Skyway's Suite of
Affordable Health Care Solutions

	Prime Plus	Prime Premier
Network: Skyway		
Network: Skyway		
Preventive Benefits – Covers all mandated Preventive benefits required by Patient Protection an Affordability Care Act (PPACA)		
Note: This list will be updated from time to time and a current list of covered preventive services is available by visiting: www.Healthcare.gov/center/regulations/prevention.html		
Medical Benefits - Must utilize Skyway participating provider or facility		
All 18 Preventive Services for Adults All 26 Preventive Services for Women All 27 Preventive Services for Children	100% Coverage for Mandated Preventive Care Services required by PPACA	100% Coverage for Mandated Preventive Care Services required by PPACA
Telemedicine: Health Wallet	$0 Copay Unlimited Use per Family Member	$0 Copay Unlimited Use per Family Member
Primary Care Office Visit, inclusive of Management Labs	$10 Copay (Max 3 visits per calendar year)	$10 Copay (Max 3 visits per calendar year)
Specialists Office Visit, inclusive of Management Labs	$50 Copay (Max 3 visits per calendar year)	$50 Copay (Max 3 visits per calendar year)
Express Cares	$50 Copay (Max 3 visits per calendar year)	$50 Copay (Max 3 visits per calendar year)
*Diagnostic X-Ray, Lab.	$50 Copay by Date of Service (Max 5 visits per calendar year)	$50 Copay by Date of Service (Max 5 visits per calendar year)
**CT Scan or MRI, inclusive of Enhanced Contrast services	$200 Copay (Max 1 CT Scan or MRI per Calendar Year)	$200 Copay (Max 1 CT Scan or MRI per Calendar Year)
***Hospital, Surgical, Ambulance, Emergency Room	Not Covered	**$0 Deductible 50% Coinsurance to $5,000, Maximum benefit $2,500.

NOTE: Skyway Plans are guaranteed issue, no underwriting, no pre-existing condition limitations

Labs ordered by Primary Care Physician and Specialists will count towards maximum of 5 visits per calendar year.

*****Prior Authorization required prior to MRI and CT Scans***

****** Pre-authorization required prior to admission for all inpatient, outpatient and surgical procedures.***

*****Exclusions for Hospital Benefit:***
Mental Health Services, Radiation Oncology and Chemotherapy. Please see Plan Document and SPD for full details

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Prescription Drug Benefits		
MetroHealth and Discount Drug Mart	MetroHealth	
Tier I – Low Cost Generics	$1 Copay	$1 Copay
Tier 2 - Generics	10% Coinsurance	10% Coinsurance
Tier 3- Preferred Brand	20% Coinsurance	20% Coinsurance
Tier 4 – Non-Preferred Brand	40% Coinsurance	40% Coinsurance
Tier 5 – Generic & Preferred Specialty	10% Coinsurance Plan pays 90% up to a maximum of $150 per Rx	10% Coinsurance Plan pays 90% up to a maximum of $150 per Rx
Tier 6 – Non-Preferred Specialty	20% Coinsurance Plan pays 80% up to a maximum of $250 per Rx	20% Coinsurance Plan pays 80% up to a maximum of $250 per Rx
Contribution Schedule (Rates)		
EE Only	$166.99	$259.76
EE Plus Child(ren)	$247.54	$435.73
EE Plus Spouse	$266.36	$435.73
EE Plus Family	$354.63	$513.85

Disclaimer: Apex Management Group Suite of Healthcare Solutions are not insurance products, but self-funded plans

To learn more, call 814-737-9052 or visit skyway.healthcare/prime