

Small Group Guide

2027 Plan Guide

This publication is only intended to be used for agent and broker education and must not be distributed or used with the general public.



Table of contents

This plan guide is for the Small Group market segment. If you are looking for information about other plans, such as our level-funded product, Business**EDGE**®, or about Mid-Market and Large Group employers, contact your local Sentara Health Plans sales team. Learn more at sentarahealthplans.com/brokers.

Group sizes

03

Plan grids

04

Sentara Vantage Plans

04

Sentara Vantage HSA Plans

14

Sentara POS Plans

16

Sentara POS HSA Plans

26

Sentara POS HRA Plan

29

Sentara Plus Plans

30

Sentara Plus HSA Plans

36

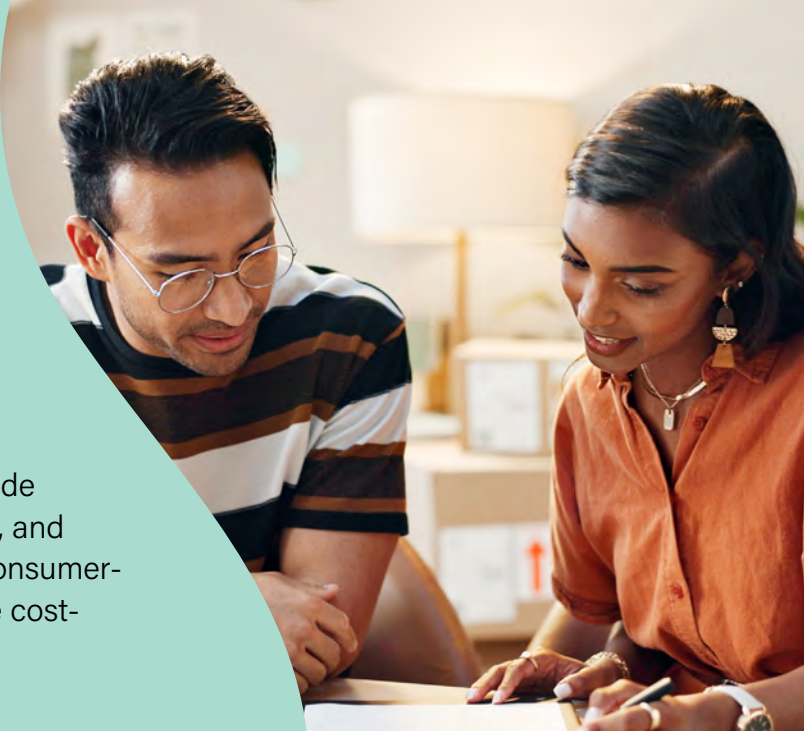
Service descriptions

38

Group sizes

Serving the needs of individuals and employer groups of all sizes

Sentara Health Plans makes it easier for people and businesses to get the health coverage they need with the quality they deserve. Our group health plans include a robust portfolio of benefit plans, exceptional service, and budget-friendly options for access to care. We offer consumer-driven health plans that empower employees to make cost-conscious care decisions.



Groups that are eligible for our Small Group plans include:



1-4

total enrolled employees

Micro Small Business Unit (MSBU)

The Micro Small Business Unit (MSBU) is dedicated to serving our smaller groups with 1-4 enrolled employees. These groups are able to choose a plan from our existing Small Group portfolio. Contact our Micro Small Business Team at **1-888-706-2850** or **MSBU@sentara.com**.



1-50

total employees

Self-employed individuals' and Small Group

Our small business health insurance options allow self-employed individuals and employers to offer competitive benefits while staying within budget. Members have access to robust benefits that include wellness programs and support for chronic illness.



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

¹Terms and conditions apply.

2027 Sentara **Vantage Plans**

Plan Name	Sentara Vantage Platinum 0 Ded	Sentara Vantage Platinum 0 Ded 3500 MOOP	Sentara Vantage Platinum 0 Ded 200 Rx Ded	Sentara Vantage Platinum 250 Ded	Sentara Vantage Gold 0 Ded
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	\$0/\$0	\$0/\$0	\$0/\$0	\$250/\$500	\$0/\$0
In-network out-of-pocket max (individual/family)	\$3,500/\$7,000	\$3,500/\$7,000	\$3,000/\$6,000	\$3,000/\$6,000	\$8,500/\$17,000
Physician services					
Primary care physician office visit	\$10	\$15	\$25	\$30	\$35
Virtual consult	No charge	No charge	No charge	No charge	No charge
Specialist office visit	\$30	\$35	\$50	\$60	\$70
Outpatient services					
Outpatient surgery	\$150	\$200	\$300	30% AD	\$400
Outpatient diagnostic procedures and tests	\$30	\$35	20%	\$30	\$35
Outpatient lab work	\$30	\$35	20%	\$30	\$35
Advanced imaging and testing procedures	\$200	\$150	\$150	30% AD	\$300
Inpatient services					
Inpatient hospital services	\$300/day (\$1,200 max)	\$600	\$300/day (\$1,200 max)	30% AD	\$600/day (\$2,400 max)
Emergency and urgent care services					
Emergency services (in- and out-of-network)	\$350	\$350	30%	40% AD	40%
Urgent care center services	\$30	\$35	\$50	\$70	\$70
Mental/behavioral health and substance use disorder services					
Inpatient services	\$300/day (\$1,200 max)	\$600	\$300/day (\$1,200 max)	30% AD	\$600/day (\$2,400 max)
Outpatient office visits (PCP, specialist or virtual consults)	\$20	\$25	\$35	\$40	\$45
Other outpatient services	\$40	\$45	\$60	30% AD	\$80
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment					
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge	No charge	No charge
Testing supplies [∘] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services					
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	\$20	20%	20%	30% AD	30%
Maternity care	\$400	\$600	\$300	30% AD	\$600
Hearing aid (Available for dependent children up to age 18)	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy					
Prescription drug coverage deductible, if applicable tier 1/tier 2/ tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	No deductible \$10/\$50/\$250/\$350	No deductible \$10/\$40/20%/25%*	Rx p/p deductible \$200 \$10/\$40 AD/20% AD/25% AD*	No deductible \$10/\$40/20%/25%*	No deductible \$10/\$40/30%/35%*

∘Continuous blood glucose monitors, sensors and supplies are Covered under the plan's prescription drug benefit for the associated cost share.

