Peoni
PLANS ADMINISTERED BY VERDEGARD™

DESCRIPTION OF BENEFITS		NAVIGATOR PPO PRIME 4000 HEALTH PLAN		
PLAN PROVISIONS				
		Member Pays		
		Care Advocate	**In-Network**	**Out-of-Network**
Annual Medical Deductible		None	$4,000 Per Person $8,000 Per Family	$8,000 Per Person $16,000 Per Family
Annual Out of Pocket Maximum (includes Medical and Pharmacy) The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum.		None	$8,700 Per Person $17,400 Per Family	Unlimited
Amounts in Excess of Negotiated Rates/Maximum Allowable Charges		Not Applicable	For Participating Providers, the Member is responsible for the difference between the Plan payment and 100% of the negotiated rate. The Member will be responsible for the Deductible, Copayments, and Coinsurance.	For Non-Participating Providers, the Member is responsible for the amounts listed as well as the difference between the Maximum Allowable Charge reimbursement level and 100% of the billed amount. Amounts in excess of the Maximum Allowable Charge payable to Non-Participating Providers **DO NOT** apply to the Annual Deductible **NOR** the Annual Out-of-Pocket Maximum.
Lifetime Maximum		None		
Dependent Coverage		To age 26		
Care Advocate tier option with no out of pocket cost may be available if Verdegard + Advanta is notified 5 business days or more prior to the service date, however we can not guarantee a Care Advocate option will be available. Verdegard + Advanta will attempt a no out of pocket cost for notifications with less than 5 business days, but a Care Advocate option may not be available.				
MEDICAL SERVICES				
All plan benefits shown as a percentage of Eligible Charge.				
	Do Services Require Prior Authorization?	**Member Pays**		
		Care Advocate	**In-Network**	**Out-of-Network**
PHYSICIAN SERVICES				
Primary Care Office Visits	No	Not Applicable	$5 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Specialist Care Office Visits	No	Not Applicable	$50 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	Not Applicable	0% 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)	Yes**	Not Applicable	0% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Physician Services in a Facility (Emergency Room)	No	Not Applicable	0% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Urgent Care	No	Not Applicable	$50 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
MATERNITY				
Physician Services	No (Unless stay exceeds 48 hours (vaginal delivery) or 96 hours (cesarean section delivery))**	Not Applicable	0% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge

	Do Services Require Prior Authorization?	Member Pays		
		Care Advocate	In-Network	Out-of-Network
PREVENTIVE CARE				
BENEFITS FOR CHILDREN				
Newborn Circumcision	No	Not Applicable	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	Not Applicable	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Well Child Care Immunization (as recommended by Bright Futures Project)	No	Not Applicable	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Well Child Care Lab Tests (as recommended by Bright Futures Project)	No	Not Applicable	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
ADULT PREVENTIVE SCREENING/TESTING				
Adults, one (1) physical exam per benefit year to obtain recommended preventive and diagnostic services	No	Not Applicable	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	Not Applicable	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	Not Applicable	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Colorectal cancer screening for adults of certain ages or at higher risk (Covered in a non-Hospital setting only unless medically necessary)	No	Not Applicable	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Abdominal Aortic Aneurysm one-time screening for men of certain ages who have ever smoked (Covered in non-Hospital setting only)	No	Not Applicable	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Lung cancer screening for adults of certain ages at increased risk. (Covered in a non-Hospital setting only)	No	Not Applicable	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Screenings such as; Obesity, Blood Pressure, Cholesterol, HIV, Alcohol Misuse	No	Not Applicable	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	Not Applicable	Covered in Full	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge

	Do Services Require Prior Authorization?	Member Pays		
		Care Advocate	In-Network	Out-of-Network
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	Not Applicable	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	Not Applicable	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	Not Applicable	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	Not Applicable	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	Not Applicable	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**	$0 Copayment / 0% Coinsurance*	$1,500 Copayment after Annual Deductible	$1,500 Copayment after Annual Deductible, then 50% Coinsurance plus amounts that exceed the Maximum Allowable Charge
Outpatient / Ambulatory Surgery Services & Birthing Centers	Yes**	$0 Copayment / 0% Coinsurance*	$1,000 Copayment after Annual Deductible	$1,000 Copayment after Annual Deductible, then 50% Coinsurance plus amounts that exceed the Maximum Allowable Charge
Other Outpatient Hospital Services (such as Cardiac, Pulmonary, PT/OT/ST)	Yes**	$0 Copayment / 0% Coinsurance*	$50 Copayment after Annual Deductible	$50 Copayment after Annual Deductible, then 50% Coinsurance plus amounts that exceed the Maximum Allowable Charge
Transplant Procedures	Yes**	$0 Copayment / 0% Coinsurance*	$4,700 Copayment after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Spinal Fusion Surgery	Yes**	$0 Copayment / 0% Coinsurance*	$4,700 Copayment after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Planned Cardiovascular Procedures	Yes**	$0 Copayment / 0% Coinsurance*	$4,700 Copayment after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Emergency Room Services	No	Not Applicable	$1,000 Copayment after Annual Deductible (Copay waived if admitted)	$1,000 Copayment after Annual Deductible (Copay waived if admitted) plus amounts that exceed the Maximum Allowable Charge
DIAGNOSTIC SERVICES				
Laboratory Services				
Non Hospital Based	No	Not Applicable	0% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Hospital Based	Yes**	Not Applicable	0% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge

