Volusia Health Network

Effective January 1, 2022

Financial Features	Local Network	Specialty & Extended Networks
Lifetime Maximum	Unlimited	Unlimited
Annual Deductible	$750 Individual $2,250 Family	$1,200 Individual $3,600 Family
Annual Out-of-Pocket Maximum	$4,000 Individual/$8,000 Family	
Co-Insurance	Plan pays 90% Member pays 10%	Plan pays 75% Member pays 25%
Penalty for failure to obtain Pre-Certification	**50% of Fee Schedule**	**Member Pays 100% Billed Charges**
Wellness Services	**Local Network**	**Extended Network (EN) Specialty Network (SN)**
Well-Baby Care/Well Child Visit	$0 (Covered in full)	EN covered in full SN not covered
Annual Adult Physical Health Screening	$0 (Covered in full)	EN covered in full SN not covered
Well Woman's Assessment (Primary Care or Specialist)	$0 (Covered in full)	EN covered in full SN not covered
Routine Pap Smear – one per calendar year	$0 (Covered in full)	EN covered in full SN not covered
Mammography Screening – one per calendar year	$0 (Covered in full)	EN covered in full SN not covered
Colonoscopy Screening (pre-cert required)	$0 (Covered in full)	EN covered in full SN not covered
Bone Density Screening	$0 (Covered in full)	EN covered in full SN not covered
Inpatient Services	**Local Network**	**Specialty/Extended Network**
Pre-Cert Required for all inpatient admissions (Penalty Applies without Pre-Cert)		
Inpatient Admission	Deductible = $100 per day (Capped at $500 per confinement)	Deductible + 25%
In-Hospital Ancillary Services (Pathology. Radiology, Labs, Anesthesiology) Inpatient Outpatient Lab – Halifax Health	 Deductible + 10% $0	 Deductible + 25% N/A
Outpatient Hospital Facility Services X-Rays and Ultrasounds Diagnostic Services (except AIS) Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med)	Deductible + 10%	Deductible + 25%
Inpatient Physician Services	Deductible +10%	Deductible + 25%
Inpatient Rehabilitation	Deductible + 10%	Deductible + 25%
Radiology Services	**Local Network**	**Specialty/Extended Network**
Outpatient X-ray, Ultrasound	$35	Deductible + 25%
MRI, CT Scan, PET Scan, Nuclear Stress Test	$150	Deductible + 25%
EEG, EMG	Deductible + 10%	Deductible + 25%
Cardiac PET Scan	$150	Deductible + 25%

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Outpatient Services – Local Network Primary Care Office Visit	
Office Visit	$30
• Procedure in office	Deductible + 10%
• Lab Tests in office sent to Halifax Health Outpatient lab	Deductible + 10%
• Lab Tests in office sent to network lab other than Halifax Health	$1,200 deductible + 25%
• X-Ray/Ultrasound in office	$35
• Other Diagnostic Procedures	Deductible + 10%
• Allergy Shots in office	Deductible + 10%

Outpatient Services – Local Network Specialist Office Visit	
Office Visit	$45
• Procedure in office (check pre-cert list)	Deductible + 10%
• Lab Tests in office sent to Halifax Health Outpatient lab	Deductible + 10%
• Lab Tests in office sent to network lab other than Halifax Health	$1,200 deductible + 25%
• X-Ray/Ultrasound in office	$35
• Other Diagnostic Procedures	Deductible + 10%
• Exercise Stress Test	$50
• Cardiac PET Scan, Nuclear Stress Test (with pre-cert)	$75
• Allergy Shots/Injections in office	Deductible + 10%

Restorative Therapy	Local Network	Specialty/Extended Network	Pre-cert
Occupational, Physical, Speech (Limit 24 visits per calendar year)	Deductible + 10%	$1,200 deductible + 25%	No
ABA (Applied Behavioral Analysis) limit 24 visits per calendar year	Deductible + 10%	$1,200 deductible + 25%	No
Chiropractic (Non-Surgical Back), (Limited to Spinal Manipulation/one office visit per year. Limited 24 visits per calendar year	Deductible + 10%	$1,200 deductible + 25%	No

Doctor On Demand	
Medical Doctor	**Psychologist/Psychiatrist**
$10 co-pay	$30 co-pay

Emergency Care	Local Network	Specialty/Extended Network
Emergency Room Visit (waived if admitted) Non-emergency care provided at emergency facilities is NOT COVERED (See Medical Emergency Definition)	$250 Halifax ED $250 Obstetrics ER	$250
Urgent Care Centers – Halifax Health Facilities	$60	N/A
Ambulance Services	Deductible + 10%	Deductible + 25%

