| DESCRIPTION OF BENEFITS | | |
|---|---|---|
| ***PLAN PROVISIONS*** | **In-Network** | **Out-of-Network** |
| Annual Medical Deductible | None | Not Applicable |
| Annual Medical Out-of-Pocket Maximum | None | Not Applicable |
| Amounts in Excess of Negotiated Rates/Maximum Allowable Charges | For Participating Providers, the contract generally prohibits the provider from charging more than the negotiated rate for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance. | For Non-Participating Providers, the Member is responsible for the full amount billed by the provider. Amounts billed by Non-Participating Providers are not covered and DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum. |
| Lifetime Maximum | None | |
| Dependent Coverage | To age 26 | |
| ***MEDICAL SERVICES*** | **Member Pays** | |
| | **In-Network** | **Out-of-Network** |
| ***PHYSICIAN SERVICES*** | | |
| Primary Care Office Visits | $30 Copayment | Not Covered |
| Specialist Care Office Visits | $50 Copayment | Not Covered |
| Other Services performed in the office - including Office Surgery, Diagnostic Services such as Laboratory and Pathology services | $150 Copayment | Not Covered |
| Other Services performed in the office - including Radiology services | $50 Copayment | Not Covered |
| Physician Services in a Facility (Hospital, Outpatient Surgery)<br>Limited to $500 per year | $150 Copayment,<br>then 0% Coinsurance | Not Covered |
| Physician Services in a Facility (Emergency Room)<br>Limited to $500 per year | $75 Copayment,<br>then 0% Coinsurance | Not Covered |
| Anesthesia Professional Services - Limited to $250 per year | $150 Copayment,<br>then 0% Coinsurance | Not Covered |
| Urgent Care | $75 Copayment | Not Covered |
| ***PREVENTIVE SERVICES*** | | |
| **Benefits For Children** | | |
| Covered Preventive Services for Children per PPACA | Covered in Full | Not Covered |
| Newborn Circumcision | Covered in Full | Not Covered |
| Well Child Care Office Visits<br>0 to 11 months (6 “well-baby visits”)<br>1 to 4 years (7 “well-child visits”)<br>5 to 17 years (1 per year, “well-child visit”) | Covered in Full | Not Covered |
| Well Child Care Immunizations (As recommended by Bright Futures Project) | Covered in Full | Not Covered |
| Well Child Care Lab Tests (As recommended by Bright Futures Project) | Covered in Full | Not Covered |

| *MEDICAL SERVICES* | Member Pays | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| ***PREVENTIVE SERVICES*** | | |
| **Adult Preventive Screening/Testing** | | |
| Covered Preventive Services for Adults (ages 18 and older) per PPACA | Covered in Full | Not Covered |
| Adults, one (1) physical exam per benefit year to obtain recommended preventive and diagnostic services | Covered in Full | Not Covered |
| Immunization Services for Adults<br>Immunizations - doses, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP) | Covered in Full | Not Covered |
| Prostate Specific Antigen (Men, one per CY, age ≥ 50) | Covered in Full | Not Covered |
| Screenings such as; Obesity, Blood Pressure, Cholesterol, Colorectal Cancer, HIV, Alcohol Misuse | Covered in Full | Not Covered |
| Counseling such as; Alcohol Misuse, Sexually Transmitted Infection (STI) Prevention, Nutritional Counseling, Tobacco Use | Covered in Full | Not Covered |
| **Benefits For Women** | | |
| 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) | Covered in Full | Not Covered |
| Well Woman exam per benefit year to obtain recommended preventive and diagnostic services (Subject to all limitations as described under Covered Medical Benefits) | Covered in Full | Not Covered |
| Screenings such as Pap Smears, Mammography, Domestic and interpersonal violence screening, Osteoporosis screening (Subject to all limitations as described under Covered Medical Benefits) | Covered in Full | Not Covered |
| Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements | Covered in Full | Not Covered |
| Services for Pregnant Women including but not limited to Anemia Screening, Rh Incompatibility Screening, Breastfeeding, Hepatitis B Screening.<br><br>Breastfeeding: Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. | Covered in Full | Not Covered |
| ***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<br>Limited to $500 per day benefit, limited to 30 days per year | $1,000 Copayment per admission, then 0% Coinsurance | Not Covered |
| Outpatient Surgery in a Hospital Limited to $2,000 per year | $500 Copayment, then 0% Coinsurance | Not Covered |
| Outpatient Surgery in an Ambulatory Surgical Center<br>Limited to $2,000 per year | $250 Copayment, then 0% Coinsurance | Not Covered |
| Emergency Room Services Limited to $1,500 per year | $250 Copayment, then 0% Coinsurance | Not Covered |
| ***DIAGNOSTIC SERVICES*** | | |
| **Laboratory Services** | | |
| Non-Hospital Based | $50 Copayment, | Not Covered |
| Hospital Based Limited to $750 per year | $250 Copayment, then 0% Coinsurance | Not Covered |

