Sentara Health Plans

https://www.sentarahealthplans.com/federal

757-552-7550 or 800-206-1060

Sentara® Health Plans

2024

A Health Maintenance Organization (High Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 3 for details. This plan is accredited. See page 12.

Serving: Northern Virginia region of Virginia

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2024: Page 14
- Summary of Benefits: Page 80

Enrollment codes for this Plan:

F21 High Option - Self Only
F23 High Option - Self Plus One
F22 High Option - Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-910

Important Notice from Sentara Health Plans About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Sentara Health Plans' prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low-Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 TTY 800-325-0778.

Potential Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of Sentara Health Plans under contract (CS 2968) between Sentara Health Plans and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This plan is underwritten by Sentara Health Plans. Customer service may be reached at 757-552-7550 or 800-206-1060 or through our website: www.sentarahealthplans.com/federal. The address for Sentara Health Plans' administrative offices is:

Sentara Health Plans
PO Box 66189
Virginia Beach, VA 23466

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2024, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2024, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member, "we" means Sentara Health Plans.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Healthcare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud– Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 757-687-6326, or 866-826-5277 and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE
1-877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise);
  - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26).

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions, and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medication and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will this be in person, by phone, mail, through the Plan or Provider's portal?
- Do not assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/ The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org/ The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment;
  - How you can cover your family members;
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
  - What happens when your enrollment ends;
  - When the next Open Season for enrollment begins.

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, disability leave, pensions, etc you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.
You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2024 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2023 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at //www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered child and you turn 26.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-741-4825 or visit or website at www.sentarahealthplans.com/federal.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Sentara Health Plans holds the following accreditation: National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation, please visit the following website: www.ncqa.org.

We require you to see specific providers, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We offer a High Option HMO plan.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our High Option

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care provider or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance and non-covered services and supplies). Except for emergencies outside the service area, we will not pay for care or services from non-Plan providers unless it has been authorized by us. You are responsible for making sure that a provider is a Plan provider. If you use a non-Plan provider without our prior authorization, you may be responsible for charges.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments or annual limits when received from a network provider.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including copayments, cannot exceed $5,500 for Self Only enrollment, and $11,000 for a Self Plus One or Self and Family.

Health education resources and accounts management tools

We have online, interactive health and benefits information tools to help you make more informed health decisions (see page 106).

Your rights and responsibilities

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance/) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Sentara Health Plans is a not-for-profit health maintenance organization fully licensed under the laws of the Commonwealth of Virginia to arrange for the provision of health care services to its members.
- Sentara Health Plans is one of the first HMOs in the Hampton Roads area of Virginia operating since 1984.
- Sentara Health Plans pays providers on a fee for service basis according to a fee schedule. You may find some additional information about the Plan's providers in this brochure in Section 3, *"Where You Get Covered Care"*. If you would like information about the Plan's provider network, including participating hospitals, physician education, and board certification, and whether or not providers are accepting new patients, you may check your provider directory, or the Plan's website at www.sentarahealthplans.com/federal or call Member Services at 757-552-7550 or 800-206-1060.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website at www.sentarahealthplans.com/federal. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 757-552-7550 or 800-206-1060, or write to Sentara Health Plans, PO Box 66189 Virginia Beach, VA 23466. You may also visit our website at www.sentarahealthplans.com/federal.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.sentarahealthplans.com/federal to obtain our Notice of Privacy Practices. You can also contact us to request that we mail a copy of the Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area in the State of Virginia:

Cities of:

Aldie, Alexandria, Annadale, Arlington, Ashburn, Bealeton, Bentonville, Berryville, Bluemont, Boyce, Bristow, Broad Run, Brooke, Burke, Calverton, Casanova, Catharpin, Catlett, Centreville, Chantilly, Clifton, Delaplane, Dulles, Dumfries, Dunn Loring, Fairfax, Fairfax Station, Falls Church, Fort Belvoir, Fredericksburg, Front Royal, Ft. Myer, Gainesville, Garrisonville, Goldvein, Great Falls, Greenway, Hamilton, Hartwood, Haymarket, Herndon, Hume, Leesburg, Lincoln, Linden, Lorton, Lovettsville, Manassas, Markham, Marshall, McLean, Merrifield, Middleburg, Middletown, Midland, Millwood, Mount Vernon, Newington, Nokesville, Oakton, Occoquan, Orlean, Paeonian Springs, Paris, Partlow, Philmont, Purcellville, Quantico, Rectortown, Remington, Reston, Round Hill, Ruby, Somerville, Spotsylvania, Springfield, Stafford, Sterling, Sumerduck, The Plains, Thornburg, Triangle, Upperville, Vienna, Warrenton, Waterford, West McLean, White Post and Woodbridge.

Counties of:

Alexandria, Arlington, Clarke, Fairfax, Fauquier, Loudoun, Manassas City, Manassas Park City, Prince William, Spotsylvania, Stafford, and Warren.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other healthcare services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2024

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5. Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

This is a new plan offering in the FEHB for 2024.

Section 3. How You Get Care

Open Access HMO

Sentara Health Plans offers Open Access to our members within the Plan's service area identified on page 14. You can go directly to any network specialist for covered services without a referral from your primary care provider (PCP). Whether your covered services are provided by your primary care physician (for your PCP copay) or by any other participating provider in the network (for the specialist copay), you will be responsible for payment which may be in the form of a copay (flat dollar amount) or coinsurance (a percentage of covered expenses). You still must select a PCP and notify member services of your selection. If you go directly to a specialist, you are responsible for verifying that the specialist is participating in the Plan. There are three ways you can check to see if your specialty provider is in the Plan's network. You can call Member Services, you can check your provider directory, or you can log onto the Plan's website at www.sentarahealthplans.com/federal to verify that your specialty provider is in the Plan's network. Please remember that although you do not need a referral for specialty care some services, supplies, and drugs require precertification. Please refer to Section 3 for precertification information and to make sure which services require precertification.

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 757-552-7550 or 800-206-1060 or write to us at Sentara Health Plans, PO Box 66189, Virginia Beach, VA 23466. You may also request replacement cards through our website at www.sentarahealtlhplans.com/federal.

