AdventHealth Advantage Plans

Health First Health Plans

Medicare Advantage Plans
Benefits at a Glance
Effective January 1, 2020
(Employer Group Plans)

Benefits	AdventHealth Group Plus C (HMO)	AdventHealth Group Plus D (HMO)	AdventHealth Group POS B (HMO-POS)
Premium (in addition to Part B premium)	$185 per month	$130 per month	$170 per month
Maximum Out-of-Pocket (not including prescriptions)	$2,000	$3,000	$3,000 $6,000 (out-of-network)
Deductible	$0	$0	$0
Preventive Services			
Annual wellness exam, bone mass measurement, colorectal and prostate cancer screening, colonoscopy, pneumonia and flu vaccines, mammograms, pap smears/pelvic exams	$0 for Medicare-covered screenings, exams, vaccines & measurements	$0 for Medicare-covered screenings, exams, vaccines & measurements	$0 for Medicare-covered screenings, exams, vaccines & measurements
Inpatient Care			
Hospital Care (90 days covered / benefit period†)	$250 per admission	▪ Days 1-5: $150 per day ▪ Days 6-90: $0 per day ▪ Out-of-pocket max/benefit period†: $750	▪ Days 1-5: $150 per day ▪ Days 6-90: $0 per day ▪ Out-of-pocket max/benefit period†: $750
Skilled Nursing Facility (100 days covered / benefit period†) 1-day prior inpatient stay required	▪ Days 1-20: $20 per day ▪ Days 21-100: $0 per day	▪ Days 1-20: $20 per day ▪ Days 21-100: $0 per day	▪ Days 1-20: $20 per day ▪ Days 21-100: $0 per day
Home Health Care	$0	$0	$0
Outpatient Care / Supplies			
Doctor Office Visits Referrals for specialists – Not required	▪ $0 – PCP ▪ $20 – Specialist	▪ $0 – PCP ▪ $25 – Specialist	▪ $0 – PCP ▪ $25 – Specialist
Surgery / Services	$125 per visit	$150 per visit	$150 per visit
Ambulance	$50 one way	$75 one way	$75 one way
Emergency Care – Worldwide*	$80	$80	$80
Urgent Care / Walk-In Clinic*	$10	$15	$15
Outpatient Rehabilitation Services (Physical, occupational, speech therapy)	$15	$20	$20
Mental Health Services	$20 for each individual/group therapy visit	$25 for each individual/group therapy visit	$25 for each individual/group therapy visit
Durable Medical Equipment	10%	10%	10%
Diabetes Programs / Supplies	$0	$0	$0
Foot Care (podiatry services)	$10	$25	$25
Diagnostic Services	▪ $0 for lab services ▪ $0 for X-rays ▪ $150 for specialty imaging services including MRI, CT, Nuclear and PET scans	▪ $0 for lab services ▪ $0 for X-rays ▪ $150 for specialty imaging services including MRI, CT, Nuclear and PET scans	▪ $0 for lab services ▪ $0 for X-rays ▪ $150 for specialty imaging services including MRI, CT, Nuclear and PET scans
Part B Drugs	0%	0%	0%
Additional Benefits			
Dental	▪ $200 annual allowance for dental services	▪ $100 annual allowance for dental services	▪ $100 annual allowance for dental services
Hearing	▪ $15 for Medicare-covered exam ▪ $15 routine exam ▪ $250 annual allowance towards hearing aids	▪ $25 for Medicare-covered exam ▪ $25 routine exam ▪ $250 annual allowance towards hearing aids	▪ $25 for Medicare-covered exam ▪ $25 routine exam ▪ $250 annual allowance towards hearing aids
Vision	▪ $15 for each Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye) ▪ $15 one routine eye exam ▪ $0 for one pair of eyeglasses or contacts after cataract surgery ▪ $250 annual allowance for eyewear including contact lenses	▪ $15 for each Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye) ▪ $25 one routine eye exam ▪ $0 for one pair of eyeglasses or contacts after cataract surgery ▪ $250 annual allowance for eyewear including contact lenses	▪ $15 for each Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye) ▪ $25 one routine eye exam ▪ $0 for one pair of eyeglasses or contacts after cataract surgery ▪ $250 annual allowance for eyewear including contact lenses
Fitness Center Membership	$0 Silver&Fit Program	$0 Silver&Fit Program	$0 Silver&Fit Program

(A Medicare Advantage plan is not a Medigap policy)

