AdventHealth
Advantage Plans

2021

Comparison of Benefits

for Small Groups

HMO ■ POS

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10/7/2020

AdventHealth Advantage Plans
Underwritten by Health First Commercial Plans

AdventHealth Advantage Plan - Small Group HMO

	Coinsurance applies after deductible has been satisfied	Calendar Year Deductible (Single / Family)	Maximum Out of Pocket (Single / Family)	PCP Office Visit	Specialist Visit	Diagnostic Testing (Routine Labs & X-rays)	Advanced Imaging Services (per visit, per type)	Urgent Care (In and Out of Network)	Emergency Room (In and Out of Network)	Inpatient Admission (per admission)	Outpatient Surgery (Facility)	Rx Benefit (Single / Family) Deductible applies to Tiers 3 - 5
AdventHealth Platinum HMO 100 5590	0%	$0 / $0	$1,300 / $2,600	$20	$40	Routine labs $0 X-rays $75	$150	$40	$100	$300 per day 1-4, $0 days 5+	$200	$2/15/30/50/30% ($0 / $0 Rx deductible)
AdventHealth Platinum HMO 80 5594	20%	$0 / $0	$1,800 / $3,600	$20	$40	Routine labs $0 X-rays 20%	$175	$40	$150	$250 per day 1-5, $0 days 6+	$200	$2/15/30/50/30% ($0 / $0 Rx deductible)
AdventHealth Platinum HMO 80 5611	20%	$0 / $0	$3,000 / $6,000	$25	$45	Routine labs $0 X-rays 20%	$275	$50	$300	$1,000	$300	$2/15/30/50/30% ($0 / $0 Rx deductible)
AdventHealth Platinum HMO 80 5016 **(NEW PLAN FOR 2021)**	20%	$0 / $0	$5,250 / $10,500	$10	$45	Routine labs $0 X-rays 20%	$275	$50	$300	$1,000	$300	$2/15/30/50/30% ($0 / $0 Rx deductible)
AdventHealth Gold HMO 80 5577	20%	$500 / $1,000	$6,850 /$ 13,700	$40	$60	Routine labs $0 X-rays 20%	$400	$60	$500	20%	$500	$2/15/30/50/30% ($200 / $400 Rx deductible)
AdventHealth Gold HMO 50 5583	50%	$500 / $1,000	$8,550 / $17,100	$25	$55	Routine labs 50% X-rays 50%	$250	$50	$250	$1,250	$400	$'2/15/30/50/30% ($0 / $0 Rx deductible)
AdventHealth Gold HMO 50 5012	50%	$1,000 / $2,000	$7,350 / $14,700	$30	$60	Routine labs $0 X-rays 50%	50%	$50	50%	$1,500	50%	$2/15/30/50/30% ($500 / $1,000 Rx deductible)
AdventHealth Gold HMO 80 5575	20%	$1,050 / $2,100	$8,550 / $17,100	$25	$55	Routine labs $0 X-rays 20%	$275	$45	$350	20%	20%	$2/15/30/50/30% ($200 / $400 Rx deductible)
AdventHealth Gold HMO 80 5580	20%	$1,500 / $3,000	$8,550 / $17,100	$30	$45	Routine labs $0 X-rays 20%	20%	$45	$200	20%	$250	$2/15/30/50/30% ($200 / $400 Rx deductible)
AdventHealth Silver HMO 50 5555	50%	$2,050 / $4,100	$8,150 / $16,300	Visit 1-4, $35, Visit 5+, 50%	Visit 1-4, $50, Visit 5+, 50%	Routine labs 50% X-rays 50%	50%	Visit 1-4, $50, Visit 5+, 50%	50%	50%	50%	$2/15/30/50/30% ($200/ /$400 Rx deductible)
AdventHealth Silver HMO 50 5563	50%	$3,000 / $6,000	$8,150 / $16,300	$50	$100	Routine labs $0 X-rays 50%	50%	50%	50%	50%	50%	$2/15/30/50/30% ($0 / $0 Rx deductible)
AdventHealth Silver HMO 80 5018 **(NEW PLAN FOR 2021)**	20%	$4,500 / $9,000	$8,550 / $17,100	$65	$100	Routine labs $0 X-rays 20%	20%	$75	$500	20%	20%	$2/15/30/50/30% ($750 / $1,500 Rx deductible)
AdventHealth Silver HMO 80 5560	20%	$5,600 / $11,200	$8,150 / $16,300	Visit 1, $50, Visit 2+, 20%	Visit 1, $75, Visit 2+, 20%	Routine labs $0 X-rays 20%	20%	$75	$400	20%	20%	$2/15/30/50/30% ($200/ /$400 Rx deductible)
AdventHealth Silver HMO 50 5599	50%	$6,350 / $12,700	$7,350 / $14,700	Visit 1, $75 Visit 2+, 50%	Visit 1, $125 Visit 2+, 50%	Routine labs $0 X-rays 50%	$500	Visit 1-3, $100, Visits 4+, 50%	Visit 1, $500, Visits 2+, 50%	$2,500	$1,250	$2/15/30/50/30% ($1,000 / $2,000 Rx deductible)
AdventHealth Silver HMO 50 5597	50%	$7,200 / $14,400	$7,350 / $14,700	Visit 1, $75, Visit 2+, 50%	Visit 1, $125, Visit 2+, 50%	Routine labs $0 X-rays 50%	50%	Visit 1, $125, Visit 2+, 50%	50%	50%	50%	$2/15/30/50/50% ($500 / $1,000 Rx deductible)
AdventHealth Bronze HMO 100 5014	0%	$8,550 / $17,100	$8,550 / $17,100	Visit 1-2, $75, Visit 3+, 0%	Visit 1-2, $120, Visit 3+, 0%	Routine labs 0% X-rays 0%	0%	$100	0%	0%	0%	$2/15/30/50/30% ($1,300 / $2,600 Rx deductible)

