Optima Vantage

Newport News Public Schools
Sentara Health Plan
Large Group Benefit Summary

This benefit summary is not a contract or health plan policy from Optima Health. If there are any differences between this benefit summary and the Optima Health 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 Benefit Summary is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. You or Your means the Subscriber and each family member who is a Covered Person under the Plan. Details about Covered Services are in the section "What is Covered." Details about services and treatments that are not covered are in the section "What is Not Covered."

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

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

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

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

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

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

Your Plan's Maximum Out-of-Pocket Amount means the total dollar amount Members pay, 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.

Effective Period: From 01/01/2022 through 12/31/2022		
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

Amounts You Pay for In-Network Covered Services will count toward meeting the In-Network Deductible. The Deductible applies to all Covered Services except for:

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

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

	In-Network	**Out-of-Network**
Maximum Out-of-Pocket Plan Year	$4,750/Individual; $9,000/Family	Not Covered

Most amounts You pay, or that are paid on Your behalf, for In-Network Covered Services will count toward meeting the In-Network Maximum Out of Pocket Amount.
The following will not count toward the Plan maximum amount(s):

- Amounts You pay for services not covered under Your Plan;
- Amounts You pay for any services after a benefit limit has been reached;
- Balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers;
- Premium amounts;
- 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 Benefit Summary 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 Optima Health approved providers. ***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. 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
Outpatient Therapies and Services You Pay a Copayment or Coinsurance amount for each visit for services done in a Physician's office, a free-standing outpatient facility, a Hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of a treatment plan for Autism Spectrum Disorder.		
Occupational and Physical Therapy* 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* 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

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

Benefit	In-Network	Out-of-Network
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
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.		
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 free-standing outpatient facility or a Hospital outpatient facility or lab.		
Magnetic Resonance Imaging (MRI)* **Magnetic Resonance Angiography (MRA)*** **Positron Emission Tomography (PET)*** **Computerized Axial Tomography (CT)*** **Computerized Axial Tomography Angiogram (CTA)*** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Sleep Studies***	You Pay 10%	Not Covered
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are covered under preventive benefits.		
Maternity Care ***Pre-Authorization is required for prenatal services**	You Pay $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

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

Benefit	In-Network	Out-of-Network
Skilled Nursing Facility Services* Limited to a maximum of 90 days per Plan year.	You Pay 20%	Not Covered
Ambulance Services Includes Emergency transportation, or non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way.		
Air, Water, Ground Services *Pre-Authorization is required for non-emergency transportation.	You Pay $100	Not Covered except for Emergency Services
Emergency Services Includes 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 In-Network or Out-of-Network.		
Emergency Services	You Pay $500	You Pay $500
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.		
Urgent Care Services	You Pay $50	Not Covered
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. ***Pre-Authorization is required for Inpatient Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.** Virtual Consults must be furnished by approved Optima Health providers.		
Inpatient Services*	You Pay $350 per day Copayment	Not Covered
Outpatient Office Visits	You Pay $35	Not Covered
Virtual Consults	You Pay $25	Not Covered
Other Outpatient Visits (Facility/Freestanding Centers)	You Pay $35	Not Covered
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is covered from an In-Network Plan Provider or a participating EyeMed Vision Services provider at the office visit Copayment or Coinsurance amount.		
Insulin Pumps*	No Charge	Not Covered
Pump Infusion Sets and Supplies*	No Charge	Not Covered
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution. ***Pre-Authorization is required for talking blood glucose monitors**	Covered under the Plan's Prescription Drug Benefit	Not Covered
Insulin, Needles, Syringes	Covered under the Plan's Prescription Drug Benefit	Not Covered
Outpatient Self-Management Training, Education, Nutritional Therapy	No Charge	Not Covered

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

Benefit	In-Network	Out-of-Network
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	You Pay 20%	Not Covered
Autism Spectrum Disorder Includes diagnosis and treatment of Autism Spectrum Disorder.		
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.	Not Covered
Durable Medical Equipment (DME) and Supplies		
DME, Orthopedic Devices, Prosthetic Appliances, Devices ***Pre-Authorization is required for items over $750** ***Pre-Authorization is required for repair, replacement and rental items.**	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 for home bound Members. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home		
Home Health Care*	You Pay $50	Not Covered
Hospice Care		
Hospice Care*	No Charge	Not Covered
Vision Care Optima Health contracts with EyeMed Vision Services to administer this benefit. Services must be received from EyeMed providers.		
Vision Exams Limited to one exam every 12 months from an EyeMed provider.	No Charge Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost.	Members will be reimbursed up to $30 for an eye examination
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.		
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing is 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
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 **Sims-Huhner test (smear)** Limited to 4 per lifetime **Diagnostic laparoscopy** Limited to 1 per lifetime	Cost sharing is 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 is determined by the type and place of service.	Not Covered
Allergy Care		
Allergy Care, Testing, and Serum	Cost sharing is determined by the type and place of service.	Not Covered
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.		
Telemedicine Services	Cost sharing is determined by the type and place of service.	Not Covered
Optional benefit Chiropractic Care Rider Optima Health contracts with American Specialty Health Group (ASH) to administer this benefit.		
Chiropractic Care Rider Maximum number of visits 30 per Calendar year. This benefit also includes coverage of Chiropractic appliances up to a maximum benefit of 1 appliance per Person per Calendar year when medically necessary.]	You Pay $35	Not Covered

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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.

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

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Need help in another language? Call us.

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다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

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Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

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

1-855-687-6260

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