Sentara Health Plans
Sentara Vantage HMO
Commonwealth of Virginia
Plan Effective Date: 07/01/2025
Large Group Benefit Summary

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

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

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

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

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

Services or treatment You receive Out-of-Network or from Non-Plan Providers will not be Covered under Your Plan unless:

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

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

If Your Plan has a Deductible that is the dollar amount that must be paid out-of-pocket by a Member for Covered Services each year before the Plan begins to pay for benefits.

Copayments and Coinsurances listed in this document are amounts You pay directly to a Provider for a Covered Service. Copayments are shown as flat dollar amounts. Coinsurance is shown as a percentage of the Plan’s Allowable Charge for Your Covered Service. You will pay a Copayment or Coinsurance, but not both, for a Covered Service. For some benefits You may see the statement, “Cost sharing determined by the type and place of service.”

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

For these services Your cost sharing will be based on where You receive a service, for example in a Physician office or inpatient setting, and/or the type of service.

Your Plan's Maximum Out-of-Pocket Amount means the total dollar amount Members pay, or that are paid on their behalf, out-of-pocket for most Covered Services during a year. Deductibles, Copayments and Coinsurance for most Covered Services count toward the Maximum amount.

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

Deductible and Maximum Out-of-Pocket Amount (MOOP)			
	In-Network Tier 1	**In-Network Tier 2**	**Out-of-Network**
Deductible Plan Year	$200/Individual; $400/Family		Not Covered

The Plan has one combined In-Network Deductible for Tier 1 and Tier 2 In-Network Covered Services. Most amounts You pay for Tier 1 and Tier 2 Covered Services will count toward meeting the In-Network Deductible.

The Deductible applies to all Covered Services except for:

- In-Network Preventive Care Services required by law;
- Other services in this document shown as Covered without a Deductible.

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

	In-Network Tier 1	**In-Network Tier 2**	**Out-of-Network**
Maximum Out-of-Pocket Plan Year	$2,000/Individual; $4,000/Family		Not Covered

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

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

- Amounts You pay for services not covered under Your Plan;
- Amounts You pay for any services after a benefit limit has been reached;
- Balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers;
- Premium amounts;
- Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits;
- Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic is available;
- Other services in this document that are shown as excluded from the maximum amount.

