Decision briefs by role

Employees, HR, CFOs, CEOs — what Apiary means for each, and how the parts work.

FOR YOU AND YOUR FAMILY

Employee decision brief

Apiary puts your primary care, specialists, prescriptions, and hospital coverage in one plan instead of a stack of separate cards. Everyday care runs through Apiary Care — in person and virtual — and on the copay plans, eligible Tier 1 everyday visits are $0.

HOW THE RELEVANT PARTS WORK

Where you start for care. Apiary Care is your front door for everyday needs. On copay plans, eligible Tier 1 everyday care is $0; you can still go straight to a specialist once you confirm their tier.

How the two tiers work. Tier 1 is Logro + Apiary Care at the lowest cost share. Tier 2 is PHCS, a national network for care outside Tier 1. Care outside both tiers isn't covered except a true emergency, which is always covered.

What you'll actually pay. On a copay plan, everyday Tier 1 care is $0 with set copays elsewhere. On an HSA plan, you pay negotiated rates until the deductible, then the plan pays its share — and your employer seeds an HSA you own.

A SCENARIO

“I already see a specialist I trust.”

You may be able to keep them — the check is specific, not the name on the card. Confirm the physician participates, the facility participates, and which tier they fall under. If they're outside both tiers, ask how ongoing treatment and authorizations transfer before you decide.

QUESTIONS TO BRING

- [ ] Does my physician and their facility participate, and in which tier?
- [ ] What will my prescriptions cost under the plan's formulary?
- [ ] Is my plan a copay plan or an HSA plan — and what changes before the deductible?
- [ ] Who do I call for a bill, a benefit question, or help with ongoing care?

DOCUMENTS TO REQUEST

- [ ] Your provider and facility participation results
- [ ] A prescription and formulary check for your medications
- [ ] The selected plan's benefit summary and member materials
- [ ] Member support, urgent-care, and emergency instructions

Next step: before enrollment, check the providers and medications that matter to you against the proposed plan, and note which tier each falls under.

FOR THE PEOPLE WHO MAKE BENEFITS WORK

HR & benefits decision brief

Apiary replaces a stack of disconnected vendors with one plan — medical, pharmacy, primary care, and ancillary benefits administered together — which means fewer handoffs for your team. What makes or breaks a change is provider continuity, enrollment, communications, and clear ownership of support.

HOW THE RELEVANT PARTS WORK

Disruption you can see in advance. Before anyone enrolls, Apiary runs a provider- and prescription-disruption review against your census, so you know who faces a change and can handle anyone in active treatment through a transition process.

A rollout with named owners. Enrollment, eligibility files, payroll coordination, ID materials, and communications are sequenced on a calendar agreed for your group, each with a named owner so nothing falls between desks.

Support that doesn't land back on HR. Member questions route to the plan's member support and Apiary Care, not your inbox. The escalation path and issue ownership are documented before launch, with the ongoing review cadence.

A SCENARIO

“We can't run another benefits fire drill.”

The implementation plan is built before you commit. You get the milestone calendar, the files required at each step, the employee messages, and the escalation owners in writing up front — and employees in active treatment are handled through the transition process, not surprised mid-care.

QUESTIONS TO BRING

- [ ] Which employees would see a provider or prescription change, and how is active treatment handled?
- [ ] Who owns enrollment, eligibility files, payroll coordination, and ID materials?
- [ ] What member support reaches employees directly, and what stays with HR?
- [ ] How are unresolved issues escalated, tracked, and reported back?

DOCUMENTS TO REQUEST

- [ ] A provider and prescription disruption review on your census
- [ ] An implementation calendar with named owners
- [ ] Employee communication and enrollment materials
- [ ] A support-responsibility and escalation matrix

Next step: assess the impact — review providers, prescriptions, active care, eligibility, and the benefit differences employees will notice.