§Plan visit limits apply. | AD: After Deductible | p/p: Per Person

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

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

Plan Name	Sentara Vantage Gold 500 Ded 200 Rx Ded	Sentara Vantage Gold 750 Ded	Sentara Vantage Gold 1000 Ded 250 Rx Ded	Sentara Vantage Gold 1000 Ded 200 Rx Ded	Sentara Vantage Gold 1250 Ded 200 Rx Ded
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	\$500/\$1,000	\$750/\$1,500	\$1,000/\$2,000	\$1,000/\$2,000	\$1,250/\$2,500
In-network out-of-pocket max (individual/family)	\$7,500/\$15,000	\$7,700/\$15,400	\$7,500/\$15,000	\$6,500/\$13,000	\$7,000/\$14,000
Physician services					
Primary care physician office visit	\$25	\$30	\$20	\$25	\$20
Virtual consult	No charge	No charge	No charge	No charge	No charge
Specialist office visit	\$50	\$60	\$40	\$50	\$40
Outpatient services					
Outpatient surgery	20% AD	20% AD	\$250 AD	30% AD	20% AD
Outpatient diagnostic procedures and tests	\$50	\$60	\$50	\$50 AD	20% AD
Outpatient lab work	\$50	\$60	\$50	\$30 AD	20% AD
Advanced imaging and testing procedures	20% AD	20% AD	\$300 AD	\$300 AD	20% AD
Inpatient services					
Inpatient hospital services	20% AD	20% AD	\$500 AD	30% AD	20% AD
Emergency and urgent care services					
Emergency services (in- and out-of-network)	30% AD	30% AD	\$350 AD	40% AD	30% AD
Urgent care center services	\$50	\$60	\$40	\$50	\$40
Mental/behavioral health and substance use disorder services					
Inpatient services	20% AD	20% AD	\$500 AD	30% AD	20% AD
Outpatient office visits (PCP, specialist or virtual consults)	\$35	\$40	\$30	\$35	\$30
Other outpatient services	20% AD	20% AD	\$50	30% AD	20% AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment					
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge	No charge	No charge
Testing supplies [◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services					
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	20% AD	20% AD	\$20 AD	30% AD	20% AD
Maternity care	20% AD	20% AD	\$500 AD	30% AD	20% AD
Hearing aid (Available for dependent children up to age 18)	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy					
Prescription drug coverage deductible, if applicable tier 1/tier 2/ tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	Rx p/p deductible \$200 \$15/\$50 AD/20% AD/25% AD*	No deductible \$15/\$50/20%/25%*	Rx p/p deductible \$250 \$25/\$75 AD/\$250 AD/\$350 AD	Rx p/p deductible \$200 \$15/\$50 AD/30% AD/35% AD*	Rx p/p deductible \$200 \$15/\$50 AD/20% AD/25% AD*

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

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

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

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

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



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

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

Plan Name	Sentara Vantage Silver 3000 Ded	Sentara Vantage Silver 4000 Ded 250 Rx Ded	Sentara Vantage Silver 4850 Ded 250 Rx Ded	Sentara Vantage Silver 5600 Ded 200 Rx Ded	Sentara Vantage Silver 6500 Ded 250 Rx Ded	Sentara Vantage Silver 7000 Ded
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	\$3,000/\$6,000	\$4,000/\$8,000	\$4,850/\$9,700	\$5,600/\$11,200	\$6,500/\$13,000	\$7,000/\$14,000
In-network out-of-pocket max (individual/family)	\$9,800/\$18,600	\$9,100/\$18,200	\$9,200/\$18,400	\$9,000/\$18,000	\$8,000/\$16,000	\$9,500/\$19,000
Physician services						
Primary care physician office visit	\$50	\$40	\$45	\$50	No charge AD	\$50
Virtual consult	No charge	No charge	No charge	No charge	No charge AD	No charge
Specialist office visit	\$90	\$80	\$90	\$90	No charge AD	\$100
Outpatient services						
Outpatient surgery	25% AD	20% AD	\$300 AD	20% AD	No charge AD	40% AD
Outpatient diagnostic procedures and tests	25% AD	\$80 AD	\$90 AD	20% AD	No charge AD	\$150 AD
Outpatient lab work	25% AD	\$80 AD	\$90 AD	20% AD	No charge AD	\$150 AD
Advanced imaging and testing procedures	25% AD	20% AD	\$300 AD	20% AD	No charge AD	\$450 AD
Inpatient services						
Inpatient hospital services	25% AD	20% AD	\$500 AD	20% AD	No charge AD	40% AD
Emergency and urgent care services						
Emergency services (in- and out-of-network)	35% AD	30% AD	\$350 AD	30% AD	20% AD	50% AD
Urgent care center services	\$90	\$80	\$90	\$90	No charge AD	\$100
Mental/behavioral health and substance use disorder services						
Inpatient services	25% AD	20% AD	\$500 AD	20% AD	No charge AD	40% AD
Outpatient office visits (PCP, specialist or virtual consults)	\$60	\$50	\$55	\$60	No charge AD	\$60
Other outpatient services	25% AD	20% AD	\$100 AD	20% AD	No charge AD	40% AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment						
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge	No charge	No charge	No charge
Testing supplies [◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services						
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	25% AD	20% AD	\$55 AD	20% AD	No charge AD	40% AD
Maternity care	25% AD	20% AD	\$500 AD	20% AD	No charge AD	40% AD
Hearing aid (Available for dependent children up to age 18)	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy						
Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	After medical deductible \$15/\$50 AD/25% AD/30% AD*	Rx p/p deductible \$250 \$25/\$65/20% AD/25% AD*	Rx p/p deductible \$250 \$15/\$65/\$250 AD/\$350 AD	Rx p/p deductible \$200 \$15/\$55 AD/20% AD/25% AD*	Rx p/p deductible \$250 \$15 AD/\$50 AD/25% AD/30% AD*	No deductible \$25/\$50/\$250/\$400

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

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



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

Plan Name	Sentara Vantage Bronze 6600 Ded	Sentara Vantage Bronze 7200 Ded	Sentara Vantage Bronze 8500 Ded
Embedded/non-embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	\$6,600/\$13,200	\$7,200/\$14,400	\$8,500/\$17,000
In-network out-of-pocket max (individual/family)	\$8,600/\$17,200	\$9,500/\$19,000	\$8,500/\$17,000
Physician services			
Primary care physician office visit	30% AD	\$45 AD	No charge AD
Virtual consult	No charge AD	No charge	No charge AD
Specialist office visit	30% AD	\$90 AD	No charge AD
Outpatient services			
Outpatient surgery	30% AD	40% AD	No charge AD
Outpatient diagnostic procedures and tests	30% AD	\$90 AD	No charge AD
Outpatient lab work	30% AD	\$90 AD	No charge AD
Advanced imaging and testing procedures	30% AD	\$400 AD	No charge AD
Inpatient services			
Inpatient hospital services	30% AD	40% AD	No charge AD
Emergency and urgent care services			
Emergency services (in- and out-of-network)	40% AD	50% AD	No charge AD
Urgent care center services	30% AD	\$90 AD	No charge AD
Mental/behavioral health and substance use disorder services			
Inpatient services	30% AD	40% AD	No charge AD
Outpatient office visits (PCP, specialist or virtual consults)	30% AD	\$55 AD	No charge AD
Other outpatient services	30% AD	40% AD	No charge AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment			
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge
Testing supplies [Ⓓ] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services			
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [Ⓔ]	30% AD	40% AD	No charge AD
Maternity care	30% AD	40% AD	No charge AD
Hearing aid (Available for dependent children up to age 18)	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy			
Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	After medical deductible \$15/\$50 AD/30% AD/35% AD*	After medical deductible \$25/\$65/40% AD/45% AD*	After medical deductible No charge AD/No charge AD No charge AD/ No charge AD