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

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by approved Plan providers. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits. ***Pre-Authorization is required for in-office surgery.**			
Primary Care Visit	You Pay $10	You Pay $30	Not Covered
Virtual Consult	No Charge	No Charge	Not Covered
Specialist Visit	You Pay $20	You Pay $50	Not Covered
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of $250 per dose. This does not include routine immunizations Covered under Preventive Care.	After Deductible You Pay 20%		Not Covered
Preventive Care Recommended preventive care services are Covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. (See Your EOC under "OFFICE VISIT COPAYMENTS FOR PREVENTIVE CARE"). Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.			
Recommended exams, screenings, tests, immunizations, and other services	No Charge		Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Outpatient Therapies and Services You pay a Copayment or Coinsurance amount for each visit at a Physician's office, a free-standing outpatient Facility, a Hospital outpatient Facility, or at home. 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* Rehabilitative Services limited to 30 combined visits per Plan year. Habilitative Services limited to 30 combined visits per Plan year.	You Pay $30		Not Covered
Speech Therapy* Rehabilitative Services limited to 30 visits per Plan year. Habilitative Services limited to 30 visits per Plan year.	You Pay $30		Not Covered
Cardiac Rehabilitation* Services limited to 30 visits per Plan year.	No Charge		Not Covered
Pulmonary Rehabilitation* Services limited to 30 visits per Plan year.	No Charge		Not Covered
Vascular Rehabilitation* Services limited to 30 visits per Plan year.	No Charge		Not Covered
Vestibular Rehabilitation* Services limited to 30 visits per Plan year.	No Charge		Not Covered
IV Infusion Therapy	You Pay $40		Not Covered
Respiratory/Inhalation Therapy	You Pay $40		Not Covered
Chemotherapy and Chemotherapy Drugs*	You Pay $40		Not Covered
Radiation Therapy*	You Pay $40		Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
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.	You Pay $100		Not Covered
Outpatient Dialysis You Pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.			
Dialysis Services	No Charge		Not Covered
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free-standing ambulatory surgery center or Hospital outpatient surgical Facility.			
Surgery Services*	You Pay $200		Not Covered
Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient Facility or lab or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.			
Diagnostic Procedures	After Deductible You Pay 20%		Not Covered
X-Ray Ultrasound Doppler Studies	After Deductible You Pay 20%		Not Covered
Lab Work	After Deductible You Pay 20%		Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a freestanding outpatient Facility or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.			
Magnetic Resonance Imaging (MRI)* **Magnetic Resonance Angiography (MRA)*** **Positron Emission Tomography (PET)*** **Computerized Axial Tomography (CT)*** **Computerized Axial Tomography Angiogram (CTA)*** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Sleep Studies***	After Deductible You Pay 20%		Not Covered
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are Covered under preventive benefits.			
Maternity Care	You Pay $150 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services		Not Covered
Inpatient Services			
Inpatient Hospital Services*	You Pay $500		Not Covered
Transplants* Covered at contracted facilities only.	You Pay $500		Not Covered
Skilled Nursing Facility Services* Limited to a maximum of 90 days per Plan year.	No Charge		Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay a Copayment or Coinsurance per transport each way. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.			
Water and Ground Services Non-Emergent Transportation*	After Deductible You Pay 20%		Not Covered
Air Ambulance Services Non-Emergent Transportation*	After Deductible You Pay 20%		After Deductible You Pay 20%
Emergency Services Includes medical and mental health and substance use disorder Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other Facility charges, such as diagnostic x-ray and lab services and medical supplies provided in an Emergency Department, including and independent freestanding Emergency Department, In-Network or Out-of-Network.			
Emergency Services	You Pay $200		You Pay $200
Emergency Ambulance	You Pay $200		You Pay $200
Urgent Care Services Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care Facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.			
Urgent Care Services	You Pay $60		Not Covered
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Virtual Consults must be furnished by approved Plan providers. ***Pre-Authorization is required for Inpatient Hospital Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.**			
Inpatient Hospital Services*	You Pay $500		Not Covered
Residential Treatment Services*	You Pay $500		Not Covered
Outpatient Office Visits (PCP and Specialist)	You Pay $10		Not Covered
Outpatient Office Visits (Virtual Consult)	You Pay $10		Not Covered
Partial Hospitalization/Intensive Outpatient Program Facility Services*	You Pay $200		Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Other Outpatient Services	You Pay $200		Not Covered
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.		Not Covered
Employee Assistance Visits Services include short-term problem assessment by licensed behavioral health providers, and referral services for employees, and other Covered family members and household members. To use services call 757-363-6777 or 1-800-899-8174.	No Charge for up to 5 visits from Plan Employee Assistance providers per presenting issue as determined by treatment protocols.		
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is Covered from an In-Network Plan Provider or a participating Vision Services Plan (VSP) provider at the office visit Copayment or Coinsurance amount.			
Insulin Pumps*	No Charge		Not Covered
Pump Infusion Sets and Supplies*	After Deductible You Pay 20%		Not Covered
Testing Supplies Includes test strips, lancets, lancet devices, Blood Glucose Meters and control solution, and Continuous Blood Glucose Monitors, sensors, and supplies. ***Pre-Authorization is required for Continuous Blood Glucose Monitors, sensors, and supplies**	Covered under the Plan's Prescription Drug Benefit		Not Covered
Insulin, and Needles and Syringes for Injection	Covered under the Plan's Prescription Drug Benefit		Not Covered
Outpatient Self-Management Training, Education, Nutritional Therapy	No Charge		Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Prosthetic Limb Replacement			
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	After Deductible You Pay 20%		Not Covered
Durable Medical Equipment (DME) and Supplies			
DME, Orthopedic Devices, Prosthetic Appliances, Devices *Pre-Authorization is required for items over $750 *Pre-Authorization is required for repair, replacement and rental items.	After Deductible You Pay 20%		Not Covered
Early Intervention Services For Dependent children from birth to age three.			
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices.*	Cost sharing determined by the type and place of service.		Not Covered
Home Health Care Includes skilled home health care services. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home. Visit limits do not apply to outpatient habilitative or rehabilitative therapy services for mental health conditions and substance use disorders.			
Home Health Care* Limited to a maximum of 100 visits per Plan year.	No Charge		Not Covered
Private Duty Nursing			
Private Duty Nursing* Includes services provided by an RN or LPN in the home. Limited to 16 hours per Plan year.	No Charge		Not Covered
Hospice Care			
Hospice Care*	No Charge		Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Chiropractic Care The Plan 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 Services Maximum number of visits 30 per Plan year. This benefit also includes Coverage of Chiropractic appliances up to a maximum benefit of 1 appliance per Person per Plan year when medically necessary.	You Pay $35		Not Covered
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.			
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing determined by the type and place of service.		Not covered
Infertility Services Includes the services listed below to diagnose and treat conditions resulting in infertility.			
Endometrial biopsies Limited to 2 per lifetime **Semen analysis** Limited to 2 per lifetime **Hysterosalpingography** Limited to 2 per lifetime **Diagnostic laparoscopy** Limited to 1 per lifetime **Sims-Huhner test (smear)** Limited to 4 per lifetime	Cost sharing determined by the type and place of service.		Not Covered
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.		Not Covered
Allergy Care			
Allergy Care, Testing, and Serum	Cost sharing determined by the type and place of service.		Not Covered

