POS Large Group
Schedule of Benefits

Provided by:

About this Schedule of Benefits
This Schedule of Benefits outlines the cost-shares (such as deductibles, copayments and coinsurance) that apply to covered services under your plan. It is intended only to highlight your benefits and should not be relied upon to fully determine your coverage. If this Schedule of Benefits 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.

For multiple outpatient services received on the same date of service, more than one cost-share may apply, unless expressly stated otherwise herein. For example, if you receive an injection in your physician's office, you may be responsible for the cost-share associated with a physician visit and the cost-share associated with practitioner-administered medications under this plan.

How to contact us for help
For assistance regarding information about coverage, questions or complaints, please call Customer Service toll-free at 1.844.522.5279. You may also log onto your secure member portal at myAHplan.com.

AdventHealth Advantage Plans
Underwritten by Health First Commercial Plans

AdventHealth HDPOS 4500 HSA 6201
SCHEDULE OF BENEFITS

	MEMBER COST-SHARE	
PLAN FEATURES	**In-Network**	**Out-of-Network**
Deductible (Per Individual/Family) Includes medical and pharmacy expenses per calendar year. Individual deductible does not apply if policy covers 2+ people.	$4,500/$9,000	$9,000/$18,000
Coinsurance	20%	40%
Maximum Out-of-Pocket Expense Limit (Per Individual/Family) Includes medical and pharmacy expenses per calendar year.	$6,350/$12,700	$12,700/$25,400
Out-of-Network Fee Schedule	N/A	Health First Allowable Fee Schedule
COVERED SERVICES[1]	**In-Network**	**Out-of-Network[2]**
OUTPATIENT SERVICES AND SUPPLIES Authorization rules may apply. Access your member portal at myAHplan.com to view the Authorization List.		
Preventive Care Services Services are covered in accordance with Affordable Care Act requirements, including age, risk-factor and frequency guidelines. See HealthCare.gov for the current list of covered preventive services.	$0	Deductible then Coinsurance
Primary Care Physician Office Visit	Deductible then Coinsurance	Deductible then Coinsurance
Specialist Office Visit	Deductible then Coinsurance	Deductible then Coinsurance
Chiropractic Services 20 visits maximum per calendar year	Deductible then Coinsurance	Deductible then Coinsurance
Podiatry Services	Deductible then Coinsurance	Deductible then Coinsurance
Diabetic Retinopathy Screening Coverage is limited to one screening per calendar year for covered persons with diabetes. Additional vision services are not included.	Deductible then Coinsurance	Deductible then Coinsurance
Prenatal/Postnatal Office Visit (not including perinatology) Up to 15 visits per calendar year are covered without cost-sharing in-network. Additional visits are subject to the appropriate physician office visit cost-share.	$0	Deductible then Coinsurance

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COVERED SERVICES[1]	MEMBER COST-SHARE In-Network	Out-of-Network[2]
Urgent Care Clinic Visit	Deductible then Coinsurance	Deductible then Coinsurance
Diagnostic Lab Services (e.g., blood work) Includes independent clinical labs. Does not include genetic testing.	Deductible then Coinsurance	Deductible then Coinsurance
Genetic Testing Lab Services	Deductible then Coinsurance	Deductible then Coinsurance
Radiology Services (Per visit, per type) Includes x-rays, ultrasounds, echocardiograms, fluoroscopies, diagnostic mammography and other standard radiology services.	Deductible then Coinsurance	Deductible then Coinsurance
Maternity Ultrasounds	Deductible then Coinsurance	Deductible then Coinsurance
Advanced Imaging Services (Per visit, per type) CT, MRI, MRA, PET and Nuclear Studies	Deductible then Coinsurance	Deductible then Coinsurance
Allergy Testing and Immunotherapy (Per visit) Includes allergy injections administered by a health care provider.	Deductible then Coinsurance	Deductible then Coinsurance
Practitioner-Administered Medications Medications administered by a health care provider in an office or outpatient setting. Includes chemotherapy, infusions, therapeutic injections and other medications ordered and administered by a provider.	Deductible then Coinsurance	Deductible then Coinsurance
Physician Office Drug Administration Fee	Deductible then Coinsurance	Deductible then Coinsurance
Radiation Services	Deductible then Coinsurance	Deductible then Coinsurance
Dialysis Services	Deductible then Coinsurance	Deductible then Coinsurance
Other Diagnostic and Therapeutic Tests and Services Medically necessary outpatient diagnostic and therapeutic services not classified elsewhere within this Schedule of Benefits	Deductible then Coinsurance	Deductible then Coinsurance
Emergency Room Visit	Deductible then Coinsurance	
Outpatient Surgery – Facility Services Includes outpatient hospital & Ambulatory Surgery Center.	Deductible then Coinsurance	Deductible then Coinsurance

