



N POS BENEFITS-AT-A GLANCE	Level 1	Level 2 (POS)
Individual Deductible (Calendar year)	\$250	\$1,000
Family Deductible (Calendar year)	\$750	\$3,000
Individual Out-of-Pocket Maximum (OOPM) (Including deductible)	\$1,250	None
Family Out-of-Pocket Maximum (OOPM) (Including deductible)	\$3,750	None
Annual Maximum for Essential Benefits (Per Individual)	\$1,250,000	
Primary Care Physician Office Visit	\$10 Copay	30%; after deductible
Specialty Care Physician Office Visit	\$15 Copay	30%; after deductible
Physician Services for Wellness & Preventive Services	Included in Office Visit copayment	30%; after deductible*
<i>Physician Services for wellness and preventative services will be covered as regulated by the Patient Protection and Affordable Care Act (PPACA).</i>		
Emergency Services & Emergency Ambulance	20%; after deductible	Level 1 benefits apply
Urgent Care Center	\$25 Copay	Level 1 benefits apply
Inpatient Hospital (Semi-private room and board)	20%; after deductible	30%; 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	20%; after deductible	30%; after deductible
Colonoscopy	\$0 Copay	30%; after deductible
Labs, pathology, radiology, (EKG) and (EEG)	\$0 Copay	30%; after deductible
MRI, CT, MRA, PET and SPECT scan	\$0 Copay	30%; after deductible
Allergy Serum	20%; after deductible	30%; after deductible
Dialysis	20%; after deductible	30%; after deductible
DME & Corrective Appliances	20%; after deductible	Not Covered
Family Planning Services: (\$2,500 lifetime maximum)	50%	50%
Home Health Services	20%; after deductible	30%; after deductible
Infertility Diagnostic Testing up to diagnosis	\$15 Copay	30%; after deductible
Injections (Therapeutic and Infusion Therapy)	\$0 Copay	30%; after deductible
Maternity Care PCP/SCP (Physician routine obstetrical services only)	\$100 Copay PCP/\$150 Copay SCP	30%; after deductible
Non-Surgical Treatment of Morbid Obesity (Maximum of 6 visits per calendar year)	Enrollment fees in excess of \$50 after \$15 copay per visit	Not Covered
Physician Non-Office Visits (Hospital & Home Visits)	\$0 Copay	30%; after deductible
Skilled Nursing Facility (Limited to 100 days per Medicare guidelines)	20%; after deductible	30%; 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)	20%; after deductible	30%; after deductible
Vision Services: Routine annual eye exam and discount frames & eyeglasses when purchased at participating VSP providers.	\$10 Copay	Not Covered
Mental Health Inpatient	20%; after deductible	30%; after deductible
Mental Health Outpatient	\$10 Copay	30%; after deductible
Substance Abuse Inpatient (Up to maximum of 14 days per calendar year; detoxification: two admissions per lifetime)	20%; after deductible	Not Covered
Substance Abuse Outpatient (Up to maximum of 20 days per calendar year; No limits if part of Mental Health treatment)	20%; after deductible	Not Covered
Pervasive Developmental Disorder (PDD)	Applicable copayment/coinsurance applies based on services provided	30%; after deductible
Prescription Drug Coverage:	Retail	Mail-Order
• OTC with Prescription (Allegra, Claritin, Prevacid 24-hr, Prilosec Zyrtec)	\$5 Copay	\$10 Copay
• Generic-Preferred		
• Brand Name-Preferred		
• Brand Name Non-Preferred		
<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. 		
Specialty Pharmaceuticals (\$2,500 maximum out of pocket per member per calendar year PLUS applicable office visit copay)	20%	Not Covered
Diabetic Supplies (Includes glucometer, lancets & test strips)	Included in rx copays	Not Covered

* Level 2 = Second Level Benefits include the benefits above, except: routine physicals other than mammograms, PSA tests, and colorectal screening described above; hearing and vision services; immunizations and injections; well child care; substance abuse services; DME; artificial aids and corrective appliances; treatment for morbid obesity; and outpatient prescription drugs. These services are only covered under the First Level Benefits. Most Second Level (non-referred) non-emergency benefits (except physician office visits and outpatient diagnostic tests) require you to seek prior authorization by calling the Pre-Cert phone number on your ID card during regular business hours. An additional coinsurance penalty may apply for any service that is received out of network without prior authorization.

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