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

Benefit	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.			
Telemedicine Services	Cost sharing determined by the type and place of service.		Not Covered
Out of Area Dependent Program Dependent Children who are Covered Persons and living outside of their Plan's Service Area will receive In-Network benefits when Covered Services are received from Plan providers that participate in the Out-of-Area Program. The Plan will require eligible out-of-area Dependents to complete an annual certification form prior to being eligible for the program. Except for Emergency Services any Covered Services received outside of the service area from Out of Network Non-Plan Providers that are not included in the Out-of-Area Dependent Program will not be Covered.			
Out-of-Area Program Services ***Pre-Authorization requirements apply depending on the type and place of service.**	Cost sharing determined by the type and place of service		Not Covered
Hearing Aid Services for Children Age 18 and Younger Includes hearing aids and related services (earmolds, initial batteries, other necessary equipment, maintenance, and adaption training). Benefits for hearing aids and related services are limited to a combined benefit for Tier 1 and Tier 2 In-Network benefits of $1500 per hearing impaired ear every 24 months.			
Hearing Aids and Related Services*	No Charge up to $1500 per hearing aid per hearing impaired ear every 24 months.		Not Covered
Morbid Obesity Rider			
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		Not Covered

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

Adult Hearing Aid Rider Ages 19 and Up		
Hearing Aid Services* Covered Services include the following up to the annual maximum benefit of $1,200: • 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 48 months from date of acquisition. Batteries and supplies are not covered.	You Pay $40 Cost sharing amounts You pay for this rider will not count toward Your Deductible or Maximum Out of Pocket Amount.	Not Covered

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

VISION CARE AND MATERIALS RIDER

Includes Covered Services for expanded vision care services in lieu of those Preventive Vision Care Benefits described in Section 6 of the Evidence of Coverage.

Sentara Health Plans has a contract with VSP Vision Care to administer this benefit for Our Members. To receive Covered Services:

1. Select a participating VSP network provider from the Plan's enhanced provider directory or by calling VSP at 1-800-877-7195. Automated location information is available 24 hours a day. Customer service representatives are available Monday through Saturday 9 a.m. –8 p.m.
2. Visit or call the participating provider and identify yourself as a participant by providing Your Member ID information. The provider will verify eligibility, Your Plan's Covered Services and any applicable Copayment or Coinsurance. Payment is due when You receive services.
3. If the vision provider determines that You need additional medical care You should contact Your Plan Physician.