Where you get covered care

If you use our Plan you can receive covered services from a participating provider without a required referral from your primary care provider or by another participating provider in the network. You will not have to file claims.

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

This Plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This Plan provides Care Coordinators for complex conditions and can be reached at 757-552-7550 or 800-206-1060 for assistance.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically, or you can call Member Services to find out if a hospital or other facility is a participating provider. The list is also on our web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care provider. This decision is important since your primary care provider provides or arranges for most of your healthcare.

- **Primary care**

Your primary care provider can be a family practitioner, internist or pediatrician. Your primary care provider will provide most of your healthcare or refer you to see a specialist.

If you want to change primary care provider or if your primary care provider leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

You do not need a referral from your primary care provider (PCP) for specialty care from a Plan provider.

Here are some other things you should know about specialty care:

- If you are seeing a specialist when you enroll in our Plan, you must make sure that they participate with us. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, you may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
  - reduce our Service Area and you enroll in another FEHB plan;

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new Plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call Member Services immediately at 757-552-7550 or 800-206-1060. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB Plan to us, your former Plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center; or
- the day your benefits from your former Plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your Plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new Plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care provider arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other Services*.

You must get prior approval for certain services. Your benefits for Covered Services may be reduced or denied if you do not comply with the Plan's precertification requirements.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other Services**

For certain services your provider must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain precertification for:

- Transplants,
- scheduled ambulance transport,
- outpatient surgery and services,
- inpatient facility admission,
- mental health and substance use disorder services, including:
  - Partial Hospitalization
  - Residential Treatment
  - Intensive Outpatient Programs (IOP)
  - Transcranial Magnetic Stimulation (TMS)
  - Electro-convulsive therapy
- durable medical equipment,
- hearing aids,
- artificial limbs,
- prosthetic and orthopedic appliances,
- home health care services,
- skilled nursing facility care,
- physical therapy, occupational therapy, speech therapy,
- cardiac rehabilitation,
- pulmonary rehabilitation, vascular rehabilitation, vestibular rehabilitation,
- early intervention services,
- clinical trials,
- hospice services,
- oral surgery,

- TMJ services,
- mental health services,
- growth hormone therapy,
- maternity services,
- Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CT) Scans,
- chemotherapy services, chemotherapy drugs and radiation therapy,
- sleep studies performed in a facility,
- infertility services
- services from non-Plan providers, and,
- certain prescription drugs.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 757-552-7550 or 800-206-1060 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days of requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 757-552-7550. You may also call OPM's FEHB 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 757-552-7550 or 800-206-1060. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 757-552-7550 or 800-206-1060.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

  Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

  1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
  2. Ask you or your provider for more information.
     - You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
     - If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

  After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Costs for Covered Services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. coinsurance, and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care provider you pay a copayment of $25 per office visit, and $55 per specialist office visit.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

This Plan does not have a deductible.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care.

Example: In our Plan, you pay 30% of our allowance for durable medical equipment

Differences between our Plan allowance and the bill

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

With the High Option, after your (copayments and coinsurance) total $5,500 per person regardless of enrollment tier and will not exceed more than $11,000 combined per Self Plus One or $11,000 combined for Self Plus Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments/coinsurance for these services:

- Balance-billed charges
- Healthcare charges this plan does not cover
- Precertification penalties
- Infertility drugs and procedures
- Premiums

We will notify you when you reach the maximum.

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year’s benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your prior plan's option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills. In addition, your health plan adopts and complies with the surprise billing laws of Virginia and § 38.2-3445.01. For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.sentarahealthplans.com/federal or contact the health plan at 757-552-7550 or 800-206-1060.

The Federal Flexible Spending Account Program – FSAFEDS

- **Healthcare FSA (HCFSA)** – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you, your tax dependents, and your adult children (through the end of the calendar year in which they turn 26).
- **FSAFEDS** offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

High Option Table of Contents

See page 15 for how our benefits changed this year and page 132 for a benefits summary.

Section 5. High Option Benefits

The benefit package is described in Section 5. Make sure that you review the benefits that are available.

Section 5 is divided into subsections. Please read *Important Things You Should Keep in Mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about the benefits, contact us at 757-552-7550 or on our website at www.sentarahealthplans.com/federal.

Benefits:

- $25 copayment for primary care provider office visits
- $55 copayment for specialist office visits
- No copayment for primary care provider office visits for preventive care
- No referral needed to see a specialist
- $10 copayment for Tier 1 prescription drugs
- Protection against catostrophic costs (out of pocket maximum) is $5,500 for Self Only or $11,000 for Self Plus One or Self Plus Family enrollment per year

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • Office medical consultation • Second surgical opinion • Advance care planning	$25 copayment per visit to your primary care provider $55 copayment per visit to a specialist
Professional services of physicians • During a hospital stay • In a skilled nursing facility	20% coinsurance of our Plan allowance
Professional services of physicians • In an Urgent Care Center	$55 copayment per visit
Telehealth Services	**High Option**
• MDLIVE Virtual Office Visit ***How to get started?*** • Sign in to your member portal at www.sentarahealthplans.com and select Access MDLIVE, or call 866-648-3638. • Have your Sentara Health Plans member ID number available to register. Please note that you'll need to create an account for each covered member of your family over the age of two. • When you want to see a doctor, you can go online to request immediate access to a provider on-call via phone or schedule a time at your convenience. You can also get connected by calling 866-648-3638.	Nothing

