HMO Individual
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 Gold HMO 80 1772
SCHEDULE OF BENEFITS
AV = 80.40%

PLAN FEATURES	MEMBER COST-SHARE
Medical Calendar Year Deductible (Per Individual/Family)	$1,600/$3,200
Pharmacy Calendar Year Deductible (Per Individual/Family)	$0
Coinsurance	20%
Maximum Out-of-Pocket Expense Limit (Per Individual/Family) Includes medical and pharmacy expenses per calendar year.	$8,700/$17,400
COVERED SERVICES[1]	**MEMBER COST-SHARE**
OUTPATIENT SERVICES AND SUPPLIES Authorization rules may apply. Access your member portal 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
Primary Care Physician Office Visit	$20
Specialist Office Visit	$50
Chiropractic Services 26 visits maximum per calendar year	$50
Podiatry Services	$50
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
Urgent Care Clinic Visit	$60

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COVERED SERVICES[1]	MEMBER COST-SHARE
Diagnostic Lab Services (e.g., blood work) Includes independent clinical labs. Does not include genetic testing.	Deductible then Coinsurance
Genetic Testing Lab Services	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
Maternity Ultrasounds	Deductible then Coinsurance
Advanced Imaging Services (Per visit, per type) CT, MRI, MRA, PET and Nuclear Studies	Deductible then Coinsurance
Allergy Testing (Per visit)	Deductible then Coinsurance
Practitioner-Administered Medications Medications administered by a health care provider in an office or outpatient setting. Includes chemotherapy, infusions, therapeutic injections, allergy immunotherapy, and other medications ordered and administered by a provider.	Deductible then Coinsurance
Radiation Services	Deductible then Coinsurance
Dialysis Services	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
Emergency Room Visit	Deductible then Coinsurance
Outpatient Surgery – Facility Services Includes outpatient hospital & Ambulatory Surgery Center.	Deductible then Coinsurance
Outpatient Surgery – Physician/Surgeon Services Includes outpatient hospital & Ambulatory Surgery Center.	Deductible then Coinsurance

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COVERED SERVICES[1]	MEMBER COST-SHARE
Outpatient Observation (Per stay)	Deductible then Coinsurance
Durable Medical Equipment, Orthotics, & Prosthetic Devices	Deductible then Coinsurance
Home Health Care 60 visits maximum per calendar year	Deductible then Coinsurance
Rehabilitative Physical, Speech and Occupational Therapies 35 visits maximum per calendar year for each condition being treated	Deductible then Coinsurance
Habilitation Services 35 visits maximum per calendar year for each condition being treated	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
Hyperbaric Oxygen Therapy	Deductible then Coinsurance
Ambulance Services	Deductible then Coinsurance
Outpatient Hospice Services	Deductible then Coinsurance
All Other Medically Necessary Outpatient Services	Deductible then Coinsurance
INPATIENT MEDICAL SERVICES Authorization rules may apply. Access your member portal to view the Authorization List.	
Inpatient Hospital Facility Services (Per admission) Inpatient rehabilitation services limited to 21 days per calendar year.	Deductible then Coinsurance
Inpatient Physician and Surgical Services	Deductible then Coinsurance
Skilled Nursing Facility Services (Per admission) 60 days maximum per calendar year	Deductible then Coinsurance

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Inpatient Hospice Services	Deductible then Coinsurance
BEHAVIORAL HEALTH SERVICES Authorization rules may apply. Access your member portal to view the Authorization List.	
Inpatient Mental Health Care (Per admission)	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
Mental Health Care Office Visit	$20
Outpatient Mental Health Services	Deductible then Coinsurance
Inpatient Substance Abuse (Per admission) Detoxification and acute care only for alcohol/substance abuse	Deductible then Coinsurance
Substance Abuse Office Visit	$20
Outpatient Substance Abuse Services	Deductible then Coinsurance
PEDIATRIC SERVICES	
Pediatric Dental Services Includes one dental check-up visit every six months, basic and major dental care and medically necessary orthodontic services.	$0
Pediatric Vision Services Includes one routine eye exam and one pair of standard child eyeglasses (frame and lenses) per calendar year from a participating provider. Up to two prescription fills of standard contact lenses are covered, in lieu of eyeglasses, per calendar year from a participating provider.	$0
ADDITIONAL BENEFITS	

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COVERED SERVICES[1]	MEMBER COST-SHARE	
Fitness Center Membership	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 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
Tier 1 – Preferred Generic Prescription Drugs	$2	$6
Tier 2 – Non-preferred Generic Prescription Drugs	$10	$30
Tier 3 – Preferred Brand Name Prescription Drugs	$40	$120
Tier 4 – Non-preferred Brand Name Prescription Drugs	$75	$225
Tier 5 – Specialty Drugs Coverage is limited to a 30-day supply from preferred specialty pharmacy.	Deductible then 30%	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	$2	$4
Tier 2 – Non-preferred Generic Prescription Drugs	$10	$20
Tier 3 – Preferred Brand Name Prescription Drugs	$40	$100
Tier 4 – Non-preferred Brand Name Prescription Drugs	$75	$187.50

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Tier 5 – Specialty Drugs Coverage is limited to a 30-day supply from preferred specialty pharmacy.	Deductible then 30%	Not covered

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