible You Pay 20%	After Deductible You Pay 30%
Outpatient Office Visits (PCP, Specialist or Virtual Consults)	You Pay \$30	After Deductible You Pay 30%
Partial Hospitalization/Intensive Outpatient Program Facility Services*	After Deductible You Pay 20%	After Deductible You Pay 30%
Other Outpatient Services	After Deductible You Pay 20%	After Deductible You Pay 30%
Autism Spectrum Disorder* Covered Services include diagnosis and treatment of Autism Spectrum Disorder in children from age two through ten.	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.

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

Benefit	In-Network	Out-of-Network
<p>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.</p>	<p>No Charge for up to 3 visits from the Plan's Employee Assistance providers per presenting issue as determined by treatment protocols.</p>	
<p align="center">Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is Covered from an In-Network Plan Provider or a participating VSP Vision Care provider at the office visit Copayment or Coinsurance amount.</p>		
<p>Insulin Pumps*</p>	<p>No Charge</p>	<p>After Deductible You Pay 30%</p>
<p>Pump Infusion Sets and Supplies*</p>	<p>After Deductible You Pay 20%</p>	<p>After Deductible You Pay 30%</p>
<p>Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution, and continuous glucose monitors, sensors and supplies. *Pre-Authorization is required for talking blood glucose monitors</p>	<p>Covered under the Plan's Prescription Drug Benefit</p>	<p>Covered under the Plan's Prescription Drug Benefit</p>
<p>Insulin, and Needles and Syringes for Injection</p>	<p>Covered under the Plan's Prescription Drug Benefit</p>	<p>Covered under the Plan's Prescription Drug Benefit</p>
<p>Outpatient Self-Management Training, Education, Nutritional Therapy</p>	<p>No Charge</p>	<p>After Deductible You Pay 30%</p>
<p align="center">Prosthetic Limb Replacement</p>		
<p>Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*</p>	<p>After Deductible You Pay 30%</p>	<p>After Deductible You Pay 30%</p>
<p align="center">Durable Medical Equipment (DME) and Supplies</p>		
<p>DME, Orthopedic Devices, Prosthetic Appliances, Devices *Pre-Authorization is required for items over \$750 *Pre-Authorization is required for repair, replacement and rental items.</p>	<p>After Deductible You Pay 30%</p>	<p>After Deductible You Pay 40%</p>
<p align="center">Early Intervention Services For Dependent children from birth to age three.</p>		
<p>Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices.*</p>	<p>Cost sharing determined by the type and place of service.</p>	<p>Cost sharing determined by the type and place of service.</p>

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

Benefit	In-Network	Out-of-Network
Home Health Care		
Includes skilled home health care services for home bound Members. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home.		
Home Health Care* Limited to a maximum of 100 visits per Plan year.	You Pay \$30	After Deductible You Pay 30%
Hospice Care		
Hospice Care*	After Deductible No Charge	After Deductible You Pay 30%
Vision Care		
The Plan contracts with VSP Vision Care to administer this benefit. Services must be received from VSP Vision Care providers.		
Vision Exams Limited to one routine eye exam every 12 months from a VSP provider.	No Charge	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.
Clinical Trials		
Includes "routine patient costs" for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.		
Clinical Trial Services*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Allergy Care		
Allergy Care, Testing, and Serum	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Telemedicine Services		
Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.		
Telemedicine Services	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.

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

Prescription Drugs **LG_150/\$300D_15_40_50_20%%**

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; and
6. Medications subject to restricted distribution by the U.S. Food and Drug Administration.

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

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

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 amount 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.

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

Deductibles, Maximum Out of Pocket Amount (MOOP), and Benefits	
Deductibles	Your Plan has the following separate Pharmacy Deductible that must be met before Coverage for Prescription drugs begins unless otherwise noted: \$150 per person / \$300 per family on Tiers, 2, 3 and 4 per Plan year. Any part of the Plan year Deductible satisfied in the last three months of a Plan year can be carried forward to the next Plan year.
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 test strips, lancets, lancet devices, blood glucose monitors and control solution	No Charge 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 Glucose Monitors, Sensors and Supplies	You pay the cost sharing for the applicable Tier.
Formulary	This Plan has a closed formulary and covers a specific list of drugs and medications. If Your drug is not on Our formulary, We have a process in place to request coverage. Please use the following link to see a list of drugs on the Plan's formulary: sentarahealthplans.com/documents/drug-lists/form-doc-drug-list-standard-formulary.pdf . 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 31-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 31-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 31-day supply.

<p>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.</p>	<p>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.</p>
<p>Preferred Generic Drugs Tier 1</p>	<p>You Pay \$15</p>
<p>Preferred Brand & Other Generic Drugs Tier 2</p>	<p>After Deductible You Pay \$40</p>
<p>Non-Preferred Brand Drugs Tier 3</p>	<p>After Deductible You Pay \$50</p>
<p>Specialty Drugs Tier 4</p>	<p>After Deductible You Pay 20% up to a maximum Copayment of \$200.</p>

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 31-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.
Preferred Generic Drugs Tier 1	You Pay \$30
Preferred Brand & Other Generic Drugs Tier 2	After Deductible You Pay \$80
Non-Preferred Brand Drugs Tier 3	After Deductible You Pay \$100
Specialty Drugs Tier 4	After Deductible You Pay 20% up to a maximum Copayment of \$200.

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 laħgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'ı' hólne'.

1-855-687-6260

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



Pharmacy Information

Pharmacy



Sentara Health Plans pharmacy benefits will only apply if your employer group offers pharmacy that is administered by Sentara Health Plans. If you are unsure whether your pharmacy benefits are administered by Sentara Health Plans, you can refer to your plan documents, call member services at the number on the back of your member ID card, or ask your employer.

FAQs

How will my prescription drugs be covered under Sentara Health Plans?

Sentara Health Plans uses a prescription drug formulary. The formulary is a list of drugs that are covered under your plan. Most plans have a four (4) tier formulary. The tier your drug is placed in will determine your copayment or coinsurance amount. To view the formulary or calculate drug costs, sign in to sentarahealthplans.com/members or the Sentara Health Plans mobile app and select Pharmacy Resources.

- Some drugs require pre-authorization by Sentara Health Plans in order to be covered. Your prescribing provider is responsible for initiating pre-authorization. You should also check your plan documents to see what medications may be excluded from coverage. Sentara Health Plans may also establish monthly quantity limits for selected medications.
- In some cases, your plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition, also known as Step Therapy. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

- Sentara Health Plans may limit quantities of certain medications.

Specialty drugs may only be available through specialty pharmacies, including Proprium Pharmacy. You can check sentarahealthplans.com/member or the Sentara Health Plans mobile app for a listing of specialty medications.

How does Sentara Health Plans determine my prescription drug tier?

Sentara Health Plans has a Pharmacy and Therapeutics Committee, which is composed of doctors and pharmacists. The committee reviews all drugs, including generics, for efficacy, safety, overall disease factors, and cost. Drugs are placed in tiers based on their review and recommendation. Most generic drugs usually fall into the Preferred Generic Drugs tier (tier 1); more expensive generic drugs will be available in Preferred Brand and Other Generic Drugs tier (tier 2).

How much will I have to pay out-of-pocket for my prescription drugs?

Your deductibles, copayments, or coinsurance amounts that may apply to your pharmacy cost are outlined in your plan benefit documents. You must pay your applicable copayment/coinsurance when you pick up your drugs from the retail pharmacy. If your plan includes benefits for mail-order prescription drugs, you may be able to get certain maintenance drugs from your plan's network mail-order pharmacy for lower out-of-pocket costs.

Is it possible that I would ever pay less than my copayment/coinsurance for a prescription?

Yes. If the pharmacy's usual and customary cost is less than your copayment/coinsurance, you will pay the lesser amount. In order to maximize your pharmacy benefit, be sure to present your Sentara Health Plans



member ID card whenever you have a prescription filled. This is important whether the prescription is for a brand or a generic drug because the cost of many drugs can be less than your copayment. Some pharmacies advertise a \$4 drug list; however, that may not be the lowest price for you. For some drugs, the actual cost of the drug with your Sentara Health Plans member ID card may be less than the advertised \$4 generic program.

Are there any restrictions on filling my prescriptions?

There are several things to keep in mind before having your prescriptions filled:

- Registered members of **sentarahealthplans.com** can locate a participating pharmacy by signing in to **sentarahealthplans.com/members** or the Sentara Health Plans mobile app and selecting Pharmacy Resources.
- If you choose to have your prescription filled at a non-participating pharmacy, you will have to pay the full cost of the prescription upfront and file for reimbursement from Sentara Health Plans. You will be responsible for paying all charges in excess of the Sentara Health Plans allowable charge, in addition to any copayment, deductible, or coinsurance amounts specified in your plan documents.
- Some drugs require pre-authorization by Sentara Health Plans in order to be covered. Your prescribing provider is responsible for initiating pre-authorization.
- If you or your prescribing provider requests a brand medication when a generic equivalent is available; you may be responsible for the difference in the cost between the generic and the brand name drug in addition to your copayment/coinsurance and/or deductible.



Express Scripts® Mail-Order Program



With your pharmacy benefits from Sentara Health Plans, you can get 90-day supplies of your maintenance medications delivered right to your door from Express Scripts® Pharmacy.

Along with simple, stress-free ordering and delivery that can save you time and money, you'll also enjoy:

- FREE standard shipping,* with most orders arriving within 5-7 days once shipped
- Access to a hassle-free automatic refill program so you never run out of medication
- Sign in to sentarahealthplans.com/members or the Sentara Health Plans mobile app to refill medications, track orders, transfer prescriptions to our pharmacy, and
- make payments
- 24/7 access to pharmacists and patient care advocates to answer your questions.

Express Scripts Pharmacy is 100% focused on pharmacy and 100% focused on getting you your medications safely, quickly, and accurately.

** Standard shipping costs are included as part of your prescription plan.*

Three easy ways to switch to Express Scripts Pharmacy



ePrescribe

Ask your doctor to send your prescriptions electronically to Express Scripts Pharmacy

Online

Sign in to sentarahealthplans.com/member or the Sentara Health Plans mobile app to activate your pharmacy account. After activating your account, you'll be able to view your prescriptions and savings; then, simply click to transfer your eligible prescriptions to home delivery.

Phone

Call **1-888-899-2653** to learn how to get your long-term maintenance medications delivered by Express Scripts Pharmacy. TTY users can call 711.

sentarahealthplans.com

 **Sentara®**
Health Plans

Frequently Asked Questions

Q: What medications can be delivered?

A: Maintenance medications that you take daily or regularly for an ongoing condition can be delivered right to your door. These often come in a 90-day, versus a 30-day, supply, so you are less likely to miss a dose, which can keep you healthier.

Q: Is it safe to get my medications delivered?

A: It's very safe. Millions of people have their medications delivered every day. Express Scripts Pharmacy ensures packaging is confidential, tamper evident, and weather resistant. If your medication requires specific temperature control, it is shipped using special packaging and coolant packs, which are adjusted for weather forecast and climate.

Q: How long will it take to receive my home delivery medications?

A: After Express Scripts Pharmacy receives your prescription from your doctor, your medication usually arrives within 5-7 days once shipped. It may take longer if Express Scripts Pharmacy needs additional information from your doctor or if your medication is temporarily unavailable. In such cases, Express Scripts Pharmacy will notify you and give you options. You can always track the progress of your medication shipment online or through the Sentara Health Plans mobile app.

Q: How do I refill my prescriptions?

A: You can order a refill by:

- using the pharmacy portal on
- **sentarahealthplans.com/members**
- using the Sentara Health Plans mobile app
- calling toll-free **1-888-899-2653** or on your prescription label

All of these options are available 24 hours a day, 7 days a week.

sentarahealthplans.com

Q: How do I set up automatic refills?

Automatic refills from Express Scripts Pharmacy are available for qualifying long-term daily medications. When you enroll prescriptions in the auto-refill program, your prescriptions will be automatically refilled and shipped to you at the appropriate time. Express Scripts Pharmacy will contact you before processing the order to confirm delivery. You can make changes to the delivery date, the address, and more on the mobile app and website.

You can set up automatic refills using the pharmacy portal on **sentarahealthplans.com/members** or the Sentara Health Plans mobile app. After you sign in to your account, you simply select the prescriptions you'd like to have automatically refilled and follow the prompts. You can also speak directly to an Express Scripts Pharmacy patient care advocate to enroll your prescription(s) in the auto-refill program; simply call the toll-free number on the back of your member ID card or on your prescription label.

Q: What if I have a question about my medication or want to talk to a pharmacist? Where do I call with additional questions or for help?

A: You can always reach a live person—a patient care advocate or a pharmacist—to help you at Express Scripts Pharmacy, 24 hours a day, 7 days a week. Simply contact Express Scripts Pharmacy at **1-888-899-2653**.



Frequently Asked Questions

Express Scripts® Mail-Order Program



1. What medications can be delivered?

Maintenance medications that you take daily or regularly for an ongoing condition can be delivered right to your door. These often come in a 90-day, versus a 30-day, supply, so you are less likely to miss a dose, which can keep you healthier.

2. Is it safe to get my medications delivered?

It's very safe. Millions of people have their medications delivered every day. Express Scripts Pharmacy ensures packaging is confidential, tamper evident, and weather resistant. If your medication requires specific temperature control, it is shipped using special packaging and coolant packs, which are adjusted for weather forecast and climate.