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

2027 Sentara **Vantage HSA Plans**

Plan Name	Sentara Vantage HSA Gold 1950 Ded	Sentara Vantage HSA Silver 3500 Ded	Sentara Vantage HSA Silver 4000 Ded	Sentara Vantage HSA Bronze 6100 Ded	Sentara Vantage HSA Bronze 6750 Ded	Sentara Vantage HSA Bronze 7000 Ded
Embedded/non-embedded	Non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)¥	\$1,950/\$3,900	\$3,500/\$7,000	\$4,000/\$8,000	\$6,100/\$12,200	\$6,750/\$13,500	\$7,000/\$14,000
In-network out-of-pocket max (individual/family)	\$6,000/\$12,000	\$8,500/\$17,000	\$8,500/\$17,000	\$8,500/\$17,000	\$8,500/\$17,000	\$8,500/\$17,000
Physician services						
Primary care physician office visit	\$25 AD	20% AD	\$40 AD	\$40 AD	No charge AD	No charge AD
Virtual consult	No charge AD	No charge AD	No charge AD	No charge AD	No charge AD	No charge AD
Specialist office visit	\$50 AD	20% AD	\$80 AD	\$80 AD	No charge AD	No charge AD
Outpatient services						
Outpatient surgery	\$300 AD	20% AD	No charge AD	40% AD	No charge AD	No charge AD
Outpatient diagnostic procedures and tests	\$40 AD	20% AD	No charge AD	40% AD	No charge AD	No charge AD
Outpatient lab work	\$40 AD	20% AD	No charge AD	40% AD	No charge AD	No charge AD
Advanced imaging and testing procedures	\$300 AD	20% AD	No charge AD	40% AD	No charge AD	No charge AD
Inpatient services						
Inpatient hospital services	\$500 AD	20% AD	No charge AD	40% AD	No charge AD	No charge AD
Emergency and urgent care services						
Emergency services (in- and out-of-network)	\$350 AD	30% AD	20% AD	50% AD	30% AD	20% AD
Urgent care center services	\$50 AD	20% AD	\$80 AD	\$80 AD	No charge AD	No charge AD
Mental/behavioral health and substance use disorder services						
Inpatient services	\$500 AD	20% AD	No charge AD	40% AD	No charge AD	No charge AD
Outpatient office visits (PCP, specialist or virtual consults)	\$35 AD	20% AD	\$40 AD	\$40 AD	No charge AD	No charge AD
Other outpatient services	\$60 AD	20% AD	No charge AD	40% AD	No charge AD	No charge AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment						
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge	No charge	No charge	No charge
Testing supplies◊ (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services						
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation)§	\$50 AD	20% AD	No charge AD	40% AD	No charge AD	No charge AD
Maternity care	\$500 AD	20% AD	No charge AD	40% AD	No charge AD	No charge AD
Hearing aid (Available for dependent children up to age 18)	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy						
Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	After medical deductible \$25 AD/\$65 AD/25% AD/30% AD*	After medical deductible \$25 AD/\$65 AD/20% AD/25% AD*	After medical deductible \$25 AD/\$65 AD/20% AD/25% AD*	After medical deductible \$25 AD/\$65 AD/40% AD/45% AD*	After medical deductible 25% AD/25% AD/25% AD/30% AD*	After medical deductible 25% AD/25% AD/25% AD/30% AD*

¥ No 4th quarter deductible carryover on HSA plans. | ◊Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer.

§Plan visit limits apply. | AD: After Deductible | p/p: Per Person

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

2027 Sentara POS Plans

Plan Name	Sentara POS Platinum 0 Ded	Sentara POS Platinum 0 Ded 3500 MOOP	Sentara POS Platinum 0 Ded 200 Rx Ded	Sentara POS Platinum 250 Ded	Sentara POS Gold 0 Ded
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	\$0/\$0	\$0/\$0	\$0/\$0	\$250/\$500	\$0/\$0
Out-of-network deductible (individual/family)	\$1,750/\$3,500	\$2,000/\$4,000	\$2,500/\$5,000	\$500/\$1,000	\$3,500/\$7,000
In-network out-of-pocket max (individual/family)	\$3,500/\$7,000	\$3,500/\$7,000	\$3,000/\$6,000	\$3,000/\$6,000	\$8,500/\$17,000
Out-of-network out-of-pocket max (individual/family)	\$7,000/\$14,000	\$7,000/\$14,000	\$6,000/\$12,000	\$6,000/\$12,000	\$17,000/\$34,000
Out-of-network coinsurance	40% AD/AC	40% AD/AC	40% AD/AC	40% AD/AC	40% AD/AC
Physician services					
Primary care physician office visit	\$10	\$15	\$25	\$30	\$35
Virtual consult (no out-of-network coverage)	No charge	No charge	No charge	No charge	No charge
Specialist office visit	\$30	\$35	\$50	\$60	\$70
Outpatient services					
Outpatient surgery	\$150	\$200	\$300	30% AD	\$400
Outpatient diagnostic procedures and tests	\$30	\$35	20%	\$30	\$35
Outpatient lab work	\$30	\$35	20%	\$30	\$35
Advanced imaging and testing procedures	\$200	\$150	\$150	30% AD	\$300
Inpatient services					
Inpatient hospital services	\$300/day (\$1,200 max)	\$600	\$300/day (\$1,200 max)	30% AD	\$600/day (\$2,400 max)
Emergency and urgent care services					
Emergency services (in- and out-of-network)	\$350	\$350	30%	40% AD	40%
Urgent care center services	\$30	\$35	\$50	\$70	\$70
Mental/behavioral health and substance use disorder services					
Inpatient services	\$300/day (\$1,200 max)	\$600	\$300/day (\$1,200 max)	30% AD	\$600/day (\$2,400 max)
Outpatient office visits (PCP, specialist or virtual consults ⁴)	\$20	\$25	\$35	\$40	\$45
Other outpatient services	\$40	\$45	\$60	30% AD	\$80
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment					
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge	No charge	No charge
Testing supplies ⁵ (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services					
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) ⁵	\$20	20%	20%	30% AD	30%
Maternity care	\$400	\$600	\$300	30% AD	\$600
Hearing aid (Available for dependent children up to age 18)	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy					
Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	No deductible \$10/\$50/\$250/\$350	No deductible \$10/\$40/20%/25%*	Rx p/p deductible \$200 \$10/\$40 AD/20% AD/25% AD*	No deductible \$10/\$40/20%/25%*	No deductible \$10/\$40/30%/35%*

⁴ No out-of-network coverage for behavioral health virtual consults | ⁵Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer.
⁵Plan visit limits apply. | AC: Allowable Charge | AD: After Deductible | p/p: Per Person

