Sentara

Franklin City Public Schools

POS 1000/25/30%

Health Benefits	Member Pays	
	In-Network	Out-of-Network
Benefit Year Deductible (Individual/Family)	$1000/$2000	$2000/$4000
Coinsurance	30%	50%
Benefit Year Out-of-Pocket Maximum (Individual/Family) *In and Out-of-Network Out-of-Pocket Maximums are separate*	$4500/$9000	$9000/$18000
Maximum Lifetime Benefit Per Member	Unlimited	
Recommended Exams, screening, tests, immunizations, and other services (Preventive)	No Charge	50% after deductible
Primary Care Visit	$25 copay	50% coinsurance after deductible
Virtual Consult	No charge	Not covered
Specialist Visit	$50 copay	50% coinsurance after deductible
Maternity Care - Pre-Authorization is required for prenatal services	$350 global copayment for delivering Obstetrician prenatal, delivery and postpartum services	50% coinsurance after deductible
Inpatient Services - Pre-Authorization required for non-emergency	30% coinsurance after deductible	50% coinsurance after deductible
Diagnostic Procedures	30% coinsurance after deductible	50% coinsurance after deductible
MH Outpatient Office Visits (PCP and Specialist)	$35 copay	50% coinsurance after deductible
MH Outpatient Office Visits (Virtual Consult)	$35 copay	Not covered
Outpatient Surgery - Pre-Authorization may be required	30% coinsurance after deductible	50% coinsurance after deductible
Advanced Imaging – CT, PET, MRI, MRA, CTA, MRS, SPECT – Pre-Authorization Required	30% coinsurance after deductible	50% coinsurance after deductible
Urgent Care Services	$50 copay	50% coinsurance after deductible
Emergency Services	30% coinsurance after deductible	30% coinsurance after deductible
Emergency Ambulance	30% coinsurance after deductible	30% coinsurance after deductible
Vision Exams – Limited to one routine eye exam every 12 months from participating VSP provider	No Charge	Members will be reimbursed up to $30 for one routine eye exam only
Hospice Care – Pre-Authorization is required	No Charge after deductible	50% coinsurance after the deductible
Home Health Care (Limited to 100 visits per Plan Year). Includes Skilled home health care. Separate copayment and coinsurance for therapies and infused medications at home. Prior authorization required	$25 copay	50% coinsurance after the deductible
Physical Therapy and Occupational Therapy (limited to 30 combined visits) **Speech Therapy** (limited to 30 visits)	30% coinsurance after deductible	50% coinsurance after deductible
Diabetes Treatment		

Health Benefits	Member Pays	
	In-Network	Out- of -Network
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* – Pre-Authorization may be required	No Charge	50% coinsurance after deductible
Pump Infusion Sets and Supplies – prior authorization may be required	30% coinsurance after deductible	50% coinsurance after deductible
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	Covered under the Plan's Prescription Drug Benefit
Insulin, Needles, Syringes	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit
Employee Assistance Visits Services include short-term problem assessment by licensed behavioral health providers, and referral services for employees, and other Covered family members and household members. To use services call 757-363-6777 or 1-800-899-8174.	No Charge for up to ~~3~~ 5 visits from Plan Employee Assistance providers per presenting issue as determined by treatment protocols	
Retail Pharmacy Cost Sharing **When You pick up Your drug at a retail pharmacy You will pay the Copayment (one Copayment for each 30-day supply) or the Coinsurance amount listed under the applicable Tier for Your Drug:** **• You pay one Copayment or the Coinsurance for up to a 30-day supply;** **• You pay two Copayments or the Coinsurance for a 31 to 60-day supply;** **• You pay three Copayments or the Coinsurance for a 61 to 90-day supply.** **Tier 4 Specialty Drugs are only available from a Plan Specialty Pharmacy including Proprium Pharmacy and are limited to a 30-day supply**		
Preferred Generic Drugs: Tier 1 - $15 Copay **Preferred Brand & Other Generic Drugs: Tier 2 - $50 Copay** **Non-Preferred Brand Drugs: Tier 3 - $85 copay** **Specialty Drugs: Tier 4 – 20% coinsurance up to maximum of $250**		
Formulary	This Plan has a closed formulary and Covers a specific list of drugs and medications. If Your drug is not on Our formulary, We have a process in place to request Coverage. Please use the following link to see a list of drugs on the Plan's formulary: sentarahealthplans.com/members/manage-plans/employer-grouprescription-drug-lists. If a brand-name medication is dispensed instead of a generic equivalent, You must pay the cost difference between the dispensed brand-name drug and the Generic Drug in addition to the Copayment or Coinsurance charge, unless authorized by the Plan.	