VISION CARE SERVICES AND MATERIALS SCHEDULE OF BENEFITS

Each Covered Person is eligible to receive a routine eye examination, refraction; and lenses and frames; or contact lenses as follows:

Routine Examination: Covered once every 12 months
Lenses or Contact Lenses: Covered once every 12 months
Frames: Covered once every 12 months

To be covered at the In-Network level of benefits all services must be received from a Participating VSP provider. Some services are limited or excluded when received from non-plan or Out-of-Network providers. Members are responsible for Copayments and Coinsurances listed below. Unless otherwise stated percent Coinsurance is based on provider charges.

Copayments or Coinsurance for Covered Services under this rider that are not Essential Health Benefits (EHBs) for children are not applied toward any Plan Maximum Out-of-Pocket Amount and must continue to be paid after the Maximum is met.

Members are responsible for all applicable Plan Deductibles as stated on the Policy Schedule of Benefits.

Benefit	In-Network Coverage from an VSP Provider	Out-of-Network Coverage
Routine Exam with dilation as necessary	$15 Copayment	Members will be reimbursed up to $50 for an eye examination only
Retinal Imaging	Members pay up to $39	Not Covered
Contact Lens Exam options:		
Standard contact lens fit and follow-up	Members pay up to $40	Not Covered
Premium contact lens fit and follow-up	Members pay up to $40	Not Covered
Frames For any available frame at a provider location	No copayment up to a $100 allowance. Members receive 20% off amounts over the allowance.	Members will be reimbursed up to $80
Standard Plastic Lenses		
Single vision	$20 Copayment	Members will be reimbursed up to $50
Bifocal	$20 Copayment	Members will be reimbursed up to $75
Trifocal	$20 Copayment	Members will be reimbursed up to $100

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

Standard Progressive Lens	$55 Copayment	Members will be reimbursed up to $75
Premium Progressive Lens	$85 Copayment	Members will be reimbursed up to $75

Benefit	In-Network Coverage from an VSP provider	Out-of-Network Coverage
Lens Options		
UV Treatment	$15 Copayment	Not Covered
Tint (Solid and Gradient)	$15 Copayment	Not Covered
Standard Plastic Scratch Coating	$15 Copayment	Not Covered
Standard Polycarbonate Adults	Member is covered up to $31 for single vision Member is covered Up to $35 for multifocal	Not Covered
Standard Polycarbonate Kids Under 19	No Charge	Members will be reimbursed up to $5
Standard Anti Reflective Coating	Member is covered up to $41	Not Covered
Polarized	Member will receive 20% discount off the retail price	Not Covered
Other Add-ons	Member will receive 20% discount off the retail price	Not Covered
Contact Lenses Allowance includes materials only.		
Conventional	No copayment up to a $100 allowance. Members receive 15% off amounts over the allowance.	Members will be reimbursed up to $80
Disposable	No copayment up to a $100 allowance. Members are responsible for all amounts over the allowance.	Members will be reimbursed up to $80
Medically Necessary	No copayment covered in full.	Members will be reimbursed up to $210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	Member will receive 15% discount off the retail price or a 5% discount off a promotional price.	Not Covered
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	Not Covered

Members may receive a 20% discount on items not covered by the plan at VSP participating providers. This discount if available cannot be combined with other discounts or promotional offers. The discount would not apply to VSP's professional services or contact lenses.

Members can contact VSP or log onto www.vsp.com for additional information on replacement contact lenses after the initial purchase. The contact lenses allowance is not applicable to this service.

Exclusions and Limitations. The following services are excluded or limited under this rider:

1. Any visions care service or material not listed as covered is excluded from coverage.
2. Any Benefit Allowances not used cannot be retained or carried over for future use.
3. Certain brand name Vision Materials for which the manufacturer imposes a no-discount price may be excluded from benefit allowances and/or discounts stated in the Schedule of Benefits.

