Sentara Health Administration, Inc.
Sentara Vantage 750/25/20%
City of Chesapeake
Plan Effective Date: 01/01/2024
Large Group Benefit Summary

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

This document is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. 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;
2. During treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider; or
3. We have approved Your Covered Service in advance as an Authorized Out-of-Network Service.

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

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

Your Plan’s Maximum Out-of-Pocket Amount means the total dollar amount Members pay, out-of-pocket for most Covered Services during a year. Deductibles, Copayments and Coinsurance for most Covered Services count toward the Maximum Amount.

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

Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	**Out-of-Network**
Deductible Plan Year	$750/Individual; $1,500/Family	Not Covered

Most amounts You pay for In-Network 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	**Out-of-Network**
Maximum Out-of-Pocket Plan Year	$4,000/Individual; $8,000/Family	Not Covered

Most amounts You pay, for In-Network Covered Services will count toward meeting the In-Network Maximum Out-of-Pocket Amount.
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;
- Except for Emergency Services, amounts You pay for Out-of-Network services;
- Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits;
- 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	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 Plan approved providers. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits. ***Pre-Authorization is required for in-office surgery.**		
Primary Care Visit	You Pay $25	Not Covered
Virtual Consult	No Charge	Not Covered
Specialist Visit	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 50%	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. 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
Outpatient Therapies and Services You Pay a Copayment or Coinsurance amount for each visit for services done in a Physician's office, a free-standing outpatient Facility, a Hospital outpatient Facility, or at home as part of Your Skilled Home Health Care Services benefit. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of a treatment plan for Autism Spectrum Disorder. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Occupational and Physical Therapy* Services limited to 30 combined visits per Plan year.	After Deductible You Pay 20%	Not Covered
Speech Therapy* Services limited to 30 visits per Plan year.	After Deductible You Pay 20%	Not Covered
Cardiac Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 20%	Not Covered
Pulmonary Rehabilitation* Services limited to 30 visits per Plan year.	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	Out-of-Network
Vascular Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 20%	Not Covered
Vestibular Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 20%	Not Covered
IV Infusion Therapy	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 20%	Not Covered
Respiratory/Inhalation Therapy	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 20%	Not Covered
Chemotherapy and Chemotherapy Drugs*	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 20%	Not Covered
Radiation Therapy*	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 20%	Not Covered
Pre-Authorized Injectable and Infused Medications* Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient Facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs.	After Deductible You Pay 20%	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	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	Out-of-Network
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*	After Deductible You Pay 20%	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
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 ***Pre-Authorization is required for prenatal services**	You Pay $450 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	Not Covered
Inpatient Services		
Inpatient Hospital Services*	After Deductible You Pay 20%	Not Covered
Transplants* Covered at contracted facilities only.	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	Out-of-Network
Skilled Nursing Facility Services* Limited to a maximum of 90 days per Plan year.	After Deductible You Pay 20%	Not Covered
Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Air, Water, Ground Services*	After Deductible You Pay $100	Not Covered
Emergency Services Includes medical and mental health and substance use disorder Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other facility charges, such as diagnostic x-ray and lab services and medical supplies provided in an Emergency Department, including and independent freestanding Emergency Department, In-Network or Out-of-Network.		
Emergency Services	After Deductible You Pay 20%	After Deductible You Pay 20%
Emergency Ambulance	After Deductible You Pay $100	After Deductible You Pay $100
Urgent Care Services Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care Facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance. For mental health conditions or substance use disorders visit limits will not apply and You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Urgent Care Services	You Pay $50	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.**		
Emergency Services	After Deductible You Pay 20%	After Deductible You Pay 20%
Emergency Ambulance	After Deductible You Pay 20%	After Deductible You Pay 20%
Inpatient Hospital Services*	After Deductible You Pay 20%	Not Covered
Residential Treatment Services*	After Deductible You Pay 20%	Not Covered
Outpatient Office Visits (PCP, Specialist or Virtual Consults)	You Pay $25	Not Covered
Partial Hospitalization/Intensive Outpatient Program Facility Services*	After Deductible You Pay 20%	Not Covered
Other Outpatient Services*	After Deductible You Pay 20%	Not Covered
Autism Spectrum Disorder*	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	Out-of-Network
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is Covered from an In-Network Plan Provider or a participating VSP Vision Care provider at the office visit Copayment or Coinsurance amount.		
Insulin Pumps*	No Charge	Not Covered
Pump Infusion Sets and Supplies*	No Charge	Not Covered
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution, and continuous glucose monitors, sensors and supplies. ***Pre-Authorization is required for talking blood glucose monitors**	No Charge	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
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	After Deductible You Pay 30%	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 30%	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 for home bound Members. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home.		
Home Health Care* Limited to a maximum of 100 visits per Plan year.	You Pay $25	Not Covered
Hospice Care		
Hospice Care*	After Deductible No Charge	Not Covered

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

Benefit	In-Network	Out-of-Network
Vision Care The Plan contracts with VSP Vision Care to administer this benefit. Services must be received from VSP Vision Care providers.		
Vision Exams Limited to one routine eye exam every 12 months from a VSP provider.	No Charge	Members will be reimbursed up to $30 for one routine eye exam only
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.		
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing determined by the type and place of service.	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
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
Wigs Reimbursement for wigs in conjunction with chemotherapy	After Deductible Coverage is limited to a maximum benefit of $250 once every 12 months.	
Chiropractic Care Rider The Plan contracts with American Specialty Health Group (ASH) to administer this benefit.		
Chiropractic Care Rider ***Pre-Authorization is required by ASH for all Chiropractic services.** Maximum number of visits 20 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.	After Deductible You Pay $25	Not Covered

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

Benefit	In-Network	Out-of-Network
Hearing Aid Rider		
Hearing Aid Services* Covered Services include the following up to the annual maximum benefit of $2,500 per ear: • 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 and supplies are not covered.	After Deductible You Pay $70	Not Covered

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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