DESCRIPTION OF BENEFITS		APEX Plus Advantage 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 estabished 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 3 Visits per calendar year**	No	$20 Copayment/Visit
Primary Care Office Visits **In excess of 3 Visits per calendar year**	No	Not Covered
Physician Office Visits (Specialist) **Limited to 3 Visits per calendar year**	No	$50 Copayment/Visit
Physician Office Visits (Specialist) **In excess of 3 Visits per calendar year**	No	Not Covered
Urgent Care **Limited to 3 Visits per calendar year**	No	$50 Copayment/Visit
Urgent Care **In excess of 3 Visits per calendar year**	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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PLAN PROVISIONS		**Participating Providers** **Member Pays**
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 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

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PLAN PROVISIONS		**Participating Providers** **Member Pays**
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
DIAGNOSTIC SERVICES		
Laboratory, Radiology **Limited to 5 services per calendar year**	No	$50 Copayment/Visit
Laboratory, Radiology **In excess of 5 services per calendar year**	No	Not Covered
Radiation Oncology Services	No	Not Covered
CT/MRI/MRA/PET Scan **Limited to 1 MRI, CT Scan per calendar**	Yes	$200 copayment/Visit
CT/MRI/MRA/PET Scan **In excess of 1 MRI, CT Scan per calendar**	No	Not Covered

DESCRIPTION OF BENEFITS		APEX Plus Advantage Plan
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PLAN PROVISIONS		**Participating Providers** **Member Pays**
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 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	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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PLAN PROVISIONS		**Participating Providers** **Member Pays**
PHARMACY PROVISIONS ***(Please refer to ID Card for Pharmacy Benefit Information)***		**Participating Pharmacies**
PHARMACY BENEFITS		**Member Pays**
Annual Deductible		$0 Per Person $0 Per Family
Annual Out of Pocket Maximum		$0 Per Person $0 Per Family
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		
All prescriptions will be dispensed as Generic unless otherwise prescribed by your Physician.		
Prescription Drugs Pharmacy Retail - up to a 31 day supply		Low Cost Generic - $1 Copayment Generic - 10% Coinsurance Preferred Brand - 20% Coinsurance Non-Preferred Brand - 40% Coinsurance
Prescription Drugs Pharmacy Retail - 90 Day Supply		Low Cost Generic - $1 Copayment Generic - 10% Coinsurance Preferred Brand - 20% Coinsurance Non-Preferred Brand - 40% Coinsurance
Prescription Drugs Pharmacy Mail Order - 90 Day Supply		Low Cost Generic - $1 Copayment Generic - 10% Coinsurance Preferred Brand - 20% Coinsurance Non-Preferred Brand - 40% Coinsurance
Specialty Drugs		Generic - 10% Coinsurance, plus amounts exceeding $150 Preferred Brand - 10% Coinsurance, plus amounts exceeding $150 Non-Preferred Brand - 20% Coinsurance, plus amounts exceeding $250

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.