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

4. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing are excluded from coverage.
5. Aniseikonic lenses are excluded from coverage.
6. Medical and/or surgical treatment of the eye, eyes or supporting structure are excluded from coverage.
7. Any eye or vision examination, or any corrective eyewear required by a member as a condition of employment is excluded from coverage.
8. Safety eyewear is excluded from coverage.
9. Services or materials provided as a result of any Worker's Compensation law or similar legislation or required by any governmental agency or program whether federal, state or subdivisions thereof are excluded from coverage.
10. Plano non-prescription lenses and/or contact lenses are excluded from coverage.
11. Non-prescription sunglasses are excluded from coverage.
12. Two pair of glasses in lieu of bifocals is not covered.
13. Services or materials provided by any other group benefit plan providing vision care are excluded from coverage.
14. Services rendered or materials ordered after the date a member's coverage under the Plan ends, except vision materials ordered before coverage ended are delivered, and the services rendered to the member are within 31 days from the date of the order, are excluded from coverage.
15. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit period when vision materials would next become available.

DENTAL SERVICES SCHEDULE OF BENEFITS: CHOICE PPO		
This Schedule includes Your Covered Dental Benefits and cost sharing amounts under the Rider. You must meet all Deductibles listed below. After You meet Your Deductible You pay the applicable Coinsurance for Your Covered Service. Coverage is limited to the Maximum Benefits stated below.		
DEDUCTIBLE AND MAXIMUM OUT-OF-POCKET LIMIT		
	In-Network Benefits	**Out-of-Network Benefits**
Deductibles Combined In-Network and Out-of-Network per Member per Benefit Year.	$50 per Person $150 per Family	$50 per Person $150 per Family
Annual and Lifetime Maximum Benefits Combined In-Network and Out-of-Network per Member per Benefit Year for Annual Maximum.	**Class II and Class III Services:** Annual $2,000 per Person **Class IV Orthodontia Services** Lifetime $2,000 per Person	**Class II and Class III Services:** Annual $2,000 per Person **Class IV Orthodontia Services** Lifetime $2,000 per Person
Out-of-Network Allowance If the course of treatment exceeds $300 pre review is requested. Members may receive Covered Services from Participating Dentists or Non-Participating Dentists. Unlike Participating Dentists that have agreed to accept negotiated fees for services, Non-Participating Dentists have no contract with Dominion National or Dominion National's leased dental networks. As such, Non-Participating Dentists set their own fees and Dominion National only reimburses the Member based on the established Participating Dentist's fee schedule, which is determined by the geographic area where the expenses are incurred. This means that if the Non-Participating Dentist's fee is higher than Dominion National's Participating Dentist's fee schedule, the Member will be billed the remaining balance to cover the Non-Participating Dentist's fee.		

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

DENTAL SERVICES		
Class I Diagnostic and Preventive Services	**In-Network Benefits Copayments/Coinsurance**	**Out-of-Network Benefits Copayments/Coinsurances**
1. Two evaluations per Benefit Year including a maximum of one comprehensive evaluation per 36 months 2. One emergency or problem focused exam (D0140) per Benefit Year 3. Two prophylaxis (cleaning, scaling and polishing teeth) per Benefit Year (one additional cleaning is covered during pregnancy and for diabetic patients) 4. One topical fluoride per Benefit Year, to age 16 5. Bitewing x-rays, 2 per Benefit Year 6. Periapical x-rays 7. One diagnostic x-ray, full or panoramic per 60 months 8. Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service) 9. One sealant per tooth per lifetime, to age 16 (limited to permanent 1st and 2nd molars)	Covered at 100%	Covered at 100%