3. How long will it take to receive my home delivery medications?

After Express Scripts Pharmacy receives your prescription from your doctor, your medication usually arrives within 5-7 days once shipped. It may take longer if Express Scripts Pharmacy needs additional information from your doctor or if your medication is temporarily unavailable. In such cases, Express Scripts Pharmacy will notify you and give you options. You can always track the progress of your medication shipment online or through the Sentara Health Plans mobile app.

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You can order a refill by:

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- using the Sentara Health Plans mobile app
- calling toll-free **1-888-899-2653** or number on your prescription label

All of these options are available 24 hours a day, 7 days a week.

5. How do I set up automatic refills?

Automatic refills from Express Scripts Pharmacy are available for qualifying long-term daily medications. When you enroll prescriptions in the auto-refill program, your prescriptions will be automatically refilled and shipped to you at the appropriate time. Express Scripts Pharmacy will contact you before processing the order to confirm delivery. You can make changes to the delivery date, the address, and more on the mobile app and website.

You can set up automatic refills using the pharmacy portal on **sentarahealthplans.com/member** or the Sentara Health Plans mobile app. After you sign in to your account, you simply select the prescriptions you'd like to have automatically refilled and follow the prompts. You can also speak directly to an Express Scripts Pharmacy patient care advocate to enroll your prescription(s) in the auto-refill program; simply call the toll-free number on the back of your member ID card or on your prescription label.

Have questions about medications or want to talk to a pharmacist?

Call Express Scripts at 1-888-899-2653.

1. What is a specialty pharmacy?

Specialty pharmacies handle high-cost medications for complex health conditions. These medications often require special handling, disposal, and/or monitoring. Pharmacy team members help to identify and remove barriers so patients are able to take their medications and thus improve their quality of life.

2. What service does Proprium Pharmacy provide?

- a live answer by a team member every time you call during business hours
- support with insurance issues and financial assistance program enrollment
- refill reminder calls/text messages to help you refill your medications on time
- Patient Management Program: personalized care for every patient. We will work with you and your healthcare providers to develop a care plan based upon your individual health conditions.

3. What are some of the potential benefits of working with Proprium Pharmacy's patient management program?

- better understanding of your condition and prescribed medication regimen
- improved ability to take your medications as ordered by your doctor
- assistance with side effect management
- improvement in quality of life and overall health

4. What are some of the potential limitations of working with Proprium Pharmacy's patient management program?

The program is intended to aid patients in managing their health conditions and is not intended as a cure.

5. How much will my medications cost?

Medication costs vary based upon a patient's insurance plan and the medication prescribed. We will be able to determine your out of pocket costs such as deductibles, copayments and coinsurance as soon as we have processed the claim with the insurance company. We will ensure you are aware of your financial responsibility before sending the medication to you.

6. What if my insurance company doesn't cover my medications or I cannot afford the copayment and/or coinsurance?

We have patient care advocates who are dedicated to working with your physician and insurance company to obtain coverage for your medications wherever possible. These patient care advocates also perform a thorough investigation and eligibility review of available patient financial assistance programs with the goal of lowering your cost as much as possible.

7. What if Proprium Pharmacy is not a preferred provider for my insurance?

If Proprium Pharmacy is considered out-of-network by your insurance, our patient care advocates will consult with your insurance company to determine what the cost difference is for you to use our pharmacy versus an in-network pharmacy. We will provide our costs to you in writing and will work with you to determine the best avenue for you to obtain your medication.

**Call Proprium Pharmacy
toll-free at 1-855-553-3568**

8. Does Proprium Pharmacy have access to all specialty medications?

Proprium Pharmacy has access to most specialty medications. However, in the event we do not have access to your medication, we will transfer your prescription to a pharmacy that can provide the medication and we will contact you to let you know where your medication has been transferred.

9. Will Proprium Pharmacy ever substitute my brand name medication with a generic version?

According to the FDA, an approved generic drug is the same as a brand-name drug in dosage, safety, strength, quality, performance, and intended use; and can be safely substituted. Proprium Pharmacy will substitute for the generic alternative unless your doctor indicates the brand product is medically necessary. Your insurance may charge a higher copayment in these circumstances.

10. How do I pay for my medications?

You can pay for your medications using any major credit card or debit card. We also accept both Health Savings Account (HSA) and flexible spending account (FSA) cards.

11. How do I receive my medications?

Your medications will be shipped to your home, work, or physician's office via a local or national courier service. Confidential packaging is used to ensure protection of your privacy.

12. What is the cost for delivery?

Nothing—the pharmacy will deliver your medication at no charge. Certain circumstances may require a re-delivery fee. How do I refill my medication?

13. How do I refill my medication?

One of our staff members will contact you approximately seven days prior to your refill due date to coordinate the delivery of your medications and needed supplies. These calls/texts are

designed to serve as a reminder to refill your medications on time. If you don't hear from us and are due for your refill, please call **757-553-3568** or toll-free **1-855-553-3568**.

14. How will I know if my medication is recalled and what should I do?

Proprium Pharmacy receives alerts when a medication is recalled and we follow the provided recommendations from the FDA. We will reach out to you if you have received an affected product that requires action. Please call us if you have any questions regarding a recalled product.

15. How will I know if my order is delayed?

Meeting our promised delivery times is a top priority for Proprium Pharmacy. However, if an unforeseen delay occurs, we will contact you as soon as we learn of the delay to discuss the circumstances and will work with you to make new arrangements. If you don't receive your order as expected, please let us know as soon as possible.

16. What should I do if I am experiencing side effects to my medication?

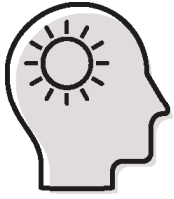
Call 911 immediately if you believe your symptoms are life threatening. Otherwise, please contact the pharmacy at **757-553-3568** or toll-free at **1-855-553-3568** any time of day and one of our pharmacists will help guide you.

17. How can I inquire about my order's status?

Please contact the pharmacy at **757-553-3568** or toll-free at **1-855-553-3568** and we can inform you of your order status.

18. Can I communicate with you by TTY or other assistive telephone device?

Absolutely. We utilize Virginia Relay (dial 7-1-1) to assist us with communication with patients who require these services. You may also designate a caregiver or family member to speak with us if you prefer.



Behavioral Health Information

Behavioral Health Information



Mental/Behavioral Health and Substance Use Disorder Services

Inpatient services, outpatient office visits, and virtual counseling for the treatment of mental health and substance use disorders are covered as medical benefits.

Pre-Authorization is required for inpatient services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electroconvulsive therapy.

How to receive services

- Call Sentara Health Plans at **1-800-648-8420** to be directed to a participating behavioral health provider. It is not necessary to go through your primary care physician.
- Contact a participating behavioral health provider directly to arrange for an initial authorization.

If hospitalization is required, the behavioral health provider will arrange for admission to the appropriate facility.

Emergency services

If currently in treatment, contact the attending behavioral health provider.

If not currently receiving care, call Sentara Behavioral Health Services, Inc. at **1-800-648-8420**, and arrangements will be made for the member to be seen by a behavioral health professional. In order to ensure a prompt response to any clinical emergency, a 24-hour crisis hotline is available.

If you feel you are engaged in behaviors that pose an immediate danger to yourself or to the life of another, please call 911 or go directly to an Emergency Department facility.

Exclusions

Non-medical ancillary services are not covered. These may include, but are not limited to: vocational rehabilitation services, employment counseling, health education, expressive therapies, or other non-medical services. Residential treatment center care or care in other non-skilled settings are not covered when services are merely custodial, residential, or domiciliary in nature.

The member is responsible for all applicable copayments, coinsurances, and any deductibles depending on the type and place of service as listed on the Benefit Summary.

Members should refer to Plan documents for Plan copayments, coinsurances, deductibles, and maximum out-of-pocket amounts, in addition to coverage exclusions and limitations.

**Behavioral Health Crisis
Line Toll free. Available
24 hours a day, 7 days a
week 833-717-2310.**





Sentara Employee Assistance Program (EAP)

Sentara EAP can assist you and your household members with challenges you may be facing in your personal and professional lives.

Whether you're trying to improve a relationship, find tools to manage stress or anger, explore child or eldercare resources, cope with grief and loss, manage conflict with a coworker or an employee, or make other positive changes in your life, Sentara EAP is here to help.

Easy

Call us at **1-800-899-8174** to schedule an in-person, telephonic, or virtual counseling appointment. You don't need to go through your manager or human resources department to access counseling services.

Confidential

Discussions with Sentara EAP are protected by strict privacy laws. We will not share any information without your consent or unless required by law.

No cost

Our services are covered by your employer, meaning there's no cost to you or your household members.

Online Resources

Sign in anonymously to **SentaraEAP.com** to:

- explore helpful articles and tools on relationships, emotional well-being, work/life balance, and financial and legal concerns
- watch webinars and on-demand courses on topics such as self-growth and professional development
- read inspirational posts and learn more about Sentara EAP and our services

Call us or contact your human resources department for your organization's username.

FAQs

What can I expect when I call Sentara EAP?

Our friendly team members will ask for basic information, such as your name and your employer. They will assist you with scheduling a counseling appointment or provide you with the right resources based on your needs. You can choose an in-person, telephonic, or HIPAA-compliant virtual counseling appointment.

How can EAP counseling help me?

When you feel overwhelmed or when your typical coping skills aren't working, our clinicians can provide you with a different perspective and offer suggestions or interventions you haven't considered. Our focus is on helping you manage your life in a healthy and productive way.

What happens at a counseling session?

You'll first complete some basic paperwork and a health questionnaire. Next, you'll meet with a clinician who will assess your situation and work with you to develop solutions. Counseling sessions typically last about 45 minutes.

Do you offer other services in addition to counseling?

Yes. We encourage you to visit **SentaraEAP.com** to access resources for personal and professional development and trusted content on work and life topics of interest to you.

You and your household members can receive up to three (3) counseling sessions per presenting issue.

Simply call 1-800-899-8174 or visit SentaraEAP.com to get started.



Other Health Insurance Information



Health and Preventive Services

Overview

Sentara Health Plans department of Health and Preventive Services provides individual and group programs to improve health and prevent disease. The department offers a wide range of services including direct mail reminders, health screenings, self-learning programs, online education, flu shots, and selected classes.

Personal Health Assessment and Health Coaching

The completion of a Personal Health Assessment (PHA) includes the identification of health risks for members and targeted interventions to reduce risks and improve health. Members receive health risk information targeted at their readiness to change. Sentara Health Plans has a powerful resource, MyLife MyPlan Connection, to help members adopt healthy behaviors, reduce health risks, and lower their lifetime cost of care. MyLife MyPlan Connection offers our members flexible programs, expert guidance, and inspiration to take charge of their own health, whether they are continuing healthy habits, or making a change to improve their health. It all begins when the member completes a Personal Health Assessment—and creates the foundation for their Health Record and coaching program. Our health coaching partner offers a comprehensive online activities tool, known as the Daily Habits. This online coaching program delivers a personalized, interactive, and motivational experience to help members take action and sustain healthy habits in a fun way. Sentara Health Plans also provides telephonic disease management coaching for coronary heart disease, heart failure, diabetes, respiratory conditions, and weight management.

Healthy Publications

Members can visit sentarahealthplans.kramesonline.com/ for valuable information about health improvement, disease and condition management, and preventive healthcare. Members can also visit WebMD® Health Services to learn about specific health topics, recipes, request newsletters and other

health resources. Access WebMD Health Services by completing your personal health assessment on sentarahealthplans.com.

Patient Identification Manager Reminder System

The Patient Identification Manager Reminder System informs members of recommended immunizations and preventive health screenings that help fight communicable disease and diagnose cancer in the earliest, most treatable stages. These programs give members valuable and current information and encouragement to reduce health risks. Employees who improve their health can reduce their healthcare needs, reduce absenteeism, and reduce healthcare costs. Initiatives of this system include:

- Mammography reminders: Women age 46 and older who have not had a mammogram in the previous 12 months receive a postcard during their birthday month. This card informs them of the recommended mammography schedule, and the importance of mammography and cervical cancer screening.
- Cervical cancer screening reminders: Women age 24 and older who have not had a cervical cancer screening in the previous 12 months receive a postcard during their birthday month. This card informs them of Pap Test recommendations, and the importance of cervical cancer and mammography screening.
- Healthy pregnancy mailings: Once the health plan learns of a member's pregnancy, she receives the following:
 - the Planning a Healthy Pregnancy Self-Care Handbook
 - a letter and magnet featuring the childhood immunization schedule and our wishes for a healthy delivery (sent once member is in her seventh month of pregnancy)
 - a paid subscription to one of four parenting magazines of her choice
- Immunization postcards: Parents receive a postcard regarding basic immunization schedule for children at 6, 12, and 18 months of age.
- Birthday cards: All plan members age 3 and over



receive a birthday card during their birthday month from the plan. Part of this mailing includes a bookmarker that serves to remind members of the preventive health guidelines they should follow to achieve their personal best health.

- **Physician notifications:** Physicians receive monthly lists of their patients (our members) who were reminded through the PIM System and have still not completed their preventive screenings.

Based on health screening findings, members receive group, individual, and self-paced programs to reduce cardiovascular health risks and promote health.

