# 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 GYM ACCESS Gold HMO 70 1743
# Zero Cost-Share
# SCHEDULE OF BENEFITS
**AV = 100.00%**

| PLAN FEATURES | MEMBER COST-SHARE |
|---|---|
| **Deductible** (Per Individual/Family)<br>Includes medical and pharmacy expenses per calendar year. | $0 |
| **Coinsurance** | 0% |
| **Maximum Out-of-Pocket Expense Limit** (Per Individual/Family)<br>Includes medical and pharmacy expenses per calendar year. | $0 |

| COVERED SERVICES[1] | MEMBER COST-SHARE |
|---|---|
| **OUTPATIENT SERVICES AND SUPPLIES**<br>Authorization rules may apply. Access your member portal to view the Authorization List. | |
| **Preventive Care Services**<br>Services are covered in accordance with Affordable Care Act requirements, including age, risk-factor and frequency guidelines.<br>See HealthCare.gov for the current list of covered preventive services. | $0 |
| **Primary Care Physician Office Visit** | $0 |
| **Specialist Office Visit** | $0 |
| **Chiropractic Services**<br>26 visits maximum per calendar year | $0 |
| **Podiatry Services** | $0 |
| **Prenatal/Postnatal Office Visit** (not including perinatology)<br>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** | $0 |
| **Diagnostic Lab Services** (e.g., blood work)<br>Includes independent clinical labs. Does not include genetic testing. | $0 |
| **Genetic Testing Lab Services** | $0 |

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|---|---|
| **Radiology Services** (Per visit, per type)<br>Includes x-rays, ultrasounds, echocardiograms, fluoroscopies, diagnostic mammography and other standard radiology services. | $0 |
| **Maternity Ultrasounds** | $0 |
| **Advanced Imaging Services** (Per visit, per type)<br>CT, MRI, MRA, PET and Nuclear Studies | $0 |
| **Allergy Testing** (Per visit) | $0 |
| **Practitioner-Administered Medications**<br>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. | $0 |
| **Radiation Services** | $0 |
| **Dialysis Services** | $0 |
| **Other Diagnostic and Therapeutic Tests and Services**<br>Medically necessary outpatient diagnostic and therapeutic services not classified elsewhere within this Schedule of Benefits | $0 |
| **Emergency Room Visit** | $0 |
| **Outpatient Surgery – Facility Services**<br>Includes outpatient hospital & Ambulatory Surgery Center. | $0 |
| **Outpatient Surgery – Physician/Surgeon Services**<br>Includes outpatient hospital & Ambulatory Surgery Center. | $0 |
| **Outpatient Observation** (Per stay) | $0 |
| **Durable Medical Equipment, Orthotics, & Prosthetic Devices** | $0 |

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|---|---|
| **Home Health Care**<br>60 visits maximum per calendar year | $0 |
| **Rehabilitative Physical, Speech and Occupational Therapies**<br>35 visits maximum per calendar year for each condition being treated | $0 |
| **Habilitation Services**<br>35 visits maximum per calendar year for each condition being treated | $0 |
| **Cardiac & Pulmonary Rehabilitation**<br>Coverage is limited to 36 sessions per lifetime, per service.<br>(Additional days may be authorized when medically necessary.) | $0 |
| **Hyperbaric Oxygen Therapy** | $0 |
| **Ambulance Services** | $0 |
| **Outpatient Hospice Services** | $0 |
| **All Other Medically Necessary Outpatient Services** | $0 |
| **INPATIENT MEDICAL SERVICES**<br>Authorization rules may apply. Access your member portal to view the Authorization List. | |
| **Inpatient Hospital Facility Services** (Per admission)<br>Inpatient rehabilitation services limited to 21 days per calendar year. | $0 |
| **Inpatient Physician and Surgical Services** | $0 |
| **Skilled Nursing Facility Services** (Per admission)<br>60 days maximum per calendar year | $0 |
| **Inpatient Hospice Services** | $0 |
| **BEHAVIORAL HEALTH SERVICES**<br>Authorization rules may apply. Access your member portal to view the Authorization List. | |

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| COVERED SERVICES[1] | MEMBER COST-SHARE |
|---|---|
| **Inpatient Mental Health Care** (Per admission) | $0 |
| **Partial Hospitalization**<br>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. | $0 |
| **Mental Health Care Office Visit** | $0 |
| **Outpatient Mental Health Services** | $0 |
| **Inpatient Substance Abuse** (Per admission)<br>Detoxification and acute care only for alcohol/substance abuse | $0 |
| **Substance Abuse Office Visit** | $0 |
| **Outpatient Substance Abuse Services** | $0 |
| **PEDIATRIC SERVICES** | |
| **Pediatric Dental Services**<br>Includes one dental check-up visit every six months, basic and major dental care and medically necessary orthodontic services. | $0 |
| **Pediatric Vision Services**<br>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** | |
| **Fitness Center Membership** | $0 |

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| **PRESCRIPTION DRUG BENEFIT**<br>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**<br>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** | $0 | $0 |
| **Tier 2 – Non-preferred Generic Prescription Drugs** | $0 | $0 |
| **Tier 3 – Preferred Brand Name Prescription Drugs** | $0 | $0 |
| **Tier 4 – Non-preferred Brand Name Prescription Drugs** | $0 | $0 |
| **Tier 5 – Specialty Drugs**<br>Coverage is limited to a 30-day supply from preferred specialty pharmacy. | $0 | Not covered |
| **Mail Order Pharmacy** | **30-Day Supply** | **90-Day Supply** |
| **Preventive Care Prescription Drugs and Supplies**<br>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** | $0 | $0 |
| **Tier 2 – Non-preferred Generic Prescription Drugs** | $0 | $0 |
| **Tier 3 – Preferred Brand Name Prescription Drugs** | $0 | $0 |
| **Tier 4 – Non-preferred Brand Name Prescription Drugs** | $0 | $0 |
| **Tier 5 – Specialty Drugs**<br>Coverage is limited to a 30-day supply from preferred specialty pharmacy. | $0 | Not covered |

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