

HDHP
Sentara Health Administration Inc.
Sentara Vantage Equity3500/0%
Portsmouth Public Schools
Plan Effective Date: 01/01/2027
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 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. 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." 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	\$3,500/Individual; \$7,000/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.		
	In-Network	Out-of-Network
Maximum Out-of-Pocket Plan Year	\$6,000/Individual; \$12,000/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 any 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 Drug 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	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	After Deductible No Charge	Not Covered
Virtual Consult	No Charge	Not Covered
Specialist Visit	After Deductible No Charge	Not Covered
Vaccines and Immunotherapeutic Agents This does not include routine immunizations Covered under Preventive Care.	After Deductible No Charge	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. _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	Not Covered
Prostate Cancer Screenings	No Charge	Not Covered
Diagnostic and Supplemental Breast Examinations*	No Charge	Not Covered
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.	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
Speech Therapy* Rehabilitative Services limited to 30 visits per Plan year. Habilitative Services limited to 30 combined visits per Plan year.	After Deductible No Charge	Not Covered
Cardiac Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible No Charge	Not Covered
Pulmonary Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible No Charge	Not Covered
Vascular Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible No Charge	Not Covered
Vestibular Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible No Charge	Not Covered
IV Infusion Therapy	After Deductible No Charge	Not Covered
Respiratory/Inhalation Therapy	After Deductible No Charge	Not Covered
Chemotherapy and Chemotherapy Drugs*	After Deductible No Charge	Not Covered
Radiation Therapy*	After Deductible No Charge	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 No Charge	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 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*	After Deductible No Charge	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 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
X-Ray Ultrasound Doppler Studies	After Deductible No Charge	Not Covered
Lab Work	After Deductible No Charge	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 No Charge	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	After Deductible No Charge for delivering Obstetrician prenatal, delivery, and postpartum services	Not Covered
Inpatient Hospital Services		
Inpatient Hospital Services*	After Deductible No Charge	Not Covered
Transplants* Covered at contracted facilities only.	After Deductible No Charge	Not Covered
Skilled Nursing Facility Services* Limited to a maximum of 90 days per Plan year.	After Deductible No Charge	Not Covered
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 and Ground Services Non-Emergent Transportation*	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
Air Ambulance Services Non-Emergent Transportation*	After Deductible No Charge	After Deductible 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	After Deductible No Charge	After Deductible No Charge
Emergency Ambulance	After Deductible No Charge	After Deductible 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	After Deductible No Charge	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*	After Deductible No Charge	Not Covered
Residential Treatment Services*	After Deductible No Charge	Not Covered
Outpatient Office Visits (PCP and Specialist)	After Deductible No Charge	Not Covered
Outpatient Office Visits (Virtual Consult)	No Charge	Not Covered
Partial Hospitalization/Intensive Outpatient Program Facility Services*	After Deductible No Charge	Not Covered
Other Outpatient Services	After Deductible No Charge	Not Covered
Autism Spectrum Disorder* Covered Services include diagnosis and treatment of Autism Spectrum Disorder in children from age two through ten.	Cost sharing determined by the type and place of service.	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
Employee Assistance Program 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.	
Mental Health 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*	After Deductible No Charge	Not Covered
Air Ambulance Services Non-Emergent Transportation*	After Deductible No Charge	After Deductible 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*	After Deductible No Charge	Not Covered
Pump Infusion Sets and Supplies*	After Deductible No Charge	Not Covered
Testing Supplies Includes test strips, lancets, lancet devices, Home Blood Glucose Meters/Monitors 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	After Deductible No Charge	Not Covered
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment*	After Deductible No Charge	Not Covered
Durable Medical Equipment (DME) and Supplies		
DME, Orthopedic Devices, Prosthetic Appliances, Devices*	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
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.	After Deductible 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.	After Deductible No Charge	Not Covered
Hospice Care		
Hospice Care*	After Deductible No Charge	Not Covered
Vision Care The Plan contracts with Vision Services Plan (VSP) to administer this benefit. Services must be received from VSP providers.		
Vision Exams Limited to one routine eye exam every 12 months from a participating 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