Healthy Programs

- **Eating for Life** is an award-winning educational program that helps participants develop healthy eating and exercise habits.
- **Get Off Your Butt: Stay Smokeless for Life** is an educational program offering support for anyone who wants to quit tobacco use.
- **Guided Meditation** is a program that invites listeners to experience a calm, peaceful retreat from everyday stressors.
- **Healthy Habits Healthy You** is a program that offers helpful ways to prevent Type 2 diabetes and heart disease with healthy food choices, managing body weight, exercising, and finding ways to relax and get more sleep.

Movement Programs

Tai Chi is a program that helps your body to mentally and physically relax. The movements enhance your blood flow, release muscle tension, and improve your balance.

The MoveAbout Program is designed to assist members in their journey to become more active and stay healthy. Learn about different types of physical activity and ways to move throughout the day to achieve a goal of 150 minutes of moderate activity each week.

Yoga programs include stretching and strengthening exercises to help improve flexibility, strength and cardiovascular health. Chair Yoga is also available.





Complementary Alternative Treatments

Each covered individual is offered a discount on acupuncture, chiropractic, therapeutic massage services, physical therapy, occupational therapy, and podiatry through the ChooseHealthy® Program. Participating providers extend a 25% discount off their usual and customary charges.

How to Receive Services

- Visit sentarahealthplan.com to register for the ChooseHealthy Program.
- Select a participating healthcare provider and schedule an appointment, a referral is not necessary.
- Present your member ID card at the time of service to receive the CAM discount. The member is responsible for payment of services at each visit. There are no claim forms to file.

If chiropractic care is covered under the Plan's medical benefit, the member may find it beneficial to use this discount program after the annual Plan limit has been met, or for services not covered under that benefit.

Please note that this program is not insurance. You should check any insurance benefits you have before using this discount program, as those benefits may result in lower costs to you than using this discount program. You are obligated to pay for all healthcare services, but will receive a discount from those healthcare practitioners who have contracted with the discount program. The discount program has no liability for providing or guaranteeing services, and assumes no liability for the quality of services rendered.

For more information, visit
sentarahealthplans.com/members/health-and-wellness/discounts/complementary-alternative-treatments





Staying Healthy

Sentara Health Plans is committed to helping you reach your best health. You can do your part by:

- eating a healthy diet
- avoiding all tobacco products
- maintaining a healthy weight
- keeping your blood pressure under control
- exercising regularly
- maintaining healthy cholesterol levels

If you do not know your blood pressure or cholesterol levels, see your doctor and get to know your numbers. Your heart health depends on your management of these essential indicators of health. If your numbers are higher than they should be, follow your doctor's advice and take advantage of information and support offered by Sentara Health Plans.

Follow the check-up and immunization schedule below to reach your best health. The screenings listed by age and frequency help diagnose diseases in the earliest, most treatable stages. This schedule is recommended for most people. If your doctor recommends a different schedule, please follow his or her advice.

Regular Check-Up Schedule

Adults: 18+ (Yearly)

Infants and Children: Under 3 (Ages 2-5 days; and 1, 2, 4, 6, 9, 12, 15, 18, and 24 months)

Children and Teens: 3-18 (Yearly)



Other Health Insurance Information



Children's Immunization Schedule

Use this chart to help keep track of your child's immunizations and ensure the best protection from disease.

Sentara Health Plans Covered Immunizations	Recommended Immunizations <i>(check your plan documents to verify coverage)</i>
Birth	Hepatitis B
2 months	Diphtheria/Tetanus/Pertussis Poliovirus Haemophilus influenza type b Hepatitis B Pneumococcal conjugate Rotavirus
4 months	Diphtheria/Tetanus/Pertussis Poliovirus Haemophilus influenza type b Pneumococcal conjugate Rotavirus
6 months	Diphtheria/Tetanus/Pertussis Poliovirus Haemophilus influenza type b Hepatitis B Pneumococcal conjugate Influenza Yearly COVID-19 Hepatitis A
12-18 months	Diphtheria/Tetanus/Pertussis Measles/Mumps/Rubella Poliovirus Haemophilus influenza type b Hepatitis B Varicella zoster virus Pneumococcal conjugate Influenza Yearly COVID-19 Varicella
4-6 years	Diphtheria/Tetanus/Pertussis Poliovirus Measles/Mumps/Rubella Influenza Year COVID-19
11-18 years	Tetanus/Diphtheria (Repeat every 10 years through life) <ul style="list-style-type: none"> If your child was unable to receive all immunizations listed above, your doctor may complete immunizations during this time. Measles/Mumps/Rubella Poliovirus (if child has not received second dose) Influenza yearly COVID-19 Meningococcal (Meningitis) Talk with your doctor about when this immunization is needed HPV (2–3 doses, depending on age at initial vaccination)

Note: Many of these immunizations may be combined, rather than given as individual injections. In addition, specific situations may arise for children who have not or should not receive their immunizations according to this schedule. Discuss immunizations with your physician.

Sources: Sentara Health 2023 Clinical Guidelines, CDC Recommended Childhood and Adolescent Immunization Schedule 2013 and CDC Recommended Adult Immunization Schedule 2023



Preventive Screening Reminders

Screening	Recommendations
Adult Immunizations	
Influenza (Flu Shot)	Annually
Tetanus, Diphtheria, Pertussis (Td/Tdap)	First dose by age 18, then every 10 years—discuss options with your physician Complete at age 65 or per your physician's recommendation
Pneumonia Shot	
COVID-19	2 or 3 dose primary and booster
Colorectal Screening*	
Colonoscopy, or	Complete by age 45 and then every 10 years
Sigmoidoscopy, or	Complete by age 45 and then every 5 years
Fecal Occult Blood Test	Complete by age 45 and then yearly
Early Cancer Detection - Female*	
Pap Test	Start by age 24 and then retest per your physician's recommendation
Clinical Breast Exam	Complete per your physician's recommendation
Mammogram	Start by age 45 and then retest per your physician's recommendation
Early Cancer Detection - Male*	
Digital Rectal Exam	Start by age 50 (age 40 for those at risk) then yearly
PSA (prostate-specific antigen)	Complete per your physician's recommendation

Visit

sentarahealthplans.com/mylifemyplan
for important information about health
improvement programs.

Sources: Sentara Health Plans 2023 Clinical Guidelines.

CDC Recommended Childhood and Adolescent Immunization Schedule 2023 and CDC Recommended Adult Immunization Schedule 2023

*Benefit coverage may vary by plan. Consult member services by calling the number on the back of your member ID card.



Preventive Services Covered Under Health Care Reform

Covered Preventive Services for Adults

Abdominal aortic aneurysm screening: men

Alcohol misuse: screening and counseling

Aspirin use: adults ages 50–59 with risk of cardiovascular disease

Cholesterol screening: regular screening for adults ages 45–75, selective screenings for adults ages 76–85

Consultation for screening colonoscopy

Depression screening

Diabetes screening: adults with high blood pressure

Falls prevention: adults 65 years or older—Vitamin D and exercise or physical therapy

Healthy diet and physical activity counseling: adults with cardiovascular disease risk factors

Hepatitis B screening: adults at increased risk

Hepatitis C virus infection screening: adults ages 18–79

HIV pre-exposure prophylaxis (PrEP)

HIV screening

Hypertension screening: adults ages 18 or older without known hypertension

Immunization vaccines:

- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus

- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella

Lung Cancer Screening: adults ages 50–80 with 20 pack-year smoking history and currently smoke or who have quit within the past 15 years

Male Condoms

Prediabetes and type 2 diabetes screening: asymptomatic adults 35–70 who are overweight

Under the Affordable Care Act, certain preventive services and medications are covered at no cost to the member¹ when administered by an in-network plan physician.

Statin medications²: adults ages 40–75 with no history of cardiovascular disease who have one or more risk factors and calculated 10-year risk

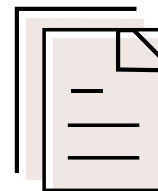
STI counseling: adults at increased risk

Syphilis screening

Tobacco use counseling, generic and over-the-counter medications, and cessation interventions

Tuberculosis screening

Unhealthy drug use: adults ages 18 and older



¹An office visit copayment may be charged to health plan members for some services.

²Select medications only are covered at no cost to the member. Please contact member services or pharmacy services at the number on the back of your member ID card for more information



Covered Preventive Services for Women, Including Pregnant Persons

Anemia screening: pregnant women

Aspirin use: after 12 weeks of gestation in women who are at high risk for preeclampsia

Bacteriuria screening

Behavioral health counseling for healthy weight and weight gain in pregnancy

BRCA risk assessment and genetic counseling/ screening

Breast cancer chemoprevention counseling

Breast cancer preventive medication²

Breast cancer screening: women over age 40

Breast feeding support and counseling

Cervical cancer screening

Chlamydia infection screening

Contraception: All Food and Drug Administration-approved contraceptive methods and intrauterine devices (IUD); sterilization procedures including tubal ligations and Essure; and patient education and counseling; not including abortifacient drugs. Generic oral contraceptives are eligible for 100% coverage.

Decision making/sharing by clinicians with women at increased risk for breast cancer

Depression screening

Double electric breast pumps, parts, and milk storage supplies

Folic acid supplementation

Gestational diabetes screening: asymptomatic pregnant persons at 24 weeks of gestation or after

Gonorrhea screening

Hepatitis B screening at first prenatal visit HIV screening: pregnant persons

HPV Test

Intimate partner violence screening and counseling

Lactation support and counseling Osteoporosis screening: postmenopausal women younger than 65 at increased risk, and women over 65 or at high risk

Perinatal depression counseling and interventions Preeclampsia screening and prevention Rh incompatibility screening: first pregnancy visit and between 24 and 28 weeks gestation

Syphilis screening

Weight and nutrition counseling: women ages 40-60

Well-woman visits

Tobacco counseling and intervention



Please visit
[sentarahealthplans.com](https://www.sentarahealthplans.com)
to determine member
cost share for brand name
oral contraceptives.



Covered Preventive Services for Children

Alcohol and drug use assessments

Autism screening: children at age 18 and 24 months

Behavioral assessments

Blood pressure screening

Cardiac disease screening: at-risk children and adolescents ages 11-21

Cervical dysplasia screening: sexually active females

Congenital hypothyroidism screening: newborns

Dental cavities prevention: infants and children up to age five years

Depression screening: adolescents

Developmental screening: children under age three, and surveillance throughout childhood

Dyslipidemia screening: children at high risk of lipid disorders

Gonorrhea prophylactic medication: newborns

Hearing loss screening: newborns

Height, weight, and body mass index measurements

Hematocrit or Hemoglobin screening

Hemoglobinopathies screening: newborns

Hepatitis B screening: ages newborn-21

Hepatitis C virus infection screening: adolescents





HIV screening Immunization vaccines:

- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type b
- Hepatitis A
- Hepatitis B
- Human
- Papillomavirus
- Inactivated
- Poliovirus Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

Iron supplementation

Lead screening: for children at risk of exposure
Medical history

Obesity screening: children and adolescents

Oral fluoride supplementation starting at age six months for children whose water is fluoride deficient

Oral health risk assessment

Phenylketonuria (PKU) screening: newborns

Skin cancer behavioral counseling: children, adolescents and young adults ages 10-24 years old

STI prevention counseling and screening: for all sexually active adolescents

Suicide risk screening: ages 12-21

Tobacco use interventions: school-aged children and adolescents

Tuberculin testing for children at higher risk of tuberculosis





Protect Yourself, Protect Others: Vaccines and Immunizations

Flu Vaccine

The flu vaccine is covered for members with medical and/or pharmacy benefits administered by Sentara Health Plans. The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccine for everyone six months of age and older, as the first and most important step in protecting against this serious disease.

COVID-19 Vaccine

The seasonal flu and COVID-19 are both contagious respiratory illnesses with similar symptoms, but they are caused by different viruses. The COVID-19 vaccine is also covered for members with medical and/or pharmacy benefits administered by Sentara Health Plans. It is safe for you to be given the flu vaccine and COVID-19 vaccine at the same time. Members may visit the following locations to receive these vaccines:

Your doctor:

- Check with your physician to see if they offer the vaccines. *A copayment may apply.*

Your local pharmacy:

- We recommend that you call the pharmacy in advance to check the availability of the vaccines

If you need additional assistance finding a location to receive the vaccines, contact Sentara Health Plans member services at the number on the back of your member ID card or go to [sentarahealthplans.com/member](https://www.sentarahealthplans.com/member) to search for participating providers and pharmacies.

Pneumonia Vaccine

The CDC defines pneumonia as an infection of the lungs that can cause mild to severe illness in people of all ages. Signs of pneumonia can include coughing, fever, fatigue, nausea, vomiting, rapid breathing or shortness of breath, chills, or chest pain. Adults 65 years of age or older, who smoke, have asthma, have underlying medical conditions (like diabetes or HIV/AIDS) and children younger than five years of age are at increased risk for getting pneumonia. There are several types of vaccines for pneumonia, to learn more visit [sentarahealthplans.com/members](https://www.sentarahealthplans.com/members).





Preventive Vision Care

Sentara Health Plans contracts with VSP to administer the preventive vision services benefit. Each member is eligible to receive a routine eye examination and refraction once every 12 months from a VSP Provider.

The member is responsible for all applicable copayments, coinsurances, and any deductibles depending on the type and place of services as listed on the Plan's Benefit Summary.

Members should refer to Plan documents for Plan copayments, coinsurances, deductibles, and maximum out-of-pocket amounts, in addition to coverage exclusions and limitations.

