

# APV Health Plan

## Benefits for 2018 - 2019

Plan Features	EPO Bronze Level 2	EPO Bronze Level 2, with H.S.A	PPO Bronze Level 1
<b>IN NETWORK</b>			
	<b>PHCS MultiPlan</b>	<b>PHCS MultiPlan</b>	<b>PHCS MultiPlan</b>
Deductibles (Indiv / Family)	\$5,000 / \$10,000	\$5,000 / \$10,000	\$2,000 / \$6,000
Preventive Care	No Charge	No Charge	No Charge
Primary Care Visit	\$60 After Deductible	\$60 After Deductible	\$25
Specialist Visit	\$60 After Deductible	\$60 After Deductible	\$25
Non Preventive Labs	30% After Deductible	30% After Deductible	30% After Deductible
Non Preventive X-Ray	30% After Deductible	30% After Deductible	30% After Deductible
Non Preventive Images	30% After Deductible	30% After Deductible	30% After Deductible
Outpatient Procedure	30% After Deductible	30% After Deductible	\$400 Copay per Visit after Deductible
Inpatient Visit	30% After Deductible	30% After Deductible	30% after deductible
Emergency Room	\$300 Copay per Visit After Deductible	\$300 Copay per Visit After Deductible	\$500 Copay per Visit after Deductible
Urgent Care	\$60 Copay per Visit After Deductible	\$60 Copay per Visit After Deductible	\$50 Copay per Visit
RX Deductible	None	None	Included with Medical Deductible
RX Out of Pocket (Indiv / Family)	None	None	Included with Medical Out of Pocket
Pharmacy / RX (30 Day Supply)	\$15 / \$50 / \$65	\$15 / \$50 / \$65	\$25 / \$50 / \$75
Pharmacy / RX (90 Day Supply)	\$30 / \$100 / \$130	\$30 / \$100 / \$130	\$50 / \$100 / \$150
Medical Out-of-Pocket Max (Indiv / Family)	\$6,250 / \$12,500	\$6,250 / \$12,500	\$6,600 / \$13,200
<b>OUT OF NETWORK</b>			
Deductibles (Indiv / Family)	Not Covered	Not Covered	\$4,000 / \$12,000
Preventive Care	Not Covered	Not Covered	50% After Deductible
Primary Care Visit	Not Covered	Not Covered	50% After Deductible
Specialist Visit	Not Covered	Not Covered	50% After Deductible
Non Preventive Labs	Not Covered	Not Covered	50% After Deductible
Non Preventive X-Ray	Not Covered	Not Covered	50% After Deductible
Non Preventive Images	Not Covered	Not Covered	50% After Deductible
Outpatient Procedure	Not Covered	Not Covered	\$400 Copay per Visit after Deductible
Inpatient Visit	Not Covered	Not Covered	50% After Deductible
Emergency Room	\$300 Copay per Visit After Deductible	\$300 Copay per Visit After Deductible	\$500 Copay per Visit after Deductible
Urgent Care	Not Covered	Not Covered	50% After Deductible
Medical Out-of-Pocket Max (Indiv / Family)	Not Covered	Not Covered	\$8,000 / \$24,000
<b>Plus fees that exceed the Allowed Amounts</b>			
<b>MONTHLY PRICING</b>			
Employee	\$345.40	\$341.00	\$390.50
Employee + Spouse	\$690.80	\$680.90	\$779.90
Employee + Child(ren)	\$639.10	\$630.30	\$721.60
Employee + Family	\$1,036.20	\$1,021.90	1169.30