Benefit Description	You pay
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap test • Pathology • X-ray • Non-routine mammogram • CT Scan • MRI • Ultrasound • Electrocardiogram and EEG	20% coinsurance of our Plan allowance
Preventive care, adult	**High Option**
Routine physical every year. The following preventive services are covered at the time interval recommended at each of the links below: • Immunizations such as Pneumococcal, influenza, shingles, tetanus/ Tdap, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for woman such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care services for woman please go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • Routine mammogram • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments and coinsurance. • Medical Nutrition Therapy and Intensive Behavioral Therapy for the prevention of obesity related comorbidities as recommended under the U.S. Preventive Services Task Force (USPSTF) A and B recommendations.	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Immunizations, boosters, and medications for travel or work-related expenses.* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving this service.*	*All charges*
Preventive care, children	**High Option**
• Well-child visits, examinations, and immunizations other preventive recommended services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Immunizations such as DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments and coinsurance.	Nothing
• Hearing services (testing, treatment, and supplies) for children - "Hearing Aid" means any wearable, non-disposable instrument or device designed or offered to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords. Hearing aids are not to be considered durable medical equipment. - Coverage includes hearing aids and related services for children 18 years of age or younger. Coverage is limited to the cost of one hearing aid per hearing-impaired ear every 24 months, up to $1,500 per hearing aid. Members may choose a higher-priced hearing aid and pay the difference. • "Related Services" includes earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training. • Coverage is limited to services and equipment recommended by an otolaryngologist (ENT) and provided or dispensed by an otolaryngologist (ENT), licensed audiologist, or licensed hearing aid specialist. Note: Pre-certification is required.	Nothing

Benefit Description	You pay
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal and postpartum care • Screening for gestational diabetes • Breastfeeding support, supplies and counseling for each birth • Screening and counseling for prenatal and postpartum depression	Nothing
• Delivery	$450 Global Copayment
Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see page 18 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospitalization services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	
Not covered: • *Routine care and services for pregnancy outside the Plan's service area.* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service.*	*All charges*
Family planning	**High Option**
A range of voluntary family planning services, limited to: • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms • Tubal ligation	Nothing

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	**High Option**
Note: We cover oral contraceptives under the prescription drug benefit. *Generic oral contraceptives are eligible for 100 percent coverage and no cost share to members. Brand name oral contraceptives will be covered based on the plan's formulary and the appropriate Copayment or Coinsurance will apply based on the drug tier. Please visit www.express-scripts.com/frontend/open-enrollment/ohpcomm to determine member cost share for brand name oral contraceptives.	Nothing
Voluntary sterilization (See Surgical Procedures Section 5 (b))	$55 copayment
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling that is determined to be not medically necessary.* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service.*	*All charges*
Infertility services	**High Option**
Infertility is defined as failure to achieve pregnancy within 12 months of unprotected intercourse or therapeutic donor insemination in an individual younger than 35 years or, for an individual 35 years and older, within 6 months. Infertility may also be established through an evaluation based on medical history and diagnostic testing. Diagnosis and treatment of infertility: • Artificial insemination-Limited to 3 per year - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Endometrial biopsies-Limited to 1 per year • Semen analysis - Limited to 2 per year • Hysterosalpingography -Limited to 2 per year • Sims-Huhner test (smear) - Limited to 2 per year • Diagnostic laparoscopy -Limited to 1 per year • Infertility Drugs - See Section5(f) Note: IVF drugs and infertility drugs under this rider will not count toward your Maximum Out-of-Pocket Amount.	Cost sharing is determined by the type and place of service.
Cryopreservation for egg or sperm for persons facing the possibility of iatrogenic infertility, including infertility associated with gender affirming surgery. • Includes short-term storage coverage while the member is undergoing therapy (up to 12 months) - Benefits are not available for embryo fertilization or transfer - Benefits are not available for long-term storage costs (greater than one year)	20% coinsurance of our Plan allowance

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
- Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per covered person during the entire period of time member is enrolled for coverage under the policy (i.e. 1 attempt at harvesting gametes).	20% coinsurance of our Plan allowance
Not covered: • *Infertility services after voluntary sterilization* • *donor egg, and any other programs not listed as a covered service* • *reproductive material storage* • *any treatment related to sexual organ function, dysfunction, or inadequacies, including but not limited to impotency*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections • Allergy serum	$25 copayment per visit to your primary care provider $55 copayment per visit to a specialist
Not covered: • *Provocative food testing and sublingual allergy desensitization* • *Food allergy ingestion testing* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants in Section 5(b). • Respiratory and inhalation therapy • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. We only cover GHT when we precertify the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to precertify GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other Services* under You Need Prior Plan Approval for certain services.	20% coinsurance of our Plan allowance
• Cardiac rehabilitation following a qualifying event/condition is provided for up to 90 consecutive days from the start of rehabilitation.	20% coinsurance of our Plan allowance, during inpatient admission
• Pulmonary, vascular, and vestibular rehabilitation is covered for up to 90 consecutive days from the start of rehabilitation.	20% coinsurance of our Plan allowance, during inpatient admission
• Dialysis – hemodialysis and peritoneal dialysis	20% coinsurance of our Plan allowance

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**High Option**
Applied Behavior Analysis (ABA) - Members with autism spectrum disorder Covered Services include “diagnosis” and “treatment” of Autism Spectrum Disorder. “Autism Spectrum Disorder” means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. “Diagnosis of autism spectrum disorder” means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder. “Treatment for autism spectrum disorder” shall be identified in a treatment plan and included the following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) applied behavioral analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine. No limit on visits. “Applied behavioral analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.	Cost sharing determined by the type and place of service.
Not covered: • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service*	*All charges*
Physical and occupational therapies	**High Option**
• Qualified physical therapists • Occupational therapists Coverage will include 30 rehabilitative combined physical therapy and occupational therapy visits per year and 30 habilitative combined physical therapy and occupational therapy visits per year. Note: For mental health conditions or substance use disorders visit limits will not apply. Note: Precertification is required. We only cover therapy when a physician: • orders the care;	20% coinsurance of our Plan allowance

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	**High Option**
• identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed.	20% coinsurance of our Plan allowance
Early Intervention Services are covered for children from birth to age three for medically necessary services limited to: • speech, language, occupational and physical therapy • assistive technology services and devices Note: Covered services are provided to enhance functional ability without effecting a cure. Department of Mental Health, Mental Retardation, and Substance Abuse Services must certify dependents as eligible for services under Part H of the Individuals with Disabilities Act. Note: Precertification is required. See Section 3.	Cost sharing determined by the type and place of service.
Not covered: • *Long-term rehabilitative therapy* • *Therapies available in a school program or available through state and local funding, including sign language therapies* • *Recreation therapies, including art, dance, or music therapies* • *Sleep therapies* • *Exercise programs, or equine therapies* • *Driver evaluations as part of occupational therapy* • *Driver training* • *Functional capacity testing needed to return to work* • *Any service or supply, unless provided in accordance with a specific treatment plan pre-authorized by the Plan* • *Therapy which is primarily educational in nature, special education, or sign language* • *Work-hardening programs* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service*	*All charges*
Speech therapy	**High Option**
Speech therapy is covered for up to 30 rehabilitative speech therapy visits per year; up to 30 habilitative speech therapy visits per year for medically necessary treatment. Note: For mental health conditions or substance use disorders visit limits will not apply.	20% coinsurance of our Plan allowance

