

DESCRIPTION OF BENEFITS		APEX Plan
All plan benefits shown as a percentage of Eligible Charge.		
PLAN PROVISIONS		Participating Providers
		Member Pays
MEDICAL SERVICES		
Annual Medical Deductible		None
Annual Medical Out of Pocket Maximum		None
Services from Participating Providers		For Participating Providers, the contract generally prohibits the provider from charging more than the amounts established in their Participating Provider agreement for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.
Services from Non-Participating Providers		Services provided by Non-Participating Providers are not covered and will be denied as non-covered services. Member will be responsible for 100% of the costs of the services provided by Non-Participating Providers.
Lifetime Maximum		None
Dependent Coverage		To age 26
PHYSICIAN SERVICES	Do Services Require Prior Authorization?	Participating Providers
		Member Pays
Telemedicine Services	No	\$0 Copayment Limited to Specific Telemedicine Vendor
Primary Care Office Visits Limited to 1 visits per calendar year	No	\$0 Copayment/Visit
Primary Care Office Visits In excess of 1 visits per calendar year	No	Not Covered
Specialist Office Visits	No	Not Covered
Other Services performed in the office - Limited to Laboratory and Radiology services in the Physician Office	No	Not Covered
Urgent Care	No	Not Covered
PREVENTIVE CARE		
BENEFITS FOR CHILDREN		
Newborn Circumcision	No	No Copayment
Well Child Care Office Visits 7 visits Birth to 12 months 3 visits During age 1 2 visits During age 2 1 visit During age 3 through 21	No	No Copayment
Well Child Care Immunization (as recommended by Bright Futures Project)	No	No Copayment
Well Child Care Lab Tests (as recommended by Bright Futures Project)	No	No Copayment

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ADULT PREVENTIVE SCREENING/TESTING		
Adults, one (1) physical exam per benefit year to obtain recommended preventive and diagnostic services	No	No Copayment
Immunizations - doses, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP)	No	No Copayment
Prostate Specific Antigen (Men, one per CY, age ≥ 50)	No	No Copayment
Screenings such as; Obesity, Blood Pressure, Cholesterol, Colorectal Cancer, HIV, Alcohol Misuse	No	No Copayment
Counseling such as; Alcohol Misuse, Sexually Transmitted Infection (STI) Prevention, Nutritional Counseling, Tobacco Use	No	No Copayment
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	No Copayment
Well Woman exam per benefit year to obtain recommended preventive and diagnostic services (Subject to all Limitations as described under Covered Medical Benefits)	No	No Copayment
Screenings such as Pap Smears, Mammography, Domestic and interpersonal violence screening, Osteoporosis screening (Subject to all Limitations as described under Covered Medical Benefits)	No	No Copayment
Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements	No	No Copayment
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	No Copayment
HOSPITAL/FACILITY SERVICES		
Inpatient Room & Care – semi-private room rate; unlimited number of days (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute or Skilled Nursing Facility setting	No	Not Covered
Inpatient Room & Care (Mental/Behavioral Health/Substance Abuse) – semi-private room rate	No	Not Covered
Outpatient / Ambulatory Surgery Services & Birthing Centers	No	Not Covered
Other Outpatient Hospital Services (such as Cardiac, Pulmonary, PT/OT/ST)	No	Not Covered
Emergency Room Services	No	Not Covered

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DIAGNOSTIC SERVICES		
Laboratory Services	No	Not Covered
Radiology & Radiation Oncology Services	No	Not Covered
CT/MRI/MRA/PET Scan	No	Not Covered
MENTAL HEALTH/BEHAVIORAL HEALTH/SUBSTANCE ABUSE DISORDER		
INPATIENT		
Hospital & Facility Services; semi-private room rate	No	Not Covered
Psychiatrist & Psychologist Services	No	Not Covered
OUTPATIENT		
Psychiatrist & Psychologist Services	No	Not Covered
Psychological Testing	No	Not Covered
OTHER SERVICES		
Allergy Testing (including injections, serums, and administration)	No	Not Covered
Ground Ambulance	No	Not Covered
Air Ambulance	No	Not Covered
Chemotherapy	No	Not Covered
Dialysis and Supplies	No	Not Covered
Durable Medical Equipment (including Orthotics/Prosthetics)	No	Not Covered
Enteral Nutrition Therapy	No	Not Covered
Hearing Aids	No	Not Covered
Evaluations for the Use of Hearing Aids	No	Not Covered
Home Health Services	No	Not Covered
Home Infusion Services	No	Not Covered
Hospice Services	No	Not Covered
Human Growth Hormone, Genetic Testing/Counseling, Other	No	Not Covered
Physical/Occupational/Speech Therapy (Non Hospital Based)	No	Not Covered
ALTERNATIVE CARE SERVICES		
Acupuncture	No	Not Covered
Chiropractic Care	No	Not Covered
Naturopathy	No	Not Covered
Massage Therapy	No	Not Covered
Prior Authorization is required for certain services (noted above). Please refer to the Plan Document for Prior Authorization requirements.		

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PHARMACY PROVISIONS	Participating Pharmacies	
(Please refer to ID Card for Pharmacy Benefit Information)		
PHARMACY BENEFITS	Member Pays	
Preventive Prescription Services		
<u>Mandatory Generic Only - Preventive Prescription Services as defined by PPACA.</u>		
In order for preventive medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs. If a generic is available and you choose to receive the brand name drug you will pay the difference between the brand name drug and the generic drug. (This is referred to as the Dispense As Written Penalty.)		
Prescription Drugs Pharmacy Retail - up to a 31 day supply	Generic - \$0 Copayment	
Prescription Drugs Pharmacy Retail - 90 Day Supply	Generic - \$0 Copayment	
Specialty Drugs	Not Covered	
Non-Preventive Prescription Services		
Pharmacy Discount Drug Access	Discount Card up to 50% off of FDA Approved Medications	
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.		