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

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

Plan Name	Sentara POS Gold 500 Ded 200 Rx Ded	Sentara POS Gold 750 Ded	Sentara POS Gold 1000 Ded 250 Rx Ded	Sentara POS Gold 1000 Ded 200 Rx Ded	Sentara POS Gold 1250 Ded 200 Rx Ded
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	\$500/\$1,000	\$750/\$1,500	\$1,000/\$2,000	\$1,000/\$2,000	\$1,250/\$2,500
Out-of-network deductible (individual/family)	\$1,000/\$2,000	\$1,500/\$3,000	\$2,000/\$4,000	\$2,000/\$4,000	\$2,500/\$5,000
In-network out-of-pocket max (individual/family)	\$7,500/\$15,000	\$7,700/\$15,400	\$7,500/\$15,000	\$6,500/\$13,000	\$7,000/\$14,000
Out-of-network out-of-pocket max (individual/family)	\$15,000/\$30,000	\$15,400/\$30,800	\$15,000/\$30,000	\$13,000/\$26,000	\$14,000/\$28,000
Out-of-network coinsurance	40% AD/AC	40% AD/AC	30% AD/AC	50% AD/AC	40% AD/AC
Physician services					
Primary care physician office visit	\$25	\$30	\$20	\$25	\$20
Virtual consult (no out-of-network coverage)	No charge	No charge	No charge	No charge	No charge
Specialist office visit	\$50	\$60	\$40	\$50	\$40
Outpatient services					
Outpatient surgery	20% AD	20% AD	\$250 AD	30% AD	20% AD
Outpatient diagnostic procedures and tests	\$50	\$60	\$50	\$50 AD	20% AD
Outpatient lab work	\$50	\$60	\$50	\$30 AD	20% AD
Advanced imaging and testing procedures	20% AD	20% AD	\$300 AD	\$300 AD	20% AD
Inpatient services					
Inpatient hospital services	20% AD	20% AD	\$500 AD	30% AD	20% AD
Emergency and urgent care services					
Emergency services (in- and out-of-network)	30% AD	30% AD	\$350 AD	40% AD	30% AD
Urgent care center services	\$50	\$60	\$40	\$50	\$40
Mental/behavioral health and substance use disorder services					
Inpatient services	20% AD	20% AD	\$500 AD	30% AD	20% AD
Outpatient office visits (PCP, specialist or virtual consults ^Δ)	\$35	\$40	\$30	\$35	\$30
Other outpatient services	20% AD	20% AD	\$50	30% AD	20% AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment					
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge	No charge	No charge
Testing supplies [◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services					
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	20% AD	20% AD	\$20 AD	30% AD	20% AD
Maternity care	20% AD	20% AD	\$500 AD	30% AD	20% AD
Hearing aid (Available for dependent children up to age 18)	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy					
Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	Rx p/p deductible \$200 \$15/\$50 AD/20% AD/25% AD*	No deductible \$15/\$50/20%/25%*	Rx p/p deductible \$250 \$25/\$75 AD/\$250 AD/\$350 AD	Rx p/p deductible \$200 \$15/\$50 AD/30% AD/35% AD*	Rx p/p deductible \$200 \$15/\$50 AD/20% AD/25% AD*

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

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

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

Plan Name	Sentara POS Gold 1500 Ded 200 Rx Ded	Sentara POS Gold 2000 Ded	Sentara POS Gold 2500 Ded
Embedded/non-embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	\$1,500/\$3,000	\$2,000/\$4,000	\$2,500/\$5,000
Out-of-network deductible (individual/family)	\$3,250/\$6,500	\$4,000/\$8,000	\$5,000/\$10,000
In-network out-of-pocket max (individual/family)	\$6,400/\$12,800	\$6,500/\$13,000	\$6,500/\$13,000
Out-of-network out-of-pocket max (individual/family)	\$12,800/\$25,600	\$13,000/\$26,000	\$13,000/\$26,000
Out-of-network coinsurance	40% AD/AC	50% AD/AC	40% AD/AC
Physician services			
Primary care physician office visit	\$25	\$25	\$30
Virtual consult (no out-of-network coverage)	No charge	No charge	No charge
Specialist office visit	\$50	\$50	\$60
Outpatient services			
Outpatient surgery	\$300 AD	30% AD	\$350 AD
Outpatient diagnostic procedures and tests	\$60 AD	\$50 AD	\$60
Outpatient lab work	\$30 AD	\$50 AD	\$30
Advanced imaging and testing procedures	\$400 AD	30% AD	\$300
Inpatient services			
Inpatient hospital services	\$400 AD	30% AD	20% AD
Emergency and urgent care services			
Emergency services (in- and out-of-network)	\$350 AD	40% AD	30% AD
Urgent care center services	\$50	\$50	\$60
Mental/behavioral health and substance use disorder services			
Inpatient services	\$400 AD	30% AD	20% AD
Outpatient office visits (PCP, specialist or virtual consults ^Δ)	\$35	\$35	\$40
Other outpatient services	\$60	30% AD	\$70
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment			
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge
Testing supplies [◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services			
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	20% AD	30% AD	20% AD
Maternity care	\$400 AD	30% AD	20% AD
Hearing aid (Available for dependent children up to age 18)	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy			
Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	Rx p/p deductible \$200 \$15/\$50 AD/20% AD/25% AD*	No deductible \$15/\$50/30%/35%*	No deductible \$10/\$50/20%/25%*

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



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

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

Plan Name	Sentara POS Silver 3000 Ded	Sentara POS Silver 3500 Ded	Sentara POS Silver 4000 Ded 250 Rx Ded	Sentara POS Silver 4850 Ded 250 Rx Ded	Sentara POS Silver 5600 Ded 200 Rx Ded
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	\$3,000/\$6,000	\$3,500/\$7,000	\$4,000/\$8,000	\$4,850/\$9,700	\$5,600/\$11,200
Out-of-network deductible (individual/family)	\$6,000/\$12,000	\$7,000/\$14,000	\$8,000/\$16,000	\$9,700/\$19,400	\$11,200/\$22,400
In-network out-of-pocket max (individual/family)	\$9,800/\$18,600	\$9,500/\$19,000	\$9,100/\$18,200	\$9,200/\$18,400	\$9,000/\$18,000
Out-of-network out-of-pocket max (individual/family)	\$18,600/\$37,200	\$19,000/\$38,000	\$18,200/\$36,400	\$18,400/\$36,800	\$18,000/\$36,000
Out-of-network coinsurance	45% AD/AC	40% AD/AC	40% AD/AC	40% AD/AC	40% AD/AC
Physician services					
Primary care physician office visit	\$50	\$35	\$40	\$45	\$50
Virtual consult (no out-of-network coverage)	No charge	No charge	No charge	No charge	No charge
Specialist office visit	\$90	\$70	\$80	\$90	\$90
Outpatient services					
Outpatient surgery	25% AD	20% AD	20% AD	\$300 AD	20% AD
Outpatient diagnostic procedures and tests	25% AD	\$70 AD	\$80 AD	\$90 AD	20% AD
Outpatient lab work	25% AD	\$70 AD	\$80 AD	\$90 AD	20% AD
Advanced imaging and testing procedures	25% AD	\$300 AD	20% AD	\$300 AD	20% AD
Inpatient services					
Inpatient hospital services	25% AD	20% AD	20% AD	\$500 AD	20% AD
Emergency and urgent care services					
Emergency services (in- and out-of-network)	35% AD	30% AD	30% AD	\$350 AD	30% AD
Urgent care center services	\$90	\$70	\$80	\$90	\$90
Mental/behavioral health and substance use disorder services					
Inpatient services	25% AD	20% AD	20% AD	\$500 AD	20% AD
Outpatient office visits (PCP, specialist or virtual consults ^Δ)	\$60	\$45	\$50	\$55	\$60
Other outpatient services	25% AD	20% AD	20% AD	\$100 AD	20% AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment					
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge	No charge	No charge
Testing supplies [◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services					
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	25% AD	20% AD	20% AD	\$55 AD	20% AD
Maternity care	25% AD	20% AD	20% AD	\$500 AD	20% AD
Hearing aid (Available for dependent children up to age 18)	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy					
Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	After medical deductible \$15/\$50 AD/25% AD/30% AD*	After medical deductible \$25 AD/\$50 AD/20% AD/25% AD*	Rx p/p deductible \$250 \$25/\$65/20% AD/25% AD*	Rx p/p deductible \$250 \$15/\$65/\$250 AD/\$350 AD	Rx p/p deductible \$200 \$15/\$55 AD/20% AD/25% AD*

