



**Hamilton County Chambers of Commerce  
POS 1 BENEFITS-AT-A GLANCE**

Policy maximum is \$1,000,000 per covered person.

BENEFITS are subject to an individual deductible of \$750/\$2,250 per family per calendar year, with the exception of physician office services which have copays only. After the deductible, benefits are payable at 80% allowable charges (unless otherwise stated) and are subject to an individual out-of-pocket max of \$750/\$2,250 per family per calendar year, not including the deductible. **Total member responsibility including deductible and out-of-pocket max is \$1,500 per individual and \$4,500 per family.**

Note: All services with copayments, family planning services, prescription benefits and vision services are not subject to deductible or out-of-pocket maximum.

PHYSICIAN SERVICES	COPAY	BEHAVIORAL HEALTH SERVICES	COPAY/COINS.
<b>Office Visits for Illness or Injuries</b>		<b>Mental Health Inpatient Services</b>	20% Coinsurance
· Primary Care Physician Office Visit	\$15 Copay per PCP visit	<b>Mental Health Outpatient Services</b>	\$30 Copay per visit
· Specialty & referral Physician Office Visit	\$30 Copay per SCP visit	<b>Substance Abuse Inpatient Services</b> (Detoxification: two admissions per lifetime)	20% Coinsurance up to 14 days per calendar year
<b>Non-Office Visits</b>		<b>Substance Abuse Outpatient Services</b> (No limits if substance abuse treatment is part of mental health treatment)	20% Coinsurance up to 20 visits per calendar year
· Physician visits in the hospital	\$0 Copay	<b>Pervasive Developmental Disorder (PDD)</b>	Included in the office visit copay
· Physician visits in the home	\$0 Copay		
<b>The following services have a copayment/ coinsurance based upon location of service:</b>			
· 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 sigmoidoscopy			
<b>Physician Services for Wellness &amp; Preventive</b>	<b>No Additional Charge after Physician Office Copay</b>		
· 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			
OTHER SERVICES	COPAY/COINS.	INPATIENT HOSPITAL SERVICES	COPAY/COINS.
<b>Allergy Serum</b>	20% Coinsurance	<b>Semi-Private room and board,</b>	20% Coinsurance
<b>Dialysis</b>	20% Coinsurance	<b>Private room if medically necessary</b> 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	
<b>Family Planning Services to include sterilization and contraceptive devices.</b>	50% Coinsurance up to \$2,500 lifetime max.	OUTPATIENT SURGERY SERVICES	COPAY/COINS.
<b>Home Health Services</b>	20% Coinsurance	<b>Outpatient surgical services</b>	20% Coinsurance
<b>Infertility Diagnostic Testing</b>	\$30 Copay	(Outpatient surgery facility services including those diagnostic invasive procedures that may or may not require anesthesia.)	
<b>Injections (Therapeutic) and Infusion Therapy</b>	\$0 Copay	OUTPATIENT SERVICES	COPAY/COINS.
<b>Maternity Care</b> - 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. <b>Note:</b> Inpatient hospital admissions related to pregnancy and/or birth are covered as any other inpatient hospital facility admission.	\$150 Copay for PCP \$300 Copay for SCP	<b>Outpatient services</b>	\$0 Copay
<b>Non-surgical Treatment of Morbid Obesity</b> (In-network physician supervised weight loss treatment program) Max of 6 visits per calendar year.	Enrollment fees in excess of \$50 after \$30 copay per visit.	{Including but not limited to: laboratory, pathology, radiology, electrocardiology (EKG) & electroencephalography (EEG)}	
<b>DME, Artificial Aids, &amp; Corrective Appliances</b>	20% Coinsurance	<b>MRI, CT, MRA, PET &amp; SPECT scan</b>	\$0 Copay
<b>Short-term Therapies:</b> 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	EMERGENCY SERVICES	COPAY/COINS.
<b>Skilled Nursing Facility:</b> (Limited to 100 days per Medicare guidelines)	20% Coinsurance	<b>Emergency Room</b>	20% Coinsurance
<b>Vision Services: Routine Annual Eye Exam</b> (Discount on frames and eyeglass lenses when purchased through participating VSP providers)	\$15 Copay per exam	<b>Emergency Ambulance Services</b>	20% Coinsurance
		<b>Urgent Care Facility Services</b>	20% Coinsurance
		PRESCRIPTION BENEFITS	COPAY/COINS.
			<u>Retail</u> <u>Mail-Order</u>
		<b>OTC (Over the Counter with Prescription) Prilosec, Claritin, Zyrtec</b>	\$5 Copay      \$10 Copay
		<b>Generic - Preferred</b>	\$7 Copay      \$14 Copay
		<b>Brand Name - Preferred</b>	\$35 Copay      \$70 Copay
		<b>Brand Name Non- Preferred</b>	\$70 Copay      \$140 Copay
		1) Mandatory generic when available or member pays copay plus the difference.	
		2) The copay 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	
		<b>Biopharmaceutical Drugs</b>	20% Coinsurance
		(\$2,500 maximum out of pocket per member per calendar year PLUS applicable office visit Copay)	
		<b>Diabetes Supplies</b> (Includes glucometer, lancets, and test strips) Covered under prescription benefits and applicable formulary copayment	

Second Level Benefits include all of 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 Benefit. **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. All Second Level Benefits are subject to an individual deductible of \$1,500/\$4,500 per family then payable at 60% of allowable charges. All Second Level Benefits shall apply toward the policy maximum of \$1,000,000.**

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**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
- 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](http://www.advantageplan.com)

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*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.*

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