Speech therapy - continued on next page

Benefit Description	You pay
Speech therapy (cont.)	**High Option**
Not covered: • *Speech therapy not precertified by the Plan as part of a specific treatment plan* • *Care and services from non-Plan providers unless precertifed by the Plan prior to receiving the service*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive Care, Children.* • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: See Section 5(a), *Orthopedic and Prosthetic Devices,* for benefits for the devices.	$25 copayment per primary care provider office visit $55 copayment per specialist office visit
Not covered: • *All other hearing testing for adults* • *Hearing aids, testing and examinations for adults* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
Preventive vision care and services are administered by Vision Service Plan (VSP). The following services are covered once every 12 months: • Annual eye refraction including care history, visual acuity test for glasses and written lens prescription. • Screening tests for diseases or abnormalities, including glaucoma and cataracts. Note: You should select a Vision Service Provider and call him or her directly to schedule an appointment. If you need help or a current list of participating providers, call Sentara Health Plans at 757-552-7550 or 800-206-1060, or visit www.sentarahealthplans.com.	Nothing
• One pair of eyeglasses or contact lenses (up to $200 allowance) to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts). Please note that New technology, intraocular lens are excluded from coverage.	Nothing
• Eye exam to determine the need for vision correction for children up to age 22 (see Preventive care, children)	Nothing per primary care provider office visit $55 copayment per specialist office visit

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay
Vision services (testing, treatment, and supplies) (cont.)	**High Option**
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Any eye examination, or any corrective eyeware required by an employer as a condition as employment* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$25 copayment per primary care provider office visit $55 copayment per specialist office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot orthotics of any kind including customized or non-customized shoes, boots, and inserts, except as medically necessary and approved by the Plan for members with diabetes* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. • Lenses following cataract removal • Repair and replacement Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical Procedures.* For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c) *Services Provided by a Hospital or Other Facility, and Ambulance Services.*	30% coinsurance of our Plan allowance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**High Option**
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Standard non-motorized wheelchairs • Crutches • Walkers • Colostomy, iliostomy, and tracheostomy supplies • Suction and urinary catheters • Formula and enteral nutrition products that are prescribed for a inherited metabolic disorder Note: When your Plan physician prescribes this equipment we will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates.	30% coinsurance of our Plan allowance
• Diabetic supplies and equipment including prescribed by a Plan physician for insulin dependent, gestational, and non-insulin dependent diabetics. **Precertification is required for insulin pumps and pump infusion sets and supplies.** Coverage includes benefits for FDA-approved equipment and supplies for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items. • Pump infusion sets and supplies, outpatient self-management training and education, and nutritional therapy are covered under the Plan's medical benefits. • Insulin, needles, and syringes as well as testing supplies (test strips, lancets, lancet devices, blood glucose monitors, continuous glucose monitors and control solution) are covered under the Plan's pharmacy benefits.	30% coinsurance of the Plan allowance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
• Diabetes testing supplies will be limited to LifeScan products, except in the case of members using an insulin pump associated with a specific, non-LifeScan meter. For members who may not be using a LifeScan meter currently, there are two ways to obtain a free LifeScan meter: 1. Order online at www.OneTouch.orderpoints.com and input the Sentara Health Plans order code 741OPT016; 2. Call the toll-free number: 855-776-4464 and provide the order code 741OPT016	30% coinsurance of the Plan allowance
External insulin pumps	Nothing
Not covered: • *Motorized wheelchairs or scooters* • *Exercise equipment* • *Air conditioners, purifiers, humidifiers, and dehumidifiers* • *Whirlpool baths* • *Convenience items, including but not limited to hypoallergenic bed linens, water purification devices, and adaptive feeding devices* • *Telephones* • *Changes made to vehicles, residences, or places of business including, but not limited to, handrails, ramps, elevators, and stair glides* • *Repair or replacement of equipment damaged through neglect or loss* • *More than one item of equipment for the same purpose* • *Disposable medical supplies, including but not limited to medical dressings, disposable diapers* • *Durable medical equipment primarily for comfort and well being of the member* • *Care and services from non-plan providers unless precertified by the Plan prior to receiving the service*	*All charges*
Home health services	**High Option**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications • Part-time or intermittent nursing care • Part-time or intermittent home health aide services • Surgical dressings and medical appliances	$25 copayment
• Physical, occupational, or speech therapy	20% coinsurance of our Plan allowance
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family*	*All charges*

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	**High Option**
• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service*	*All charges*
Chiropractic	**High Option**
No benefit	*All charges*
Alternative treatments	**High Option**
No benefit	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for: • Diabetes self management Note: Members should call 1-800-SENTARA for information on classes	Nothing
• Counseling and education for birth control options	Nothing
• Tobacco Cessation programs, including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence (see Prescription Drugs).	Nothing
• Multicomponent, family centered programs focused on childhood obesity that are part of intensive behavioral interventions (behavior change counseling for healthy diet and physical activity) as recommended under the U.S. Preventive Services Task Force (USPSTF) A and B recommendations.	Cost-sharing dependent on place of service