| *MEDICAL SERVICES* | Member Pays | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| ***DIAGNOSTIC SERVICES*** | | |
| **Radiology Services** | | |
| Non-Hospital Based | $50 Copayment | Not Covered |
| Hospital Based Limited to $750 per year | $250 Copayment, then 0% Coinsurance | Not Covered |
| **CT/MRI/MRA/PET Scan** | | |
| Non-Hospital Based Limited to $750 per year | $50 Copayment, then 0% Coinsurance | Not Covered |
| Hospital Based Limited to $750 per year | $250 Copayment, then 0% Coinsurance | Not Covered |
| **MENTAL HEALTH/BEHAVIORAL HEALTH/SUBSTANCE ABUSE DISORDER** | | |
| Inpatient | | |
| Hospital & Facility Services; semi-private room rate Limited to $500 per day benefit, limited to 30 days per year | $1,000 Copayment per admission, then 0% Coinsurance | Not Covered |
| Psychiatrist & Psychologist Services Limited to $500 per year | $150 Copayment, then 0% Coinsurance | Not Covered |
| Outpatient | | |
| Psychiatrist & Psychologist Services | $50 Copayment | Not Covered |
| ***OTHER SERVICES*** | | |
| Allergy Testing (including serums, injections, and administration) Limited to 6 visits per benefit year | $20 Copayment | Not Covered |
| Physical/Occupational/Speech/Cardiac/Pulmonary Therapies Limited to 26 visits per benefit year | $30 Copayment | Not Covered |
| Coinsurance amount is based on an approved negotiated rate for Participating Providers. | | |
| 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. | | |

| *PHARMACY PROVISIONS* | Member Pays | |
|---|---|---|
| | **In-Network Pharmacies** | **Out-of-Network Pharmacies** |
| Annual Pharmacy Deductible | None | Not Applicable |
| Annual Pharmacy Out of Pocket Maximum | None | Not Applicable |
| Lifetime Maximum | None | Not Applicable |
| ***PREVENTIVE PRESCRIPTION SERVICES*** | | |
| **Mandatory Generic Only - Preventive Prescription Services as defined by PPACA.**<br>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 – Covered in Full | Not Covered |
| ***NON-PREVENTIVE PRESCRIPTION SERVICES*** | | |
| Prescription Drugs - Pharmacy Retail - up to a 30-Day supply | $20 Copayment<br>(Generic only up to<br>$250 per prescription) | Not Covered |
| Prescription Drugs - Pharmacy Retail – 90-Day Supply | Not Covered | Not Covered |
| Prescription Drugs - Pharmacy Mail Order –30 or 90-Day Supply | Not Covered | Not Covered |
| Specialty Drugs | Not Covered | 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.**

All plans are administered by Verdegard Administrators, LLC, a licensed third-party administrator located at 8060 S. Kyrene Road, Suite #100, Tempe, AZ 85284. Products and services are not available in all states. All plans are self-funded, meaning that the employer group is responsible for funding the plan and claim costs up to applicable stop-loss limits.