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AdventHealth Advantage Plan - Small Group HMO - HSA Qualified

	Coinsurance applies after deductible has been satisfied	Calendar Year Deductible^ (Single / Family)	Maximum Out of Pocket (Single / Family)	PCP Office Visit	Specialist Visit	Diagnostic Testing (Routine Labs & X-rays)	Advanced Imaging Services (per visit, per type)	Urgent Care (In and Out of Network)	Emergency Room (In and Out of Network)	Inpatient Admission (per admission)	Outpatient Surgery (Facility)	Rx Benefit^^ (Single / Family deductible)
AdventHealth Gold HMO 90 5587	10%	$1,750 / $3,500	$3,550 / $7,100	10%	10%	10%	10%	10%	10%	10%	10%	10% after deductible
AdventHealth Silver HMO 90 5567	10%	$3,100 / $6,200	$7,000 / $14,000	10%	10%	10%	10%	10%	10%	10%	10%	10% after deductible
AdventHealth Silver HMO 80 5601	20%	$3,500 / $7,000	$5,150 / $10,300	20%	20%	20%	20%	20%	20%	20%	20%	20% after deductible
AdventHealth Silver HMO 100 5603	0%	$4,500 / $9,000	$4,500 / $9,000	0%	0%	0%	0%	0%	0%	0%	0%	0% after deductible
AdventHealth Bronze HMO 100 5552	0%	$6,900 / $13,800	$6,900 / $13,800	0%	0%	0%	0%	0%	0%	0%	0%	0% after deductible

^Individual deductible amount does not apply if policy covers 2 or more people.
Includes medical and pharmacy expenses per calendar year

^^ Includes medical and pharmacy expenses per calendar year

All plans include pediatric benefits for covered individuals under age 19. Pediatric Vision Eye Exam with standard glasses (1 per year) and pediatric dental, through Delta Dental's DHMO plan, are provided with $0 cost-sharing for covered services.

This Benefit Grid is intended only to highlight certain Benefits and should not be relied upon to fully determine coverage. If this Benefit Grid conflicts in any way with the Schedule of Benefits, the Schedule shall prevail.

AdventHealth Advantage Plans
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AdventHealth Advantage Plan - Small Group POS