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR ALL SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of severe obesity (bariatric surgery) -- a condition in which an individual weighs 100 pounds or 100% over their normal weight according to current underwriting standards; eligible members must be age 18 or over. • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	20% coinsurance of our Plan allowance
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Surgery primarily for cosmetic purposes* • *Any surgical services, other than emergent, which have not been pre-authorized by the Plan.*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
• *Any surgical services determined not medically necessary by the Plan.* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	20% coinsurance of our Plan allowance
Gender Affirming Surgery The following genital surgeries may be considered for male to female: • Orchiectomy - removal of testicles • Penectomy - removal of penis • Vaginoplasty - creation of vagina • Clitoroplasty - creation of clitoris • Labiaplasty - creation of labia • Mammaplasty - breast augmentation • Prostatectomy -removal of prostate • Urethroplasty - creation of urethra The following genital surgeries may be considered for female to male: • Breast reconstruction (e.g., mastectomy) - removal of breast • Nipple reconstruction (only if a mastectomy has been done) • Hysterectomy - removal of uterus • Salpingo-oophorectomy - removal of fallopian tubes and ovaries • Vaginectomy - removal of vagina • Vulvectomy - removal of vulva	20% coinsurance of our Plan allowance

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
• Metoidioplasty - creation of micro-penis, using clitoris • Phalloplasty - creation of penis, with or without urethra • Urethroplasty - creation of urethra within the penis • Scrotoplasty - creation of scrotum • Testicular prostheses - implantation of artificial testes	20% coinsurance of our Plan allowance
Not covered: • *Cosmetic surgery* • *Any surgical services, other than emergent, which have not been precertified by the Plan* • *Any surgical services determined not medically necessary by the Plan* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	20% coinsurance of our Plan allowance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service.*	*All charges*
Organ/tissue transplants	**High Option**
These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. See Other services under You need prior Plan approval for certain services on page 19. • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver	20% coinsurance of our Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) **Blood or marrow stem cell transplants** The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria	20% coinsurance of our Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial Ovarian Cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for	20% coinsurance of our Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic inflammatory demyelination polyneuropathy (CIDP) - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders (MSDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer	20% coinsurance of our Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) National Transplant Program (NTP) *Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.*	20% coinsurance of our Plan allowance
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service.*	*All charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	20% coinsurance of our Plan allowance

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	20% coinsurance of our Plan allowance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Presurgical testing • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Hospitalization and anesthesia for dental procedures as determined medically necessary by a Plan physician for members under age five, severely disabled or with a medical condition requiring hospitalization for dental procedures.	20% coinsurance of our Plan allowance
Not covered: • *Custodial care*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *The cost of securing the services of blood donors* • *Professional dental services* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	20% coinsurance of our Plan allowance
Not covered: • *Blood and blood derivatives not replaced by the member* • *Professional dental services and procedures* • *Care and services from non-Plan providers unless precertification by the Plan prior to receiving the service*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Extended care benefit/Skilled nursing facility : The Plan provides a comprehensive range of benefits up to 100 days per calendar year when full time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	20% coinsurance of our Plan allowance
Not covered: • *Custodial care*	*All charges*

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay
Extended care benefits/Skilled nursing care facility benefits (cont.)	**High Option**
• *Rest cures* • *Domiciliary or convalescent care* • *Personal comfort items such as telephone, and television* • *Blood and blood derivatives not replaced by the member* • *Care and services from non-Plan providers unless precertification by the Plan prior to receiving services*	*All charges*
Hospice care	**High Option**
A coordinated program of home and inpatient care under the direction of a Plan doctor for the patient who is in the terminal stages of illness with a life expectancy of six months or less that includes: • Palliative Care • Supportive physical, psychological, and psychosocial services Note: Palliative care is treatment to control pain, relieve other symptoms and focus on the special needs of the patient.	Nothing.
Advance Care Planning	20% coinsurance of our Plan allowance
Not covered: • *Independent nursing* • *Homemaker services* • *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the service*	*All charges*
Ambulance	**High Option**
Local professional ambulance service when medically appropriate	20% coinsurance of our Plan allowance

Section 5(d). Emergency Services/Accidents

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

- If the situation is life threatening, call 911 or go to the nearest hospital.
- If at all possible, call your primary care physician (PCP) or the After Hours Nurse Triage Program at the number on your Plan ID card.

Emergencies within our service area:

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition. The Plan will pay reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers. You must have any follow-up care recommended by non-Plan providers approved by the Plan and you must receive all follow-up care from Plan providers.

For urgent or emergency mental health or substance abuse services, call Sentara Behavioral Health Services Inc., at 757-552-7174 or 800-648-8420. The Psychiatric Emergency Response Service is available 24 hours a day, seven days per week to respond to clinical psychiatric and substance abuse emergencies.

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

You must have any follow-up care recommended by non-Plan providers approved by the Plan. You must receive all follow-up care from Plan providers.

With your authorization, the Plan will pay benefits directly to non-Plan providers of your emergency care upon receipt of their claims for covered services. Physicians should submit their claims on a HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure.

Benefit Description	You pay
Emergency within our service area	**High Option**
Emergency care at a doctor's office	$25 copayment per primary care provider office visit $55 copayment per specialist office visit
Emergency care at an urgent care center	$55 copayment per visit
Emergency care as an outpatient or inpatient at a hospital, including doctors services	20% coinsurance of our Plan allowance
Emergency outside our service area	**High Option**
Emergency care at a doctor's office	$25 copayment per primary care provider office visit $55 copayment per specialist office visit
Emergency care at an urgent care center	$55 copayment per visit
Emergency care as an outpatient or inpatient at a hospital, including doctors services	20% coinsurance of our Plan allowance
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*

Benefit Description	You pay
Ambulance	**High Option**
Professional ambulance service when medically appropriate Note: See Section5(c) for non-emergency service.	20% coinsurance of our Plan allowance

Section 5(e). Mental Health and Substance Use Disorder Benefits

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance misuse disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$15 copayment per office visit copay 30% coinsurance of our Plan allowance
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility • MRI, CT Scans and PET Scans	30% coinsurance of our Plan allowance