To receive covered services

- Select a participating VSP provider from the Plan's provider directory or by calling **1-800-877-7195**.
- Automated location information is available 24 hours a day. VSP Customer Service representatives are available Monday through Saturday, from 9:00 a.m. to 8:00 p.m. ET.
- When you visit or call the Plan provider, have your member ID card handy. They will verify eligibility, your Plan's covered services, and any applicable copayment or coinsurance using the information on your member. Payment is due when you receive services.
- If the vision provider determines that you need additional medical care, you should contact your primary care physician or other Plan physician for treatment options.



Out-of-Network coverage

If you visit a non-Plan provider for an examination, you will be responsible for paying the provider in full at the time services are rendered. For covered services, members will be reimbursed according to the out-of-network benefit on the Benefit Summary.

For reimbursement, please call VSP Customer Service at **1-800-877-7195** to verify eligibility and request an Out-of-Network Claim Form. You will need itemized receipts that indicate patient name and date of service, services provided, and the amount charged for each service.



Additional Information

Current members with questions regarding benefits may call member services at the number on the back of their member ID card or visit **sentarahealthplans.com** to view Plan documents and find network physicians.

If you are considering enrolling for the first time and have questions, please contact the group's Benefits Administrator.

A telecommunications device for the hearing impaired can be accessed by dialing **1-800-828-1140** or 711.



Diabetes Treatment

Pre-Authorization is required for insulin pumps and pump infusion sets and supplies.

Coverage includes benefits for FDA-approved equipment and supplies 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.

Insulin pumps, pump infusion sets and supplies, outpatient self-management training and education, and nutritional therapy are covered under the Plan's medical benefits.

Insulin, needles, and syringes as well as testing supplies (test strips, lancets, lancet devices, blood glucose meters, control solution, and continuous blood glucose monitors, sensors, and supplies) are covered under the Plan's pharmacy benefits. Members can pick up supplies at any network pharmacy or may continue

to receive their diabetic Supplies through Edgepark pharmacy, a valid prescription from their prescriber is required. LifeScan products are the preferred brand.

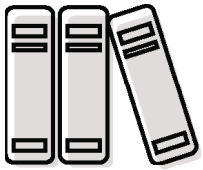
An annual diabetic eye exam is covered when received from a Sentara Health Plans provider or a participating VSP Provider.

Sentara Health Plans also covers in-person outpatient self-management training and education—including medical nutrition therapy. Training must be provided by a certified, registered, or licensed healthcare professional. Members may call 1-800-SENTARA for information on training and educational classes.

The member is responsible for all applicable copayments, coinsurances, and any deductibles depending on the type and place of service as listed on the Plan's Benefit Summary.

Contact member services at the number on the back of the member ID card or visit sentarahealthplans.com/members/health-and-wellness/health-conditions/diabetes-management for more information.






Additional Resources





Simplicity at your Fingertips


As you read through the pages of this section, you will learn more about the various tools available to our members. Sign in and register on sentarahealthplans.com/members or the Sentara Health Plans mobile app for 24/7/365 access to all your important plan information—when and where you need it.


With a consistent design and functionality for a seamless experience, both the mobile app and the member portal include secure access to deductible and maximum out-of-pocket balances, claims, authorizations, treatment cost estimates, member ID cards, flexible spending accounts¹, and other important health plan information. In addition, members can:

 schedule virtual consults for medical and behavioral healthcare

 participate in wellness activities and track health progress

 contact member services

 get important preventive care reminders

 search for nearby doctors and hospitals

and much more!

¹ Applies to members with Equity Health Savings Account or Design Health Reimbursement Account plans

At Sentara Health Plans,
we empower our members
to stay informed and
be involved in their care, so
they can get the most from
their health plan.





MYLIFE MYPLAN: My Health Assistant

Your 24/7 resource to help you keep your eyes on the prize

Make checking in with My Health Assistant part of your regular routine, and you'll have what it takes to start a good health routine and stick with it. My Health Assistant, powered by WebMD Health Services, uses the goals and activities you select to create simple weekly plans that get you from start to success. During your journey, you'll enjoy an interactive online experience that's motivational, fun, and invigorating.

Focus on one or more of the following areas:

- nutrition
- exercise
- weight loss
- stress management
- emotional health
- tobacco cessation

Your Digital Health Assistant (DHA)

The DHA is an online coach that creatively engages you to improve your overall health and wellness with specific personal calls to action to help you form healthy habits and achieve your goals.

Ready—Accessing the Digital Health Assistant

DHA activities are customized to you, your health plan, and your wellness program. You can access this tool from the Sentara Health Plans website:

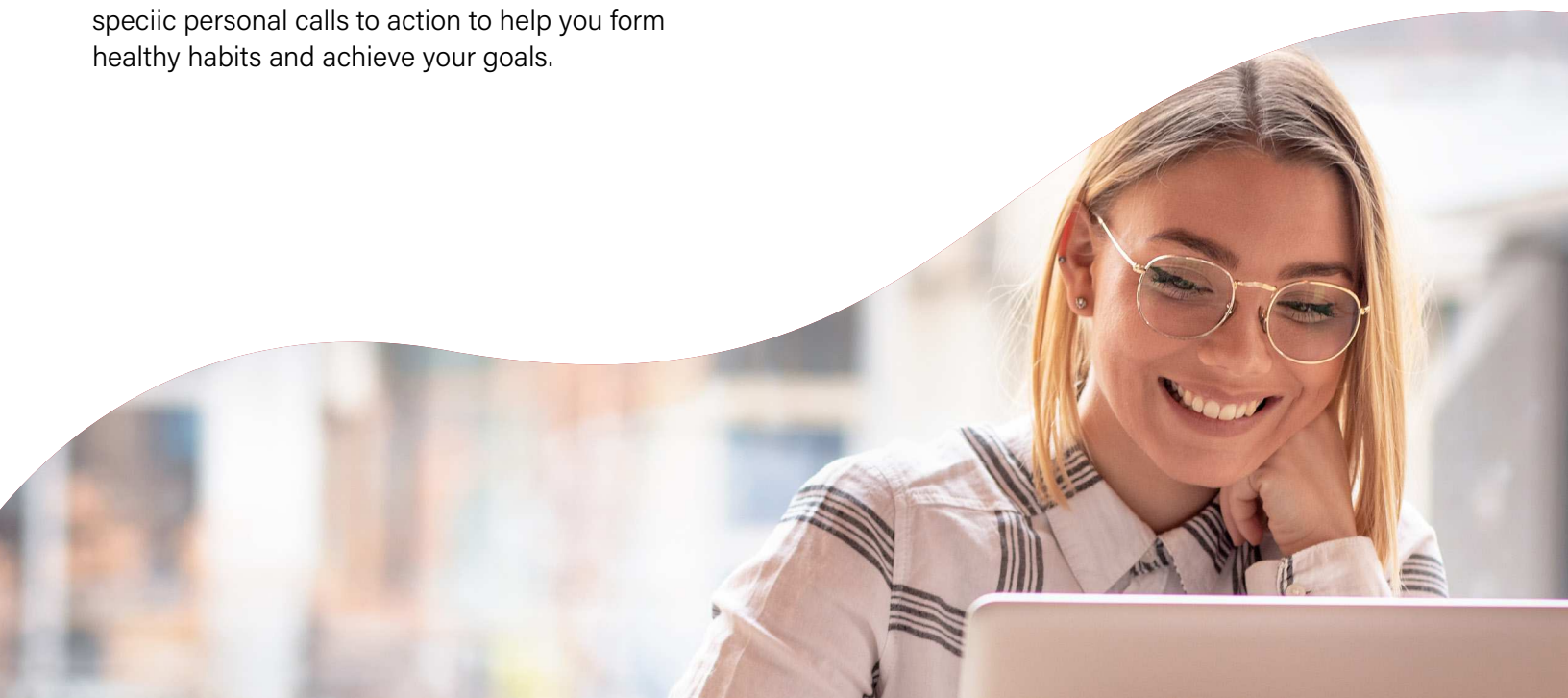
- sign in at sentarahealthplans.com/mylifemyplan
- select Wellness Tools from your MyOptima menu on the left side of the screen to navigate to your personalized WebMD wellness home page



Set—Setting Goals with the Digital Health Assistant

Option One - Set a DHA goal based on your Personal Health Assessment (PHA) score.

- complete the PHA questionnaire
- from your PHA results screen, click the green Let's Go! button to navigate to the My Health Assistant page and choose your goal(s)





Option Two - Set a DHA goal without taking the Personal Health Assessment.

- from your personalized WebMD wellness home page, select the Healthy Living tab at the top of the page
- select My Health Assistant
- choose which goal(s) you would like to work towards by clicking Manage My Goals

Choose one or more of the following DHA goals: Eat Better, Enjoy Exercise, Lose Weight, Conquer Stress, Feel Happier, Quit Tobacco.

Success—Reaching Goals with the Digital Health Assistant

Once you have selected your DHA goal(s), you are ready to begin tracking your progress. Record your daily activities following these easy steps:

- sign in at sentarahealthplans.com/mylifemyplan and select Wellness Tools from the menu
- from your personalized WebMD wellness home page, select the Healthy Living tab at the top of the page and choose My Health Assistant
- click on the icon that best represents your daily activities towards each goal
- sign in daily or weekly to record your activities: weeks begin on Sunday and end on Saturday (you may only back-track and record past activities completed since Sunday of the current week)

DHA	How to Record Your Daily Activities
Eat Better	Click On Track, A Little Of, or Off Track
Enjoy Exercise	Click More than 20 Minutes, 20 Minutes, or Less than 20 Minutes
Lose Weight	Enter your current weight
Conquer Stress	Enter your current stress level on a scale from low to high
Feel Happier	Click Happy, Okay, Down, or Sad
Quit Tobacco	Enter how many times you use tobacco daily

For more information, visit
sentarahealthplan.com/mylifemyplan



Virtual Consults Exceptional Care, Anywhere.

With virtual consults, you can visit with a doctor 24/7 from your home, or on the go. Our team of board-certified doctors is available by phone or secure video to assist with non-emergency medical conditions.

Who are our doctors?

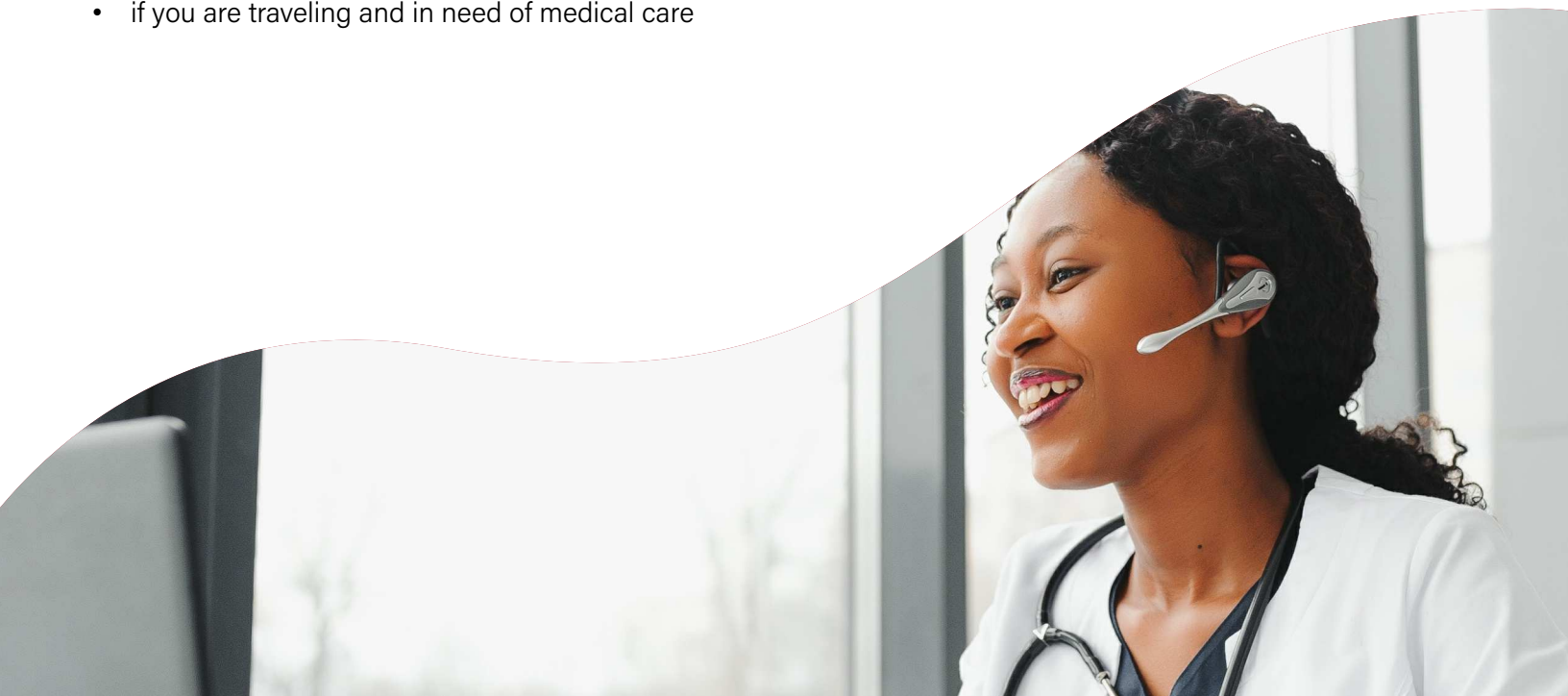
The virtual consult team has the nation's largest network of telehealth doctors. On average, our doctors have 15 years of experience practicing medicine and are licensed in the state where patients are located. Their specialties include primary care, pediatrics, emergency medicine, and family medicine. Our doctors are committed to providing convenient, quality care and are always ready to take your call.