Benefits	AdventHealth Group Plus C (HMO)	AdventHealth Group Plus D (HMO)	AdventHealth Group POS B (HMO-POS)
Part D Prescription Drugs			
Retail network pharmacy (30-day supply) ▪ Tier 1 – Preferred Generic Drugs ▪ Tier 2 – Generic Drugs ▪ Tier 3 – Preferred Brand Drugs ▪ Tier 4 – Non–Preferred Drugs ▪ Tier 5 – Specialty Tier Drugs ▪ Tier 6 – Select Care Drugs	 ▪ Tier 1 – $2 ▪ Tier 2 – $5 ▪ Tier 3 – $25 ▪ Tier 4 – $45 ▪ Tier 5 – $90 ▪ Tier 6 – $0	 ▪ Tier 1 – $2 ▪ Tier 2 – $5 ▪ Tier 3 – $45 ▪ Tier 4 – $90 ▪ Tier 5 – $33% ▪ Tier 6 – $0	 ▪ Tier 1 – $2 ▪ Tier 2 – $5 ▪ Tier 3 – $45 ▪ Tier 4 – $90 ▪ Tier 5 – $33% ▪ Tier 6 – $0
Retail network pharmacy (90-day supply) ▪ Tier 1 – Preferred Generic Drugs ▪ Tier 2 – Generic Drugs ▪ Tier 3 – Preferred Brand Drugs ▪ Tier 4 – Non–Preferred Drugs ▪ Tier 5 – Specialty Tier Drugs ▪ Tier 6 – Select Care Drugs	 ▪ Tier 1 – $6 ▪ Tier 2 – $15 ▪ Tier 3 – $75 ▪ Tier 4 – $135 ▪ Tier 5 – $N/A ▪ Tier 6 – $0	 ▪ Tier 1 – $6 ▪ Tier 2 – $15 ▪ Tier 3 – $135 ▪ Tier 4 – $270 ▪ Tier 5 – $N/A ▪ Tier 6 – $0	 ▪ Tier 1 – $6 ▪ Tier 2 – $15 ▪ Tier 3 – $135 ▪ Tier 4 – $270 ▪ Tier 5 – $N/A ▪ Tier 6 – $0
Mail order (90-day supply) ▪ Tier 1 – Preferred Generic Drugs ▪ Tier 2 – Generic Drugs ▪ Tier 3 – Preferred Brand Drugs ▪ Tier 4 – Non–Preferred Drugs ▪ Tier 5 – Specialty Tier Drugs ▪ Tier 6 – Select Care Drugs	 ▪ Tier 1 – $0 ▪ Tier 2 – $0 ▪ Tier 3 – $62.50 ▪ Tier 4 – $112.50 ▪ Tier 5 – $N/A ▪ Tier 6 – $0	 ▪ Tier 1 – $0 ▪ Tier 2 – $0 ▪ Tier 3 – $112.50 ▪ Tier 4 – $225 ▪ Tier 5 – $N/A ▪ Tier 6 – $0	 ▪ Tier 1 – $0 ▪ Tier 2 – $0 ▪ Tier 3 – $112.50 ▪ Tier 4 – $225 ▪ Tier 5 – $N/A ▪ Tier 6 – $0
Coverage Gap Stage	Coverage for All Tiers	Coverage for Tiers 1, 2 & 6	Coverage for Tiers 1, 2 & 6
	This plan does not have a Coverage Gap Stage.	After your total yearly drug costs reach $4,020, you will pay no more than 25% on brand name drugs and 25% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $6,350.	
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach $6,350 you pay a $3.60 copay for generic and a $8.95 copay for all other drugs, or 5% coinsurance *(whichever is greater).*		
Prescription Drug Cost-Sharing	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.		

AdventHealth Advantage Plans is administered by Health First Health Plans. Health First Health Plans is an HMO Plan with a Medicare contract. Enrollment in Health First Health Plans depends on contract renewal. This information is not a complete description of benefits. Call 1.855.882.6467 or TTY/TDD relay 1.800.955.8771 for more information. Benefits at a Glance is not a complete description of benefits. Please refer to EOC for additional information.

†A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

***Worldwide urgent/emergency care coverage:** Health First Medicare Advantage Plans cover emergency services and unforeseen urgently needed medical care outside the United States, including when you are on a cruise ship. If you receive covered care from a provider outside the United States that does not participate with Medicare, you may be asked to pay up front for the services and be reimbursed from the plan later. We will pay up to 115% of the Medicare-allowed amount in our service area (Medicare's limiting charge for non–participating providers), less any applicable cost-share. **Please note that Medicare-allowed amounts can be much less than the provider charges you, and you will be responsible for paying the difference.**

****** Any Medicare-covered benefit that is covered in-network is also available out-of-network. Please refer to the Evidence of Coverage for out-of-pocket and annual maximum coverage. Facilities may charge different amounts, so your final cost may vary depending on which facility you choose.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for up to seventy-five (75)% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call:

- 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048, 24 hours a day/7 days a week;
- Social Security Office at 1.800.772.1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1.800.325.0778;
- State Medicaid Office at 1.866.762.2237. TTY users should call 1.800.955.8771; or
- My Advocate™ (Third Party Administrator for Health First Health Plans) at 1.866.743.5282 between 9 a.m. to 6 p.m., Monday through Friday. TTY users should call 1.855.368.9643

For further assistance: You may call Customer Service toll-free at 1.855.882.6467 (TTY/TDD relay: 1.800.955.8771) weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1 through March 31, we're available seven days a week from 8 a.m. to 8 p.m. You may also visit our web site at myAHplan.com or visit our office Monday through Friday, 8 a.m. to 5 p.m., or write to us at 1425 W. Granada Blvd., Suite 4, Ormond Beach, FL 32174.

6450 U.S. Highway 1
Rockledge, FL 32955
myAHplan.com

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.*

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English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-882-6467 (TTY: 1-800-955-8771).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-882-6467 (TTY: 1-800-955-8771).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-882-6467 (TTY: 1-800-955-8771).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-882-6467 (TTY: 1-800-955-8771).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-882-6467 (TTY: 1-800-955-8771).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-882-6467（TTY：1-800-955-8771）。

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-882-6467 (ATS : 1-800-955-8771).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-882-6467 (TTY: 1-800-955-8771).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-882-6467 (телетайп: 1-800-955-8771).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-882-6467 (رقم هاتف الصم والبكم: 1-800-955-8771).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-882-6467 (TTY: 1-800-955-8771).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-882-6467 (TTY: 1-800-955-8771).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-882-6467 (TTY: 1-800-955-8771)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-882-6467 (TTY: 1-800-955-8771).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-882-6467 (TTY: 1-800-955-8771).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-882-6467 (TTY: 1-800-955-8771).

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