\* Member may be responsible for any amount over the allowed amount

2018 - 2019 Benefits Open Enrollment

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# APV Health Plan

## Benefits for 2018 - 2019

Plan Features	PPO Gold	EPO 20	EPO 40
<b>IN NETWORK</b>			
	<b>PHCS MultiPlan</b>	<b>PHCS MultiPlan</b>	<b>PHCS MultiPlan</b>
Deductibles (Indiv / Family)	\$2,000 / \$6,000	None	None
Preventive Care	No Charge	No Charge	No Charge
Primary Care Visit	\$25	\$20	\$40
Specialist Visit	\$25	\$20	\$40
Non Preventive Labs	No Copay After Deductible	No Copay	\$50
Non Preventive X-Ray	No Copay After Deductible	No Copay	\$50
Non Preventive Images	No Copay After Deductible	No Copay	\$50
Outpatient Procedure	\$200 Copay per Visit after Deductible	\$20 per visit	\$250 per visit
Inpatient Visit	\$200 Copay per day, up to three days after deductible	No Charge	\$500 per visit
Emergency Room	\$200 Copay per Visit after Deductible	\$100 per visit	\$100 per visit
Urgent Care	\$35 Copay per Visit	\$20 per visit	\$40 per visit
RX Deductible	Included in Medical Deductible	Included with Medical Deductible	Included with Medical Deductible
RX Out of Pocket (Indiv / Family)	\$1,700 / \$1,700	Included with Medical Out of Pocket	Included with Medical Out of Pocket
Pharmacy / RX (30 Day Supply)	\$25 / \$40 / \$55	\$10 / \$25 / \$40	\$15 / \$35 / \$50
Pharmacy / RX (90 Day Supply)	\$50 / \$80 / \$110	\$20 / \$50 / \$80	\$30 / \$70 / \$100
Medical Out-of-Pocket Max (Indiv / Family)	\$4,000 / \$12,000	\$1,500 / \$3,000	\$3,000 / \$6,000
<b>OUT OF NETWORK</b>			
Deductibles (Indiv / Family)	\$4,000 / \$12,000	Not Covered	Not Covered
Preventive Care	50% After Deductible	Not Covered	Not Covered
Primary Care Visit	50% After Deductible	Not Covered	Not Covered
Specialist Visit	50% After Deductible	Not Covered	Not Covered
Non Preventive Labs	50% After Deductible	Not Covered	Not Covered
Non Preventive X-Ray	50% After Deductible	Not Covered	Not Covered
Non Preventive Images	50% After Deductible	Not Covered	Not Covered
Outpatient Procedure	\$200 Copay per Visit after Deductible	Not Covered	Not Covered
Inpatient Visit	\$200 Copay per day, up to three days after deductible	Not Covered	Not Covered
Emergency Room	\$200 Copay per Visit after Deductible	\$100 per visit	\$100 per visit
Urgent Care	50% After Deductible	Not Covered	Not Covered
Medical Out-of-Pocket Max (Indiv / Family)	\$8,000 / \$24,000	Not Covered	Not Covered
Plus fees that exceed the Allowed Amounts			
<b>MONTHLY PRICING</b>			
Employee	\$420.20	\$493.90	\$463.10
Employee + Spouse	\$838.20	\$986.70	\$925.10
Employee + Child(ren)	\$776.60	\$913.00	\$855.80
Employee + Family	\$1,258.40	\$1,480.60	\$1,388.20

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2018 - 2019 Benefits Open Enrollment

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# APV Health Plan

## Benefits for 2018 - 2019

Plan Features	PPO Gold HSA	PPO Premium	PPO Preferred
<b>IN NETWORK</b>			
	<b>PHCS MultiPlan</b>	<b>PHCS MultiPlan</b>	<b>PHCS MultiPlan</b>
Deductibles (Indiv / Family)	\$1,350 / \$2,700	\$500 / \$1,500	\$1,000 / \$3,000
Preventive Care	No Charge	No Charge	No Charge
Primary Care Visit	\$25 After Deductible	\$10	\$20
Specialist Visit	\$25 After Deductible	\$10	\$20
Non Preventive Labs	No Copay After Deductible	No Copay After Deductible	No Copay After Deductible
Non Preventive X-Ray	No Copay After Deductible	No Copay After Deductible	No Copay After Deductible
Non Preventive Images	No Copay After Deductible	No Copay After Deductible	No Copay After Deductible
Outpatient Procedure	\$200 per visit after deductible	\$100 Copay per Visit after Deductible	\$150 Copay per Visit After Deductible
Inpatient Visit	\$150 per day, up to three days after deductible	\$100 per day, up to three days after deductible	\$150 Copay per day, up to three days after deductible
Emergency Room	\$200 per visit after deductible	\$100 Copay per Visit after Deductible	\$150 Copay per Visit After Deductible
Urgent Care	\$35 per visit After Deductible	\$20 per Visit	\$30 per Visit
RX Deductible	Included with Medical Deductible	Included with Medical Deductible	Included with Medical Deductible
RX Out of Pocket (Indiv / Family)	Included with Medical Out of Pocket	\$5,850 / \$10,700	\$4,850 / \$7,700
Pharmacy / RX (30 Day Supply)	\$25 / \$40 / \$55 After Deductible	\$10 / \$20 / \$35	\$20 / \$30 / \$45
Pharmacy / RX (90 Day Supply)	\$50 / \$80 / \$110 After Deductible	\$20 / \$40 / \$70	\$40 / \$60 / \$90
Medical Out-of-Pocket Max (Indiv / Family)	\$3,000 / \$6,000	\$1,000 / \$3,000	\$2,000 / \$6,000
<b>OUT OF NETWORK</b>			
Deductibles (Indiv / Family)	\$5,000 / \$10,000	\$1,000 / \$3,000	\$2,000 / \$6,000
Preventive Care	50% After Deductible	30% After Deductible	40% After Deductible
Primary Care Visit	50% After Deductible	30% After Deductible	40% After Deductible
Specialist Visit	50% After Deductible	30% After Deductible	40% After Deductible
Non Preventive Labs	50% After Deductible	30% After Deductible	40% After Deductible
Non Preventive X-Ray	50% After Deductible	30% After Deductible	40% After Deductible
Non Preventive Images	50% After Deductible	30% After Deductible	40% After Deductible
Outpatient Procedure	\$200 per visit after deductible	\$100 Copay per Visit after Deductible	\$150 Copay per Visit After Deductible
Inpatient Visit	\$150 per day, up to three days after deductible	\$100 per day, up to three days after deductible	\$150 Copay per day, up to three days after deductible
Emergency Room	\$200 per visit after deductible	\$100 Copay per Visit after Deductible	\$150 Copay per Visit After Deductible
Urgent Care	50% After Deductible	30% After Deductible	40% After Deductible
Medical Out-of-Pocket Max (Indiv / Family)	\$5,000 / \$10,000	\$2,000 / \$6,000	\$4,000 / \$12,000
	Plus fees that exceed the Allowed Amounts	Plus fees that exceed the Allowed Amounts	Plus fees that exceed the Allowed Amounts
<b>MONTHLY PRICING</b>			
Employee	\$447.70	\$473.00	\$457.60
Employee + Spouse	\$895.40	\$944.90	\$915.20
Employee + Child(ren)	\$828.30	\$874.50	\$847.00
Employee + Family	\$1,343.10	\$1,417.90	\$1,372.80

