



HMO H BENEFITS-AT-A GLANCE	COPAY/COINSURANCE	
Individual Deductible (Calendar year)	None	
Family Deductible (Calendar year)	None	
Individual Out-of-Pocket Maximum (OOPM) (Including deductible)	None	
Family Out-of-Pocket Maximum (OOPM) (Including deductible)	None	
Policy Maximum (Per Individual)	\$2,000,000	
Primary Care Physician Office Visit	\$15 Copay	
Specialty Care Physician Office Visit	\$20 Copay	
Physician Services for Wellness & Preventive Services	No Additional Charge after Physician Office Copay	
<i>Routine annual physician exams, routine blood cholesterol screening, colorectal cancer screening, routine gynecological services, routine mammographies, routine Prostate Specific Antigen (PSA), routine immunizations, hearing tests and vision screening in Physician's office.</i>		
Emergency Room	\$75 Copay	
Emergency Ambulance	20%	
Urgent Care Center	\$25 Copay	
Inpatient Hospital (Semi-private room and board)	\$500 Copay (waived if readmitted within 24 hours)	
<i>Private room if medically necessary, operating, recovery rooms and other special units including intensive care, maternity care, hospital ancillary services including laboratory, x-ray, EKG and other diagnostic services, other services including anesthesia, physical therapy, medications, administration of blood and blood plasma, and physician and specialty services.</i>		
Outpatient Surgery Services & Invasive Diagnostic Procedures	\$200 Copay	
Labs, pathology, radiology, (EKG) and (EEG)	\$0 Copay	
MRI, CT, MRA and PET scan	\$0 Copay	
Allergy Serum	50%	
Dialysis	\$0 Copay	
DME & Corrective Appliances	50%	
Home Health Services	\$0 Copay	
Infertility Diagnostic Testing up to diagnosis	\$20 Copay	
Injections (Therapeutic and Infusion Therapy)	\$0 Copay	
Maternity Care PCP/SCP (Physician obstetrical services only)	\$150 Copay PCP/\$200 Copay SCP	
Non-Surgical Treatment of Morbid Obesity (Maximum of 6 visits per calendar year)	Enrollment fees in excess of \$50 after \$20 copay per visit	
Physician Non-Office Visits (Hospital & Home Visits)	\$0 Copay (Hospital)/\$25 Copay (Home)	
Skilled Nursing Facility (Limited to 100 days per Medicare guidelines)	\$0 Copay	
Short-term Therapies: Physical, Speech, Occupational Therapy, Cardiac, Pulmonary Rehabilitation (Limited to a combined 60 visits per each distinct condition or episode or as authorized through the medical management regiment)	\$20 Copay	
Vision Services: Routine annual eye exam and discount frames & eyeglasses when purchased at participating VSP providers.	\$15 Copay	
Mental Health Inpatient	\$500 Copay	
Mental Health Outpatient	\$20 Copay	
Substance Abuse Inpatient	\$500 Copay	
Substance Abuse Outpatient	\$20 Copay	
Pervasive Developmental Disorder (PDD)	Included on the office visit copay	
Prescription Drug Coverage:	Retail	Mail-Order
• OTC with Prescription (Prilosec, Claritin, Zyrtec)	\$5 Copay	\$10 Copay
• Generic-Preferred	\$10 Copay	\$25 Copay
• Brand Name-Preferred	20% (\$20 min/\$70 max)	20% (\$50 min/\$175 max)
• Brand Name Non-Preferred	40% (\$40 min/\$90 max)	40% (\$100 min/\$225 max)
<ol style="list-style-type: none"> Mandatory formulary generic when available or member pays higher copayment plus difference between the brand name and the generic. The copay that you pay is per prescription dispensed up to a 30-day supply for retail and up to a 90-day supply for mail order. Step Therapy Program. 		
Biopharmaceutical Drugs (\$2,500 maximum out of pocket per member per calendar year PLUS applicable office visit copay)	20%	
Diabetic Supplies (Includes glucometer, lancets & test strips)	Included in rx copays	

Non-Covered Services

- Services and supplies that are not performed, arranged, authorized, or approved in advance by the Member's PCP, except in an emergency situation as stated in your Certificate of Coverage
- Services and supplies that are not medically necessary
- Items or devices primarily used for comfort
- Non-skilled care, rest cures, respite care, convalescent care or domiciliary care, regardless of the setting
- Physical exams and related expenses when provided for employment, school, travel, immigration, or insurance purposes (related x-rays and lab expenses)
- Orthodontia and other dental services except as expressly stated in the Certificate of Coverage
- Eyeglass lenses unless medically necessary following cataract surgery; refractive surgery performed to treat myopia or hyperopia; refractions
- 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 temporomandibular joint (TMJ) disorder
- Treatment of infertility, including drugs
- Hearing aids
- Growth Hormones
- Over-the-counter drugs
- Birth control drugs or devices that do not require a prescription
- Surgical treatment of Morbid Obesity
- 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.

If you have any questions please contact:

**Advantage Health Solutions, Inc.
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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 NON-COVERED SERVICES OF THE CERTIFICATE OF COVERAGE. PLEASE SEE THE CERTIFICATE OF COVERAGE FOR SPECIFIC DETAILS. YOU MAY REQUEST A COPY OF THE CERTIFICATE OF COVERAGE BY CALLING (317) 573-6228 or (800) 553-8933