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

Class II Basic Services	In-Network Benefits Copayments/Coinsurance	Out-of-Network Benefits Copayments/Coinsurances
1. Simple extraction of teeth 2. Amalgam and composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months 3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin) 4. Antibiotic injections administered by a dentist 5. Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment) 6. Oral surgery, including postoperative care for: a. Removal of teeth, including impacted teeth b. Extraction of tooth root c. Alveolectomy, alveoplasty, and frenectomy d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy e. Reimplantation or transplantation of a natural tooth f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst 7. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to: a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage) b. Pulpotomy c. Apicoectomy d. Retrograde fillings, per root per lifetime 8. Periodontic services, limited to: a. Two periodontal cleanings following surgery per Benefit Year (D4341 is not considered surgery) b. One root scaling and planning per quadrant of mouth per 24 months from age 21	After Deductible Covered at 80%	After Deductible Covered at 80%

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

c. Occlusal adjustment performed with covered surgery d. Gingivectomy and gingival curettage e. Osseous surgery including flap entry and closure f. One pedicle or free soft tissue graft per site per lifetime g. One appliance (night guards) per 5 years within 6 months of osseous surgery h. One full mouth debridement per lifetime		

Class III Major Services	**In-Network Benefits Copayments/Coinsurance**	**Out-of-Network Benefits Copayments/Coinsurances**
1. One study model per 36 months 2. Crown build-up for non-vital teeth 3. Recementing bridges, inlays, onlays and crowns after first 12 months and per 12 months per tooth thereafter 4. One repair of dentures or fixed bridgework per 24 months 5. General anesthesia and analgesic, including intravenous sedation, in conjunction with covered oral surgery, periodontal surgery or implant placement procedures 6. Restoration services, limited to: a. Gold or porcelain inlays, onlays, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially place or last replaced (will not apply if replacement is necessary due to the extraction of functioning natural teeth after the effective date of coverage) c. Stainless steel crowns up to age 14 (one per tooth per lifetime) d. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally 7. Prosthetic services, limited to: a. Initial placement of dentures or fixed bridgework (including acid etch metal bridges)	After Deductible Covered at 50%	After Deductible Covered at 50%

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

b. Replacement of dentures or fixed bridgework that cannot be repaired after 7 years from the date of last placement c. Addition of teeth to existing partial denture d. One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement) 8. Implants and related services		
Class IV Orthodontia Services	**In-Network Benefits Copayments/Coinsurance**	**Out-of-Network Benefits Copayments/Coinsurances**
Diagnostic, active and retention treatment to include removable fixed appliance therapy and comprehensive therapy	Covered at 50%	Covered at 50%

Plan Exclusions:
The following are not Covered Dental Services under this Rider.

1. Treatment required for conditions resulting while on active duty as a Member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
2. Services which are covered under Medicare, worker's compensation or employer's liability laws.
3. Services and treatment provided without charge or for which there would be no charge in the absence of insurance.
4. Services not listed as covered.
5. Hospitalization for any dental procedure.
6. Services and treatment for which Member is eligible for coverage under his or her hospital, medical/surgical or major medical plan.
7. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
8. Elective surgery including, but not limited to, extraction of non-pathologic,asymptomatic impacted teeth.
9. Replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; periodontal splinting of teeth.
11. Services for increasing vertical dimension, restoring occlusion, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
12. Oral hygiene instructions; plaque control; completion of a claim form; acid etch; broken appointments; prescription or take-home fluoride; or diagnostic photographs.
13. Dispensing of drugs.
14. Diagnosis or treatment of temporomandibular joint (TMJ) syndromes, problems and/or occlusal disharmony.
15. Procedures that in the opinion of Dominion National are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
16. Treatment of cleft palate, anodontia, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

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 and can be delivered to Your home address from the Plan's specialty mail order drug pharmacy.