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Other Services	Local Network	Specialty/Extended Network	Pre-cert
Bariatric Surgery (Roux-en-Y and gastric sleeve only, excludes banding) Must complete Halifax weight management program (24 weeks) and procedure must be performed by specific Halifax contracted providers.	$1,000	Not Covered	Yes
Diagnostic Work-up of Infertility/Sterility (Lifetime maximum limit of $2,000) Excludes any treatment rendered to correct the diagnosis of Infertility/Sterility.	Appropriate Co-pay Applies	Not Covered	No
Durable Medical Equipment & Supplies	Deductible + 10%	Deductible + 25%	Yes, if over $1,000/item
EKG	Deductible + 10%	Deductible + 25%	No
Free-Standing Dialysis Centers	Deductible + 10%	Deductible + 25%	Yes
Hearing Exams/Hearing Aids	Not Covered	Not Covered	N/A
Home Health (limited to 44 visits/calendar year)	Deductible + 10%	Deductible + 25%	Yes
Hospice Care	Deductible + 10%	Deductible + 25%	Yes
Interventional Pain Management	Deductible + 10% (Facility), $35 (Physician)	Not Covered	Yes
IV Infusion/Chemo & Radiation Therapy	Deductible + 20%	Deductible + 25%	Yes, >$2,000 per injection/oral
Lab Testing @ Hospital-based Laboratory	$0	Deductible + 25%	Genetic- Yes
Nutritional Counseling	$30 Co-Pay/Visit	Not Covered	No
Orthotics	$100	Deductible + 25%	Yes, if over $1,000/item
Outpatient Diabetes Self-Management Education Program (limited to 10 hours first time through; then 2 hours per calendar year thereafter).	$30 Co-Pay (1 Co-pay for entire program)	Not Covered	No
Outpatient Surgical Care of Invasive Procedure	Deductible + 10%	Deductible + 25%	Case specific
Prosthetics	Deductible + 10%	Deductible + 25%	Yes, if over $1,000/item
Skilled Nursing Facility (limit 90 days/calendar year)	Deductible + 10%	Deductible + 25%	Yes
Smoking Cessation (Quit Smart Program only)	$0	Not Covered	No
Treatment of Temporomandibular Joint Disease	50%	Not Covered	Yes
Weight Management Program	$200	Not Covered	No
Wound Care	$30/visit	Deductible + 25%	No

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Specialty and Extended Network	
A Network Exception is required for services in the Specialty Network; benefits will not apply without a Network Exception	
Inpatient Admission	
Inpatient admission	Deductible + 25%
In-Hospital Ancillary Services	Deductible + 25%
In-Hospital Physician Services	Deductible + 25%
Specialist Office Visit	
Office Visit	Deductible + 25%
Radiology Services	
All Radiology Services	Deductible + 25%
Other Diagnostic Services	
Lab Tests, EEG, EKG, EMG	Deductible + 25%

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VHN PRE-CERTIFICATION LIST

Precertification is required for the following types of service:
Behavioral Health and Substance Use- Crisis Stabilization Unit, Detoxification, Inpatient Psychiatric Hospitalization, Partial Hospitalization (PHP), Subacute Residential Treatment Center, Intensive Outpatient (IOP), Residential Treatment Center (RTC)
Inpatient Medical: Acute Level of Care, Inpatient Hospice, Maternity (beyond standard 2/4 days), Skilled Nursing Facility (SNF), Acute Inpatient Rehabilitation (AIR), Subacute Care, Long Term Acute Care (LTAC)

For additional procedures that may require pre-certification please see list below or visit myvhn.com-For Members-Your Benefits-Summary Plan Description (SPD) * Pre-cert lists are subject to change *****

Additional Procedures with Pre-Cert Required

Air Ambulance	Gender Reassignment Surgery
Artificial Cervical/Lumbar Disc Replacement	Genetic Testing and Related Services • Maternity related • Other medical conditions • Colaris
Bariatric Surgery – For Roux-en-Y and Gastric sleeve only (excludes banding) Must complete Halifax weight management program (24 weeks)	
Blood test – Colaris	Gynecomastia Surgery
Breast Implant Removal	Home Health Care (limited 44 visits/calendar year)
Breast Reduction or Enhancement	Home Infusion (> $2,000 per dose)
Childbirth over 48 hour – Vaginal Delivery	Hospice Care
Childbirth over 96 hour – Cesarean Delivery	Learning Deficiencies, Behavioral Problems and Developmental Delay after 3 years old (plan limit 24 visits per discipline per calendar year)
Childhood Early Intervention Services: Learning Deficiencies, Behavioral Problems, Developmental Delays (subject to plan guidelines)	
Clinical Trails: Experimental, Investigational, New Technologies and/or unproven procedures/services (subject to plan guidelines)	Nuclear Cardiac Stress Test
	Nutrition-Formula (Metabolic, Enteral and Infant Formula with medical condition)
Cochlear Implants	Obstructive Sleep Apnea Treatment (including by not limited to): • Genioglossus Advancement • Laser Assisted Uvula Palatoplasty (LAUP) • Somnoplasty (RBOT) • Uvulopalatopharyngoplasty (UPPP)
Colonoscopy	
Congenital Chest Wall Deformity Surgery (Pectus excavatum, Pectus Carinatum, Poland Syndrome)	
All Potentially Cosmetic Procedures (IP and OP)	
Anesthesia for Dental Services (Facility Charge)	
Dialysis	Orthognathic Surgery (Jaw)
Durable Medical Equipment • DME Purchase > $1,000 • DME Rental in excess of 3 months	Partial hospitalization for alcohol/chemical dependency
	Prophylactic Mastectomy
Early Intervention Services (*plan limit* 24 visits per discipline/per calendar year) Up to age 39 months or until September 1 of the year in which the child turns 3 if born after April 1	Prosthetics > $1,000
	Rhinophyma, excision or surgical planning
	Rhinoplasty
EGD (Upper Endoscopy)	Scar Revision or Repair, not limited to: • Keloid excision • Scar revision and/or surgery
EUS (Endoscopic Ultrasound)	
Experimental, Investigational, New Technologies and/or unproven procedures/services	
Eye Lid and Brow Surgery • Blepharoplasty • Entropion repair • Ectropion repair • Ptosis repair (eye brow, eye lid)	Sleep Apnea Treatment
	Specialty Medications billed through Medical – injectable or infusible > $2,000 per injection/infusion; Oral > $2,000 per dose

TMJ Treatment (surgery and devices)	Transplants (Organ, Bone Marrow, and Stem Cell)
Transcranial Magnetic Stimulation (TMS)	Varicose Vein Treatment