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

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

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

Plan Name	Sentara POS Silver 6500 Ded 250 Rx Ded	Sentara POS Silver 7000 Ded	Sentara POS Bronze 6600 Ded	Sentara POS Bronze 7200 Ded	Sentara POS Bronze 8500 Ded
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	\$6,500/\$13,000	\$7,000/\$14,000	\$6,600/\$13,200	\$7,200/\$14,400	\$8,500/\$17,000
Out-of-network deductible (individual/family)	\$13,000/\$26,000	\$14,000/\$28,000	\$13,200/\$26,400	\$14,400/\$28,800	\$17,000/\$34,000
In-network out-of-pocket max (individual/family)	\$8,000/\$16,000	\$9,500/\$19,000	\$8,600/\$17,200	\$9,500/\$19,000	\$8,500/\$17,000
Out-of-network out-of-pocket max (individual/family)	\$16,000/\$32,000	\$19,000/\$38,000	\$17,200/\$34,400	\$19,000/\$38,000	\$17,000/\$34,000
Out-of-network coinsurance	30% AD/AC	50% AD/AC	50% AD/AC	50% AD/AC	30% AD/AC
Physician services					
Primary care physician office visit	No charge AD	\$50	30% AD	\$45 AD	No charge AD
Virtual consult (no out-of-network coverage)	No charge AD	No charge	No charge AD	No charge	No charge AD
Specialist office visit	No charge AD	\$100	30% AD	\$90 AD	No charge AD
Outpatient services					
Outpatient surgery	No charge AD	40% AD	30% AD	40% AD	No charge AD
Outpatient diagnostic procedures and tests	No charge AD	\$150 AD	30% AD	\$90 AD	No charge AD
Outpatient lab work	No charge AD	\$150 AD	30% AD	\$90 AD	No charge AD
Advanced imaging and testing procedures	No charge AD	\$450 AD	30% AD	\$400 AD	No charge AD
Inpatient Services					
Inpatient hospital services	No charge AD	40% AD	30% AD	40% AD	No charge AD
Emergency and urgent care services					
Emergency services (in- and out-of-network)	20% AD	50% AD	40% AD	50% AD	No charge AD
Urgent care center services	No charge AD	\$100	30% AD	\$90 AD	No charge AD
Mental/behavioral health and substance use disorder services					
Inpatient services	No charge AD	40% AD	30% AD	40% AD	No charge AD
Outpatient office visits (PCP, specialist or virtual consults ⁴)	No charge AD	\$60	30% AD	\$55 AD	No charge AD
Other outpatient services	No charge AD	40% AD	30% AD	40% AD	No charge AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment					
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge	No charge	No charge
Testing supplies [◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services					
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	No charge AD	40% AD	30% AD	40% AD	No charge AD
Maternity care	No charge AD	40% AD	30% AD	40% AD	No charge AD
Hearing aid (Available for dependent children up to age 18)	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy					
Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	Rx p/p deductible \$250 \$15 AD/\$50 AD/25% AD/30% AD*	No deductible \$25/\$50/\$250/\$400	After medical deductible \$15/\$50 AD/30% AD/35% AD*	After medical deductible \$25/\$65/40% AD/45% AD*	After medical deductible No charge AD/ No charge AD No charge AD/ No charge AD

⁴ No out-of-network coverage for behavioral health virtual consults | [◇]Some pumps and pump supplies may be covered under the Plan's Prescription Drug Benefit depending on the device manufacturer.
[§]Plan visit limits apply. | AC: Allowable Charge | AD: After Deductible | p/p: Per Person

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

2027 Sentara POS HSA Plans

Plan Name	Sentara POS HSA Gold 1950 Ded	Sentara POS HSA Silver 3500 Ded	Sentara POS HSA Silver 4000 Ded	Sentara POS HSA Bronze 6100 Ded	Sentara POS HSA Bronze 6200 Ded
Embedded/non-embedded	Non-embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)*	\$1,950/\$3,900	\$3,500/\$7,000	\$4,000/\$8,000	\$6,100/\$12,200	\$6,200/\$12,400
Out-of-network deductible (individual/family)*	\$3,900/\$7,800	\$7,000/\$14,000	\$8,000/\$16,000	\$12,200/\$24,400	\$12,400/\$24,800
In-network out-of-pocket max (individual/family)	\$6,000/\$12,000	\$8,500/\$17,000	\$8,500/\$17,000	\$8,500/\$17,000	\$8,500/\$17,000
Out-of-network out-of-pocket max (individual/family)	\$12,000/\$24,000	\$17,000/\$34,000	\$17,000/\$34,000	\$17,000/\$34,000	\$17,000/\$34,000
Out-of-network coinsurance	30% AD/AC	40% AD/AC	30% AD/AC	50% AD/AC	50% AD/AC
Physician services					
Primary care physician office visit	\$25 AD	20% AD	\$40 AD	\$40 AD	\$40 AD
Virtual consult (no out-of-network coverage)	No charge AD	No charge AD	No charge AD	No charge AD	No charge AD
Specialist office visit	\$50 AD	20% AD	\$80 AD	\$80 AD	\$80 AD
Outpatient services					
Outpatient surgery	\$300 AD	20% AD	No charge AD	40% AD	30% AD
Outpatient diagnostic procedures and tests	\$40 AD	20% AD	No charge AD	40% AD	30% AD
Outpatient lab work	\$40 AD	20% AD	No charge AD	40% AD	30% AD
Advanced imaging and testing procedures	\$300 AD	20% AD	No charge AD	40% AD	30% AD
Inpatient services					
Inpatient hospital services	\$500 AD	20% AD	No charge AD	40% AD	30% AD
Emergency and urgent care services					
Emergency services (in- and out-of-network)	\$350 AD	30% AD	20% AD	50% AD	40% AD
Urgent care center services	\$50 AD	20% AD	\$80 AD	\$80 AD	30% AD
Mental/behavioral health and substance use disorder services					
Inpatient services	\$500 AD	20% AD	No charge AD	40% AD	30% AD
Outpatient office visits (PCP, specialist or virtual consults ^Δ)	\$35 AD	20% AD	\$40 AD	\$40 AD	\$50 AD
Other outpatient services	\$60 AD	20% AD	No charge AD	40% AD	30% AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment					
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge	No charge	No charge
Testing supplies [◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services					
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	\$50 AD	20% AD	No charge AD	40% AD	30% AD
Maternity care	\$500 AD	20% AD	No charge AD	40% AD	30% AD
Hearing aid (Available for dependent children up to age 18)	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy					
[†] Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	After medical deductible \$25 AD/\$65 AD/25% AD/30% AD*	After medical deductible \$25 AD/\$65 AD/20% AD/25% AD*	After medical deductible \$25 AD/\$65 AD/20% AD/25% AD*	After medical deductible \$25 AD/\$65 AD/40% AD/45% AD*	After medical deductible 30% AD/30% AD/30% AD/35% AD*

[‡] No 4th quarter deductible carryover on HSA plans.
 |
 ^Δ No out-of-network coverage for behavioral health virtual consults
 |
 [◇] Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer.
 |
 [§] Plan visit limits apply.
 |
 ^{*} Some preventive drugs are available before the deductible for HSA Plans.

