Peoni
PLANS ADMINISTERED BY VERDEGARD™

DESCRIPTION OF BENEFITS		NAVIGATOR VBP 3000 HEALTH PLAN	
PLAN PROVISIONS		**In-Network**	**Out-of-Network**
Annual Medical Deductible		$3,000 Per Person $6,000 Per Family	$6,000 Per Person $12,000 per person
Annual Out of Pocket Maximum (includes Medical and Pharmacy) The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum.		$8,700 Per Person $17,400 Per Family	$17,400 Per Person $34,800 Per Family
Amounts in Excess of Negotiated Rates/Maximum Allowable Charges		For Participating Providers, the Member is responsible for the difference between the Plan payment and 100% of the negotiated rate.	For Non-Participating Providers, the member will be responsible for the deductible, copayments, and coinsurance, as well as any amounts exceeding the Maximum Allowable Charge. Any amounts in excess of the Maximum Allowable Charge payable to Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.
Lifetime Maximum		None	
Dependent Coverage		To age 26	
MEDICAL SERVICES			
All plan benefits shown as a percentage of Eligible Charge.			
	Do Services Require Prior Authorization?	**Member Pays**	
		In-Network	**Out-of-Network**
PHYSICIAN SERVICES			
Primary Care Office Visits	No	$25 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Specialist Office Visits	No	$25 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Other Services performed in the office - including Diagnostic Services, Office Surgery and Radiology Services, Laboratory and Pathology (Prior Authorization rules for any other service performed in the office, please refer to the Diagnostic Services section).	No	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Physician Services in a Facility (Hospital, Outpatient Surgery, Emergency Room)	No	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amount that exceed the Maximum Allowable Charge
Urgent Care	No	$50 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
MATERNITY			
Physician Services	No	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
PREVENTIVE CARE			
BENEFITS FOR CHILDREN			
Newborn Circumcision	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Well Child Care Office Visits 0 to 11 months (6 "well-baby visits") 1 to 4 years (7 "well-child visits") 5 to 17 years (1 per year, "well-child visit")	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Well Child Care Immunization (recommended by Bright Futures Project)	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Well Child Care Lab Tests (recommended by Bright Futures Project)	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge

	Do Services Require Prior Authorization?	Member Pays	
		In-Network	Out-of-Network
ADULT PREVENTIVE SCREENING/TESTING			
Adults, one (1) physical exam per benefit year to obtain recommended preventive and diagnostic services	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Immunization Services for Adults Immunizations - doses, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP)	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Prostate Specific Antigen (Men, one per CY, age ≥ 50)	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Screenings such as; Obesity, Blood Pressure, Cholesterol, Colorectal Cancer, HIV, Alcohol Misuse	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Counseling such as; Alcohol Misuse, Sexually Transmitted Infection (STI) Prevention, Nutritional Counseling, Tobacco Use	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
WOMEN'S PREVENTIVE CARE SERVICES			
Prescribed contraceptive methods, sterilization procedures and patient education. (Supply and administration of Contraceptive IUDs, Implants and Injectables) (Pharmacy - birth control pills, diaphragms, emergency contraceptive pill through your Pharmacy Benefits)	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Well Woman exam per benefit year to obtain recommended preventive and diagnostic services (Subject to all Limitations as described under Covered Medical Benefits)	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Screenings such as Pap Smears, Mammography, Domestic and interpersonal violence screening, Osteoporosis screening (Subject to all Limitations as described under Covered Medical Benefits)	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Services for Pregnant Women including but not limited to Anemia Screening, Rh Incompatibility Screening, Breastfeeding, Hepatitis B Screening. Breastfeeding: Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. (Reimbursement of Non-Participating breastfeeding supplies up to the amount of $200).	No	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
HOSPITAL/FACILITY SERVICES			
Inpatient Room & Care – semi-private room rate (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute or Skilled Nursing Facility setting	Yes	$750 Copayment plus amounts that exceed the Maximum Allowable Charge	
Outpatient / Ambulatory Surgery Services & Birthing Centers	Yes	$250 Copayment, plus amounts that exceed the Maximum Allowable Charge (waived if admitted to Inpatient status)	
Other Outpatient Hospital Services (such as Cardiac, Pulmonary, PT/OT/ST)	Yes (if at a hospital)	40% Coinsurance after Annual Deductible** Plus amounts that exceed the Maximum Allowable Charge	
Emergency Room Services	No	$250 Copayment, plus amounts that exceed the Maximum Allowable Charge (waived if admitted to Inpatient status)	
DIAGNOSTIC SERVICES			
Laboratory Services			
Non Hospital Based	No	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Hospital Based	Yes	40% Coinsurance after Annual Deductible** Plus amounts that exceed the Maximum Allowable Charge	

