Sentara Health Administration, Inc.

Sentara Vantage 35/50
Newport News Public Schools
3274
10101VA000200100
Plan Effective Date: 01/01/2027

Large Group Schedule of Benefits

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

This document is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.

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

Some services require Pre-Authorization before You receive them. Your Physician or other provider is responsible for getting Pre-Authorization. We have instructions and procedures in place for providers to obtain Pre Authorization. For a list of services that require Pre-Authorization please go to [https://pal.sentarahealthplans.com/].

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

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

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

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

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

Copayments and Coinsurances listed in this document are amounts You pay directly to a Provider for a Covered Service. Copayments are shown as flat dollar amounts. Coinsurance is shown as a percentage of the Plan’s

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Allowable Charge for Your Covered Service. You will pay a Copayment or Coinsurance, but not both, for a Covered Service. For some benefits You may see the statement, “Cost sharing determined by the type and place of service.” For these services Your cost sharing will be based on where You receive a service, for example in a Physician office or inpatient setting, and/or the type of service.

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

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Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	**Out-of-Network**
Deductible Plan Year	Your Plan Does Not Have a Deductible	Not Covered
	In-Network	**Out-of-Network**
Maximum Out-of-Pocket Plan Year	$4,750/Individual; $9,000/Family	Not Covered

Most amounts You pay, or that are paid on their behalf, for In-Network Covered Services will count toward meeting the In-Network Maximum Out-of-Pocket Amount.

The following will not count toward any Plan Maximum Amount(s):

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

If You are the Subscriber, and the only Member Covered under Your Plan, the Individual Maximum applies. If You have other family members on Your Plan, the Family Maximum applies. Under family Coverage, the Individual Maximum applies separately to each Covered family member. Once the total family Coverage Maximum is met, the Family Maximum Amount is satisfied. No one Member can contribute more than their Individual Maximum Amount to the family limit.

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

Benefit	In-Network	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by approved Plan providers. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits. ***Pre-Authorization is required for in-office surgery.**		
Primary Care Visit	You Pay $35	Not Covered
Virtual Consult	You Pay $25	Not Covered
Specialist Visit	You Pay $50	Not Covered
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of $250 per dose. This does not include routine immunizations Covered under Preventive Care.	You Pay 50%	Not Covered
Preventive Care Recommended preventive care services are Covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. Cost sharing, including Deductibles, Copayments or Coinsurances do not apply to Prostate Cancer Screenings received from In-Network or Providers. Cost sharing including Deductibles, Copayments or Coinsurances does not apply to Diagnostic and Supplemental Breast Examinations to evaluate, detect, or screen for breast cancer when received from In-Network Providers. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of Covered preventive care services:https://www.healthcare.gov/what-are-my-preventive-care-benefits.		
Recommended exams, screenings, tests, immunizations, and other services	No Charge	Not Covered
Prostate Cancer Screenings	No Charge	No Charge
Diagnostic and Supplemental Breast Examinations*	No Charge	No Charge

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

Benefit	In-Network	Out-of-Network
Outpatient Therapies and Services You pay a Copayment or Coinsurance amount for each visit at a Physician's office, a free-standing outpatient Facility, a Hospital outpatient Facility, or at home. Visit limits do not apply to outpatient habilitative or rehabilitative therapy services if You get that care as part of the Hospice or Early Intervention benefit, or as part of a treatment plan for Autism Spectrum Disorder. Visit limits do not apply to outpatient or home health habilitative or rehabilitative therapy services for mental health conditions or substance use disorders. For Mental Health conditions or Substance Use Disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Occupational and Physical Therapy* Rehabilitative Services limited to 30 combined visits per Plan year. Habilitative Services limited to 30 combined visits per Plan year.	**PCP Office Visit** You Pay $35 **Specialist Office Visit** You Pay $35 **Outpatient Facility** You Pay $35	Not Covered
Speech Therapy* Rehabilitative Services limited to 30 visits per Plan year. Habilitative Services limited to 30 visits per Plan year.	**PCP Office Visit** You Pay $35 **Specialist Office Visit** You Pay $35 **Outpatient Facility** You Pay $35	Not Covered
Cardiac Rehabilitation*	**PCP Office Visit** You Pay $50 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
Pulmonary Rehabilitation*	**PCP Office Visit** You Pay $50 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
Vascular Rehabilitation*	**PCP Office Visit** You Pay $50 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered

