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		
Preventive Care Office Visits	Covered in Full	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 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”)	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
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 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

MEDICAL SERVICES	Member Pays	
	In-Network	**Out-of-Network**
PREVENTIVE SERVICES		
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. 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
Coinsurance amount is based on an approved negotiated rate for Participating Providers.		
Benefits that are subject to the No Surprises Act will be reimbursed at the In-Network 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. 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	Not Covered	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.