When should I use Virtual Consults?

- for non-emergency issues that do not require a trip to the ER or an urgent care center
- during or after normal business hours, nights, weekends, and even holidays
- if your primary care doctor is not available
- if you need to request prescription refills (when appropriate)
- if you are traveling and in need of medical care

Common Conditions We Treat

- allergies
- asthma
- bronchitis
- cold and flu
- diarrhea
- earaches
- fever
- headache
- infections
- insect bites
- joint aches
- rashes
- respiratory infections
- sinus infections
- skin infections
- sore throat
- urinary tract infections
- and more!





How much does it cost?

You are able to take advantage of virtual appointments for the cost of a primary care physician visit or as noted in your benefit documents.

Are my children eligible?

Yes. We have pediatricians on call 24/7/365. Please note, a parent or guardian must be present during any interactions involving minors. We ask parents to establish a child record under their account. Parents must be present on each call for children 18 or younger.

Pediatric Care

- cold and flu
- constipation
- earaches
- nausea
- pink eye
- and more!

Register now!
Call 1-866-648-3638 or sign in
at [sentarahealthplans.com](https://www.sentarahealthplans.com)
and select Virtual Consult.

Treatment Cost Calculator

Better Information

View estimates on over 500 procedures and services in your area, based on your specific benefit plan information.

Better Decisions

Shop and compare out-of-pocket costs for a specific procedure at a specific doctor or medical facility.

Better Health

Compare your options, plan for future expenses, and make the best decisions for your specific needs.

Sign in at [sentarahealthplans.com/members](https://www.sentarahealthplans.com/members) to Calculate Treatment Costs

- Search for estimates two ways:
 - Total Cost Treatment Estimator - provides total cost of care for procedures
 - CPT Code Treatment Estimator - provides costs of items and services from a specific provider
- Review out-of-pocket estimates* based on real-time balances of your health plan's deductibles and out-of-pocket maximums.
- Explore cost-saving tips and additional guidance on technical healthcare information relevant to your search.
- View maps, get directions, call for appointments, and print or email estimates.

**Please Note: Estimates provided within the Treatment Cost Estimator are not quotes. While every effort is made to provide members with the most accurate information, in some instances the actual charges from your healthcare provider may be different than the average estimate provided.*

Disclaimers: Virtual consults do not replace the primary care physician. Virtual consult is not an insurance product nor a prescription fulfillment warehouse. Virtual consult operates subject to state regulation and may not be available in certain states. Virtual consult does not guarantee that a prescription will be written. Virtual consult does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Virtual consult physicians reserve the right to deny care for potential misuse of services. Virtual consult phone consultations are available 24/7/365, while video consultations are available during the hours of 7:00 a.m. – 9:00 p.m. EST, seven days a week or by scheduled availability.



EPIC Hearing Healthcare

The EPIC Hearing Service Plan is the nation's first specialty care plan devoted to the vital sense of hearing. EPIC is dedicated to delivering the highest quality of care at the best value to our members.

Provider Network

The EPIC network is comprised of professional audiologists and ENT physicians and represents the largest accredited network of its kind in the nation, with provider locations in all 50 states.

Hearing Aids

The EPIC Hearing Service Plan gives you access to all name brand hearing aid technology by the top tier hearing aid manufacturers at reduced prices, 30%–60% below MSRP; maximizing your value and savings.

How it Works

Contact an EPIC hearing counselor today. The hearing counselor can answer any questions you may have about the plan and coordinate your referral to a nearby participating provider. If the provider recommends you obtain hearing aids, an EPIC counselor will contact

you to coordinate your coverage and payment. You will receive a 45-day trial period with a complimentary extended three-year product warranty and one year supply of batteries¹.

Plan Perks

- savings on hearing exams and hearing aid devices
- access to the largest nationwide network of audiologist and ENT physicians
- pricing 30%–60% below MSRP on name brand products
- money-back trial periods
- extended warranties & batteries with purchase

Contact EPIC today to start the process to better hearing

1-866-956-5400

hear@epichearing.com

www.epichearing.com

Level of Hearing Aid Technology	Degree of Hearing Loss	Typical MSRP	EPIC Pricing
Basic	Mild to Moderate	\$1,400-\$1,600	\$495
Standard	Moderate	\$1,601-\$2,300	\$849-\$1,499
Advanced	Moderate to Severe	\$2,301-\$3,000	\$1,500-\$2,099
Premium	Moderate to Severe	\$3,001-\$4,000	\$2,100-\$2,500

¹Excludes Basic Level Products

Provided by Assist America

Sentara Health Plans Emergency Travel Assistance



Peace of Mind!

No matter where you are in the world, you will always get the care you need

Your enrollment with Sentara Health Plans includes a FREE Emergency Travel Assistance program that can handle and resolve your medical and travel emergencies. You, and any dependents on your health plan, are covered whenever traveling 100 miles or more away from your permanent residence, or in another country.

Emergency Travel Assistance Services Include:

Medical Consultation, Evaluation, and Referral

Calls to Assist America's Operations Center are evaluated by medical personnel and referred to English-speaking, Western-trained doctors and/or hospitals.

Foreign Hospital Admission Assistance

Assist America fosters prompt hospital admission by validating the member's health insurance or advancing funds as needed to the hospital. Advances must be repaid within 45 days.

For more information,
visit: sentarahealthplans.com



Assist America Operations Center

1-800-872-1414

(inside USA)

+1-609-986-1234

(outside USA)

Reference Number: 01-AA-OPT-10113

- State-of-the-art 24/7 Operations Center
- Worldwide response capabilities
- Trained multilingual and medical personnel, including doctors and nurses
- Experienced crisis management professionals
- Air and ground ambulance service providers
- Ready to help you, anytime, anywhere!

Prescription Assistance

If a participant needs a replacement prescription while traveling, Assist America will help in filling that prescription.

Emergency Trauma Counseling

Telephone-based counseling and referrals to qualified counselors.



Care of Minor Children

If an injured member has minor children left unattended, Assist America will pay for them to return home to a family member, or will arrange childcare locally or at home.

Return of Vehicle

Assist America will arrange for the return of the eligible participant's fully operable, noncommercial vehicle when necessary due to their medical condition.

Emergency Medical Evacuation

If adequate medical facilities are not available locally, Assist America will use whatever mode of transport, equipment, and personnel necessary to evacuate a participant to the nearest facility capable of providing a high standard of care. The full cost of any evacuation, including medical treatment while in transport, is paid for by Assist America.

Interpreter and Legal Referrals

Assist America can recommend trustworthy legal counsel and interpreter services in any country. Bail bonds can be coordinated in jurisdictions where they are legal.

Medical Monitoring

Assist America maintains regular communication with patients, their families, and attending medical staff, closely monitoring the quality and course of treatment.

Medical Repatriation

If a participant still requires medical assistance upon being discharged from a hospital, Assist America will repatriate them home or to a rehabilitation facility with a medical or non-medical escort, as necessary.

Compassionate Visit

Assist America will arrange and pay for a family

member or a friend to join a member who is traveling alone and is expected to be hospitalized for more than seven days.

Lost Luggage or Document Assistance

Help locating lost luggage, documents, or personal belongings.

Return of Mortal Remains

Assist America will arrange and pay for the return of mortal remains in the event of a participant's death.

Emergency Cash Coordination

Assist America will assist in coordinating the transfer of emergency cash to an eligible participant, provided they have a verifiable travel emergency and are circumstantially without other financial means. The source of the funds is the responsibility of the eligible participant.

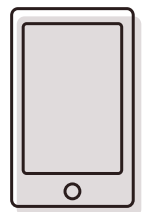
Emergency Message Transmission

Assist America will transmit emergency messages reliably between the patient, family, friends, employer, or whoever else needs to stay in the information loop.

Assist America Mobile App

Download the App and instantly connect to a wide range of services, including:

- One-touch call to 24/7 Emergency Operations Center
- Up-to-the-minute travel alerts
- Pre-trip information (e.g. country specific visa requirements, immunization regulations, security advisories)
- Global embassy locator
- U.S. pharmacy locator



**For more information,
visit: sentarahealthplans.com**



Assist America is not insurance, it is a provider of global emergency services. Assist America's services do not replace medical insurance during emergencies away from home. All medical costs incurred should be submitted to Sentara Health Plans and are subject to the policy limits of your health coverage.



The Fine Print



FAQs

Regulatory Information

How can I find out more about my covered benefits and how my Plan works?

Once you are enrolled as a Sentara Health Plans member, you are entitled to a Summary Plan Description (SPD). Your SPD is an important document. Read it carefully to understand what services are covered under your employer's health plan and services that are not covered under your plan.

Your copayments, coinsurances, and deductibles are also listed on the SPD. You are also entitled to a copy of the Uniform Summary of Benefits and Coverage (SBC) for your plan. The SBC is a federally mandated document meant to contain clear, consistent, and comparable information about your health plan benefits. When you enroll, we will send you instructions on how to access your SPD and SBC online at optimahealth.com/members or request a paper copy.

How can I find out what doctors and hospitals are in the Sentara Health Plans Provider Network?

You are entitled to a list of providers that are in the plan's network. You can find this list on sentarahealthplans.com/members or you can call Member Services at anytime to find out if your provider is in the plan's network.



How does Sentara Health Plans use my personal information?

We understand that medical information about you and your health is personal and we are committed to protecting it. We use information about you to administer your benefits, process your claims, provide education and clinical care, coordinate your benefits with other insurance carriers, and other transactions related to providing you and your dependents healthcare coverage.

How does Sentara Health Plans protect my personal information?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. Sentara Health Plans will not use or further disclose HIPAA-protected health information (PHI) except

as necessary for treatment, payment, and health plan operations, as permitted or required by law, or as authorized by you.. A copy of your health plan's notice of privacy practices will be included in your SPD or provided to you by your employer when you enroll.

We will not release data about you unless you have authorized it, or as permitted or required by law. Sentara Health Plans requires a Designated Representative Authorization form whenever anyone other than the Sentara Health Plans member needs to obtain and/or change health information. You can download a copy of the form at sentarahealthplans.com/members/manage-plans/forms, or by calling member services at the number on the back on your member ID card.



Under HIPAA, you have certain rights to see and copy health information about you. You have the right to request an accounting of certain disclosures of the information and under certain circumstances, amend the information. You have the right to file a complaint with Sentara Health Plans or with the Secretary of the U.S. Department of Health and Human Services, if you believe your rights under HIPAA have been violated.

What if I decide not to enroll with Sentara Health Plans at this time? Will my dependents or will I be able to enroll later?

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents with Sentara Health Plans if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 31 days after your or your dependents' other coverage ends, or after the employer stops contributing toward the other coverage.

If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Does Sentara Health Plans offer special enrollment for employees and dependents that lose eligibility under Medicaid or CHIP coverage?

Employees or dependents who are eligible for group coverage will be permitted to enroll late if they (1) lose eligibility for Medicaid or CHIP coverage, or (2) become eligible to participate in a premium assistance program under Medicaid or CHIP. In both cases, the employee must request special enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, contact your employer group benefits administrator.

What happens if I lose my coverage but still need health insurance?

You may be able to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under Your Plan as a result of a qualifying event. You, your spouse, or your dependents may have to pay for such coverage. Please check with your employer for information on your rights under COBRA, or other available options if you lose coverage under your group's Plan.

What if I have coverage under more than one health plan?

If you have coverage under another health plan, that plan may have primary responsibility for the covered expenses of you or your family members. Sentara Health Plans uses order of benefit rules to determine whether it is the primary or secondary plan. Generally, the plan that covers the person as a subscriber pays first. If your dependents are covered under more than one healthcare plan, Sentara Health Plans has rules based on subscriber date of birth, length of coverage, and custody obligations that determine primary responsibility.

What are my rights under the Women's Health and Cancer Rights Act?

Under the Women's Health and Cancer Rights Act of 1998, Sentara Health Plans provides benefits for the mastectomy-related services listed below in a manner determined in consultation with the attending doctor and the member:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis and any physical complications resulting from the mastectomy, including lymphedema

Coverage for breast reconstruction benefits is subject to deductibles, copayments, and/or coinsurance consistent with those established for other benefits under Sentara Health Plans. Call Member Services at



the number on the back of your member ID card for more information.

What rights do I have under Maternity Benefits?

Under Federal Law, you have certain rights and protections regarding your maternity benefits with Sentara Health Plans.

Under federal law known as the "Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act) group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However,

federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay that does not exceed 48 hours following a vaginal delivery, or 96 hours following a cesarean section.

What can I do to prevent Healthcare Fraud?

Fraud increases the cost of healthcare for everyone. Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number or other personal information over the telephone or email it to people you do not know, except for your healthcare providers or Sentara Health Plans representatives.
- Do not go to a doctor who says that an item or service is not usually covered, but they know how to bill the health plan to get it paid. Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- Carefully review your Explanation of Benefits (EOB) statements that you receive from the health

plan. If you suspect a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, contact the provider for an explanation. There may be an error.

