CHOICE CARE
VCU Health System
Plan Effective Date: 1/1/2026
Schedule of Benefits

Administered by Sentara Health Administration, Inc.

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

This document is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. One column lists cost sharing amounts You will pay for VCUHS In-Network Tier 1 benefits from VCUHS Plan Providers and another for Sentara Health Plans PPO In-Network Tier 2 benefits from Sentara Health Plans PPO Plan Providers. The third column lists cost sharing amounts You will pay for Out-of-Network benefits from Non-Plan Providers. This Plan has tiered Copayment or Coinsurance amounts listed for In-Network benefits. For some services You will pay less out-of-pocket when You use Tier 1 Physicians, Hospitals or other Facilities or providers. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.

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

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

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

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

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

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

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

VCUHS PPO

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

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. 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, or that are paid on their behalf, out-of-pocket for most Covered Services during a year. Deductibles, Copayments and Coinsurance for most Covered Services count toward the Maximum amount. Your Plan may have separate Maximum amounts for In-Network and Out-of-Network benefits.

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VCU Health System Effective Period: From 1/1/2026 through 12/31/2026			
Deductible and Maximum Out of Pocket Amount (MOOP)			
	VCUHS Network	**Sentara Health Plans PPO Network**	**Out-of-Network**
Deductible Calendar year	Your Plan Does Not Have a Deductible	$750/Individual; $1,500/Family	$2,000/Individual; $4,000/Family

Your Plan does not have an In-Network Deductible. Most amounts You pay for Out-of-Network Covered Services will count toward meeting the Out-of-Network Deductible. The Deductible applies to all Out-of-Network Covered Services unless services are shown as Covered without a Deductible.

The In-Network Tier 2 and the Out-of-Network Deductible are separate. Most amounts You pay for Covered Services Out-of-Network will count toward meeting the Out-of-Network Deductible.

The Deductible applies to all Covered Services except for:

- In-Network Preventive Care Services required by law;
- Other services in this document shown as Covered without a Deductible.
- Amounts You pay for your outpatient prescription drugs will not apply towards your deductible.

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

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

	VCUHS Network	Sentara Health Plans PPO Network	Out-of-Network
Maximum Out Of Pocket Calendar year	$2,000/Individual; $4,000/Family	$6,350/Individual; $12,700/Family	$7,500/Individual; $15,000/Family

The In-Network Tier 1 and In-Network Tier 2 Maximum Out-of-Pocket Amounts, and the Out-of-Network Maximum Out-of-Pocket Amounts are separate. Most amounts You pay, or that are paid on Your behalf, for Tier 1 Covered Services will count toward meeting both the Tier 1 and Tier 2 Maximum. Most amounts You pay, or that are paid on Your behalf, for Tier 2 Covered Services will count toward meeting both the Tier 1 and the Tier 2 Maximum. Most amounts You pay, or that are paid on Your behalf, for Covered Services Out-of-Network will count toward meeting the Out-of-Network Maximum.

The following will not count toward the Plan maximum(s) amount:

- 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;
- Amounts You pay for your outpatient prescription drugs;
- Other services in this Schedule of Benefits that are shown as excluded from the maximum amount.

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

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by approved Plan providers. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits. ***Pre-Authorization is required for in-office surgery.**			
Primary Care Visit	You Pay $25	You Pay $25	After Deductible 40%
Virtual Consult	You Pay $5 for VCUHS physicians regardless of specialty type	You Pay $25 for services with Sentara Health Plans virtual consult provider	Not Covered
Specialist Visit	You Pay $40	You Pay $75	After Deductible 40%
Vaccines and Immunotherapeutic Agents This does not include routine immunizations Covered under Preventive Care.	No Charge	No Charge	After Deductible 40%
Preventive Care Recommended preventive care services are Covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. Cost sharing, including Deductibles, Copayments or Coinsurances do not apply to Prostate Cancer Screenings received from In-Network or Out-of-Network Providers. Cost sharing including Deductibles, Copayments or Coinsurances does not apply to Diagnostic and Supplemental Breast Examinations to evaluate, detect, or screen for breast cancer when received from In-Network or Out-of-Network Providers. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.			
Recommended exams, screenings, tests, immunizations, and other services	No Charge	No Charge	In Network coverage only
Prostate Cancer Screenings	No Charge	No Charge	No Charge
Diagnostic and Supplemental Breast Examinations*	No Charge	No Charge	No Charge