FOR THE PEOPLE ACCOUNTABLE FOR THE NUMBERS

CFO & finance decision brief

Apiary is self-funded (level-funded): you fund a claims budget, a fixed administration fee, and stop-loss protection, instead of a carrier's bundled premium. The upside is visibility and the return of eligible unused claims funding when the year runs well; the obligation is real claims risk, bounded by stop-loss.

HOW THE RELEVANT PARTS WORK

What your dollars fund. A level-funded arrangement splits into three visible parts: claims funding (the budget for covered claims), administration (a fixed fee), and stop-loss (insurance that caps exposure). Unlike a premium, each part is itemized and reconcilable.

Where the risk is, and where it stops. The plan pays claims up to the funded level; stop-loss reimburses above it. Specific stop-loss caps any one member; aggregate caps the group. The limits are the attachment points, timing, and exclusions in the actual contract — the monthly figure isn't a maximum on its own.

A renewal comparison that's fair. On matched enrollment, contribution split, and benefits, a level-funded plan can return eligible surplus — what's left after claims, administration, and stop-loss — when claims run under budget, on the contract's terms, with reporting through the year.

A SCENARIO

“What if claims come in high?”

Your downside is bounded, but by the contract, not the monthly payment. Model a high-claims year against the actual specific and aggregate stop-loss terms. The claims target and the attachment point are not automatically the same number — confirm both before treating the monthly figure as a ceiling.

QUESTIONS TO BRING

- [ ] What is our annual employer cost on a comparable contribution basis?
- [ ] How do the economics change in a low-, expected-, and high-claims year?
- [ ] When is eligible surplus returned, and under what conditions?
- [ ] What reporting and reconciliation will we receive through the year?

DOCUMENTS TO REQUEST

- [ ] An itemized employer funding and fee schedule
- [ ] The specific and aggregate stop-loss terms
- [ ] A comparison on matched benefits and contribution assumptions
- [ ] A reporting sample, reconciliation rules, and renewal methodology

Next step: normalize the comparison — hold employee count, enrollment mix, contribution basis, and benefits constant across both options.

FOR THE PEOPLE SETTING THE DIRECTION

CEO & owner decision brief

Most companies don't have a benefits plan; they have a stack of vendors nobody designed, re-priced every renewal. Apiary is the opposite bet: one plan built so everyday care is easy to use, funded so a healthier team lowers cost instead of a carrier's margin.

HOW THE RELEVANT PARTS WORK

The reason to look. Re-shopping the same fragmented model just re-prices it. The structural change is bundling medical, pharmacy, primary care, and ancillary benefits into one self-funded plan, so spend becomes visible and a healthier team's savings come back to the company.

Value your people will feel. A $0 front door for everyday care through Apiary Care means people use the plan for small things before they become big ones — weighed honestly against any provider disruption, which is reviewed before you commit.

Accountability you can name. A credible proposal names the organizations behind the plan — administrator, stop-loss carrier, care, pharmacy, and your broker — and what each owns, plus a transition plan. If the fit isn't right, that's a legitimate answer, and you'll hear it.

A SCENARIO

“Why take on the work of changing?”

Because the alternative is paying more each year for a plan your people underuse. A change earns its place only when the comparison is compelling and the transition is credible — so set the business objective first, then require evidence on cost, employee impact, risk, and execution. If the evidence isn't there, staying is the right call.

QUESTIONS TO BRING

- [ ] What business problem does this change actually solve for us?
- [ ] What improves for employees, and what tradeoffs come with it?
- [ ] Who stands behind the plan, and who is accountable for each part?
- [ ] What evidence would justify the move — and what would tell us to stay?

DOCUMENTS TO REQUEST

- [ ] An executive comparison of cost, care, risk, and transition
- [ ] Defined roles for the administrator, stop-loss carrier, care, and service teams
- [ ] A provider and employee-impact review on your group
- [ ] Documented decision criteria and implementation readiness

Next step: set the objective — name what has to improve (spend visibility, affordability, care access, or service) — then review the whole case with finance, HR, and your broker.