Benefit Description	You pay
Inpatient hospital or other covered facility	**High Option**
Inpatient services or residential treatment provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	30% coinsurance of our Plan allowance per admission
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, full-day hospitalization, or facility-based intensive outpatient treatment	30% coinsurance of our Plan allowance
Not covered	**High Option**
• *Care and services from non-Plan providers unless precertified by the Plan prior to receiving the services.*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed /certified providers with prescriptive authority prescribing within their scope of practice.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy, or a non-Plan pharmacy that has agreed to accept our reimbursement as payment in full. Specialty drugs must be filled through our Specialty mail order vendor, Proprium Pharmacy. You may also use our mail order program for maintenance medications.
- **We use a closed formulary.** That means the Plan includes coverage for a specific list of drugs and medications determined by our Pharmacy and Therapeutics Committee. Drugs that are not included on the Standard formulary will not be covered. Please use the following link to see a list of drugs on the Standard formulary: https://www.express-scripts.com/frontend/open-enrollment/ohpcomm. Your physician is responsible for obtaining precertification. Sentara Health Plans' Pharmacy and Therapeutics Committee places covered drugs into the following Tiers:
  - **Selected Generic (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.
  - **Selected Brand & Other Generic (Tier 2)** includes brand-name drugs, and some generic drugs with higher costs than Tier 1 generics, that are considered by the Plan to be standard therapy.
  - **Non-Selected Brand/Other (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 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 Specialty Drugs that have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty Drugs typically require special dosing, administration, and additional education and support from a health care professional**.**
- **Coverage of Specialty Drugs:** Specialty Drugs are only available through Proprium Pharmacy at 757-553-3568 or 855-553-3568 (toll free). Specialty Drugs include the following:
  - Medications that treat certain patient populations including those with rare diseases;
  - Medications that require close medical and pharmacy management and monitoring;
  - Medications that require special handling and/or storage;
  - Medications derived from biotechnology and/or blood derived drugs or small molecules; and
  - Medications that can be delivered via injection, infusion, inhalation, or oral administration.

Your Specialty Drug 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 Member Services at the number on Your Sentara Health Plans ID Card. You can also log onto https://www.sentarahealthplans.com/federal for a list of Specialty Drugs.

- **These are the dispensing limitations.** Prescription drugs dispensed at a Plan pharmacy will be dispensed for up to a 31-day supply. We will permit and apply a prorated daily cost sharing rate to prescription drugs for the purpose of synchronizing medications. Prescriptions will be dispensed by a Plan pharmacy for a partial supply if the prescribing provider or pharmacist determines the fill or refill to be in the best interest of the Member, and the Member requests or agrees to a partial supply. You may receive up to a 90-day supply of a prescribed maintenance medication through our mail-order program or at one of our retail pharmacies. Specialty drugs are limited to a 31-day supply.

You may use the Plan's mail order prescription drug benefit for Tier 1, 2 or 3 drugs and purchase a 90 day supply of maintenance drugs, for two prescription drug copayments. If you have a question about the mail order prescription drug program, or if you want to find out if your prescription is available through the program, you may call Express Scripts Pharmacy at 888-899-2653, 24 hours a day, 7 days a week.

If you are called to active duty, or in time of national or other emergency please call Member Services for assistance in obtaining a medium term supply of your prescription drugs.

- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug, or a higher costing generic, when a FDA approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic in addition to your copayment. The Plan limits the quantities of drugs you will receive for your copayment. Please read the information below to determine what you will receive for your prescription drug copay. If you have any questions about your prescription drug benefit please call Member Services.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the brand name is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and brand name drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you -and us- less than a brand name prescription.
- **When have to file a claim.** Members will be reimbursed for outpatient prescription drugs obtained from other than a Plan-participating pharmacy (or a non-Plan pharmacy that has agreed to accept reimbursement as payment in full for their services at rates applicable to Plan participating pharmacies) when:
  - Ordered in connection with an out-of-area emergency
  - Ordered by a Plan provider for immediate use because of a medical necessity and because no Plan –participating pharmacy was open for business at the time
  - Reimbursement will be limited to a quantity sufficient to treat the acute phase of the illness.

Benefit Description	You Pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan provider and obtained from a Plan pharmacy or through our mail order program: Drugs and medications (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Rescue and maintenance inhalers • Insulin • Drugs for sexual dysfunction (limited to four pills per month) • Drugs to treat gender dysphoria • Intravenous fluids and medication for home use • Infertility medications to increase production and release of as many eggs as possible may be covered with a three-cycle annual limit. Common infertility drugs used are: - Clomiphene citrate	**Retail Pharmacy:** $10 copayment per Tier 1 Drug 50% coinsurance per Tier 2 Drug 50% coinsurance per Tier 3 Drug **Mail Order (90-day supply of Maintenance Drugs):** $20 copayment per Tier 1 Drug 50% coinsurance per Tier 2 Drug 50% coinsurance per Tier 3 Drug **Specialty Drugs are only available through Proprium Pharmacy (limited to a 31 day supply):** 50% coinsurance per Tier 4 Specialty Drug

Covered medications and supplies - continued on next page

Benefit Description	You Pay
Covered medications and supplies (cont.)	**High Option**
- hCG (human Chorionic Gonadotropin) - FSH (follicle-stimulating hormone) - Menotropins Note: IVF drugs and infertility drugs do not count toward your Deductible or Maximum Out-of-Pocket Amount.	**Retail Pharmacy:** $10 copayment per Tier 1 Drug 50% coinsurance per Tier 2 Drug 50% coinsurance per Tier 3 Drug **Mail Order (90-day supply of Maintenance Drugs):** $20 copayment per Tier 1 Drug 50% coinsurance per Tier 2 Drug 50% coinsurance per Tier 3 Drug **Specialty Drugs are only available through Proprium Pharmacy (limited to a 31 day supply):** 50% coinsurance per Tier 4 Specialty Drug
Diabetic supplies limited to: • Disposable needles and syringes for the administration of covered medications • Continuous Glucose Monitor (CGM)	Applicable copayment or coinsurance
• Test strips, lancet devices and lancets • Blood glucose monitors and control solution	Nothing
• Contraceptive drugs and devices listed in the ACA/HRSA Note: If you need assistance requesting a medical exception for a non-formulary contraceptive, please contact Sentara Health Plans at 1-800-229-5522. If you have concerns about our Plan's compliance with the requirements for coverage of oral contraception, please contact contraception@opm.gov, or refer to OPM's web page about contraception. Note: Injectable contraceptive drugs are covered under Family Planning Section 5(a). • Tobacco eCessation medications Note: The above over-the-counter drugs and devices approved by the FDA require a written prescription by an approved plan provider. Some restrictions apply.	Nothing
Preventive care medications to promote better health as recommended by ACA. The following are covered: • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 0-2 years	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You Pay
Covered medications and supplies (cont.)	**High Option**
• Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Bowel Evacuant drugs • Tamoxifen and Raloxefin for women • Generic and over-the-counter tobacco cessation medications • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-7 Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browserecommendations	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them (except Vitamin D, as stated above)* • *Over-the-counter medications, except as noted above* • *Appetite suppressants or other weight management medications* • *Medical supplies such as dressings and antiseptics* • *Immunization agents, biological sera, blood or blood products*	*All charges*