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Outpatient Therapies and Services You pay a Copayment or Coinsurance amount for each visit at a Physician's office, a free-standing outpatient Facility, a Hospital outpatient Facility, or at home. Visit limits do not apply to outpatient habilitative or rehabilitative therapy services if You get that care as part of the Hospice or Early Intervention benefit, or as part of a treatment plan for Autism Spectrum Disorder. Visit limits do not apply to outpatient or home health habilitative or rehabilitative therapy services for mental health conditions or substance use disorders. For Mental Health conditions or Substance Use Disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.			
Occupational and Physical Therapy* Therapy, rehabilitative and habilitative services limited to 90 combined visits per Calendar year. Outpatient Therapy Services provided in the home are not subject to the Home Health Care Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Outpatient Therapy Services Maximum shown in The Schedule.	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $75 **Outpatient Facility** You Pay $75	After Deductible 40%
Speech Therapy* Therapy, rehabilitative and habilitative services limited to 90 combined visits per Calendar year. Outpatient Therapy Services provided in the home are not subject to the Home Health Care Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Outpatient Therapy Services Maximum shown in The Schedule	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $75 **Outpatient Facility** You Pay $75	After Deductible 40%
Cardiac Rehabilitation* Therapy, rehabilitative and habilitative services are unlimited	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	After Deductible 40%
Pulmonary Rehabilitation* Therapy, rehabilitative and habilitative services limited to 90 combined visits per Calendar year.	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	After Deductible 40%

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

Vascular Rehabilitation* Therapy, rehabilitative and habilitative services limited to 90 combined visits per Calendar year.	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	After Deductible 40%
Vestibular Rehabilitation* Therapy, rehabilitative and habilitative services limited to 90 combined visits per Calendar year.	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	After Deductible 40%
IV Infusion Therapy	No Charge	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $75 **Outpatient Facility** You Pay $75	After Deductible 40%
Respiratory/Inhalation Therapy	No Charge	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $75 **Outpatient Facility** You Pay $75	After Deductible 40%
Chemotherapy and Chemotherapy Drugs*	No Charge	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $75 **Outpatient Facility** You Pay $75	After Deductible 40%
Radiation Therapy*	No Charge	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $75 **Outpatient Facility** You Pay $75	After Deductible 40%
Pre-Authorized Injectable and Infused Medications* Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs.	No Charge	**PCP Office Visit** No Charge **Specialist Office Visit** No Charge **Outpatient Facility** After Deductible 30% **Home Health Care** After Deductible 30%	After Deductible 40%

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

Outpatient Dialysis You Pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.			
Dialysis Services	No Charge	After deductible You Pay $200 and 30%	After Deductible 40%
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free-standing ambulatory surgery center or Hospital outpatient surgical facility.			
Outpatient Surgery Services	You Pay $250	After deductible You Pay $200 and 30%	After Deductible 40%

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

Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient facility or lab or a Hospital outpatient facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Services.			
Diagnostic Procedures	No Charge	After Deductible 30%	After Deductible 40%
X-Ray **Doppler Studies**	**PCP Office Visit** No Charge **Specialist Office Visit** No Charge **Outpatient Facility** No Charge	After Deductible 30%	After Deductible 40%
Ultrasound	**PCP Office Visit** No Charge **Specialist Office Visit** No Charge **Outpatient Facility** No Charge	After Deductible 30%	After Deductible 40%
Lab Work	No Charge	After Deductible 30%	After Deductible 40%
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a free-standing 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 Outpatient Services.			
Magnetic Resonance Imaging (MRI)* **Magnetic Resonance Angiography (MRA) *** **Positron Emission Tomography (PET) *** **Computerized Axial Tomography (CT) *** **Computerized Axial Tomography Angiogram (CTA) *** **Magnetic Resonance Spectroscopy (MRS) *** **Single Photon Emission Computed Tomography (SPECT)*** **Nuclear Cardiology*** **Sleep Studies**	No Charge	You Pay 30%	After Deductible 40%