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COVERED SERVICES[1]	MEMBER COST-SHARE In-Network	Out-of-Network[2]
Outpatient Surgery – Physician/Surgeon Services Includes outpatient hospital & Ambulatory Surgery Center.	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Observation (Per stay)	Deductible then Coinsurance	Deductible then Coinsurance
Durable Medical Equipment, Orthotics, & Prosthetic Devices	Deductible then Coinsurance	Deductible then Coinsurance
Home Health Care 60 visits maximum per calendar year	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Physical, Speech and Occupational Therapies 20 visits maximum per calendar year for each condition being treated	Deductible then Coinsurance	Deductible then Coinsurance
Cardiac & Pulmonary Rehabilitation Coverage is limited to 36 sessions per lifetime, per service. (Additional days may be authorized when medically necessary.)	Deductible then Coinsurance	Deductible then Coinsurance
Hyperbaric Oxygen Therapy	Deductible then Coinsurance	Deductible then Coinsurance
Ambulance Services	Deductible then Coinsurance	
Outpatient Hospice Services	Deductible then Coinsurance	Deductible then Coinsurance
All Other Medically Necessary Outpatient Services	Deductible then Coinsurance	Deductible then Coinsurance
INPATIENT MEDICAL SERVICES Authorization rules may apply. Access your member portal at myAHplan.com to view the Authorization List.		
Inpatient Hospital Facility Services (Per admission)	Deductible then Coinsurance	Deductible then Coinsurance
Inpatient Physician and Surgical Services	Deductible then Coinsurance	Deductible then Coinsurance
Skilled Nursing Facility Services (Per admission) 120 days maximum per calendar year	Deductible then Coinsurance	Deductible then Coinsurance

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COVERED SERVICES[1]	MEMBER COST-SHARE In-Network	Out-of-Network[2]
Inpatient Hospice Services	Deductible then Coinsurance	Deductible then Coinsurance
BEHAVIORAL HEALTH SERVICES Authorization rules may apply. Access your member portal at myAHplan.com to view the Authorization List.		
Inpatient Mental Health Care (Per admission)	Deductible then Coinsurance	Deductible then Coinsurance
Partial Hospitalization A structured program of active treatment for psychiatric care that is more intense than the care performed in a physician's or therapist's office.	Deductible then Coinsurance	Deductible then Coinsurance
Mental Health Care Office Visit	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Mental Health Services	Deductible then Coinsurance	Deductible then Coinsurance
Inpatient Substance Abuse (Per admission) Detoxification and acute care only for alcohol/substance abuse	Deductible then Coinsurance	Deductible then Coinsurance
Substance Abuse Office Visit	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Substance Abuse Services	Deductible then Coinsurance	Deductible then Coinsurance
ADDITIONAL BENEFITS		
Fitness Center Membership	$0	Not covered
PRESCRIPTION DRUG BENEFIT Covered prescription drugs are listed in the plan formulary. Authorization rules, step therapy requirements and quantity limits may apply. Please access your member portal at myAHplan.com to view the formulary.		
Retail Pharmacy	**30-Day Supply**	**90-Day Supply**
Preventive Care Prescription Drugs and Supplies Covered in accordance with Affordable Care Act requirements. A health care professional's prescription is required for all drugs and supplies.	$0	$0

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SCHEDULE OF BENEFITS

	MEMBER COST-SHARE	
Tier 1 – Preferred Generic Prescription Drugs	Deductible then Coinsurance	Deductible then Coinsurance
Tier 2 – Non-preferred Generic Prescription Drugs	Deductible then Coinsurance	Deductible then Coinsurance
Tier 3 – Preferred Brand Name Prescription Drugs	Deductible then Coinsurance	Deductible then Coinsurance
Tier 4 – Non-preferred Brand Name Prescription Drugs Coverage for 90-day supply is limited to contracted mail order pharmacy.	Deductible then Coinsurance	Not covered
Tier 5 – Specialty Drugs Coverage is limited to a 30-day supply from preferred specialty pharmacy.	Deductible then Coinsurance	Not covered
Mail Order Pharmacy	**30-Day Supply**	**90-Day Supply**
Preventive Care Prescription Drugs and Supplies Covered in accordance with Affordable Care Act requirements. A health care professional's prescription is required for all drugs and supplies.	$0	$0
Tier 1 – Preferred Generic Prescription Drugs	Deductible then Coinsurance	Deductible then Coinsurance
Tier 2 – Non-preferred Generic Prescription Drugs	Deductible then Coinsurance	Deductible then Coinsurance
Tier 3 – Preferred Brand Name Prescription Drugs	Deductible then Coinsurance	Deductible then Coinsurance
Tier 4 – Non-preferred Brand Name Prescription Drugs Coverage for 90-day supply is limited to contracted mail order pharmacy.	Deductible then Coinsurance	Deductible then Coinsurance
Tier 5 – Specialty Drugs Coverage is limited to a 30-day supply from preferred specialty pharmacy.	Deductible then Coinsurance	Not covered

[1] Covered services are subject to limitations, exclusions and plan provisions listed in the Certificate of Coverage.

[2] In addition to the member cost-share, covered persons who receive non-emergent services out-of-network shall be responsible for the difference between the non-participating provider's charge and our out-of-network allowance.