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

Benefit	In-Network	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

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

Prescription Drugs

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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 31-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 31-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;
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 31-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 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	You must meet the medical Deductible listed on Your Plan document before Coverage for Tier 1, Tier 2, Tier 3, and Tier 4 drugs begin.
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	You pay the cost sharing for the applicable Tier. A Member's cost sharing payment for a Covered insulin drug will not exceed \$35 per 31-day supply per prescription, regardless of the amount or type of insulin needed to fill each prescription. Deductible does not apply.
Diabetic Equipment and Supplies including blood glucose meters and strips, urine-testing strips, syringes, continuous glucose monitors and supplies, needles, lancets, lancet devices, control solution, insulin pumps, pump infusion sets, and pump supplies	You pay the cost sharing for the applicable Tier. A Member's cost sharing payment for Covered equipment and supplies will not exceed \$35 in aggregate, including situations where the covered person is prescribed more than one piece of equipment or type of supplies, per 30-day supply of the equipment and supplies, regardless of the amount or type of equipment or supplies needed to fill the covered person's prescription. Some insulin pumps and pump supplies may be covered under the Plan's medical benefits depending on the manufacturer.
Formulary	This Plan has a closed formulary and Covers a specific list of drugs and medications. If Your drug is not on Our formulary, We have a process in place to request Coverage. Please use the following link to see a list of drugs on the Plan's formulary: sentarahealthplans.com/members/manage-plans/employer-group-prescription-drug-lists. 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 and Specialty Pharmacy Cost Sharing

The Plan may limit the day supply, or other quantity of any drug dispensed when your prescription is filled. A manufacturer's packaging may also affect how your drug is dispensed. When You obtain Your drug from a retail or specialty pharmacy, You will pay the Copayment (one Copayment for each 31-day supply) or the Coinsurance amount listed under the applicable Tier for Your Drug or the total amount dispensed:

- You pay one Copayment or the Coinsurance for up to a 31-day supply;
- You pay two Copayments or the Coinsurance for a 31 to 60-day supply;
- You pay three Copayments or the Coinsurance for a 61 to 90-day supply.

Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy including Proprium Pharmacy and are limited to a 31-day supply unless a higher day supply must be dispensed due to a manufacturer's packaging.

Affordable Care Act (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 or other requirements under the ACA. 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.
Other Preventive Drugs HSA Includes outpatient prescription drugs that are considered by the Plan to be preventive care. Please use this link for a list of drugs under this benefit: sentarahealthplans.com/members/manage-plans/employer-group-prescription-drug-lists .	You pay the cost sharing for the applicable Tier. Deductible does not apply.
Preferred Generic Drugs (Tier 1)	After Deductible You Pay \$15
Preferred Brand & Other Generic Drugs (Tier 2)	After Deductible You Pay \$40
Non-Preferred Brand Drugs (Tier 3)	After Deductible You Pay \$50
Specialty Drugs (Tier 4)	After Deductible You Pay 20% up to a maximum Copayment of \$200.

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

Copayment and Coinsurance Mail Order (If Your Drug is available) for up to a 90-day supply

The Plan may limit the day supply, or other quantity of any drug dispensed when your prescription is filled. A manufacturer's packaging may also affect how your drug is dispensed. Some Outpatient prescription drugs in Tier 1, Tier 2, and Tier 3 are available from the Plan's Mail Order Pharmacy Express Scripts. You may call Express Scripts at 1-888-899-2653 to find out if Your drug is available. Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy including Proprium Pharmacy and are limited to a 31-day supply unless a higher day supply must be dispensed due to a manufacturer's packaging.

Affordable Care Act (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 or other requirements under the ACA. 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)	After Deductible You Pay \$45
Preferred Brand & Other Generic Drugs (Tier 2)	After Deductible You Pay \$120
Non-Preferred Brand Drugs (Tier 3)	After Deductible You Pay \$150
Specialty Drugs (Tier 4)	Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy including Proprium Pharmacy and are limited to a 31-day supply unless a higher day supply must be dispensed due to a manufacturer's packaging.

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.

Availability of Language Assistance Services and Auxiliary Aids and Services

Amharic:

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Arabic:

تنبيه: إذا كنت تتحدث اللغة العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر خدمات ومساعدات إضافية مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على 1-855-687-6260 (الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة الخاص بك.

Bengali/Bangla:

বিঃদ্র: আপনি যদি বাংলা ভাষায় কথা বলেন, তবে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ। তথ্য সহজে বোঝার উপযোগী ফরম্যাটে দেওয়ার জন্য প্রয়োজনীয় সহায়ক উপকরণ এবং পরিষেবাও বিনামূল্যে প্রদান করা হয়। কল করুন 1-855-687-6260 (TTY: 711)-তে অথবা আপনার পরিষেবা প্রদানকারীর সঙ্গে কথা বলুন।"

Chinese (Mandarin):

注意：如果您说普通话，我们可为您提供免费的语言协助服务。我们还免费提供适当的辅助工具和服务，确保您可以无障碍获取信息。请拨打 1-855-687-6260（文本电话服务：711），或与您的服务提供商联系。

French:

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

ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont mis à votre disposition. Des aides et des services auxiliaires appropriés destinés à fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-687-6260 (TTY : 711) ou adressez-vous à votre prestataire. »

French Creole/Haitian Creole:

ATANSYON: Si w pale kreyòl Ayisyen, ou gen sèvis asistans lengwistik gratis ki disponib pou ou. Gen èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòm aksèsib ki disponib gratis egalman. Rele 1-855-687-6260 (TTY: 711) oubyen pale ak founisè swen sante w la.