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

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

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

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

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

1. Medications that treat certain patient populations including those with rare diseases;
2. Medications that require close medical and pharmacy management and monitoring;
3. Medications that require special handling and/or storage;
4. Medications derived from biotechnology and/or blood derived drugs or small molecules;
5. Medications that can be delivered via injection, infusion, inhalation, or oral administration;
6. Medications subject to restricted distribution by the U.S. Food and Drug Administration; and

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

7. Medications that require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

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

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

Refills

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

Deductibles, Maximum Out of Pocket Amount (MOOP), and Benefits	
Deductibles	Your Plan does not have a Deductible
Maximum Out-of-Pocket Amount	Outpatient Prescription Drug Deductibles, Copayments or Coinsurance apply to the Plan's Maximum Medical Out-of-Pocket Limit. Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available are not Covered, do not count toward the Plan's Maximum Out-of-Pocket Amount and must continue to be paid after the Maximum Out-of-Pocket Amount has been met.
Insulin, and Needles and Syringes for Injection	You pay the cost sharing for the applicable Tier. A Member's cost sharing payment for a Covered insulin drug will not exceed $50 per 30-day supply per prescription, regardless of the amount or type of insulin needed to fill each prescription. Deductible does not apply.
Diabetic Testing Supplies including Blood Glucose Meters, test strips, lancets, lancet devices, and control solution	No Charge Members can pick up supplies at any network pharmacy. LifeScan products will be the preferred brand. However, the Plan reserves the right to change or add additional preferred brands. Members that request other brand name supplies will pay the applicable cost share depending on the Tier. *Pre-Authorization is required for talking Blood Glucose Meters.
Continuous Blood Glucose Monitors, Sensors and Supplies*Pre-authorization is required	You pay the cost sharing for the applicable Tier.
Formulary	This Plan has an open formulary. Please use the following link to see a list of drugs on the open formulary: sentarahealthplans.com. If a brand-name medication is dispensed instead of a generic equivalent, You must pay the cost difference between the dispensed brand-name drug and the Generic Drug in addition to the Copayment or Coinsurance charge, unless authorized by the Plan.

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

Retail Pharmacy Cost Sharing When You pick up Your drug at a retail pharmacy You will pay the Copayment (one Copayment for each 30-day supply) or the Coinsurance amount listed under the applicable Tier for Your Drug: • You pay one Copayment or the Coinsurance for up to a 30-day supply; • You pay two Copayments or the Coinsurance for a 31 to 60-day supply; • You pay three Copayments or the Coinsurance for a 61 to 90-day supply. Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply.	
ACA Preventive Drugs ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force. **Please use this link for a list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.**	No Charge. Deductible does not apply. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day courses of treatment per year when prescribed by a health care provider.
Preferred Generic Drugs **Tier 1**	You Pay $15
Preferred Brand & Other Generic Drugs **Tier 2**	You Pay $30
Non-Preferred Brand Drugs **Tier 3**	You Pay $45
Specialty Drugs **Tier 4**	You Pay $55

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

Copayment and Coinsurance Mail Order (If Your Drug is available) for up to a 90-day supply Some Outpatient prescription drugs in Tier 1, Tier 2, and Tier 3 are available from the Plan's Mail Order Pharmacy Express Scripts. You may call Express Scripts at 1-888-899-2653 to find out if Your drug is available. Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply.	
ACA Preventive Drugs ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force. **Please use this link for a list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.**	No Charge. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day courses of treatment per year when prescribed by a health care provider.
Preferred Generic Drugs **Tier 1**	You Pay $30
Preferred Brand & Other Generic Drugs **Tier 2**	You Pay $60
Non-Preferred Brand Drugs **Tier 3**	You Pay $90
Specialty Drugs **Tier 4**	Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply.

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

Notice/Notes/Terms & Conditions:

Dependent Children enrolled in the Plan are Covered until the end of month they turn 26.

This Plan does not have pre-existing condition exclusions.

This Plan does not have annual or lifetime dollar limits on Essential Health Benefits.

This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

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다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

Quý vị cần được giúp đỡ bằng một ngôn ngữ khác? Hãy gọi cho chúng tôi.

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¿Necesita ayuda en algún otro idioma? Llámenos.

Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

1-855-687-6260

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