AdventHealth Advantage Plans

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Nondiscrimination Notice

AdventHealth Advantage Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AdventHealth Advantage Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AdventHealth Advantage Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact our Civil Rights Coordinator.

If you believe that AdventHealth Advantage Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, 6450 US Highway 1, Rockledge, FL 32955, 321-434-4521, 1-800-955-8771 (TTY), Fax: 321-434-4362, civilrightscoordinator@hf.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

AdventHealth Advantage Plans is underwritten by Health First Commercial Plans, Inc. Health First Commercial Plans 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.

AdventHealth
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English:
This Notice has Important Information. This notice has important information about your application or coverage through AdventHealth Advantage Plans. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 844-522-5279.

Spanish:
Este Aviso contiene información importante. Este aviso contiene información importante acerca de la solicitud o cobertura que usted tiene con AdventHealth Advantage Plans. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 844-522-5279.

Haitian Creole:
Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a gen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè AdventHealth Advantage Plans. Chèche dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 844-522-5279.

Vietnamese:
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc hợp đồng bảo hiểm qua chương trình AdventHealth Advantage Plans của Quý vị. Xin xem các ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 844-522-5279.

Portuguese:
Este aviso contém informações importantes. Este aviso contém informações importantes a respeito da sua solicitação ou cobertura por meio dos AdventHealth Advantage Plans. Consulte datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter a sua cobertura de plano de saúde ou ajuda com custos. Você tem o direito de obter estas informações e ajuda no seu idioma e sem custos. Ligue para 844-522-5279.

Chinese:
本通知包含重要的資訊。本通知包含關於您透過 AdventHealth Advantage Plans 提交的申請或保險的重要資訊。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或費用補貼。您有權以您的母語免費取得本資訊及幫助。請撥電話 844-522-5279。

French:
Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire AdventHealth Advantage Plans. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 844-522-5279.

Tagalog:
Ang Paunawa na ito ay naglalaman ng Mahalagang Impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagkakasaklaw sa AdventHealth Advantage Plans. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan kang magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagkakasaklaw sa kalusugan o makatulong sa mga gastusin. May karapatan kang makuha ang impormasyon at tulong na ito sa iyong wika nang libre. Tumawag sa 844-522-5279.

Russian:
Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через AdventHealth Advantage Plans. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 844-522-5279.

Arabic:
يحوي هذا الإشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال AdventHealth Advantage Plans. ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التغطية الصحية أو للمساعدة في دفع التكاليف. لك الحق في الحصول على معلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بالرقم 844-522-5279.

Italian:
Questo avviso contiene informazioni importanti. Questo avviso contiene informazioni importanti sulla sua domanda o copertura attraverso AdventHealth Advantage Plans. Cerchi le date chiave in questo avviso. Potrebbe essere necessario un suo intervento entro una scadenza determinata per consentirle di mantenere la sua copertura o sovvenzione. Ha il diritto di ottenere queste informazioni e assistenza nella sua lingua gratuitamente. Chiami il numero 844-522-5279.

German:
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch AdventHealth Advantage Plans. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Anspruch auf Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 844-522-5279.

Korean:
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 AdventHealth Advantage Plans를 통한 보장에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 확인하십시오. 귀하는 건강 보장을 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 844-522-5279로 전화하십시오.

Polish:
Niniejsze ogłoszenie zawiera ważne informacje. Niniejsze ogłoszenie zawiera ważne informacje dotyczące Państwa wniosku lub zakresu świadczeń realizowanych poprzez AdventHealth Advantage Plans. Może zaistnieć potrzeba podjęcia przez Państwa pewnych działań w określonym terminie w celu zachowania ubezpieczenia zdrowotnego lub otrzymania pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnego uzyskania informacji i pomocy w języku ojczystym. Prosimy zadzwonić pod numer 844-522-5279.

Gujarati:
આ સૂચનામાં અગત્યની માહિતી છે. આ સૂચનામાં ફ્લોરિડા હોસ્પિટલ કેર એડવાંટેજ દ્વારા તમારી અરજી અથવા કવરેજ વિશેની અગત્યની માહિતી છે. આ સૂચનામાંની ખાસ તારીખો જુઓ. તમારા આરોગ્ય કવરેજને જાળવી રાખવા અથવા ખર્ચ અંગે મદદ મેળવવા માટે ચોક્કસ સમયમર્યાદા સુધીમાં તમારે કાર્યવાહી કરવાની જરૂર પડી શકે છે. તમને આ માહિતી અને મદદ તમારી ભાષામાં વિના મૂલ્યે મેળવવાનો અધિકાર છે. 844-522-5279 પર કૉલ કરો.

Thai:
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอบเขตการประกันสุขภาพของคุณผ่าน AdventHealth Advantage Plans โปรดดูกำหนดการสำคัญในประกาศนี้
คุณอาจจะต้องดำเนินการภายในเวลาที่กำหนดเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย
คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 844-522-5279.