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

Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are Covered under preventive benefits.			
Maternity Care	No Charge	After Deductible 30%	After Deductible 40%
Home Births & Midwifery Services	No Charge	After Deductible 30%	
Birthing Center	You Pay $500	You Pay $1,000 and 30%	
Inpatient Services			
Inpatient Hospital Services*	You Pay $500	You Pay $1,000 and 30%	You Pay $2,000 and 40%
Transplants* Covered at contracted facilities in the ***Transplant Network (including VCUHS facilities.)***	No Charge	No Charge	Not Covered
Skilled Nursing Facility Services* Limited to a maximum of 100 days per Calendar year	No Charge	After Deductible 30%	After Deductible 40%
Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay a Copayment or Coinsurance per transport each way. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services.			
Water, Ground Services ***Pre-Authorization is required for Non-Emergent Transportation***	No Charge	No Charge	No Charge
Air Ambulance Services Non-Emergent Transportation	No Charge	No Charge	No Charge
Emergency Services Includes medical and mental health and substance use disorder Emergency Services, mobile crisis response and support and stabilization 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 an independent freestanding Emergency Department, In-Network or Out-of-Network.			
Emergency Services	You Pay $200	You Pay $200	You Pay $200
Emergency Ambulance	No Charge	No Charge	No Charge
Urgent Care Services Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care Facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.			
Urgent Care Services	You Pay $25	You Pay $25	You Pay $25

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

Mental 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) services, Transcranial Magnetic Stimulation (TMS), electro-convulsive therapy, and residential services.** Virtual Consults must be furnished by approved Plan providers.			
Inpatient Services*	You Pay $500	You Pay $500	You Pay $2,000 and 40%
Residential Treatment Services*	You Pay $500	You Pay $500	You Pay $2,000 and 40%
Outpatient Office Visits (PCP and Specialist)	You Pay $10	You Pay $10	After Deductible 40%
Partial Hospitalization/Intensive Outpatient Program Facility Services*	No Charge	No Charge	After Deductible 40%
Outpatient Office Visits (Virtual Consults)	You Pay $5	You Pay $10	Not Covered
Other Outpatient Services	No Charge	No Charge	After Deductible 40%
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service
Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay a Copayment or Coinsurance per transport each way.			
Water and Ground Services Non-Emergent Transportation*	No Charge	No Charge	No Charge
Air Ambulance Services Non-Emergent Transportation*	No Charge	No Charge	No Charge
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is covered from an In-Network Plan Provider or a participating Vision Services Plan (VSP) provider at the office visit Copayment or Coinsurance amount.			
Insulin Pumps*	You Pay 20% Deductible does not apply	You Pay 20% Deductible does not apply	After Deductible 40%
Pump Infusion Sets and Supplies*	You Pay 20% Deductible does not apply	You Pay 20% Deductible does not apply	After Deductible 40%
Testing Supplies Includes test strips, lancets, devices, Blood Glucose Meters and control solution and Continuous Blood Glucose Monitors, sensors and supplies. ***Pre-Authorization is required for talking Blood Glucose Meters**	Covered under the Plan's Prescription Drug Benefit at the applicable tier	Covered under the Plan's Prescription Drug Benefit at the applicable tier	Covered under the Plan's Prescription Drug Benefit at the applicable tier

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

Insulin, Needles, Syringes	Covered under the Plan's Prescription Drug Benefit at the applicable tier	Covered under the Plan's Prescription Drug Benefit at the applicable tier	Covered under the Plan's Prescription Drug Benefit at the applicable tier
Nutritional Therapy			
Outpatient Self-Management Training, Education, Nutritional Therapy – related to any diagnosis as medically necessary	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service
Prosthetic Limb Replacement			
Prosthetic Devices and Components, repair, fitting, replacement, adjustment. *	You Pay 20% Deductible does not apply	You Pay 20% Deductible does not apply	After Deductible 40%
Durable Medical Equipment (DME) and Supplies			
DME, Orthopedic Devices, Prosthetic Appliances, Devices*	You Pay 20% Deductible does not apply	You Pay 20% Deductible does not apply	After Deductible 40%
Early Intervention Services For Dependent children from birth to age three.			
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices.*	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service
Home Health Care Includes skilled home health care services. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home. Visit limits do not apply to outpatient habilitative or rehabilitative therapy services for mental health conditions and substance use disorders.			
Home Health Care* Limited to a maximum of 120 visits per Calendar year. Outpatient Therapy Services provided in the home are not subject to the Home Health Care Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Outpatient Therapy Services Maximum shown in The Schedule.	No Charge	No Charge	After Deductible 40%
Private Duty Nursing			
Private Duty Nursing* Limited to a maximum of 120 visits per Calendar year. Includes up to 16 hours per day of private duty nursing as medically necessary.	No Charge	No Charge	After Deductible 40%
Hospice Care			
Hospice Care*	No Charge	No Charge	After Deductible 40%
Chiropractic Care			