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Unterstützungsdienste in Ihrer Sprache zur Verfügung. Entsprechende zusätzliche Hilfsmittel und Dienste, um Informationen in zugänglichen Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie uns an unter 1-855-687-6260 (TTY: 711) oder sprechen Sie mit Ihrem Anbieter.”

Gujarati:

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમને મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ કરાવવામાં છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ મફતમાં ઉપલબ્ધ કરાવવામાં આવે છે. 1-855-687-6260 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.”

Hindi:

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-855-687-6260 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।”

Hmong:

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LUS TSEEM CEEB: Yog koj hais lus Hmoob, yuav muaj cov kev pab los muab kev pab txhais lus dawb rau koj. Tsis tas li ntawd, kuj tseem muaj cov kev pab thiab cov kev pab cuam uas tsim nyog los muab cov ntaub ntawv ua cov qauv nkag siv tau pub dawb thiab. Hu rau 1-855-687-6260 (TTY: 711) los sis tham nrog koj tus kws kho mob.

Igbo:

GEE NTỊ: Ọ bụrụ na ị na-asụ asụsụ Igbo, e nwere ọrụ enyemaka asụsụ n'efu dị maka gị. Ngwaọrụ na ọrụ enyemaka kwekọrọ ekwekọ ịji nye ozi n'ụdị ndị mmadụ nwere ike ịji rụọ ọrụ dịkwa n'efu. Kpọọ 1-855-687-6260 (TTY:711) ma ọ bụ kwuoro onye na-enye gị ọrụ."

Italian:

ATTENZIONE: Se parla italiano, sono per Lei disponibili servizi di assistenza linguistica gratuiti. Sono, inoltre, disponibili gratuitamente strumenti e servizi ausiliari appropriati per fornire informazioni in formati accessibili. Chiami il numero 1-855-687-6260 (TTY: 711) o consulti il Suo fornitore".

Japanese:

ご注意：日本語を話される場合、無料の言語支援サービスをご利用いただけます。接近可能な形式の情報を提供するための適切な補助器具やサービスも無料でご利用いただけます。1-855-687-6260（テキスト電話（TTY）：711）番までお電話いただくか、ご担当のプロバイダーにお問い合わせください。

Korean:

중요 안내: 한국어를 구사할 시 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하기 위한 적절한 보조 수단 및 서비스도 무료로 제공됩니다. 1-855-687-6260번(중계 통화: 711)으로 전화하거나 제공자에게 알리십시오."

Kru/Bassa:

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DYÉDÉ-GBO-DÈ-ÐÈ: ᠘ jũ ké m̐ dyi Bǎsǎw-wùdũ po-nyò jũin, wuḍu-xwíníin-mú-zà-zà bě se wídí pée-pée ḍò kǎe nì bó m̐ biì. Hwòḍḍ-fónó-nyó kè nyò-bwǎn-po-kà bě b́e nyuεε se wídí pée-pée ḍò kǎ. 1-855-687-6260 (TTY: 711) ᠘ ḍà mòwò wùdũ gbo nyò-kpò nyí.”

Laotian:

ຄວນເອົາໃຈໃສ່: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ມີບໍລິການຊ່ວຍເຫຼືອທາງດ້ານພາສາພຣີໃຫ້ກັບທ່ານ. ນອກຈາກນີ້ຍັງມີບໍລິການຊ່ວຍເຫຼືອເພີ່ມຕື່ມທີ່ເໝາະສົມໃນການໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ເຂົ້າເຖິງໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ໂທ 1-855-687-6260 (TTY: 711) ຫຼື ເວົ້າກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Mon-Khmer, Cambodian:

ការយកចិត្តទុកដាក់: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយភាសាគឺមានសម្រាប់អ្នកដោយឥតគិតថ្លៃ។ ជំនួយ និងសេវាកម្មជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏មានដោយឥតគិតថ្លៃផងដែរ។ សូមទូរស័ព្ទទៅលេខ 1-855-687-6260 (ទូរលេខ: 711) ឬទាក់ទងទៅកាន់អ្នកផ្តល់សេវាកម្មរបស់អ្នក។