 AC: Allowable Charge
 |
 AD: After Deductible
 |
 p/p: Per Person

This is a summary of the standard covered expenses. Exclusions and limitations apply. Additional benefits may be available. Please see plan-specific summary for more information.

 Most values reflect in-network coverage. Coinsurance amounts represent the percentage the member pays.

2027 Sentara **POS HSA Plans** *(continued)*

Plan Name	Sentara POS HSA Bronze 6750 Ded	Sentara POS HSA Bronze 7000 Ded
Embedded/non-embedded	Embedded	Embedded
In-network deductible (individual/family)*	\$6,750/\$13,500	\$7,000/\$14,000
Out-of-network deductible (individual/family)*	\$13,500/\$27,000	\$14,000/\$28,000
In-network out-of-pocket max (individual/family)	\$8,500/\$17,000	\$8,500/\$17,000
Out-of-network out-of-pocket max (individual/family)	\$17,000/\$34,000	\$17,000/\$34,000
Out-of-network coinsurance	30% AD/AC	30% AD/AC
Physician services		
Primary care physician office visit	No charge AD	No charge AD
Virtual consult (no out-of-network coverage)	No charge AD	No charge AD
Specialist office visit	No charge AD	No charge AD
Outpatient services		
Outpatient surgery	No charge AD	No charge AD
Outpatient diagnostic procedures and tests	No charge AD	No charge AD
Outpatient lab work	No charge AD	No charge AD
Advanced imaging and testing procedures	No charge AD	No charge AD
Inpatient services		
Inpatient hospital services	No charge AD	No charge AD
Emergency and urgent care services		
Emergency services (in- and out-of-network)	30% AD	20% AD
Urgent care center services	No charge AD	No charge AD
Mental/behavioral health and substance use disorder services		
Inpatient services	No charge AD	No charge AD
Outpatient office visits (PCP, specialist or virtual consults ^Δ)	No charge AD	No charge AD
Other outpatient services	No charge AD	No charge AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment		
Insulin pumps, pump infusion sets, and supplies	No charge	No charge
Testing supplies [◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services		
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	No charge AD	No charge AD
Maternity care	No charge AD	No charge AD
Hearing aid (Available for dependent children up to age 18)	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy		
[†] Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	After medical deductible 25% AD/25% AD/25% AD/30% AD*	After medical deductible 25% AD/25% AD/25% AD/30% AD*

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

2027 Sentara **POS HRA Plan**

Plan Name	Sentara POS HRA Silver 3500 Ded 250 Rx Ded
Embedded/non-embedded	Embedded
In-network deductible (individual/family)*	\$3,500/\$7,000
Out-of-network deductible (family/individual)*	\$7,000/\$14,000
Max out-of-pocket individual/family (in-network)	\$9,500/\$19,000
Max out-of-pocket individual/family (out-of-network)	\$19,000/\$38,000
Out-of-network coinsurance	40% AD/AC
Physician services	
Primary care physician office visit	\$30 AD
Virtual consult (no out-of-network coverage)	No charge AD
Specialist office visit	\$60 AD
Outpatient services	
Outpatient surgery	20% AD
Outpatient diagnostic procedures and tests	20% AD
Outpatient lab work	20% AD
Advanced imaging and testing procedures	20% AD
Inpatient services	
Inpatient hospital services	20% AD
Emergency and urgent care services	
Emergency services (in- and out-of-network)	30% AD
Urgent care center services	\$60 AD
Mental/behavioral health and substance use disorder services	
Inpatient services	20% AD
Outpatient office visits (PCP, specialist or virtual consults ^Δ)	\$30 AD
Other outpatient services	20% AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment	
Insulin pumps, pump infusion sets, and supplies	No charge
Testing supplies [◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services	
Adult preventive vision exams	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	20% AD
Maternity care	20% AD
Hearing aid (Available for dependent children up to age 18)	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy	
Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	Rx p/p deductible \$250 \$25 AD/\$65 AD/20% AD/25% AD*

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

2027 Sentara **Plus Plans**

Plan Name	Sentara Plus Platinum 0 Ded	Sentara Plus Platinum 0 Ded 3500 MOOP	Sentara Plus Platinum 250 Ded	Sentara Plus Gold 500 Ded 200 Rx Ded	Sentara Plus Gold 750 Ded
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	\$0/\$0	\$0/\$0	\$250/\$500	\$500/\$1,000	\$750/\$1,500
Out-of-network deductible (individual/family)	\$1,750/\$3,500	\$2,000/\$4,000	\$500/\$1,000	\$1,000/\$2,000	\$1,500/\$3,000
In-network out-of-pocket max (individual/family)	\$3,500/\$7,000	\$3,500/\$7,000	\$3,000/\$6,000	\$7,500/\$15,000	\$7,700/\$15,400
Out-of-network out-of-pocket max (individual/family)	\$7,000/\$14,000	\$7,000/\$14,000	\$6,000/\$12,000	\$15,000/\$30,000	\$15,400/\$30,800
Out-of-network coinsurance	40% AD/AC	40% AD/AC	40% AD/AC	40% AD/AC	40% AD/AC
Physician services					
Primary care physician office visit	\$10	\$15	\$30	\$25	\$30
Virtual consult (no out-of-network coverage)	No charge	No charge	No charge	No charge	No charge
Specialist office visit	\$30	\$35	\$60	\$50	\$60
Outpatient services					
Outpatient surgery	\$150	\$200	30% AD	20% AD	20% AD
Outpatient diagnostic procedures and tests	\$30	\$35	\$30	\$50	\$60
Outpatient lab work	\$30	\$35	\$30	\$50	\$60
Advanced imaging and testing procedures	\$200	\$150	30% AD	20% AD	20% AD
Inpatient services					
Inpatient hospital services	\$300/day (\$1,200 max)	\$600	30% AD	20% AD	20% AD
Emergency and urgent care services					
Emergency services (in- and out-of-network)	\$350	\$350	40% AD	30% AD	30% AD
Urgent care center services	\$30	\$35	\$70	\$50	\$60
Mental/behavioral health and substance use disorder services					
Inpatient services	\$300/day (\$1,200 max)	\$600	30% AD	20% AD	20% AD
Outpatient office visits (PCP, specialist or virtual consults ^Δ)	\$20	\$25	\$40	\$35	\$40
Other outpatient services	\$40	\$45	30% AD	20% AD	20% AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment					
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge	No charge	No charge
Testing supplies [◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services					
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	\$20	20%	30% AD	20% AD	20% AD
Maternity care	\$400	\$600	30% AD	20% AD	20% AD
Hearing aid (Available for dependent children up to age 18)	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy					
Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	No deductible \$10/\$50/\$250/\$350	No deductible \$10/\$40/20%/25%*	No deductible \$10/\$40/20%/25%*	Rx p/p deductible \$200 \$15/\$50 AD/20% AD/25% AD*	No deductible \$15/\$50/20%/25%*