Section 5(g). Dental Benefits

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Care must be received by Plan providers only.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits and coverage for hospitalization and anesthesia for dental procedures. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit	You pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	20% coinsurance of our Plan allowance
Dental benefits	**High Option**
We have no other dental benefits.	*All charges*

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call and talk with a registered nurse who will discuss treatment options and answer your health questions. When you call the Nurse Triage Program have your Plan ID card handy, and describe your medical situation in as much detail as possible. Please remember that the Nurse Triage Program professional cannot diagnose medical conditions or write prescriptions. You can call the 24 Hours Nurse Triage Program at 757-552-7250 or 800-394-2237.
Services for deaf and hearing impaired	TDD number: 757-552-7120 or 800-225-7784
High risk pregnancies	A Plan Care Manager will assist with a treatment plan prescribed by your OB/GYN physician.
Wellness Tools - My Life My Plan Connection	Through a partnership with **WebMD**, we offer our members flexible programs, expert guidance, and inspiration to take charge of their own health—whether they are continuing healthy behaviors, or making a change to improve their health. It all begins when the member completes a Personal Health Assessment—and creates the foundation for their Health Record and coaching program. Our health-coaching partner, WebMD, offers a comprehensive online activities tool, known as the Digital Health Assistant (DHA). The DHA delivers a personalized, interactive, and motivational experience to help members take action and sustain healthy behaviors in a fun way.

Non-FEHB Benefits Available to Plan Members

"Staying Healthy", an award-winning collection of nutrition, fitness, tobacco cessation and screening programs. Health Coaches and online resources are part of "Staying Healthy." You can find more information on these programs at www.sentarahealthplans.com/members/health-and-wellness/prevention-and-wellness/.

Health and Fitness Center Discounts:

- **Husk Wellness:** Sentara Health Plans members have access to premier fitness, weight loss, and wellness brands at discounted pricing. You must sign in to access the shopping platform to browse for services and activate your discount.

Complementary Alternative Treatments:
For more information about the complementary alternative treatments listed below, call toll-free 877-327-2746.

- **Acupuncture**: Up to 25% discount for acupuncture exams and treatment.
- **Chiropractic Care:** Up to 25% discount for routine chiropractic care.
- **Massage Therapy**: Up to 25% discount for massage therapy.
- **Physical Therapy:** Up to 25% discount for physical therapy.
- **Occupational Therapy:** Up to 25% discount for occupational therapy.
- **Podiatry:** Up to 25% discount for podiatry services.

Search for a participating provider near you (one-time registration is required at Choosehealthy.com)

Learn more about all of the "Saving More" Complementary Alternative Treatment programs:

- **Hearing Extras:**
  - Reduced pricing for hearing care services, including functional testing, hearing aid evaluation, fitting, programming, training and up to 50% discount (from manufacturer's suggested retail) for a hearing aid.
  - For additional information, call toll-free 866-956-5400 or visit the Epic Hearing Web site.
  - Learn more about the Saving More Hearing Care programs
- **Vision Extras:**
  - For additional information about savings offered by Vision Service Plan (VSP) call toll-free 800-206-1060, or visit www.sentarahealthplans.com.
  - Vision Extras: Significant savings on routine eye exams, lenses and frames, contact lenses.
  - Laser Vision: Up to $1,000 discount on the cost of laser vision surgery.
  - Learn more about the "Saving More" Vision Care programs

Important Points to Remember:

- The savings brought to you as part of the Sentara Health Plans Member Discount Program do not affect your premiums and are not covered benefits of your Plan.
- Discounts may not be used in conjunction with any other discount, rider, or benefit.
- You will be responsible for applicable taxes.

Section 6. General Exclusions –Services, Drugs and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When You Need Prior Plan Approval for Certain Services.***

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see Emergency services/accidents);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;
- Services or supplies we are prohibited from covering under the law.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 757-552-7550 or 800-206-1060, or at our Web site at www.sentarahealthplans.com/federal.

When you must file a claim – such as for services you receive outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Claims
P.O. Box 5028
Troy, MI 48007-5028

Other supplies or services

For Vision Service Plan non-Plan provider or out-of-network provider claims, please send your health plan name, your name, member ID number, current address, telephone number and your itemized statement. Claims must be submitted within six months of the time services are received.

Submit your claims to:

Vision Service Plan
Attn: Claims Services
PO Box 385018
Birmingham, AL 35238-5018

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the following year after you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If You Disagree With Our Pre-service Claim Decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Sentara Health Plans, PO Box 66189, Virginia Beach, VA 23466 or calling 800-206-1060.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take in account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

1 Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at: Sentara Health Appeals Department, PO Box 66189, Virginia Beach, VA 23466; and

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

e) Include your e-mail address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 757-552-7550 or 800-206-1060. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.sentarahealthplans.com/federal.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

TRICARE and CHAMPVA

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for your injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 877-888-3337 (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes 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 and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.

- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

What is Medicare?

