



HDHP 6 BENEFITS-AT-A GLANCE	COPAY/COINSURANCE	
Individual Deductible (Calendar year)	\$2,600	
Family Deductible (Calendar year)	\$5,200	
<i>Family coverage requires the family deductible to be met before copayment applies.</i>		
Individual Out-of-Pocket Maximum (OOPM) (Including deductible)	\$2,600	
Family Out-of-Pocket Maximum (OOPM) (Including deductible)	\$5,200	
<i>Family coverage requires the family Out-of-pocket Maximum to be met before copayments or 100% coinsurance applies.</i>		
Annual Maximum for Essential Benefits (Per Individual)	\$1,250,000	
Primary Care Physician Office Visit	\$15 Copay; after deductible	
Specialty Care Physician Office Visit	\$30 Copay; after deductible	
Wellness & Preventive Services	\$0 Copay*	
<i>Physician Services for wellness and preventative services will be covered as regulated by the Patient Protection and Affordable Care Act (PPACA).</i>		
Emergency Room	\$100 Copay; after deductible	
Emergency Ambulance	0%; after deductible	
Urgent Care Center	\$50 Copay; after deductible	
Inpatient Hospital (Semi-private room and board. Limited to 2 copays per member per calendar year)	\$250 Copay (waived if readmitted within 24 hours); after deductible	
<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	\$100 Copay; after deductible	
Colonoscopy (Diagnostic)	0%; after deductible	
Labs, pathology, radiology, (EKG) and (EEG)	0%; after deductible	
MRI, CT, MRA, PET and SPECT scan	0%; after deductible	
Allergy Serum	0%; after deductible	
Dialysis	0%; after deductible	
DME & Corrective Appliances	0%; after deductible	
Family Planning Services: (\$2,500 lifetime maximum)	0%; after deductible	
Home Health Services	0%; after deductible	
Infertility Diagnostic Testing up to diagnosis	0%; after deductible	
Injections (Therapeutic and Infusion Therapy)	0%; after deductible	
Maternity Care PCP/SCP (Physician routine obstetrical services only)	0%; after deductible	
Non-Surgical Treatment of Morbid Obesity (Maximum of 6 visits per calendar year)	0%; after deductible	
Physician Non-Office Visits (Hospital & Home Visits)	0%; after deductible	
Skilled Nursing Facility (Limited to 100 days per Medicare guidelines)	0%; after deductible	
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)	0%; after deductible	
Vision Services: Routine annual eye exam and discount frames & eyeglasses when purchased at participating VSP providers.	\$10 Copay*	
Mental Health Inpatient	0%; after deductible	
Mental Health Outpatient	0%; after deductible	
Substance Abuse Inpatient (Up to maximum of 14 days per calendar year; detoxification: two admissions per lifetime)	0%; after deductible	
Substance Abuse Outpatient (Up to maximum of 20 days per calendar year; No limits if part of Mental Health treatment)	0%; after deductible	
Pervasive Developmental Disorder (PDD)	0%; after deductible	
Prescription Drug Coverage After Deductible is Met:	Retail	Mail-Order
• Generic-Preferred	\$10 Copay; after deductible	\$20 Copay; after deductible
• Brand Name-Preferred	\$25 Copay; after deductible	\$50 Copay; after deductible
• Brand Name Non-Preferred	\$50 Copay; after deductible	\$100 Copay; after deductible
<ol style="list-style-type: none"> 1. Mandatory formulary generic when available or member pays higher copayment plus difference between the brand name and the generic. 2. 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. 3. Step Therapy Program. 		
Specialty Pharmaceuticals	\$50 Copay; after deductible	
Diabetic Supplies (Includes glucometer, lancets & test strips)	Included in rx copays; after deductible	

* Not subject to deductible

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 specifically stated in the Certificate of Coverage and/or Member Reference Guide;
- Services and supplies that are not medically necessary;
- Items or devices primarily used for comfort, including, but not limited to air purifiers, humidifiers, dehumidifiers, whirlpools, air conditioning, waterbeds, exercise equipment, and ultraviolet lighting;
- Non-skilled care, rest cures, respite care, or domiciliary care, regardless of the setting;
- Physical exams and related x-ray and lab expenses, when provided for employment, school, sports' programs, travel, immigration, administrative purposes, or insurance purposes;
- 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;
- Cosmetic or reconstructive procedures, and any related services or supplies, which alter appearance, but do not restore or improve impaired physical function (except for services covered in accordance with the Women's Health and Cancer Act of 1998 and services covered for newborns as outlined in Indiana Code 27-8-5.6-2;); wigs;
- Except for physician-supervised programs referred by your physician and authorized by ADVANTAGE, services, drugs, and supplies for weight loss, diet, health or exercise programs, health clubs dues, or weight reduction clinics. However, you are 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 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, except when due to congenital abnormality, Hearing therapy, or cochlear implants and their fitting
- Growth Hormones and related products;
- Over-the-counter drugs, except those listed within your ADVANTAGE Prescription Formularies;
- Birth control drugs, supplies, or devices; however, you are entitled to access ADVANTAGE's discount for such drugs through a contracting pharmacy;
- Surgical treatment for 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/Coinsurance plus the cost difference between the Generic and the Brand Name Drug.

Patient Protection Disclosure

- ADVANTAGE Health Solutions, Inc. generally requires the designation of a primary care provider upon enrollment. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. You may designate a participating pediatrician for your dependent child. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Member Services at 1-800-553-8933 or log on to www.advantageplan.com.
- You do not need prior authorization from ADVANTAGE Health Solutions, Inc. or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your selected network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Member Services at 1-800-553-8933 or log on to www.advantageplan.com.

**If you have any questions please contact:
ADVANTAGE Health Solutions, Inc.
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