

Trinity Health Home Office BENEFIT SUMMARY

**Unless otherwise noted, all services must be provided, authorized or referred by the Member's Primary Care Physician.
Policy maximum is \$2,000,000 per covered person.**

PHYSICIAN OFFICE SERVICES	MEMBER COPAY
Primary Care Physician Office Visit	\$15 Copay per PCP visit
Specialty & Referral Physician Office Visit	\$20 Copay per SCP visit
<ul style="list-style-type: none"> Office visits, services & supplies for the determination and/or treatment of illness or prevention of same Periodic health evaluations (physical examinations for the prevention and detection of disease) limited to the extent Medically Necessary or appropriate Immunizations & inoculations (vaccine & administration of vaccine) Allergy Testing Diabetes self-management training 	

INPATIENT HOSPITAL SERVICES	MEMBER COPAY
Semi-Private room and board, Private room if medically necessary (Limited to two copays per member per calendar year) Services include:	\$500 Copay per admission (waived if re-admitted within 24 hours of discharge)
<ul style="list-style-type: none"> Operating, recovery room and other special units including intensive care Maternity care Hospital, ancillary services including lab, x-ray, EKG and other diagnostic services Anesthesia, physical therapy and medications Administration of blood and blood plasma Physician and Specialist services 	

OTHER SERVICES	MEMBER COPAY
Allergy Serum	50% Coinsurance
Biotech Drugs	\$125 Copay/30-days
Diabetes Supplies	50% Coinsurance
Home Health Services	\$0 Copay
Hospice	\$0 Copay
Maternity Care -prenatal visits, delivery and one postnatal visit per pregnancy term	\$150 Copay for PCP \$200 Copay for SCP
Non-surgical Treatment of Morbid Obesity: (in-network physician supervised weight loss treatment program)	Enrollment fees in excess of \$50 and \$20 Copay per visit. Maximum 6 visits per calendar year
Pervasive Development Disorder (PDD)	\$20 Copay
DME, Artificial Aids, & Corrective Appliances	50% Coinsurance
Short-term Therapies: Cardiac Rehabilitation, Physical, Speech, Occupational Therapy, Pulmonary Rehabilitation (Limited to a combined 60 visits per each distinct condition or episode or as authorized through a medical management regimen)	\$20 Copay per visit
Skilled Nursing Facility: (Limited to 100 days per Medicare guidelines)	\$0 Copay

OUTPATIENT SURGERY SERVICES	MEMBER COPAY
Outpatient surgical services (Includes professional services & any related lab & x-ray services, including those diagnostic invasive procedures that may or may not require anesthesia)	\$200 Copay per visit

OUTPATIENT SERVICES	MEMBER COPAY
Outpatient services (Including but not limited to: laboratory, pathology, radiology, electrocardiology (EKG) & electroencephalography (EEG))	\$0 Copay
MRI, CT, MRA, & PET scan	\$0 Copay

EMERGENCY SERVICES	MEMBER COPAY
Emergency Room	\$75 Copay per visit (Copay waived if admitted)
Emergency Ambulance Services	20% Coinsurance
Urgent Care Services	\$25 Copay per visit

PRESCRIPTION BENEFITS	MEMBER COPAY
Prescription Drugs:	Retail Mail-Order
Generic – Formulary *	\$15 Copay \$30 Copay
Brand Name – Formulary *	\$30 Copay \$60 Copay
Non-Formulary *	\$60 Copay \$120 Copay
Retail limited to 30-day supply;	
Mail-order limited to 90-day supply;	
Step Therapy Program;	
*Mandatory formulary generic when available or member pays difference.	

OPTIONAL BENEFITS	MEMBER COPAY
Mental Health Inpatient Services (limited to two copays per calendar year)	\$500 Copay per admission
Mental Health Outpatient Services	\$20 Copay per visit
Substance Abuse Inpatient Services (Detoxification: two admissions per lifetime)	\$500 Copay up to 14 days per benefit year
Substance Abuse Outpatient Services (No limits if substance abuse treatment is part of mental health treatment)	50% Coinsurance up to 20 visits per benefit year

OPTIONAL BENEFITS	MEMBER COPAY
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Vision Services: Routine Annual Eye Exam (Discount on frames and eyeglass lenses when purchased at Participating Providers)	\$15 Copay per exam

EXCLUSIONS

- Services and supplies that are not performed, arranged, authorized, or approved in advance by the Member's PCP, except in an emergency situation
- Services and supplies that are not medically necessary
- Items or devices primarily used for comfort, such as television and telephone while in a hospital
- Non-skilled care, rest cures, respite care, convalescent care or domiciliary care
- Physical exams and related expenses when provided for employment, school, travel, immigration, or insurance purposes
- Orthodontia and other dental services except as expressly stated in the Certificate of Coverage
- Cosmetic or reconstructive procedures and any related services or supplies unless deemed medically necessary
- Except for physician-supervised weight loss treatment programs authorized by ADVANTAGE, services, drugs and supplies for weight loss, diet, health or exercise programs, health club dues, or weight reduction clinics. However, Member is entitled to access ADVANTAGE's discount for such drugs through a Participating Pharmacy
- All treatment, procedures, facilities, equipment, drugs, devices, services or supplies that are considered to be investigational/experimental
- Voluntary termination of pregnancy, except when the life of the mother would be endangered if the fetus were carried to term
- Treatment of infertility, including drugs
- Hearing aids
- Growth Hormones
- Over-the-counter drugs
- Birth control drugs or devices that do not require a prescription
- Other exclusions as described in the Certificate of Coverage.

LIMITATIONS

- Short-term therapies are limited to conditions the physician feels are subject to continuing improvement with treatment over a two-month period.
- Members must use the Plan's participating providers. These providers are subject to change from time to time.
- Members must live or work within the Plan's service area to remain covered by the Plan.
- Members must select a PCP within a 30-mile radius of their residence or place of work
- Mandatory Generic Substitution is required for all prescription drugs. When the Member or the Member's physician requests a Brand Name prescription drug and a Generic equivalent is available, the Member will pay his/her applicable Copayment plus the cost difference between the Generic and the Brand Name Drug.

COPAYMENTS

- Copayments must be paid at the time services are rendered.

ETHICAL AND RELIGIOUS DIRECTIVES

ADVANTAGE is an institution operated in accordance with The Ethical and Religious Directives for Catholic Health Care Services, as approved by the National Conference of Catholic Bishops. ADVANTAGE shall not be required to provide services that are inconsistent with the medical ethics of the Catholic Church.

**If you have any questions please contact ADVANTAGE Health Solutions, Inc. at:
P.O. Box 80069
Indianapolis, Indiana 46280
(317) 573-6228 or (800) 553-8933, 7:30 a.m. – 5:30 p.m. (Monday-Friday)
TDD: 800-743-3333 (hearing impaired)**

VISIT OUR WEBSITE AT
www.advantageplan.com

THIS SUMMARY IS A GENERAL OUTLINE OF COVERED BENEFITS UNDER YOUR PLAN AND DOES NOT INCLUDE ALL THE BENEFITS, LIMITATIONS AND EXCLUSIONS OF THE POLICY. PLEASE SEE THE GROUP POLICY AND/OR CERTIFICATE OF COVERAGE FOR SPECIFIC DETAILS.