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

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

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

Plan Name	Sentara Plus Gold 1000 Ded 250 Rx Ded	Sentara Plus Gold 1250 Ded 200 Rx Ded	Sentara Plus Gold 1500 Ded 200 Rx Ded	Sentara Plus Gold 2000 Ded	Sentara Plus Gold 2500 Ded
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	\$1,000/\$2,000	\$1,250/\$2,500	\$1,500/\$3,000	\$2,000/\$4,000	\$2,500/\$5,000
Out-of-network deductible (individual/family)	\$2,000/\$4,000	\$2,500/\$5,000	\$3,250/\$6,500	\$4,000/\$8,000	\$5,000/\$10,000
In-network out-of-pocket max (individual/family)	\$7,500/\$15,000	\$7,000/\$14,000	\$6,400/\$12,800	\$6,500/\$13,000	\$6,500/\$13,000
Out-of-network out-of-pocket max (individual/family)	\$15,000/\$30,000	\$14,000/\$28,000	\$12,800/\$25,600	\$13,000/\$26,000	\$13,000/\$26,000
Out-of-network coinsurance	30% AD/AC	40% AD/AC	40% AD/AC	50% AD/AC	40% AD/AC
Physician services					
Primary care physician office visit	\$20	\$20	\$25	\$25	\$30
Virtual consult (no out-of-network coverage)	No charge	No charge	No charge	No charge	No charge
Specialist office visit	\$40	\$40	\$50	\$50	\$60
Outpatient services					
Outpatient surgery	\$250 AD	20% AD	\$300 AD	30% AD	\$350 AD
Outpatient diagnostic procedures and tests	\$50	20% AD	\$60 AD	\$50 AD	\$60
Outpatient lab work	\$50	20% AD	\$30 AD	\$50 AD	\$30
Advanced imaging and testing procedures	\$300 AD	20% AD	\$400 AD	30% AD	\$300
Inpatient services					
Inpatient hospital services	\$500 AD	20% AD	\$400 AD	30% AD	20% AD
Emergency and urgent care services					
Emergency services (in- and out-of-network)	\$350 AD	30% AD	\$350 AD	40% AD	30% AD
Urgent care center services	\$40	\$40	\$50	\$50	\$60
Mental/behavioral health and substance use disorder services					
Inpatient services	\$500 AD	20% AD	\$400 AD	30% AD	20% AD
Outpatient office visits (PCP, specialist or virtual consults ^Δ)	\$30	\$30	\$35	\$35	\$40
Other outpatient services	\$50	20% AD	\$60	30% AD	\$70
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment					
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge	No charge	No charge
Testing supplies [◊] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services					
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	\$20 AD	20% AD	20% AD	30% AD	20% AD
Maternity care	\$500 AD	20% AD	\$400 AD	30% AD	20% AD
Hearing aid (Available for dependent children up to age 18)	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy					
Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	Rx p/p deductible \$250 \$25/\$75 AD/\$250 AD/\$350 AD	Rx p/p deductible \$200 \$15/\$50 AD/20% AD/25% AD*	Rx p/p deductible \$200 \$15/\$50 AD/20% AD/25% AD*	No deductible \$15/\$50/30%/35%*	No deductible \$10/\$50/20%/25%*

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

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

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

Plan Name	Sentara Plus Silver 3000 Ded	Sentara Plus Silver 4000 Ded 250 Rx Ded	Sentara Plus Silver 6500 Ded 250 Rx Ded	Sentara Plus Silver 7000 Ded	Sentara Plus Bronze 7200 Ded	Sentara Plus Bronze 8500 Ded
Embedded/non-embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family)	\$3,000/\$6,000	\$4,000/\$8,000	\$6,500/\$13,000	\$7000/\$14,000	\$7,200/\$14,400	\$8,500/\$17,000
Out-of-network deductible (individual/family)	\$6,000/\$12,000	\$8,000/\$16,000	\$13,000/\$26,000	\$14,000/\$28,000	\$14,400/\$28,800	\$17,000/\$34,000
In-network out-of-pocket max (individual/family)	\$9,800/\$18,600	\$9,100/\$18,200	\$8,000/\$16,000	\$9,500/\$19,000	\$9,500/\$19,000	\$8,500/\$17,000
Out-of-network out-of-pocket max (individual/family)	\$18,600/\$37,200	\$18,200/\$36,400	\$16,000/\$32,000	\$19,000/\$38,000	\$19,000/\$38,000	\$17,000/\$34,000
Out-of-network coinsurance	45% AD/AC	40% AD/AC	30% AD/AC	50% AD/AC	50% AD/AC	30% AD/AC
Physician services						
Primary care physician office visit	\$50	\$40	No charge AD	\$50	\$45 AD	No charge AD
Virtual consult (no out-of-network coverage)	No charge	No charge	No charge AD	No charge	No charge	No charge AD
Specialist office visit	\$90	\$80	No charge AD	\$100	\$90 AD	No charge AD
Outpatient services						
Outpatient surgery	25% AD	20% AD	No charge AD	40% AD	40% AD	No charge AD
Outpatient diagnostic procedures and tests	25% AD	\$80 AD	No charge AD	\$150 AD	\$90 AD	No charge AD
Outpatient lab work	25% AD	\$80 AD	No charge AD	\$150 AD	\$90 AD	No charge AD
Advanced imaging and testing procedures	25% AD	20% AD	No charge AD	\$450 AD	\$400 AD	No charge AD
Inpatient services						
Inpatient hospital services	25% AD	20% AD	No charge AD	40% AD	40% AD	No charge AD
Emergency and urgent care services						
Emergency services (in- and out-of-network)	35% AD	30% AD	20% AD	50% AD	50% AD	No charge AD
Urgent care center services	\$90	\$80	No charge AD	\$100	\$90 AD	No charge AD
Mental/behavioral health and substance use disorder services						
Inpatient services	25% AD	20% AD	No charge AD	40% AD	40% AD	No charge AD
Outpatient office visits (PCP, specialist or virtual consults ^Δ)	\$60	\$50	No charge AD	\$60	\$55 AD	No charge AD
Other outpatient services	25% AD	20% AD	No charge AD	40% AD	40% AD	No charge AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment						
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge	No charge	No charge	No charge
Testing supplies [◊] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services						
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	25% AD	20% AD	No charge AD	40% AD	40% AD	No charge AD
Maternity care	25% AD	20% AD	No charge AD	40% AD	40% AD	No charge AD
Hearing aid (Available for dependent children up to age 18)	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy						
Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	After medical deductible \$15/\$50 AD/25% AD/30% AD*	Rx p/p deductible \$250 \$25/\$65/20% AD/25% AD*	Rx p/p deductible \$250 \$15 AD/\$50 AD/25% AD/30% AD*	No deductible \$25/\$50/\$250/\$400	After medical deductible \$25/\$65/40% AD/45% AD*	After medical deductible No charge AD/ No charge AD/ No charge AD/ No charge AD