	Do Services Require Prior Authorization?	Member Pays	
		In-Network	Out-of-Network
Radiology			
Non Hospital Based	No	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Hospital Based	Yes	40% Coinsurance after Annual Deductible** Plus amounts that exceed the Maximum Allowable Charge	
Radiation Oncology Services			
Non Hospital Based	Yes	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Hospital Based	Yes	40% Coinsurance after Annual Deductible** Plus amounts that exceed the Maximum Allowable Charge	
CT/MRI/MRA/PET Scan			
Non Hospital Based	Yes	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Hospital Based	Yes	40% Coinsurance after Annual Deductible** Plus amounts that exceed the Maximum Allowable Charge	
MENTAL HEALTH/BEHAVIORAL HEALTH/SUBSTANCE ABUSE DISORDER			
INPATIENT			
Hospital & Facility Services; semi-private room rate	Yes	$750 Copayment plus amounts that exceed the Maximum Allowable Charge	
Psychiatrist & Psychologist Services	No	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
OUTPATIENT			
Psychiatrist & Psychologist Services	Yes (if at hospital)	$25 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Psychological Testing	Yes	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
OTHER SERVICES			
Allergy Testing (including serums, injections, and administration)	No	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Ambulance (Ground & Air)	Yes (Non-emergent)	40% Coinsurance after Annual Deductible** Plus amounts that exceed the Maximum Allowable Charge	
Chemotherapy	Yes	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Dialysis and Supplies	Yes	40% Coinsurance after Annual Deductible** Plus amounts that exceed the Maximum Allowable Charge	

	Do Services Require Prior Authorization?	Member Pays	
		In-Network	Out-of-Network
Durable Medical Equipment (including Orthotics/Prosthetics)	Yes (If greater than $500 charge per single item)	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Enteral Nutrition Therapy	Yes	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Hearing Aids (Limited to one (1) device per ear every five (5) years) Maximum of $1,500 per covered device	No	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Evaluations for the Use of Hearing Aids	No	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Home Health Services (Maximum of 120 visits per year)	Yes	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Home Infusion Services	Yes	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Hospice Services	Yes	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Human Growth Hormone, Genetic Testing/Counseling, Other	Yes	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Physical/Occupational/Speech Therapy (Non Hospital Based)	Yes	30% Coinsurace after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
ALTERNATIVE CARE SERVICES			
There is a combined benefit year benefit maximum of $400.00 paid by the Plan for Alternative Care Services.			
Acupuncture	No	$35 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Chiropractic Care	No	$35 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Naturopathy	No	$35 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Massage Therapy	No	$35 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
** In-Network Annual Deductible and Annual Out of Pocket Maximum applies. Amounts in excess of the Maximum Allowable Charge DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.			
Coinsurance amount is based on an approved negotiated rate for Participating Providers or the Maximum Allowable Charge and Allowed reimbursement level for Non-Participating Providers as established by the Plan.			
Prior Authorization is required for certain services (noted above). Please refer to the Plan Document for Prior Authorization requirements.			
Benefits that are determined to be emergent services or services that are subject to the No Surprises Act will be reimbursed at the Participating Provider level of benefits.			
The Plan reserves the right to audit all claims to ensure appropriate billing and medical appropriateness for all services provided.			
This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence.			

DESCRIPTION OF BENEFITS		NAVIGATOR VBP 3000 HEALTH PLAN	
PHARMACY PROVISIONS ***(Please refer to the ID Card for Pharmacy Benefit Information)***		**In-Network Pharmacies**	**Out-of-Network Pharmacies**
PHARMACY BENEFITS		**Member Pays**	
Annual Deductible		None	Not Applicable
Annual Out of Pocket Maximum		Combined with the Medical Out of Pocket Maximum	Not Applicable
Lifetime Maximum		None	Not Applicable
Preventive Prescription Services			
Mandatory Generic Only - Preventive Prescription Services as defined by PPACA. In order for preventive medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs.			
Prescription Drugs Pharmacy Retail - up to a 30 Day Supply		Generic - $0	Not Covered
Non-Preventive Prescription Services			
All prescriptions will be dispensed as Generic unless otherwise prescribed by your Physician. All specialty drugs and certain non-specialty drug categories are mandated to process through the mail order pharmacy or specialty program including, but not limited to: diabetic supplies and insulins, behavioral health, HIV, transplant and anticoagulant drugs. These drugs are only allowed to process through the mail order pharmacy or specialty pharmacy as applicable.			
Prescription Drugs Pharmacy Retail - up to a 30 Day Supply		Generic - $10 Copayment Preferred Brand - $20 Copayment Non-Preferred Brand - $35 Copayment	Not Covered
Prescription Drugs Pharmacy Retail - 90 Day Supply		Generic - $30 Copayment Preferred Brand - $60 Copayment Non-Preferred Brand - $105 Copayment	Not Covered
Prescription Drugs Pharmacy Mail Order - 90 Day Supply		Generic - $20 Copayment Preferred Brand - $40 Copayment Non-Preferred Brand - $70 Copayment	Not Covered
Specialty Drugs		50% Coinsurance	Not Covered

This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence.

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