Sentara Health Plans provides its members a way to report situations or actions they think may be potentially illegal, unethical, or improper. If you want to report fraudulent or abusive practices, you can call the Fraud and Abuse Hotline at the number below. You can also send an email or forward your information to the address below. All referrals may remain anonymous. Please be sure to leave your name and number if you wish to be contacted for follow up. If appropriate, the necessary governmental agency (e.g. CMS, OIG) will be notified as required by law.

Mail:
**Sentara Health Plans c/o Special
Investigations Unit PO Box 66189
Virginia Beach, VA 23466**

**Sentara Health Plans
Fraud & Abuse Hotline:
1-866-826-5277**

Email:
compliancealert@sentara.com



Member Rights and Responsibilities

As a member of Sentara Health Plans, you are entitled to all covered benefits; however, you must learn how the health plan works, follow the proper procedures, and use the proper network (e.g. Plan doctors, hospitals, mental health providers, and other specialists participating with Sentara Health Plans.

Sentara Health Plans members have the right to:

Timely and Quality Care:

- access to Protected Health Information (PHI), medical records, physicians, and other healthcare professionals; and referrals to specialists when medically necessary
- continuity of care and to know in advance the time and location of an appointment, as well as the physicians and other health care professionals providing care
- receive the medical care that is necessary for the proper diagnosis and treatment of any covered illness or injury
- participate with physicians and healthcare professionals in:
 - discussing their diagnosis, the prognosis of the condition, and instructions required for follow-up care
 - understanding the health problems and assisting to develop mutually agreed-upon goals for treatment
 - decision-making regarding their healthcare and treatment planning
 - a candid discussion of appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage

- the right to affirm that all practitioners, providers, and employees who make utilization management (UM) decisions:
 - base decisions on appropriateness of care, services and existence of coverage
 - are not rewarded for issuing medical denials of coverage
 - do not encourage decisions that result in underutilization through financial incentives

Treatment with Dignity and Respect—Members will

- be treated with respect, dignity, compassion and the right to privacy
- exercise these rights regardless of race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for their care. Expect this right by both Plan and contracting physicians
- expect protection of all oral, written, and electronic information across the Plan, and information to plan sponsors and employers
- extend their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding medical care
- be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- be able to refuse treatment or to sign a consent form if the member feels they do not clearly understand its purpose, or crossout any part of the form they do not want applied to their care, or change their mind about any treatment for which they have previously given consent and be informed of the medical consequences of this action



Receive Health Plan Information— Members will

- receive information about their health plan, its services, its physicians, other health care professionals, facilities, clinical guidelines and member rights and responsibilities statements; and collection, use, and disclosure of PHI
- know by name, title, and organization the physicians, nurses or other health care professionals providing care
- receive information about medications (what they are, how to take them and possible side effects) and pharmacy benefit information (effective date of formulary change, new drugs available, or recalled medications)
- receive clear information regarding benefits and exclusions of their policy, how medical treatment decisions are made/authorized by the health plan or contracted medical groups, payment structure, and the right to approve the release of information
- be advised if a practitioner proposes to engage in experimentation affecting care or treatment. The member may have the right to refuse to participate in such research
- be informed of policies regarding Advance Directives (living wills) as required by state and federal laws

Members Solve Problems in a Timely Manner by

- presenting questions, concerns or complaints to a customer service specialist without discrimination and expect problems to be fairly examined and appropriately addressed
- voicing concerns or complaints to Sentara Health Plans about their health plan, if the care provided was inadequate, or feel their rights have been compromised. This includes the right to appeal an action or denial and the process involved
- making recommendations regarding the health plan members rights and responsibilities policies

Member Responsibilities

In addition to their rights, Sentara Health Plans subscribers and their enrolled dependents have the responsibility:

- to identify themselves, and their family members as a Sentara Health Plans enrollee and present their identification card(s) when requesting healthcare services.
- to be on time for appointments and contact the physician or other healthcare personnel at once if there is a need to cancel or if they are going to be late for an appointment. If the physician, other healthcare personnel or facility, has a policy assessing charges regarding late cancellations or “no shows”, the member will be responsible for such charges.
- to provide information about their health to physicians and other health care professionals so they may provide appropriate medical care.
- to actively participate and understand improving their health condition(s) by following the plans and instructions for care and treatment goals that they agreed upon with the physician or healthcare professional.
- to act in a manner that supports the care provided to other patients and the general functioning of the office or facility.
- to review the employee handbook and Plan documentation:
 - to make sure the services are covered under the plan,
 - to approve release of information and have services properly authorized before receiving medical attention,
 - to follow proper procedures for illness before and after business hours, and
 - for materials concerning health benefits (e.g. UM issues) and educate other covered family members.
- to accept financial responsibility for any copayment



or coinsurance associated with services received while under the care of a physician or other healthcare professional or while a patient at a facility.

- to contact Sentara Health Plans if they have concerns, or if they feel their rights have been compromised.

For questions, concerns, or additional information, please visit [sentarahealthplans.com](https://www.sentarahealthplans.com) or contact Member Services at the number on the back of your member ID card. TDD/TTY services and language assistance are available.

Code of Federal Regulations. Revised as of July 2020. 482.13, 482.58, 45 C.F.R. § 164.520, 42 C.F.R. §489.102, 422.128, and 438.6(i)(1). Retrieved from gpo.gov/.

National Committee for Quality Assurance (NCQA) (2019). Standards and Guidelines for the Accreditation of Health Plans. 2020 HP Standards and Guidelines. Washington, DC

Advance Directives

Federal Law requires Sentara Health Plans to provide enrolled members 18 years of age or older the opportunity to make decisions concerning their right to accept or refuse medical or surgical treatment and their right to formulate written instructions called an Advance Directive.

An Advance Directive consists of three parts: a living will, designation of healthcare agent, and wishes regarding anatomical gift or organ donation. Advance Directives are recognized under State Law and Federal Law and are to provide for the wishes of individuals who are unable to make medical care decisions on their own.

The law requires that the care you receive from any Plan provider will not be affected by your making (or not making) an Advance Directive, unless your Advance Directive states that medical care should not be given to you.

In compliance with Federal Law, Sentara Health Plans is providing you with information about the Patient Self-Determination Act. The following is a summary of our policies regarding patients' rights and Advance Directives. It means you have a chance to make important life choices. You may never need to exercise these choices, but making them ahead of any event can give peace of mind to you and your family.

You may want to take this opportunity to discuss and document your wishes with your family, attorney, and/ or a close friend. It is also important to talk with your Plan doctor about your choices, so he or she is informed and understands your wishes.

We will gladly send you an advance care planning guide, which tells more about Advance Directives, and information on a Virginia living will, designation of healthcare agent, and wishes regarding anatomical gift or organ donation form.

If you have an Advance Directive, take a copy of the member statement to your next Plan doctor appointment. You may download an Advance Directive from [sentarahealthplans.com/members](https://www.sentarahealthplans.com/members). If you would like more information, call Member Services at the number on the back of your member ID card.

Summary of Policies on Patient Rights and Advance Directives

Purpose

This policy is intended to enable Sentara Health Plans to comply with the Patient Self-Determination Act. The purpose of the act is to protect each adult patient's right to participate in healthcare decision making to the maximum extent of his or her ability and to prevent discrimination based on whether the patient has executed an Advance Directive for healthcare.

Practice Statement

Sentara Health Plans supports a patient's right to participate in healthcare decision making. Through education and inquiry about Advance Directives, this health plan will encourage patients to communicate



their healthcare preferences and values to others. Such communication will guide others in healthcare decision making for the patient if the patient is incapacitated.

Procedures

At enrollment, you will be provided information about your rights under Virginia law to:

- make decisions about your medical care, including your right to accept or refuse medical and surgical treatment
- make an Advance Directive, such as a living will or durable power of attorney for healthcare, if you choose to do so

You will be asked if you have made an Advance Directive.

- If you have, you will need to give this form to your plan doctor so it will be made part of your medical record. You will need to keep an additional copy for yourself.
- If you have not, and wish to do so, you will be provided additional information upon request in order to make an Advance Directive.
- You will be encouraged to discuss your Advance Directive with your family, plan doctor, clergy, attorney, or a close friend.

If you do not have an Advance Directive, do not want to make one, and do not want more information, you will not be asked any more questions.

You may revoke your Advance Directive at any time in writing or by oral declaration. Your making (or not making) an Advance Directive will not affect the care you receive from any plan provider, unless your Advance Directive states that medical care should not be given to you. Your Advance Directive will be followed unless it requests medical care that is inappropriate, unethical, or is of no medical benefit or harmful to you.

If your plan doctor is unwilling to comply with your Advance Directive, or with the decision of a person you designate to make decisions for you, he or she will make a reasonable effort to transfer your care to another plan doctor within 14 days. During this period, your plan doctor must continue any life-sustaining care.

Code of Federal Regulations. Revised as of July 2020. 42 C.F.R. §§ 489.102, 422.128, and 438.6(i)(1). Retrieved from <https://www.gpo.gov/>.

Your Rights and Protections Against Surprise Medical Bills

Please see your SPD for your Plan's full notice of your protections against surprise billing

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.



You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services at the same facility that you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may use the following contact information for help at the federal level:

Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the DOL's website (www.dol.gov/ebsa). In addition, information from HHS on private health insurance coverage and coverage provided by nonfederal governmental group health plans can be found on the Centers for Medicare & Medicaid Services (CMS) website (www.cms.gov/cciiio), and information on health care reform can be found at www.HealthCare.gov.

Consumers covered under the Virginia state employee health benefit plan; or a self-funded group that opted-in to the Virginia protections are also protected from balance billing under Virginia law. Visit scc.virginia.gov/pages/Balance-Billing-Protection for more information about your rights under Virginia law.



Resolving Member Grievances, Complaints, and Appeals of Adverse Benefit

If you have a problem or concern about Sentara Health Plans and/or the quality of care, services, and/or policies and procedures of Sentara Health Plans call member services at the number on the back of your member ID card.

Sentara Health Plans has a formal grievance and complaint process that allows your concern to be addressed with the appropriate department or persons within Sentara Health Plans. You can file a complaint within 180 days from the date of your concern or services. We will review your complaint as quickly as possible and notify you of how it will be resolved.

If your concern involves an adverse benefit determination, such as a denial of pre-authorization, denial of a covered service or denial of a claim, Sentara Health Plans has a formal internal appeals process. You may choose to have another individual or your doctor file an appeal on your behalf. You can download an appeal packet from the Manage My Plan section on sentarahealthplans.com/members or contact member services to initiate an internal appeal.

We will notify you of the decision on your appeal in writing. If you are not satisfied with the internal appeal decision, an external appeal may be available. Check your plan documents or Summary Plan Description for instructions on how to file an external appeal. You can also call member services at the number on the back of your member ID card for help.

Additional Resources

The U.S. Department of Labor, Pension, and Welfare Benefits Administration can assist members in finding out what other voluntary alternative dispute resolutions are available.

U.S. Department of Labor

Toll Free: **1-866-4-USA-DOL (1-866-487-2365)**
or **1-866-275-7922**

For questions about your appeal rights or for assistance, contact:

Employee Benefits Security Administration
1-866- 444-EBSA (1-866-444-3272)

An internal or external appeal is expedited if a member's life, health, or the ability to regain maximum function is in jeopardy, or if a physician believes a member would be subjected to severe pain that could not be adequately managed without the requested care or treatment.

You can download an Appeals Packet at sentarahealthplans.com/members.





EXCLUSIONS AND LIMITATIONS

Plus Products

The following is a list of Exclusions and Limitations that generally apply to all Optima Health self-funded plans. Once you are an enrolled member please refer to your Plan documents for the Exclusions and Limitations specific to your plan.

This chapter lists services that are not covered under Large Group plans administered by Sentara Health Plans, Inc. Services mean both medical and behavioral health (mental health) services and supplies unless otherwise specifically stated. The Plan does not cover any services that are not listed in this section unless required to be covered under state or federal laws and regulations. The Plan does not cover services unless they are Medically Necessary. In this section examples may be given of specific services that are covered. However, that does not mean that other similar services are covered. Some services are covered only if they have been authorized by the Plan.

A

Abortion is a Covered Service in the first 12 weeks of pregnancy. After 12 weeks abortion is a Covered Service if the mother's life is at risk, if there are major fetal abnormalities, or in the case of rape or incest.

Acupuncture is not a Covered Service.

Adaptations to Your Home, Vehicle or Office are not Covered Services. Handrails, ramps, escalators, elevators, or any other changes because of a medical condition or disability are not Covered Services.

Ambulance Service for non-emergency transportation is not a Covered Service unless authorized by the Plan.

Non-medical **Ancillary Services** You are referred to are not Covered Services. Vocational rehabilitation services, employment counseling, relationship counseling for unmarried couples, pastoral counseling, expressive therapies, health education, or other non-medical services are not Covered Services.

General **Anesthesia** in a Physician's office is not a Covered Service.

Aromatherapy is not a Covered Service.

Autopsies are not Covered Services.

B

Batteries are not covered except for motorized wheelchairs, Left Ventricular Assist Device (LVAD), and cochlear implants when authorized.

Blood Donors. We do not cover any costs for finding blood donors. We do not cover the cost of transportation and storage of blood in or outside the Plan's Service Area.

Bone Densitometry Studies more than once every two years are not covered unless authorize by the Plan.

Bone or Joint treatment of the head, neck, face or jaw. The Plan does not exclude or impose limits on bone or joint treatments of the head, neck, face, or jaw that are more restrictive than limits on treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or Accident/Injury which prevents normal function of the joint or bone, and is deemed Medically Necessary to attain functional capacity of the affected part. The treatment must be Medically Necessary and be required because of a medical condition or Accident/Injury that prevents normal function of the joint or bone.