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

Benefit	In-Network	Out-of-Network
Vestibular Rehabilitation*	**PCP Office Visit** You Pay $50 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
IV Infusion Therapy	**PCP Office Visit** You Pay $35 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
Respiratory/Inhalation Therapy	**PCP Office Visit** You Pay $35 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
Chemotherapy and Chemotherapy Drugs*	**PCP Office Visit** You Pay $35 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
Radiation Therapy*	**PCP Office Visit** You Pay $35 **Specialist Office Visit** You Pay $50 **Outpatient Facility** You Pay $50	Not Covered
Pre-Authorized Injectable and Infused Medications* Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient Facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs.	You Pay $50	Not Covered

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

Benefit	In-Network	Out-of-Network
Outpatient Dialysis You Pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.		
Dialysis Services	You Pay $5	Not Covered
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free-standing ambulatory surgery center or Hospital outpatient surgical Facility.		
Surgery Services*	You Pay $500	Not Covered
Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient Facility or lab or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Diagnostic Procedures	You Pay $50	Not Covered
X-Ray **Ultrasound** **Doppler Studies**	You Pay $50	Not Covered
Lab Work	You Pay $50	Not Covered
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a freestanding outpatient Facility or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Magnetic Resonance Imaging* **Magnetic Resonance Angiography (MRA)*** **Positron Emission Tomography (PET)*** **Computerized Axial Tomography (CT)*** **Computerized Axial Tomography Angiogram (CTA)*** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Sleep Studies***	You Pay 10%	Not Covered

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

Benefit	In-Network	Out-of-Network
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are Covered under preventive benefits.		
Maternity Care	You Pay $400 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	Not Covered
Inpatient Services		
Inpatient Hospital Services*	You Pay $350 per day Copayment	Not Covered
Transplants* Covered at contracted facilities only.	You Pay $350 per day Copayment	Not Covered
Skilled Nursing Facility Services* Limited to a maximum of 100 days per Plan year.	You Pay 20%	Not Covered
Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay a Copayment or Coinsurance per transport each way. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services.		
Water and Ground Services Non-Emergent Transportation*	You Pay $100	Not Covered except for Emergency Services
Air Ambulance Services Non-Emergent Transportation*	You Pay $100	You Pay $100
Emergency Services Includes medical and mental health and substance use disorder Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other Facility charges, such as diagnostic x-ray and lab services and medical supplies provided in an Emergency Department, including an independent freestanding Emergency Department, In-Network or Out-of-Network.		
Emergency Services	You Pay $300	You Pay $300
Emergency Ambulance	You Pay $300	You Pay $300
Urgent Care Services Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care Facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Urgent Care Services	You Pay $50	Not Covered

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

Benefit	In-Network	Out-of-Network
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Virtual Consults must be furnished by approved Plan providers.		
Inpatient Hospital Services*	You Pay $350 per day Copayment	Not Covered
Residential Treatment Services*	You Pay $350 per day Copayment	Not Covered
Outpatient Office Visits (PCP and Specialist)	You Pay $35	Not Covered
Outpatient Office Visits (Virtual Consult)	You Pay $25	Not Covered
Partial Hospitalization/Intensive Outpatient Program Facility Services*	You Pay $350 per day Copayment	Not Covered
Other Outpatient Services	You Pay $35	Not Covered
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Mental Health and Substance Use Disorder Services Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay a Copayment or Coinsurance per transport each way.		
Water and Ground Services Non-Emergent Transportation*	You Pay $100	Not Covered except for Emergency Services
Air Ambulance Services Non-Emergent Transportation*	You Pay $100	You Pay $100
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is Covered from an In-Network Plan Provider or a participating Vision Services Plan (VSP) provider at the office visit Copayment or Coinsurance amount.		
Insulin Pumps, Pump Infusion Sets and Supplies* Some pumps and pump supplies may be covered under the Plan's Prescription Drug Benefit depending on the device manufacturer	No Charge	Not Covered