	In-Network										In- and Out- of-Network (IN / OON)		Out-of-Network		
	Coinsurance applies after deductible has been satisfied	Calendar Year Deductible (Single / Family)	Maximum Out of Pocket (Single / Family)	PCP Office Visit	Specialist Visit	Diagnostic Testing (Routine Labs & X-rays)	Advanced Imaging Services (per visit, per type)	Inpatient Admission (per admission)	Outpatient Surgery (Facility)	Rx Benefit (Single / Family) Deductible applies to Tiers 3 - 5	Urgent Care	Emergency Room	Coinsurance applies after deductible has been satisfied	Calendar Year Deductible (Single / Family)	Maximum Out of Pocket (Single / Family)
AdventHealth Platinum POS 100 5591	0%	$0 / $0	$1,300 / $2,600	$20	$40	Routine labs $0 X-rays $75	$150	$300 per day 1-4 $0 days 5+	$200	$2/15/30/50/30% ($0 /$0 Rx deductible)	$40 IN 30% OON	$100	30%	$500 / $1,000	$2,600 / $5,200
AdventHealth Platinum POS 80 5595	20%	$0 / $0	$1,800 / $3,600	$20	$40	Routine labs $0 X-rays 20%	$175	$250 per day 1-5 $0 days 6+	$200	$2/15/30/50/30% ($0 /$0 Rx deductible)	$40 IN 50% OON	$150	50%	$500 / $1,000	$3,600/ $7,200
AdventHealth Gold POS 70 5573	30%	$750 / $1,500	$8,550 / $17,100	$25	$60	Routine labs $0 X-rays 30%	$250	30%	$300	$2/15/30/50/30% ($0 /$0 Rx deductible)	$45 IN 50% OON	$250	50%	$1,500 / $3,000	$17,100 / $34,200
AdventHealth Gold POS 80 5581	20%	$1,500 / $3,000	$8,550 / $17,000	$30	$45	Routine labs $0 X-rays 20%	20%	20%	$250	$2/15/30/50/30% ($200 / $400 Rx deductible)	$45 IN 50% OON	$200	50%	$3,000 / $6,000	$17,100 / $34,200
AdventHealth Silver POS 50 5557	50%	$2,450 / $4,900	$8,150 / $16,300	Visit 1-4, $35, Visit 5+, 50%	Visit 1-4, $50, Visit 5+, 50%	Routine labs 50% X-rays 50%	50%	50%	50%	$2/15/30/50/30% ($0 /$0 Rx deductible)	Visit 1-4, $50, Visit 5+, 50% IN 50% OON	50%	50%	$4,900 / $9,800	$16,300 / $32,600
AdventHealth Silver POS 80 5561	20%	$5,600 / $11,200	$8,150 / $16,300	Visit 1, $50, Visit 2+, 20%	Visit 1, $75, Visit 2+, 20%	Routine labs $0 X-rays 20%	20%	20%	20%	$2/15/30/50/30% ($200 / $400 Rx deductible)	$75 IN 50% OON	$400	50%	$11,200 / $22,400	$16,300 / $32,600
AdventHealth Bronze POS 50 5549	50%	$7,700^ / $15,400	$8,150 / $16,300	Visit 1-3, $50, Visit 4+, 50%	Visit 1-3, $100, Visit 4+, 50%	Routine labs 50% X-rays 50%	50%	50%	50%	50% after deductible	Visit 1-3, $100, Visit 4+, 50% IN 50% OON	50%	50%	$15,400 / $30,800	$16,300 / $32,600

^ Includes medical and pharmacy expenses per calendar year

AdventHealth Advantage Plan - Small Group POS - HSA Qualified

	In-Network										In- and Out- of-Network (IN / OON)		Out-of-Network		
	Coinsurance applies after deductible has been satisfied	Calendar Year Deductible^ (Single / Family)	Maximum Out of Pocket (Single / Family)	PCP Office Visit	Specialist Visit	Diagnostic Testing (Routine Labs & X-rays)	Advanced Imaging Services (per visit, per type)	Inpatient Admission (per admission)	Outpatient Surgery (Facility)	Rx Benefit^^ (Single / Family deductible)	Urgent Care	Emergency Room	Coinsurance applies after deductible has been satisfied	Calendar Year Deductible^ (Single / Family)	Maximum Out of Pocket^^ (Single / Family)
AdventHealth Gold POS 90 5585	10%	$1,500 / $3,000	$5,200 / $10,400	10%	10%	10%	10%	10%	10%	10% after deductible	10% IN 50% OON	10%	50%	$3,000 / $6,000	$11,400 / $22,800
AdventHealth Silver POS 90 5571	10%	$3,100 / $6,200	$7,000 / $14,000	10%	10%	10%	10%	10%	10%	10% after deductible	10% IN 50% OON	10%	50%	$6,200 / $12,400	$15,000 / $30,000
AdventHealth Silver POS 100 5565	0%	$4,250 / $8,500	$4,250 / $8,500	0%	0%	0%	0%	0%	0%	0% after deductible	0% IN 50% OON	0%	50%	$8,500 / $17,000	$9,500 / $19,000
AdventHealth Bronze POS 100 5553	0%	$6,900 / $13,800	$6,900 / $13,800	0%	0%	0%	0%	0%	0%	0% after deductible	0% IN 50% OON	0%	50%	$13,800 / $27,600	$14,800 / $29,600

^Individual deductible does not apply if policy covers 2 or more people.
Includes medical and pharmacy expenses per calendar year

^^ Includes medical and pharmacy expenses per calendar year

All plans include pediatric benefits for covered individuals under age 19. Pediatric Vision Eye Exam with standard glasses (1 per year) and pediatric dental, through Delta Dental's DHMO plan, are provided with $0 cost-sharing for covered services.

This Benefit Grid is intended only to highlight certain Benefits and should not be relied upon to fully determine coverage. If this Benefit Grid conflicts in any way with the Schedule of Benefits, the Schedule shall prevail.

(9/22/20) This is a summary of benefits only. It is intended only to highlight some benefits and should not be relied upon to fully determine coverage. If this summary conflicts in any way with the Certificate of Coverage (contract), the contract shall prevail. Please review your contract for a description of services, supplies, terms and conditions of coverage. AdventHealth Advantge Plans is underwritten by Health First Commercial Plans, Inc. Health First Commercial Plans, Inc. does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

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