Pennsylvania Dutch:

Uffbassa: Wann du Pennsylvaanisch Deitsch schwetzscht, sinn Hilf mit die Schprooch fer nix zu hawe. Aagmässiche Hilfsmittel un Hilfsdienscht fer Auskunft in e leichter verstaendlicher Gstalt sinn aach fer nix zu hawe. Ruf 1-855-687-6260 (TTY: 711) odder schwetz mit dei Versorger

Navajo:

NÁÁNÍZIN: Diné bizaad yiníí't'éego, t'áá jíík'eh saad bee áká anilyeedígíí t'áá hadoohkáát nihá. T'áá jíík'ehgo bee áká anídaaltsoozígíí át'égo bee haz'ání dóó áká aná'álwo'ígíí t'áá jíík'ehgo doo biniiyé łahgo ájiltsooz doo. Jooba' 1-855-687-6260 (TTY: 711) doo nihá bee áłchíní nínízingo bína'nitinígíí bich'į́' ákót'é.

Persian/Farsi:

توجه: اگر فارسی صحبت می‌کنید، خدمات کمک زبانی رایگان برای شما موجود است. کمک‌ها و خدمات کمکی مناسب برای ارائه اطلاعات در قالب‌های قابل‌دسترس نیز به صورت رایگان موجود است. با شماره 1-855-687-6260 (TTY: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

Polish:

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UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Odpowiednie pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-855-687-6260 (TTY: 711) lub porozmawiaj ze swoim dostawcą.”

Portuguese:

ATENÇÃO: Se você fala português, estão disponíveis serviços gratuitos de assistência linguística. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também são oferecidos sem custo. Ligue para 1-855-687-6260 (TTY: 711) ou fale com seu prestador.”

Russian:

ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Также бесплатно предоставляются необходимые вспомогательные средства и услуги для получения информации в доступных форматах. Позвоните по номеру 1-855-687-6260 (TTY: 711) или обратитесь к своему поставщику услуг.

Spanish:

ATENCIÓN: Si habla en español, se encuentran disponibles servicios gratuitos de asistencia lingüística para usted. También hay disponibles servicios y ayudas auxiliares adecuados para brindar información en formatos accesibles sin cargo. Llame al 1-855-687-6260 (TTY: 711) o hable con su proveedor.

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, may available na libreng serbisyo ng tulong sa wika para sa iyo. Available din nang libre ang mga angkop na pantulong na kagamitan at serbisyo para magbigay ng impormasyon sa mga accessible na format. Tumawag sa 1-855-687-6260 (TTY: 711) o kausapin ang iyong provider.”

Thai:

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หมายเหตุ: หากคุณพูดภาษาไทย เรามีบริการช่วยเหลือด้านภาษาให้กับคุณฟรี
มีความช่วยเหลือและบริการที่เหมาะสมเพื่อให้ได้รับข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่มีค่าใช้จ่าย โทร 1-855-687-6260 (TTY: 711) หรือสอบถามเพิ่มเติมกับผู้ให้บริการของคุณ”

Urdu:

توجہ فرمائیے: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت زبان میں مدد فراہم کی جا سکتی ہے۔ معلومات کو قابل رسائی شکل میں فراہم کرنے کے لیے موزوں معاون سہولیات اور خدمات بھی بلا معاوضہ دستیاب ہیں۔ 1-855-687-6260 پر کال کریں (TTY: 711) یا اپنے فراہم کنندہ سے بات کریں۔

Vietnamese:

CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các phương tiện và dịch vụ hỗ trợ phù hợp nhằm cung cấp thông tin bằng các định dạng dễ tiếp cận. Hãy gọi 1-855-687-6260 (TTY: 711) hoặc trò chuyện với nhà cung cấp dịch vụ của quý vị.

Yoruba:

ÀKÍYÈSÍ: Ti o bá n sọ èdè Yorùbá, isẹ̀ irànlọ̀wọ́ èdè wà fún ọ lọfẹ́ẹ̀. Àwọn irin isẹ̀ àti isẹ̀ irànlọ̀wọ́ tí ó yẹ láti pèsè àlàyẹ ní àwọn ọ̀nà tí ọwọ́ ká wà ní àrọ̀wọ́tọ́ lọfẹ́ẹ̀ bakan náà. Pe 1-855-687-6260 (TTY: 711) tàbí kí o bá olùpèsè rẹ sọrọ́."

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