	Do Services Require Prior Authorization?	Member Pays		
		Care Advocate	In-Network	Out-of-Network
Radiology Services				
Non Hospital Based	No	Not Applicable	0% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Hospital Based	Yes**	Not Applicable	0% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Radiation Oncology Services				
Non Hospital Based	Yes**	$0 Copayment / 0% Coinsurance*	$100 Copayment after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Hospital Based	Yes**	$0 Copayment / 0% Coinsurance*	$100 Copayment after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
CT/MRI/MRA/PET Scan				
Non Hospital Based	Yes**	$0 Copayment / 0% Coinsurance*	$100 Copayment after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Hospital Based	Yes**	$0 Copayment / 0% Coinsurance*	$100 Copayment after Annual Deductible	50% 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**	$0 Copayment / 0% Coinsurance*	$1,500 Copayment after Annual Deductible	$1,500 Copayment after Annual Deductible, then 50% Coinsurance plus amounts that exceed the Maximum Allowable Charge
Psychiatrist & Psychologist Services	Yes**	Not Applicable	0% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
OUTPATIENT				
Psychiatrist & Psychologist Services	No	Not Applicable	$50 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Psychological Testing	Yes**	Not Applicable	0% 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	Not Applicable	$25 Copayment after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Ambulance - Emergent (Ground)	No	Not Applicable	$500 Copayment after Annual Deductible	$500 Copayment after Annual Deductible then 50% Coinsurance plus amounts that exceed the Maximum Allowable Charge
Ambulance - Emergent (Air)	No	Not Applicable	$2,500 Copayment after Annual Deductible	$2,500 Copayment after Annual Deductible then 50% Coinsurance plus amounts that exceed the Maximum Allowable Charge
Ambulance - Non-Emergent (Ground)	Yes**	Not Applicable	$500 Copayment after Annual Deductible	$500 Copayment after Annual Deductible then 50% Coinsurance plus amounts that exceed the Maximum Allowable Charge
Ambulance - Non-Emergent (Air)	Yes**	Not Applicable	$2,500 Copayment after Annual Deductible	$2,500 Copayment after Annual Deductible then 50% Coinsurance plus amounts that exceed the Maximum Allowable Charge

	Do Services Require Prior Authorization?	Member Pays		
		Care Advocate	In-Network	Out-of-Network
Chemotherapy	Yes**	$0 Copayment / 0% Coinsurance*	$4,700 Copayment after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Dialysis and Supplies	Yes**	Not Applicable	$4,700 Copayment after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Durable Medical Equipment (including Orthotics/Prosthetics)	Yes** (If greater than $500 charge per single item)	$0 Copayment / 0% Coinsurance*	0% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Enteral Nutrition Therapy	Yes**	Not Applicable	0% 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	Not Applicable	0% 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	Not Applicable	0% 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**	Not Applicable	0% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Home Infusion Services	Yes**	Not Applicable	0% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Hospice Services	Yes**	Not Applicable	0% 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**	Not Applicable	0% 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**	Not Applicable	0% Coinsurance 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	Not Applicable	$50 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Chiropractic Care	No	Not Applicable	$50 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Naturopathy	No	Not Applicable	$50 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge
Massage Therapy	No	Not Applicable	$50 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Maximum Allowable Charge

* Cannot guarantee a "Care Advocate" option will be available in your area for every medical service or procedure in this category. Some travel may be necessary to receive $0 Copay for larger cost non-emergent procedures.

** No benefit if Prior Authorization is not provided. Prior Authorization must be obtained in order to be a covered benefit.

Coinsurance amount is based on an approved negotiated rate for Participating Providers or the Maximum Allowable Charge 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 PPO PRIME 4000 HEALTH PLAN		
PHARMACY PROVISIONS ***(Please refer to Member ID Card for Pharmacy Benefit Information)***		**Care Advocate**	**In-Network Pharmacies**	**Out-of-Network Pharmacies**
PHARMACY BENEFITS		**Member Pays**		
Annual Pharmacy Deductible		None	None	Not Applicable
Annual Out of Pocket Maximum		None	Combined with Medical Out of Pocket Maximum	Not Applicable
Lifetime Maximum		None		
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		Not Applicable	Generic - $0 Copayment	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		Not Applicable	Generic - $10 Copayment Preferred Brand - $20 Copayment Non-Preferred Brand - $35 Copayment	Not Covered
Prescription Drugs Pharmacy Retail - 90 Day Supply		Not Applicable	Generic - $30 Copayment Preferred Brand - $60 Copayment Non-Preferred Brand - $105 Copayment	Not Covered
Prescription Drugs Pharmacy Mail Order - 90 Day Supply		Not Applicable	Generic - $20 Copayment Preferred Brand - $40 Copayment Non-Preferred Brand - $70 Copayment	Not Covered
Specialty Drugs		Not Applicable	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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