Botox injections are not Covered Services unless the Plan has approved them.

Breast Augmentation or Mastopexy is not a Covered Service unless the Plan has authorized them. Cosmetic procedures or surgery for breast enlargement or reduction are not Covered Services for correction of cosmetic physical imperfections. Breast

implants are not a Covered Service. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Breast Ductal Lavage is not a Covered Service.

Breast Milk from a donor is not a Covered Service.

C

Chelation Therapy is not a Covered Service except for arsenic, copper, iron, gold, mercury or lead poisoning.

Contact Lenses are not a Covered Service. Fitting of lenses or eyeglasses is not a Covered Service. Covered Services include the first pair of lenses following cataract surgery including contact lens, or placement of intraocular lens or eyeglass lens only.

Cosmetic Surgery and Cosmetic Procedures are not Covered Services. Medical, surgical, and mental health services for or related to cosmetic surgery or cosmetic procedures are not Covered Services. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary. **The following are not Covered Services:**

- Surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- Treatment or services resulting from complications due to cosmetic or experimental procedures;
- Breast augmentation or mastopexy procedures for correction of cosmetic physical imperfections, except as required by state or federal law regarding breast reconstruction and symmetry following mastectomy;
- Tattoo removal;
- Keloid treatment as a result of the piercing of any body part;
- Consultations or office visits for obtaining cosmetic or experimental procedures;
- Penile implants;
- Vitiligo or other cosmetic skin condition treatments by laser, light or other methods unless Medically Necessary and approved by the Plan.

Costs of Services paid for by Another Payor are not Covered Services. Covered Services do not include the cost of services, which are or may be covered through a group insurance mechanism or governmental program, such as Workers Compensation, occupational disease laws and other employers' liability laws. If You have the cost of services denied by one of the above insurance programs, the Plan will only consider payment of covered services in those cases where You received services in accordance with the Plan's referral procedures. Covered Services will not include the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.

Court ordered examinations or treatments are not Covered Services unless they are determined to be Medically Necessary and are listed as a Covered Service under the Plan

Custodial Care is not a Covered Service. The following are not Covered Services:

- Rest cures;
- Examination or care ordered by a court of law not authorized by the Plan to be

provided at a Plan Provider.

D

Dentistry/Oral Surgery/Dental Care

Dentistry

- Restorative services and supplies necessary to treat, repair or replace sound natural teeth are not Covered Services.
- Covered Services include Medically Necessary dental services from an Accident/Injury. It does not matter when the Accident/Injury occurred. For Accident/Injury occurring on or after Your effective date of Coverage treatment must be sought within 60 days of the Accident/Injury.
- Covered Services include Medically Necessary dental services performed during an Emergency department visit immediately after a traumatic injury and in conjunction with the initial stabilization of the traumatic injury subject to utilization review for Medical Necessity.
- Cosmetic services to restore appearance are not Covered Services.
- Dental implants or dentures and any preparation work for them are not Covered Services.
- Dental services performed in a hospital or any outpatient facility are not Covered Services. This does not include Covered Services listed under “Hospitalization and Anesthesia for Dental procedures.”

Oral Surgery

- Oral surgery which is part of an orthodontic treatment program is not a Covered Service.
- Orthodontic treatment prior to orthognathic surgery is not a Covered Service.
- Dental implants or dentures and any preparation work for them are not Covered Services.
- Extraction of wisdom teeth is not a Covered Service.

Dental Care

- Dental care, treatment, supplies, orthodontia, extractions, repositioning, X-rays, periodontal work, or any other services dental in nature are not Covered Services.
- Dental implants or dentures and any preparation work for them are not Covered Services.

Diagnostic tests, or Diagnostic Imaging, or Surgical Procedures are not Covered Services where there is insufficient scientific evidence of the safety or efficacy of the test or procedure in improving clinical outcomes.

Disposable Medical Supplies are not Covered Services unless ordered as part of wound care and authorized by the Plan. Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide and other disposable supplies are not Covered Services.

Driver Training is not a Covered Service.

Durable Medical Equipment (DME) is a Covered Service only up to the limits stated on Your Plan’s Schedule of Benefits. DME is limited to an amount, supply or type of DME that will safely and adequately treat Your condition. Covered Services will not include any of the following:

- More than one item of DME for the same or similar purpose;
- DME and appliances not uniquely relevant to the treatment of disease;
- Disposable medical supplies and medical equipment;
- Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide;
- DME for use in altering air quality or temperature;
- DME for exercise or training;
- DME mainly for comfort, convenience, well-being or education;
- Batteries for repair or replacement except for motorized wheelchairs or cochlear implants;
- Blood pressure monitors unless authorized by the Plan.

Drugs for certain clinical trials are not Covered Services. This includes drugs paid for directly by the clinical trial or another payor.

E

Electron Beam Computer Tomography (EBCT) is not a Covered Service. Other diagnostic imaging tests are not Covered Services where there is insufficient scientific evidence of its safety or efficacy in improving clinical outcomes.

Services, treatment, or testing required to complete **Educational Programs**, degree requirements, or residency requirements are not Covered Services.

Educational Testing, Evaluation, Screening, or tutorial services are not Covered Services. Any other service related to school or classroom performance is not a Covered Service. This does not include services that qualify as Early Intervention Services under the Plan's benefit or those services covered under Autism spectrum disorder benefits.

Enteral or Parenteral Feeding supplements are not Covered Services unless covered under the Plan's benefit for Medically Necessary And Enteral Nutrition Products. Over the counter supplements, over the counter infant formulas, or over the counter medical foods are not Covered Services.

Examinations, testing or treatment required for employment, insurance, or judicial or administrative proceedings are not Covered Services.

Exercise Equipment is not a Covered Service. Bicycles, treadmills, stair climbers, free weights, exercise videos, or any other exercise equipment are not Covered Services. Pool, gym, or health club membership fees are not Covered Services.

Experimental or Investigative drugs, devices, treatments, or services are not Covered Services. Experimental or Investigative means any of the following situations:

- The majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
- The use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable value as reported by current scientific literature and/or regulatory agencies; or
- The research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
- The drug or device is not approved for marketing by the United States Food and Drug Administration (FDA); or

- The drug, device, medical treatment or procedure is currently under study in a Non-FDA approved Phase I or Phase II clinical trial, an experimental study/investigational arm of a Phase III clinical study, or otherwise under study to determine safety and efficacy or to compare its safety and efficacy to current standards of care; or
- The drug device or medical services is classified by the FDA as a Category B Non-experimental/investigational drug, device, or medical treatment.

Eye Examinations required for work are not Covered Services. Corrective or protective eyewear required for work is not a Covered Service.

Eye Glasses and contact lenses are not Covered Services. Fitting of lenses or eyeglasses is not a Covered Service. Covered Services are limited to the first pair of lenses following cataract surgery including contact lenses, or placement of intraocular lenses or eyeglass lenses only.

Eye Movement Desensitization and Reprocessing Therapy are not a Covered Service.

Eye Corrective Surgery such as Radial Keratotomy, PRK, LASIK, or any other eye corrective surgery is not a Covered Service.

E

The following **Foot Care Services** are not Covered Services unless authorized by the Plan.

- Operations which involves the exposure of bones, tendons, or ligaments for the treatment of tarsalgia, metatarsalgia or bunions;
- Treatment and services related to plantar warts.

The following **Foot Care Services** are not Covered Services unless Medically Necessary and approved by the Plan:

- Removal of corns or calluses;
- Nail trimming;
- Treatment and services for or from flat-feet, fallen arches, weak feet, or chronic foot strain;
- Foot Orthotics of any kind;
- Customized or non-customized shoes, boots, and inserts.

G

Genetic Testing and Counseling are not Covered Services unless authorized by the Plan. Counseling is a Covered Service only when part of the approved genetic test unless considered preventive care.

GIFT programs (Gamete Intrafallopian Transfer) are not Covered Services.

Growth Hormones are Covered Services only under the Plan's Outpatient Prescription Drug Benefits. Growth hormones for the treatment of idiopathic short stature are not Covered Services.

H

Hearing Aids are not Covered Services. Fittings, molds, batteries or other supplies are not Covered Services.

Home Births are not Covered Services.

Home Health Care Skilled Services are not Covered unless deemed Medically Necessary and authorized by the Plan. Services or visits are limited as stated on Your Plan's Schedule of Benefits. We do not cover any services after You have reached Your Plan's home health visit limit. Custodial Care is not a Covered Service.

Hypnotherapy is not a Covered Service.

I

Immunizations required for foreign travel or for employment are not a Covered Service.

Implants for cosmetic breast enlargement are not a Covered Service. Cosmetic procedures or cosmetic surgery for breast enlargement or reduction are not Covered Services. Procedures for correction of cosmetic physical imperfections are not Covered Services. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Incarceration –Services and treatments done during incarceration in a Local, State, Federal or Community Correctional Facility or prison are not Covered Services.

Infertility Treatment or Services listed below are not Covered Services.

- Services, tests, medications, and treatments for the diagnosis or treatment of Infertility not listed as a Covered Service in this SPD;
- Services, tests, medications, and treatments for the enhancement of conception;
- Services, tests, medications, and treatments that aid in or diagnose potential problems with conception not listed as a Covered Service in this SPD;
- In-vitro Fertilization programs;
- Artificial insemination or any other types of artificial or surgical means of conception;
- Drugs administered in connection with infertility procedures;
- GIFT/ZIFT programs;
- Reproductive material storage;
- Treatment related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;
- Semen recovery or storage,
- Sperm washing;
- Services to reverse voluntary sterilization;
- Infertility Treatment or services from reversal of sterilization;
- Surrogate pregnancy services;
- Drugs used to treat infertility.

J

K

Treatment of **Keloids** from body piercing or pierced ears are not Covered Services.

L

Laboratory Services from Non-Plan Providers or laboratories are Covered Services under the Plan's Out-of-Network benefits only. This does not apply to Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility.

M

Massage Therapy is not a Covered Service unless provided as part of an approved therapy program.

Matristem Extracellular Wound Care System is not a Covered Service.

Maximum Benefit Amounts are stated on Your Plan's Schedule of Benefits. Additional benefits after a benefit limit has been reached are not Covered Services.

Measurement of Ocular Blood Flow by Tonometer Repetitive IOP is not a Covered Service.

Medically Necessary Treatments - Any services, supplies, treatments, or procedures not specifically listed as a Covered Service, and any other services, supplies, or treatments or procedures determined not to be Medically Necessary are not Covered Services unless required to be covered under state or federal laws and regulations.

Medical Equipment, Devices and Supplies that are disposable or mainly for convenience are not Covered Services. **The following are not Covered Services:**

- Exercise equipment;
- Air conditioners, purifiers, humidifiers and dehumidifiers,
- Whirlpool baths,
- Hypoallergenic pillows or bed linens,
- Telephones,
- Handrails, ramps, elevators and stair glides;
- Orthotics not approved by Us;
- Changes made to vehicles, residences or places of business;
- Adaptive feeding devices, adaptive bed devices;
- Water filters or purification devices;
- Disposable Medical Supplies such as medical dressings, disposable diapers;
- Over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

Medical Nutritional Therapy and nutrition counseling are not Covered Services except when provided as part of preventive care, diabetes education or when received as part of preventive wellness services or screening visits. Nutritional formulas and dietary supplements that are available over the counter and/or without a written prescription are not Covered Services.

Membership Fees to pools, gyms, health clubs, or athletic clubs are not Covered Services.

Mobile Cardiac Outpatient Telemetry - (MCOT) is not a Covered Service.

Morbid Obesity treatment including gastric bypass surgery, other surgeries, services or drugs are not Covered Services unless Your plan includes a rider, and services have been **authorized by the Plan for Members who meet established criteria.**

Motorized or Power Operated Vehicles or chair lifts are not Covered Services unless authorized by the Plan.

N

Neuro-cognitive therapy is not a Covered Service.

Newborns or other children of a Covered Dependent Child are not eligible for Covered Services.

O

Obstetrical Care Home births are not Covered Services.

Oral Surgery services listed below are not Covered Services:

- Oral surgery which is part of an orthodontic treatment program;
- Orthodontic treatment prior to orthognathic surgery;
- Dental implants or dentures and any preparation work for them;
- Extraction of wisdom teeth.

Orthoptics or vision or visual training and any associated supplemental testing are not covered services except when medically necessary for treatment of convergence and insufficiency. Pre-authorization is required.

Out-of-Network Medical, Mental Health, and Laboratory Services You receive from Non-Plan Providers, whether referred or directed by a Plan Provider, are Covered Services under the Plan's Out-of-Network benefits only. This exclusion does not apply to Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility.

P

PARS System (Physical Activity Reward System) is not a Covered Service.

Pass Devices (Patient Activated Serial Stretch) are not Covered Services.

Paternity Testing is not a Covered Service.

Penile implants are not a Covered Service.

Personal comfort items are not Covered Services. Telephones, televisions, extra meal trays, personal hygiene items, under pads, diapers, ice bags, chairs, air conditioners, water purifiers, humidifiers, dehumidifiers, saunas, swimming pools or hot tubs and any other similar items for personal comfort are not Covered Services.

