DESCRIPTION OF BENEFITS		APEX BASIC HDHP HEALTH PLAN
All plan benefits shown as a percentage of Eligible Charge.		
PLAN PROVISIONS		**Member Pays** **Participating Providers** ***(No Out-of-Network benefits are available through this Plan)***
MEDICAL SERVICES		
Annual Medical Deductible		$3,000 Individual / $6,000 Family
Annual Medical Out of Pocket Maximum		$6,650 Individual / $13,300 Family
Amounts in Excess of Negotiated Rates/Reasonable and Allowed Charges		For Participating Providers, the contract generally prohibits the provider from charging more than the amounts estabished in their Participating Provider agreement for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.
Lifetime Maximum		None
Dependent Coverage		To age 26
COVERED SERVICES	**Do Services Require Prior Authorization?**	**Member Pays** **Participating Providers**
Telemedicine Services	No	$0 Copayment **Limited to Specific Telemedicine Vendor*
Physician Office Visit (Primary Care)	No	20% after Annual Deuductible
Laboratory Services	No	20% after Annual Deuductible
Urgent Care	No	20% after Annual Deuductible
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

DESCRIPTION OF BENEFITS		APEX BASIC HDHP HEALTH PLAN
All plan benefits shown as a percentage of Eligible Charge.		
PLAN PROVISIONS		**Member Pays** **Participating Providers** ***(No Out-of-Network benefits are available through this Plan)***
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
One (1) Well Woman exam per benefit year to obtain recommended preventive and diagnostic services	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

DESCRIPTION OF BENEFITS		APEX BASIC HDHP HEALTH PLAN
All plan benefits shown as a percentage of Eligible Charge.		
PLAN PROVISIONS		**Member Pays** **Participating Providers** ***(No Out-of-Network benefits are available through this Plan)***
DIAGNOSTIC SERVICES		
Radiology & Radiation Oncology Services	No	Not Covered
CT/MRI/MRA/PET Scan	No	Not Covered
NON-COVERED SERVICES		
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

DESCRIPTION OF BENEFITS		APEX BASIC HDHP HEALTH PLAN
All plan benefits shown as a percentage of Eligible Charge.		
PLAN PROVISIONS		**Member Pays** **Participating Providers** ***(No Out-of-Network benefits are available through this Plan)***
OTHER SERVICES		
Allergy Testing (including serums, injections, 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 (Limited to one (1) device per ear every five (5) years) Maximum of $1,500 per covered device	No	Not Covered
Evaluations for the Use of Hearing Aids	No	Not Covered
Home Health Services (Maximum of 120 visits per year)	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
Coinsurance amount is based on an approved negotiated rate for Participating Providers. Services provided by a Non-Participating Prover are not covered by this Plan.		
Prior Authorization is required for certain services (noted above). Please refer to the Plan Document for Prior Authorization requirements.		

DESCRIPTION OF BENEFITS		APEX BASIC HDHP HEALTH PLAN
All plan benefits shown as a percentage of Eligible Charge.		
PLAN PROVISIONS		**Member Pays** **Participating Providers** ***(No Out-of-Network benefits are available through this Plan)***
PHARMACY PROVISIONS ***(Please refer to ID Card for Pharmacy Benefit Information)***	**Participating Pharmacies**	
PHARMACY BENEFITS	**Member Pays**	
Annual Pharmacy Deductible	None	
Annual Pharmacy Out of Pocket Maximum	None	
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. 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.