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, such as prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

- Claims process when you have the Original Medicare Plan– You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 757-552-7550 or 800-206-1060 or see our website at www.sentarahealthplans.com/federal.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

- **Medical services and supplies provided by physicians and other healthcare professionals.**

Please review the following table as it illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Primary Care Provider
Medical Cost Without Medicare: $25 Copayment
Medical Cost with Medicare Part A and B: After Part A deductible, 20% coinsurance of Medicare allowed amount

Benefit Description: Specialist
Medical Cost Without Medicare: $55 Copayment
Medical Cost with Medicare Part A and B: After Part A deductible, 20% coinsurance of Medicare allowed amount

Benefit Description: Inpatient Hospital
Medical Cost Without Medicare: 20% Coinsurance of our Plan allowance
Medical Cost with Medicare Part A and B: $1,260 deductible for each benefit period, Days 1-60: $0 coinsurance for each benefit period, Days 61-90: $315 coinsurance per day of each benefit period, Days 91 and beyond: $630 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)

Benefit Description: Outpatient Hospital
Medical Cost Without Medicare: 20% Coinsurance of our Plan allowance
Medical Cost with Medicare Part A and B: After Part A deductible, 20% coinsurance of Medicare allowed amount

Benefit Description: Rx
Medical Cost Without Medicare: Tier 1 - $10, Tier 2 - 50% Coinsurance, Tier 3 – 50% Coinsurance, Tier 4 - Specialty (31 day supply) – 50% Coinsurance
Medical Cost with Medicare Part A and B: Part D benefit varies by plan

Benefit Description: Rx – Mail Order (90 day supply)
Medical Cost Without Medicare: 2x retail copay (No mail order for Tier 4 drugs)
Medical Cost with Medicare Part A and B: Part D benefit varies by plan

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (800-633-4227) (TTY 877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium). For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP)

If you are enrolled in Medicare, and are not enrolled in a Medicare Advantage Plan (Part C), you have the opportunity to enroll in the Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP). The PDP EGWP is a prescription drug benefit for FEHB covered annuitants and their FEHB covered family members who are eligible for Medicare. This allows you to receive benefits that will never be less than your coverage that is available to members with only FEHB but more often you will receive benefits that are better than members with only FEHB.

In the case of those with higher incomes you may have a separate premium payment for your PDP EGWP benefit. Please refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Catastrophic limit

The maximum amount that an insured person will have to pay for covered expenses under the plan, usually within the plan effective dates.

- The High Option catastrophic limit is $5,500 for Self Only, $11,000 for Self Plus One or $11,000 for Self and Family enrollment.

Clinical Trials Cost Categories

An approved clinical trial includes 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 and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 20% of our allowance for durable medical equipment

Copayment

A copayment is a fixed amount of money you pay when you receive covered services.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Care or services that can be provided by a non-medically skilled person. Such services help the patient with daily living activities, and include but are not limited to: walking, dressing, bathing, exercising, preparing meals, moving the patient, acting as a companion, administering medication which can usually be self-administered, and rest cures. Custodial care that lasts 90 days or more is sometimes known as long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. This plan does not have a deductible.

Experimental or investigational service

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); and approval for marketing has not been given at the time it is furnished. Note: Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product, is experimental or investigational if:

1. Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
2. Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only:

- Published reports and articles in the authoritative medical and scientific literature;
- The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or
- The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.

Group health coverage

A plan or contract that provides coverage for health care services to eligible employees and their dependents.

Habilitative Therapy

Includes coverage for health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.

Healthcare professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

Services, treatment, or supplies provided by a hospital, skilled nursing facility, physician, or other provider required to identify or treat your illness or injury and that as determined by your primary care physician and the Plan are:

- Consistent with the symptoms, diagnosis and treatment of your condition, disease, injury, or ailment;
- In accordance with recognized standards of care for your condition
- Appropriate standards of good medical practice
- Not solely for your convenience, or the convenience of your primary care physician, Plan provider, hospital or other provider;

- The most appropriate supply or level of service, which can be safely provided to you. As an inpatient this means that your medical symptoms or condition requires that the diagnosis, treatment or service cannot be safely provided to you as an outpatient.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: We use a fee schedule which means our Plan providers accept a negotiated fee from us and you will only be responsible for your copayments or coinsurance.

You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require pre-certification, prior approval, or a referral and (2) where failure to obtain pre-certification, prior approval, or a referral results in a reduction of benefits.

Rehabilitative Therapy

Includes coverage for therapies to restore and in some cases, maintain capabilities lost due to disease, illness, injury, or in the case of speech therapy, loss additionally due to congenital anomaly or prior medical treatment.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Surprise bill

An unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Urgent care claims

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

	Urgent care claims usually involve pre-service claims and not post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 757-552-7550 or 800-206-1060. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We	Us and We refer to Sentara Health Plans.
You	You refers to the enrollee and each covered family member.

Index

Notes

Summary of Benefits for the High Option Sentara Health Plans - 2024

- This is a summary. Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.sentarahealthplans.com/federal.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You pay	Page
Deductible	This Plan does not have a deductible.	21
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copayment: $25 primary care; $55 specialist	26
Services provided by a hospital: Inpatient and Outpatient	20% coinsurance of Plan allowance	46
Emergency benefits: In-area	20% coinsurance of Plan allowance $55 copayment per Urgent Care Center visit	50
Emergency benefits: Out-of-area	20% coinsurance of Plan allowance	50
Mental health and substance use disorder treatment:	Regular cost-sharing	52
Prescription drugs: Retail pharmacy	Retail copayment/coinsurance per 31-day supply: • $10 copayment per Tier 1 Drug • 50% coinsurance of plan allowance per Tier 2 Drug • 50% coinsurance of plan allowance per Tier 3 Drug • 50% coinsurance of plan allowance per Specialty Drug - Specialty Drugs must be obtained through Proprium Pharmacy	55
Prescription drugs: Mail Order	Mail Order copayment/coinsurance for 90-day supply of Maintenance Drugs: • $20 copayment per Tier 1 Drug • 50% coinsurance of plan allowance per Tier 2 Drug • 50% coinsurance of plan allowance per Tier 3 Drug	55
Dental Care:	No benefit	58
Vision care:	Covered at 100% per eyeglass exam once every 12 months	35
Wellness and other special features:	Nothing	59
Protection against catastrophic costs (out-of-pocket maximum):	$5,500 per person regardless of enrollment tier and will not exceed more than $11,000 combined per Self Plus One or $11,000 combined per Self Plus Family. Some costs do not count toward this protection.	21

2024 Rate Information for Sentara Health Plans

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Virginia					
High Option Self Only	F21	$245.57	$81.85	$532.06	$177.35
High Option Self Plus One	F23	$561.95	$187.31	$1,217.55	$405.85
High Option Self and Family	F22	$561.99	$187.33	$1,217.65	$405.88