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# APV Health Plan

## Benefits for 2018 - 2019

Plan Features	Silver Level 1 HSA
<b>IN NETWORK</b>	
Deductibles (Indiv / Family)	\$3,000 / \$6,000
Preventive Care	No Charge
Primary Care Visit	No Copay After Deductible
Specialist Visit	No Copay After Deductible
Non Preventive Labs	No Copay After Deductible
Non Preventive X-Ray	No Copay After Deductible
Non Preventive Images	No Copay After Deductible
Outpatient Procedure	No Copay After Deductible
Inpatient Visit	No Copay After Deductible
Emergency Room	\$100 After Deductible
Urgent Care	No Copay After Deductible
RX Deductible	Included with Medical Deductible
RX Out of Pocket (Indiv / Family)	\$3,650 / \$7,300
Pharmacy / RX (30 Day Supply)	\$25 / \$50 / \$75 After Deductible
Pharmacy / RX (90 Day Supply)	\$50 / \$100 / \$150 After Deductible
Medical Out-of-Pocket Max (Indiv / Family)	\$3,000 / \$6,000
<b>OUT OF NETWORK</b>	
Deductibles (Indiv / Family)	\$6,000 / \$12,000
Preventive Care	30% After Deductible
Primary Care Visit	30% After Deductible
Specialist Visit	30% After Deductible
Laboratory Services (Non Hospital Based)	30% After Deductible
Radiology (Non Hospital Based)	30% After Deductible
Complex Images	30% After Deductible
Outpatient Procedure	30% After Deductible
Inpatient Visit	30% After Deductible
Emergency Room	\$100 After Deductible
Urgent Care	No Charge After Deductible
Medical Out-of-Pocket Max (Indiv / Family)	\$12,000 / \$24,000
Plus fees that exceed the Allowed Amounts	
<b>MONTHLY PRICING</b>	
Employee	\$404.80
Employee + Spouse	\$809.60
Employee + Child(ren)	\$749.10
Employee + Family	\$1,214.40

\* Member may be responsible for any amount over the allowed amount

## Benefits for 2018 - 2019

### Medical

#### Key Terms to Remember



#### Annual Deductible

The amount you have to pay each plan year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).

#### Out-of-Pocket Maximum

This is the total amount you can pay out of pocket each calendar year before the plan pays 100 percent of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible\*, copays and coinsurance.

\*Except for Grandfathered medical plans

#### Copays and Coinsurance

These expenses are your share of cost paid for covered health care services. **Copays** are a fixed dollar amount, and are usually due at the time you receive care. **Coinsurance** is your share of the allowed amount charged for a service, and is generally billed to you after the health insurance company reconciles the bill with the provider.

#### Plan Types

EPO/PPO – A network of doctors, hospitals and other health care providers

HDHP – A plan that has higher annual deductibles in exchange for lower premiums. An HSA is a HDHP

## Benefits for 2018 - 2019

### Medical

### Wellness and Health Management



#### Which Preventive Care Services Are Covered?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (i.e. Health Care Reform) compliant insurance plans should cover at 100% for in-network providers. Below is a list of common services that are included in the plans offered this year:

- Routine Physical Exam
- Well Baby and Child Care
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence

*“An ounce of prevention is worth a pound of cure”*

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporating healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms and immunizations. Through the plans offered by APV health, all covered individuals and family members are **eligible to receive routine wellness services like these, at no cost; all copays, coinsurance, and deductibles are waived.**