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

Sentara Health Plans Contracts with American Specialty Health Group (ASH) to administer this benefit. Services include therapy to treat problems of the bones, joints, and back. Services must be received from ASH providers.			
Chiropractic Care ***Pre-Authorization is required by ASH for all Chiropractic services.** Maximum number of visits 30 per Calendar year. This benefit also includes coverage of Chiropractic appliances up to a maximum benefit of 1 appliance per Person per Calendar year when medically necessary.	You Pay $25	You Pay $25	After Deductible 40%
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.			
Surgery and Reconstruction* **Prostheses*** **Physical Complication and Lymphedema***	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service
Clinical Trials Includes "routine patient costs" for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.			
Clinical Trial Services*	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service
Allergy Care			
Allergy Care, Testing, and Serum	No Charge	No Charge	After Deductible 40%
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.			
Telemedicine Services	You Pay $5 for VCUHS physicians regardless of specialty type	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service

Infertility Services			
Infertility Services* Endometrial biopsies Semen analysis Hysterosalpingography Sims-Huhner test (smear) Artificial Insemination Diagnostic laparoscopy **IVF *** (In-vitro Fertilization) **ZIFT *** (Zygote Intrafallopian Transfer) Covered infertility services are limited to $75,000 lifetime limit on all related services	You Pay $40 Per Visit	Not Covered	Not Covered
Embryology Clinic Services performed on embryos when patient is not present at office visit Covered infertility services are limited to $75,000 lifetime limit on all related services	No Charge	Not Covered	Not Covered
Infertility drugs and injections used in connection with these procedures.* **These are not subject to the $75,000 lifetime limit on infertility**	Covered under the Plan's Prescription Drug Benefit.	Not Covered	Not Covered
Hearing Aid Services for Children Age 18 and Younger Includes hearing aids and related services (earmolds, initial batteries, other necessary equipment, maintenance, and adaption training.) Benefits for hearing aids and related services are limited to a combined benefit for In-Network benefits and Out-of-Network benefits of $3,000 per hearing impaired ear every 24 months.			
Hearing Aids and Related Services*	No charge up to $3,000 per hearing aid per hearing impaired ear every 24 months	Not Covered	Not Covered

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

Adult Hearing Aid Benefit Rider **Ages 19 and Up** Available from VCUHS Network providers			
Hearing Aid Services* Covered Services include the following up to the maximum benefit of $3,000 every 36 months: • the hearing aid(s); • audiometric specialist office visits for fitting, including molds and dispensing; • repair, replacement or refurbishment of the hearing aid(s) Replacement is covered only every 36 months from date of acquisition. Batteries are not covered. Supplies are not covered.	No Charge	Not Covered	Not Covered
Morbid Obesity Rider* Covered Services include the treatment of morbid obesity through gastric bypass surgery or other methods recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service

Oral Surgery Wisdom Teeth Extraction Rider			
Wisdom Teeth Services * Covered Services include surgical and anesthesia services required for the extraction of impacted wisdom teeth.	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service	Cost sharing determined by the type and place of service

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

Prescription Drugs

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 unless a higher day supply must be dispensed due to a manufacturer's packaging 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;

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

6. Medications subject to restricted distribution by the U.S. Food and Drug Administration; and
7. Medications that require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

Specialty Drugs are available through the Plan specialty mail order network and VCU Health System pharmacy depending on the medication. Specialty Drugs will be delivered to Your home address. If You have a question or need to find out if Your drug is considered a Specialty Drug please call Pharmacy Member Services at the number on Your Plan ID Card. You can also log onto sentarahealthplans.com for a list of Specialty Drugs.

