AdventHealth

2024 Health Benefits at a Glance

Health Plan Rates – Per Pay Period

Traditional Plan (PPO)				
Per Pay Period	Full-Time Team Members		Part-time Team Members	
Coverage Level	Employer Contribution	Team Member Cost	Employer Contribution	Team Member Cost
Team Member Only	$248.81	**$107.40**	$211.18	**$145.02**
Team Member + Spouse	$484.92	**$266.02**	$405.80	**$345.13**
Team Member + Child(ren)	$468.10	**$220.61**	$383.95	**$304.75**
Team Member + Family	$717.54	**$401.78**	$582.18	**$537.13**

Health Savings Plan (HDHP)				
Per Pay Period	Full-Time Team Members		Part-time Team Members	
Coverage Level	Employer Contribution	Team Member Cost	Employer Contribution	Team Member Cost
Team Member Only	$286.88	**$36.28**	$276.11	**$47.05**
Team Member + Spouse	$552.35	**$128.90**	$462.92	**$218.33**
Team Member + Child(ren)	$529.18	**$95.61**	$448.38	**$176.42**
Team Member + Family	$815.79	**$199.67**	$666.68	**$348.78**

Bi-weekly, non-tobacco rates are shown above. Tobacco users are subject to an additional $600 annual surcharge. Attestation required to receive non-tobacco user rate.

	Health Savings Plan***			Traditional Plan		
Network Tiers	**Maximum Savings (In-Network Preferred)** **Tier 1**	**Standard Savings (In-Network)** **Tier 2**	**Significant Member Cost (Out-of-Network)** **Tier 3**	**Maximum Savings (In-Network Preferred)** **Tier 1**	**Standard Savings (In-Network)** **Tier 2**	**Significant Member Cost (Out-of-Network)** **Tier 3**
Annual Deductible* • Individual • Family	$2,000 $4,000	$4,000 $6,000	$8,000 $12,000	$700 $1,400	$1,400 $2,800	$3,000 $6,000
Coinsurance	You pay 10% of the cost	You pay 25% of the cost	You pay 60% of the cost	You pay 15% of the cost	You pay 25% of the cost	You pay 60% of the cost
Doctor Office Visit (PCP/Specialist)	You pay 10% of the cost	You pay 25% of the cost	You pay 60% of the cost	You pay $25/$50	You pay $40/$65	You pay 60% of the cost
Retail Prescription Drugs (30-day or less)	$10 copay for generic drugs 20% of the cost of formulary drugs** ($25 minimum/$150 maximum) 20% of the cost of non-formulary drugs** ($50 minimum/no maximum) 20% of the cost of specialty drugs ($50 minimum/$200 maximum)		Not covered	$10 copay for generic drugs 20% of the cost of formulary drugs** ($25 minimum/$150 maximum) 20% of the cost of non-formulary drugs** ($50 minimum/no maximum) 20% of the cost of specialty drugs ($50 minimum/$200 maximum)		Not covered
Mail Order Prescription Drugs (90-day)	$10 copay for generic drugs 20% of the cost of formulary drugs** ($50 minimum/$300 maximum) 20% of the cost of non-formulary drugs** ($100 minimum/no maximum) 20% of the cost of specialty drugs ($100 minimum/$400 maximum)		Not covered	$10 copay for generic drugs 20% of the cost of formulary drugs** ($50 minimum/$300 maximum) 20% of the cost of non-formulary drugs** ($100 minimum/no maximum) 20% of the cost of specialty drugs ($100 minimum/$400 maximum)		Not covered
Annual Out-of-Pocket Maximum • Individual • Family	$4,000 $8,150	$6,000 $8,150	No Limit No Limit	$4,000 $8,000	$6,000 $12,000	No limit No limit

** Tier 3 deductibles don't apply to your out-of-pocket maximum.*

*** Certain "preferred" brand-name drugs are in what's called a "formulary"—a list of brand-name drugs that are preferred over other brand-name drugs that may be prescribed for the same condition. You pay less for formulary drugs than non-formulary drugs. A list of these drugs can be found online at myadventhealthrx.com and may change from time to time.*

****** All eligible covered expenses count toward the deductible. The deductible must be met before the coinsurance on the health plan and prescription drug copay applies (certain preventive/generic drugs are not subject to the deductible).***