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Benefit	In-Network	Out-of-Network
Equipment and Supplies Includes test strips, lancets, lancet devices, Home Blood Glucose Meters/Monitors and control solution, and Continuous Blood Glucose Monitors, sensors, and supplies. ***Pre-Authorization is required for Continuous Blood Glucose Monitors, sensors, and supplies**	Covered under the Plan's Prescription Drug Benefit	Not Covered
Insulin, and Needles and Syringes for Injection	Covered under the Plan's Prescription Drug Benefit	Not Covered
Outpatient Self-Management Training, Education, Nutritional Therapy	No Charge	Not Covered
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment*	You Pay 20%	Not Covered
Durable Medical Equipment (DME) and Supplies		
DME, Orthopedic Devices, Prosthetic Appliances, Devices*	No Charge	Not Covered
Early Intervention Services For Dependent children from birth to age three.		
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices*	Cost sharing determined by the type and place of service.	Not Covered
Home Health Care Includes skilled home health care services. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home. Visit limits do not apply to outpatient habilitative or rehabilitative therapy services for mental health conditions and substance use disorders.		
Home Health Care*	You Pay $50	Not Covered
Private Duty Nursing		
Private Duty Nursing* Includes services provided by an RN or LPN in the home. Limited to 16 hours per Plan year.	You Pay $50	Not Covered

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Benefit	In-Network	Out-of-Network
Hospice Care		
Hospice Care*	No Charge	Not Covered
Vision Care The Plan contracts with Vision Services Plan (VSP) to administer this benefit. Services must be received from VSP providers.		
Vision Exams Limited to one routine eye exam every 12 months from a participating VSP provider.	No Charge	Members will be reimbursed up to $30 for one routine eye exam only
Chiropractic Care The Plan Contracts with American Specialty Health Group (ASH) to administer this benefit. Services include therapy to treat problems of the bones, joints, and back. Services must be received from ASH providers.		
Chiropractic Care Maximum number of visits 30 per Plan year. This benefit also includes Coverage of Chiropractic appliances up to a maximum benefit of 1 appliance per Person per Plan year when medically necessary.	You Pay $35	Not Covered
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.		
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing determined by the type and place of service.	Not covered
Infertility Services Includes limited services, for Members only, to diagnose and treat underlying medical conditions resulting in Infertility.		
Endometrial biopsies Limited to 2 per lifetime **Semen analysis** Limited to 2 per lifetime **Hysterosalpingography** Limited to 2 per lifetime **Diagnostic laparoscopy** Limited to 1 per lifetime	Cost sharing determined by the type and place of service.	Not Covered
Clinical Trials Includes “routine patient costs” for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.		
Clinical Trial Services*	Cost sharing determined by the type and place of service.	Not Covered

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

Benefit	In-Network	Out-of-Network
Allergy Care		
Allergy Care, Testing, and Serum	No Charge	Not Covered
Hearing Aid Services for Children Age 18 and Younger Includes hearing aids and related services (earmolds, initial batteries, other necessary equipment, maintenance, and adaption training.) Benefits for hearing aids and related services are limited to a combined benefit for In-Network benefits and Out-of-Network benefits of $1500 per hearing impaired ear every 24 months.		
Hearing Aids and Related Services*	You Pay $50	Not Covered
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.		
Telemedicine Services	Cost sharing determined by the type and place of service.	Not Covered

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

Hearing Aid Rider		
Hearing Aid Services* Covered Services include the following up to the annual maximum benefit of $1,200 per ear: • the hearing aid(s); • audiometric specialist office visits for fitting, including molds and dispensing; • repair, replacement or refurbishment of the hearing aid(s) Replacement is covered only every 48 months from date of acquisition. Batteries and supplies are not covered.	You Pay $50	Not Covered

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

Notice/Notes/Terms & Conditions:

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

This Plan does not have pre-existing condition exclusions.

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

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1-855-687-6260

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