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

Refills

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

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 does not have a Deductible.
Maximum Out-of-Pocket Amount	This Plan has a separate Maximum Out-of-Pocket Amount for Prescription Drug Benefits filled though the VCUHS Pharmacy Network. Deductible, Copayment and Coinsurance amounts You pay, or that are paid on Your behalf, for Covered prescription drugs will apply to the following amounts: $250 per person per Calendar year $500 per Family per Calendar year This Plan has a separate Maximum Out-of-Pocket Amount for Prescription Drug Benefits filled through the Sentara Health Plans Pharmacy Network $1,000 per person per Calendar year $2,000 per Family per Calendar year The VCUHS Pharmacy Network and the Sentara Health Plans Pharmacy Network Maximum Out-of-Pocket Amounts are separate. Most amounts You pay, or that are paid on Your behalf, for VCUHS Pharmacy will count towards both your VCUHS Pharmacy and Sentara Health Plans Pharmacy maximums. Most amounts You pay, or that are paid on Your behalf, for Sentara Health Plans Pharmacy with count towards both your VCUHS Pharmacy and Sentara Health Plans Pharmacy maximums. 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.
Home Blood Glucose Meters/Monitors	You pay the cost share for the applicable Tier. Members can pick up supplies at any network pharmacy. LifeScan products will be the preferred brand. However, the Plan reserves the right to change or add additional preferred brands. Members that request other brand name supplies will pay the applicable cost share depending on the Tier. *Pre-Authorization is required for talking Blood Glucose Meters/Monitors.

VCUHS PPO

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

Diabetic Testing Supplies including test strips, lancets, lancet devices, and control solution*	You pay the cost share for the applicable Tier. Members can pick up supplies at any network pharmacy. LifeScan products will be the preferred brand. However, the Plan reserves the right to change or add additional preferred brands.
Continuous Blood Glucose Monitors, Sensors and Supplies*	You pay the cost sharing for the applicable Tier. *Pre-Authorization may be required.
Insulin Pumps*	Refer to Insulin Pump note in medical section. *Pre-Authorization is required for insulin pumps.
Pump Infusion Sets and Supplies*	You pay the cost sharing for the applicable Tier if product available through pharmacy mail order or Also refer to Pump Infusion Sets and Supplies MEDICAL SECTION *Pre-Authorization is required for pump infusion sets and supplies.
Infertility drugs and injections	You pay the cost sharing for the applicable Tier. Available from VCUHS Network providers.
Weight Loss drugs*	You pay the cost share for the applicable Tier. • Requires participation in approved weight loss program • Must be filled at VCUHS pharmacy unless otherwise approved by The Plan *Pre-Authorization may be required.
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.

Copayments and Coinsurance Retail Pharmacy or the Plan's Specialty Pharmacy for up to a 30 day supply	
ACA Preventive Drugs ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force. Please use this link for a list of covered preventive care services: https://www.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.
Generic Drugs **(Tier 1)**	VCUHS Network: You Pay $0 Sentara Health Plans Pharmacy Network: You Pay 10%, with a minimum cost of $10
Preferred Brand **(Tier 2)**	VCUHS Network: You Pay $17 Sentara Health Plans Pharmacy Network: You Pay 20%, with a minimum cost of $45
Non-Preferred Brand Drugs **(Tier 3)**	VCUHS Network: You Pay $25 Sentara Health Plans Pharmacy Network: You Pay 30%, with a minimum cost of $75
Specialty Drugs **(Tier 4)**	VCUHS Network: You Pay $50 Sentara Health Plans Pharmacy Network: You Pay $50

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

Copayments and Coinsurance for up to a 90 day supply Some outpatient prescription drugs in Tier 1, Tier 2 or Tier 3 are available to fill up-to a 90 day supply. You may fill a 90 day supply at a VCUHS pharmacy, a Plan network retail pharmacy, or the Plan's Mail Order Pharmacy (Express Scripts). You may call Express Scripts at - 1-800-922-1557to find out if Your drug is available. Tier 4 Specialty Drugs are only available from VCU Health System pharmacy or the Plan's Specialty Pharmacy depending on the medication and are limited to a 30 day supply.	
ACA Preventive Drugs ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force. Please use this link for a list of covered preventive care services: https://www.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.
Generic Drugs **(Tier 1)**	VCUHS Network: You Pay $0 Sentara Health Plans Pharmacy Network: You Pay 10%, with a minimum cost of $38
Preferred Brand **(Tier 2)**	VCUHS Network: You Pay $34 Sentara Health Plans Pharmacy Network: You Pay 20%, with a minimum cost of $100
Non-Preferred Brand Drugs **(Tier 3)**	VCUHS Network: You Pay $50 Sentara Health Plans Pharmacy Network: You Pay 30%, with a minimum cost of $150
Specialty Drugs **(Tier 4)**	VCUHS Network: N/A Sentara Health Plans Pharmacy Network: N/A

Notice/Notes/Terms & Conditions:

Dependent Children enrolled in the Plan are Covered until the end of the year 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.

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