Hamilton County Chambers of Commerce
HDHP 3 BENEFITS-AT-A GLANCE

Policy maximum is $1,000,000 per covered person.
BENEFITS are subject to a $3,000 Single deductible / $6,000 Family deductible, with the exception of Wellness& Preventive services/visits which have a $15 copay ony and Vision services. After the deductible, the benefits are payable at 80% of allowable charges (unless otherwise stated). The Single out-of-pocket maximum (including deductible) is $4,000 per calendar year. The Family out-of pocket maximum (including deductible) is $8,000 per calendar year.

PHYSICIAN SERVICES	COPAY/COINS.
Office Visits for Illness or Injuries	
· Primary Care Physician Office Visit	**20% Coinsurance**
· Specialty & referral Physician Office Visit	**20% Coinsurance**
Non-Office Visits	
· Physician visits in the hospital	**20% Coinsurance**
· Physician visits in the home	**20% Coinsurance**
The following services have a copayment/ coinsurance based upon location of service: · Professional services related to a surgical procedure · Physician services for visit examinations when confinement in a Hospital or Skilled Nursing Facility · Radiology, laboratory, EKG, EEG, and sigmoidscopy	
Physician Services for Wellness & Preventive · Routine Annual Physical Exam · Routine Blood Cholesterol Screening · Colorectal Cancer Screening · Routine Gynecological Services · Routine Mammographies · Routine Prostate Specific Antigen (PSA) · Routine Immunizations · Hearing Tests · Vision Screening in Physician's Office	**$15 Copay per PCP visit**

OTHER SERVICES	COPAY/COINS.
Allergy Serum	**20% Coinsurance**
Dialysis	**20% Coinsurance**
Family Planning Services to include sterilization and contraceptive devices.	**20% Coinsurance up to $2,500 lifetime max.**
Home Health Services	**20% Coinsurance**
Infertility Diagnostic Testing	**20% Coinsurance**
Injections (Therapeutic) and Infusion Therapy	**20% Coinsurance**
Maternity Care - Professional obstetrical care, including prenatal visits, antepartum care, and one postpartum visit per pregnancy term regardless of date of conception. Including physician services, laboratory and x-ray services as medically necessary and appropriate. **Note:** Inpatient hospital admissions related to pregnancy and/or birth are covered as any other inpatient hospital facility admission.	**20% Coinsurance**
Non-surgical Treatment of Morbid Obesity (In-network physician supervised weight loss treatment program) Max of 6 visits per calendar year.	**20% Coinsurance**
DME, Artificial Aids, & Corrective Appliances	**20% 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% Coinsurance**
Skilled Nursing Facility: (Limited to 100 days per Medicare guidelines)	**20% Coinsurance**

OTHER SERVICES CONT.	COPAY/COINS.
Vision Services: Routine Annual Eye Exam (Discount on frames and eyeglass lenses when purchased through participating VSP providers)	**$10 Copay per exam**

BEHAVIORAL HEALTH SERVICES	COPAY/COINS.
Mental Health Inpatient Services	**20% Coinsurance**
Mental Health Outpatient Services	**20% Coinsurance**
Substance Abuse Inpatient Services (Detoxification: two admissions per lifetime)	**20% Coinsurance up to 14 days per calendar year**
Substance Abuse Outpatient Services (No limits if substance abuse treatment is part of mental health treatment)	**20% Coinsurance up to 20 visits per calendar year**
Pervasive Developmental Disorder (PDD)	**20% Coinsurance**

INPATIENT HOSPITAL SERVICES	COPAY/COINS.
Semi-Private room and board, **Private room if medically necessary** Services include: · 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	**20% Coinsurance**

OUTPATIENT SURGERY SERVICES	COPAY/COINS.
Outpatient surgical services (Outpatient surgery facility services including those diagnostic invasive procedures that may or may not require anesthesia.)	**20% Coinsurance**

OUTPATIENT SERVICES	COPAY/COINS.
Outpatient services {Including but not limited to: laboratory, pathology, radiology, electrocardiology (EKG) & electroencephalography (EEG)}	**20% Coinsurance**
MRI, CT, MRA, PET & SPECT scan	**20% Coinsurance**

EMERGENCY SERVICES	COPAY/COINS.
Emergency Room	**20% Coinsurance**
Emergency Ambulance Services	**20% Coinsurance**
Urgent Care Facility Services	**20% Coinsurance**

PRESCRIPTION BENEFITS	COPAY/COINS.
Retail	**20% Coinsurance**
Mail-Order	**20% Coinsurance**

1) Mandatory generic when available or member pays coinsurance plus the
2) The coinsurance that you will pay is per prescription dispensed up to a 30-day supply for retail and up to a 90-day supply for mail-order
3) Step Therapy Program

Biopharmaceutical Drugs	**20% Coinsurance**

Diabetes Supplies
(Includes glucometer, lancets, and test strips) Covered under prescription benefits and applicable coinsurance

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
- 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. at:
P.O. Box 80069
Indianapolis, IN 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 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.