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

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

2027 Sentara **Plus HSA Plans**

Plan Name	Sentara Plus HSA Gold 1950 Ded	Sentara Plus HSA Silver 3500 Ded	Sentara Plus HSA Silver 4000 Ded	Sentara Plus HSA Bronze 6750 Ded	Sentara Plus HSA Bronze 7000 Ded
Embedded/non-embedded	Non-embedded	Embedded	Embedded	Embedded	Embedded
In-network deductible (individual/family) [¥]	\$1,950/\$3,900	\$3,500/\$7,000	\$4,000/\$8,000	\$6,750/\$13,500	\$7,000/\$14,000
Out-of-network deductible (individual/family) [¥]	\$3,900/\$7,800	\$7,000/\$14,000	\$8,000/\$16,000	\$13,500/\$27,000	\$14,000/\$28,000
In-network out-of-pocket max (individual/family)	\$6,000/\$12,000	\$8,500/\$17,000	\$8,500/\$17,000	\$8,500/\$17,000	\$8,500/\$17,000
Out-of-network out-of-pocket max (individual/family)	\$12,000/\$24,000	\$17,000/\$34,000	\$17,000/\$34,000	\$17,000/\$34,000	\$17,000/\$34,000
Out-of-network coinsurance	30% AD/AC	40% AD/AC	30% AD/AC	30% AD/AC	30% AD/AC
Physician services					
Primary care physician office visit	\$25 AD	20% AD	\$40 AD	No charge AD	No charge AD
Virtual consult (no out-of-network coverage)	No charge AD	No charge AD	No charge AD	No charge AD	No charge AD
Specialist office visit	\$50 AD	20% AD	\$80 AD	No charge AD	No charge AD
Outpatient services					
Outpatient surgery	\$300 AD	20% AD	No charge AD	No charge AD	No charge AD
Outpatient diagnostic procedures and tests	\$40 AD	20% AD	No charge AD	No charge AD	No charge AD
Outpatient lab work	\$40 AD	20% AD	No charge AD	No charge AD	No charge AD
Advanced imaging and testing procedures	\$300 AD	20% AD	No charge AD	No charge AD	No charge AD
Inpatient services					
Inpatient hospital services	\$500 AD	20% AD	No charge AD	No charge AD	No charge AD
Emergency and urgent care services					
Emergency services (in- and out-of-network)	\$350 AD	30% AD	20% AD	30% AD	20% AD
Urgent care center services	\$50 AD	20% AD	\$80 AD	No charge AD	No charge AD
Mental/behavioral health and substance use disorder services					
Inpatient services	\$500 AD	20% AD	No charge AD	No charge AD	No charge AD
Outpatient office visits (PCP, specialist or virtual consults ^Δ)	\$35 AD	20% AD	\$40 AD	No charge AD	No charge AD
Other outpatient services	\$60 AD	20% AD	No charge AD	No charge AD	No charge AD
Employee assistance visits	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered	No charge for up to 5 visits per presenting concern for each individual covered
Diabetes treatment					
Insulin pumps, pump infusion sets, and supplies	No charge	No charge	No charge	No charge	No charge
Testing supplies [◇] (Includes test strips, lancets, lancet devices, home blood glucose meters, control solution, continuous blood glucose monitors, sensors and supplies)	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share	Covered under the plan's prescription drug benefit for the associated cost share
Other covered services					
Adult preventive vision exams	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months	No charge for 1 in-network visit every 12 months
Chiropractic care (spinal manipulation) [§]	\$50 AD	20% AD	No charge AD	No charge AD	No charge AD
Maternity care	\$500 AD	20% AD	No charge AD	No charge AD	No charge AD
Hearing aid (Available for dependent children up to age 18)	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months	No charge AD up to \$1,500 per hearing aid per hearing impaired ear, every 24 months
Pharmacy					
[‡] Prescription drug coverage deductible, if applicable tier 1/tier 2/tier 3/tier 4 (*\$350 max out-of-pocket, per prescription)	After medical deductible \$25 AD/\$65 AD/25% AD/30% AD*	After medical deductible \$25 AD/\$65 AD/20% AD/25% AD*	After medical deductible \$25 AD/\$65 AD/20% AD/25% AD*	After medical deductible 25% AD/25% AD/25% AD/30% AD*	After medical deductible 25% AD/25% AD/25% AD/30% AD*

[¥] No 4th quarter deductible carryover on HSA plans. | ^Δ No out-of-network coverage for behavioral health virtual consults | [◇] Some pumps and pump supplies may be covered under the plan's prescription drug benefit depending on the device manufacturer. | [§] Plan visit limits apply. | [‡] Some preventive drugs are available before the deductible for HSA Plans.

AC: Allowable Charge | AD: After Deductible | p/p: Per Person

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

Service descriptions

Physician services

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

Virtual consult

Medical virtual consult

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

Behavioral health virtual consult

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

Outpatient services

Outpatient surgery

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

Outpatient diagnostic procedures and tests

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

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

Maternity care

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

Emergency services

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

Mental/behavioral health and substance use disorder services

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

Other outpatient services

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

Employee assistance visits

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

Diabetes treatment

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

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

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



Vision services through VSP Vision Care

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

Chiropractic care

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

Hearing aid services

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

For additional details on covered services, reference benefit documents.

Choose Sentara Health Plans

- ✓ Simple
- ✓ Seamless
- ✓ Personal
- ✓ Affordable

Improving health every day



Website:

sentarahealthplans.com



Email:

sales@sentara.com



Broker services:

1-866-927-4785

8 a.m. to 5 p.m. EST,

Monday through Friday

brokerservices@sentara.com



Scan to learn more.

Sentara Health Plans is the trade name of Sentara Health Plans, Sentara Health Insurance Company, Sentara Behavioral Health Services, Inc., and Sentara Health Administration, Inc. Sentara Vantage Health Maintenance organization (HMO), Point of Service (POS), and Tiered plans are issued and underwritten by Sentara Health Plans. Sentara Plus Preferred Provider Organization (PPO) products are issued and underwritten by Sentara Health Insurance Company. Self-funded employer group health plans and Business**EDGE**® level-funded plans are administered, but not underwritten, by Sentara Health Administration, Inc. Stop-loss products are issued and underwritten by Sentara Health Insurance Company. All plans have benefit exclusions and limitations, and terms under which the policy may be continued in force or discontinued. Wellness and rewards programs are administered by Sentara Health Administration, Inc. and are not covered benefits under any of our health plans. Value-added services are not covered benefits under any plans through Sentara Health Plans. For costs and complete details of coverage, please call your broker or Sentara Health Plans at 1-800-745-1271 or visit sentarahealthplans.com.