Physician Examinations are limited as follows:

- Physicals for employment, insurance or recreational activities are not Covered Services.
- Executive physicals are not Covered Services.
- A second opinion from a Non-Plan Provider is a Covered Service only under the Plan's Out-of-Network benefits. A second opinion by a Plan Provider does not require authorization by the Plan.
- Services or supplies ordered or done by a provider not licensed to do so are not Covered Services.

Physician's Clerical Charges are not Covered Services. Charges for broken appointments, telephone calls, completion of forms, transfer of medical records, the cost of copying medical records or correspondence to other parties, and any other clerical services are not Covered Services.

Private Duty Nursing is not a Covered Service.

Pulsed Irrigation Evacuation System is not a Covered Service.

Q

R

Reconstructive surgery - is not a Covered Service unless services follow trauma which causes anatomic functional impairment or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. If the trauma occurred before the Member's effective date of Coverage, the reconstructive surgery is a Covered Service subject to the Plan's Medical Necessity determination. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is a Covered Service.

Remedial Education and Programs are not Covered Services. Services which are extended beyond the period necessary for the evaluation and diagnosis of learning and behavioral disabilities or for mental are not Covered Services.

Residential or Sub-Acute Level of Care or treatment is not a Covered Service unless authorized by the Plan. Services that are merely custodial, residential, or domiciliary in nature are not Covered Services.

S

Second Opinions from Plan providers do not require authorization. A second opinion from a Non-Plan provider is a Covered Service only under the Plan's Out-of-Network benefits.

Services. The following are not Covered Services:

- Services for which a charge is not normally made;
- Services or supplies prescribed, performed or directed by a provider not licensed to do so;
- Services provided before Your plan effective date;
- Services provided after Your coverage ends;
- Virtual Consults except when provided by Optima Health approved providers;
- Charges for missed appointments;
- Charges for completing forms
- Charges for copying medical records.
- Services not listed as a covered service under this plan.
- Any service or supply that is a direct result of a non-covered service.

Spinal Manipulation is not a Covered Service.

Sterilization

- Reversal of voluntary sterilizations is not a Covered Service.

- Any infertility services required because of a reversal are not Covered Services.

I

Non-interactive **Telemedicine Services** such as Fax, telephone only conversations, or email are not Covered Services.

Physical, Speech, and Occupational **Therapies** are limited as stated on Your Schedule of Benefits. Therapies will be Covered Services only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status. Covered Services do not include any of the following except for those services that are covered through Early Intervention Services or Autism spectrum disorder benefits:

- Therapies for developmental delay or abnormal speech pathology;
- Therapies which are primarily educational in nature;
- Special education services;
- Treatment of learning disabilities;
- Lessons for sign language;
- Therapies to correct an impairment resulting from a functional nervous disorder (i.e. stuttering, stammering);
- Therapies to maintain current status or level of care;
- Restorative therapies to maintain chronic level of care;
- Therapies available in a school program;
- Therapies available through state and local funding;
- Recreational or nature therapies;
- Art, craft, dance, or music therapies;
- Exercise, or equine, therapies;
- Sleep therapies;
- Driver evaluations as part of occupational therapy;
- Driver training;
- Functional capacity testing needed to return to work;
- Work hardening programs;
- Gambling therapies;
- Remedial education and programs.

Total Body Photography is not a Covered Service.

Transplant Services. Covered Services do not include any of the following:

- Organ and tissue transplant services not listed as covered;
- Organ and tissue transplants not Medically Necessary;
- Organ and tissue transplants considered experimental or investigative;
- Services from non-contracted providers unless pre-authorized by the plan;
- Services and supplies for organ donor screenings, searches and registries;
- Services related to donor complications following a transplant.

Travel and Transportation expenses are not Covered Services. Medically Necessary transport is a Covered Service only when approved by the Plan. Elective or non-emergent ambulance services are only covered when approved and authorized by Us. Treatment and services, other than Emergency Services, received outside of the United States of America are Covered Services under Out-of-Network benefits only.

Transportation expenses are not Covered Services. Medically Necessary transport is a Covered Service only when approved by the Plan. Elective or non-emergent ambulance services are Covered Services when approved and authorized by the Plan.

Travel and lodging expenses are not Covered Services unless approved by the Plan related to authorized transplant services. Covered Services will not include Child care, rental cars, buses, taxis or other transportation not approved by the Plan, frequent flyer miles, or any other travel services not related to the transplant.

Treatment and services, other than Emergency Services, received while **traveling outside of the United States of America** are Covered Services under Out-of-Network benefits only.

U

V

Video Recording or Video Taping of procedures or treatment is not a Covered Service. Treatment of **Varicose Veins or telangiectatic dermal veins** (spider veins) for cosmetic purposed is not a Covered Service.

Vision Exams and Materials not listed as a Covered Services are not covered.

W

Wigs or cranial prostheses for hair loss for any reason are not Covered Services.

Wisdom Teeth extraction is not a Covered Service.

Work-related injuries or diseases when the employer must provide benefits or when that person has been paid by the employer are not Covered Services.

X, Y, Z

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

Outpatient Prescription Drugs

The following limitations and exclusions apply to the Plan's Prescription drug benefits.

Limitations And Other Coverage Terms.

1. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.
2. Copayment and Coinsurance are out-of-pocket amounts You pay directly to the pharmacy provider for a Covered prescription drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health's Allowable Charge.
3. Deductible means the dollar amount You must pay out-of-pocket each year for Covered Services before the Plan begins to pay for Your benefits.
4. Prescriptions may be filled at a Plan pharmacy or at a non-participating pharmacy if the non-participating pharmacy or its intermediary has agreed in writing to accept as payment in full reimbursement from the Plan, including any Copayment or Coinsurance consistently imposed by the plan, at the same level as the Plan gives to participating pharmacies.
5. All covered outpatient prescription drugs must have been approved by the Food and Drug Administration and require a prescription either by state or federal law.
6. Amounts You pay for any outpatient prescription drug after a benefit Limit has been reached, or for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out-of-Pocket Limit.
7. Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription that is available as an OTC medication are excluded from Coverage. However, the Plan may approve Coverage of limited quantities of an OTC drug. You must have a Physician's prescription for the drug, and the drug must be included on the Plan's list of covered Preferred and Standard drugs.
8. Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization. You can call Member Services at the number on Your ID card to verify that your prescription drug has been pre-authorized.
9. Unless required by law, certain Prescription Drugs may not be Covered under the Plan if You could use a "clinically equivalent drug." "Clinically equivalent drug" means a drug that for most individuals will give You similar results for a disease or condition. If You have questions about whether a certain drug is covered by the Plan please call the Member Services number on the back of Your Optima identification card. If You or Your doctor believes You need to use a different Prescription Drug, please have Your doctor contact Us. If We agree that it is Medically Necessary and appropriate we will cover the other Prescription Drug instead of the "clinically equivalent drug."
10. At its' sole discretion Optima Health's Pharmacy and Therapeutics Committee determines which Tier a covered drug is placed in or if a particular drug is included on the Plan's formulary. The Plan's Pharmacy and Therapeutics

Committee is composed of physicians and pharmacists. The committee looks at the medical literature and then evaluates whether to add or remove a drug from the preferred/standard drug list or Your Plan's formulary. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity Limits for selected medications.

11. Insulin, syringes, and needles are covered under the Plan's prescription drug benefit. Blood glucose monitors, test strips, lancets, lancet devices and control solution are covered under the Plan's prescription drug benefit. Insulin pumps, pump infusion sets and 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 health care professional legally authorized to prescribe such items under law, are covered under the Plan's medical benefit. Any Plan maximum benefit does not apply to Physician prescribed diabetic supplies covered under the Plan's prescription drug benefit or the Plan's medical benefit.
12. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.
13. 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.

For Optima Health Plans with Open Formulary Plans:

Prescription Drug Coverage Exclusions.

The following is a list of exclusions that apply to the Plan's prescription drug benefits.

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.
2. Medications with no approved FDA indications are excluded from Coverage.
3. Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are excluded from Coverage and do not count toward any Plan Maximum Out-of-Pocket Limit.
4. All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
5. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
6. Immunization agents, other than those covered by the formulary, biological sera, blood, or blood products are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage under this rider.
8. Medication taken or administered to the Member in the Physician's office is

excluded from Coverage under this rider.

9. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage under this rider.
10. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
11. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
12. Therapeutic devices or appliances, including but not Limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from Coverage.
13. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from Coverage.
14. Drugs with a therapeutic over-the-counter (OTC) equivalent are excluded from Coverage unless authorized by the Plan.
15. Certain off-label drug usage is excluded from Coverage unless the use has been approved by the Plan.
16. Compound drugs are excluded from Coverage when alternative products are commercially available.
17. Cosmetic health and beauty aids are excluded from Coverage
18. Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage
19. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an emergency while traveling out of the country
20. Flu symptom drugs are excluded from Coverage unless approved by the Plan.
21. Human growth hormone for the treatment of idiopathic short stature are excluded from Coverage
22. Medical foods are excluded from Coverage. This does not apply to Medically Necessary formula and enteral nutrition products covered under the Plan's benefit for treatment for an inherited metabolic disorder for which the covered individual's physician has issued a written order stating that the formula or enteral nutrition product is Medically necessary and has been proven effective as a treatment regimen for the covered individual and that the formula or enteral nutrition product is a critical source of nutrition as certified by the physician by diagnosis.
23. Drugs not meeting the minimum levels of evidence based on one or more of the following Standard reference compendia are not Covered Services:
 - a. American Hospital Formulary Service Drug Information;
 - b. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
 - c. Elsevier Gold Standard's Clinical Pharmacology.
24. Minerals, fluoride, and vitamins are excluded from Coverage unless determined to be Medically Necessary to treat a specifically diagnosed Illness or when included under ACA Recommended Preventive Care.
25. Non-Sedating antihistamines are excluded from Coverage.
26. Pharmaceuticals approved by the FDA as a medical device are excluded from

Coverage.

27. Drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless authorized by the Plan.
28. Prescriptions written by a licensed dentist are excluded from Coverage, except for the prevention of infection or pain in conjunction with a Covered dental procedure.
29. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription
30. Sexual dysfunction drugs are excluded from Coverage
31. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
32. Infertility drugs are excluded from Coverage.
33. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
34. Abortifacient drugs that cause abortions are not covered.
35. Digital Therapeutics, including digital devices, software and applications are excluded from Coverage.

For Optima Health Plans with Standard (Closed) Formulary Plans:

Prescription Drug Coverage Exclusions.

The following is a list of exclusions that apply to the Plan's prescription drug benefits.

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.
2. Medications with no approved FDA indications are excluded from Coverage.
3. Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are excluded from Coverage and do not count toward any Plan Maximum Out-of-Pocket Limit.
4. All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
5. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
6. Immunization agents, other than those covered by the formulary, biological sera, blood, or blood products are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage under this rider.
8. Medication taken or administered to the Member in the Physician's office is excluded from Coverage under this rider.
9. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage under this rider.
10. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.

11. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
12. Therapeutic devices or appliances, including but not Limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from Coverage.
13. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from Coverage.
14. Drugs with a therapeutic over-the-counter (OTC) equivalent are excluded from Coverage unless authorized by the Plan.
15. Certain off-label drug usage is excluded from Coverage unless the use has been approved by the Plan.
16. Compound drugs are excluded from Coverage when alternative products are commercially available.
17. Cosmetic health and beauty aids are excluded from Coverage
18. Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage
19. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an emergency while traveling out of the country
20. Flu symptom drugs are excluded from Coverage unless approved by the Plan.
21. Human growth hormone for the treatment of idiopathic short stature are excluded from Coverage
22. Medical foods are excluded from Coverage. This does not apply to Medically Necessary formula and enteral nutrition products covered under the Plan's benefit for treatment for an inherited metabolic disorder for which the covered individual's physician has issued a written order stating that the formula or enteral nutrition product is Medically necessary and has been proven effective as a treatment regimen for the covered individual and that the formula or enteral nutrition product is a critical source of nutrition as certified by the physician by diagnosis.
23. Drugs not meeting the minimum levels of evidence based on one or more of the following Standard reference compendia are not Covered Services:
 - d. American Hospital Formulary Service Drug Information;
 - e. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
 - f. Elsevier Gold Standard's Clinical Pharmacology.
24. Minerals, fluoride, and vitamins are excluded from Coverage unless determined to be Medically Necessary to treat a specifically diagnosed Illness or when included under ACA Recommended Preventive Care.
25. Non-Sedating antihistamines are excluded from Coverage.
26. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage.
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 33. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
 34. Abortifacient drugs that cause abortions are not covered.
 35. Digital Therapeutics, including digital devices, software and applications are excluded from Coverage.
 36. **This Plan uses a Closed Formulary. Any prescription drugs, over the counter drugs, or devices that are not included on the Plan's Prescription Drug Formulary are excluded from Coverage.**

Non-formulary requests. You have the right to request a non-formulary prescription drug if You believe that You need a prescription drug that is not on the Plan's list of covered drugs (formulary), or You have been receiving a specific non-formulary prescription drug for at least six months previous to the development or revision of the formulary and Your prescribing physician has determined that the formulary drug is inappropriate for Your condition or that changing drug therapy presents a significant health risk to You. Your physician must complete a medical necessity form and deliver it to the Optima Health pharmacy authorization department. After reasonable investigation and consultation with the prescribing physician, Optima Health will make a determination. Optima Health will act on such requests within one business day of receipt of the request. You will be responsible for all applicable Copayments, Coinsurance, or Deductibles depending upon which Tier a drug is placed in by the Plan.