The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit http://www.fhcp.com/documents/coc/2021-large-group.pdf. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.fhcp.com or call 1-877-615-4022 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $2,700 Individual / $5,400 Family Out-of-network providers: $4,500 Individual / $9,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, and services not subject to the deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network providers: $6,000 Individual/$12,000 Family. Out-of-network providers: $10,000 Individual/$20,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.fhcp.com/find-providers/physician or call 1-877-615-4022 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the Specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 Copay/Visit	Deductible + 50% Coinsurance	Additional cost share may apply for Allergy shots, Injections and Infusions.
	Specialist visit	$50 Copay/Visit	Deductible + 50% Coinsurance	Additional cost share may apply for Allergy shots, Injections and Infusions.
	Preventive care/screening/ immunization	No charge	Deductible + 50% Coinsurance	Preventive Colonoscopy (age 50+) 1 every 10 years. High Risk Colonoscopy 1 every 2 years. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab work: No charge X-ray: $50 Copay/Test	Deductible + 50% Coinsurance	Cost sharing varies based on type of diagnostic test performed. Tests in hospitals, or facilities owned and operated by hospitals, may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Prior approval required. Your benefits / services may be denied. Tests in hospitals, or facilities owned and operated by hospitals, may have higher cost share.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://fm.formularynavigator.com/FBO/126/2021_NGF_Formulary.pdf	Generic drugs	Retail: $3 Copay per prescription for Preferred at FHCP / Mail Order: $6 Copay per prescription for Preferred / $12 Copay per prescription for Preferred at Walgreen's/Publix. Retail: $12 Copay per prescription for Non-Preferred at FHCP / Mail Order: $33 Copay per prescription for Non-Preferred / Retail: $20 Copay per prescription for Non-Preferred at Walgreen's/Publix.	Not covered	Covers up to 31 day supply at retail pharmacy, and up to 93 day supply for mail order.
	Preferred brand drugs	Retail: $35 Copay per prescription at FHCP / Mail Order: $102 Copay per prescription / Retail: $40 Copay per prescription at Walgreen's/Publix.	Not covered	Covers up to 31 day supply at retail pharmacy, and up to 93 day supply for mail order.
	Non-preferred brand drugs	Retail: $60 Copay per prescription at FHCP / Mail Order: $177 Copay per prescription/ Retail: $65 Copay per prescription at Walgreen's/Publix.	Not covered	Covers up to 31 day supply at retail pharmacy, and up to 93 day supply for mail order.
	Specialty drugs	Retail: 15% Coinsurance for Preferred Specialty at FHCP. 25% Coinsurance for Non-Preferred Specialty at FHCP.	Not covered	Available at FHCP pharmacies only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Pre-certification/pre-authorization of coverage required for non-emergency outpatient surgical care. Your benefits / services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Prior approval required. Your benefits / services may be denied.
If you need	Emergency room care	Deductible + 10% Coinsurance	In-Network Deductible +	————none————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
immediate medical attention			10% Coinsurance	
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Urgent care	10% Coinsurance	10% Coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 Copay/Visit	Deductible + 50% Coinsurance	————none————
	Inpatient services	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
If you are pregnant	Office visits	$50 Copay/Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
	Childbirth/delivery facility services	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Prior approval required. Your benefits / services may be denied. Prior approval required. Coverage limited to 60 visits.
	Rehabilitation services	$50 Copay/Visit	Deductible + 50% Coinsurance	Coverage limited to 20 visits. Includes Physical, Speech, Occupational Therapy

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Pre-certification/pre-authorization of coverage required. Your benefits / services may be denied. Coverage limited to 20 days.
	Durable medical equipment	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior approval required. Your benefits / services may be denied.
	Hospice services	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Bariatric surgery

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-877-615-4022. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-877-615-4022.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-615-4022.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-615-4022.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-615-4022.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2700
Specialist copayment	$50
Hospital (facility) coinsurance	10%
Other copayment	$50

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$200
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,560

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2700
Specialist copayment	$50
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,220

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2700
Specialist copayment	$50
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,400

The plan would be responsible for the other costs of these EXAMPLE covered services.

Discrimination is Against the Law

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

Florida Health Care 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, audio, accessible electronic formats, other 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, contact:

- Florida Health Care Plans : 1-877-615-4022

If you believe that Florida Health Care 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: Florida Health Care Plans, Civil Rights Coordinator, 1340 Ridgewood Avenue, Holly Hill, FL 32117. Phone: 1-844-219-6137, TTY: 1-800-955-8770. Fax: 386-676-7149, Email: rights@fhcp.com.

You can file grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-615-4022. (TTY: 1-800-955-8770)**

Florida Health Care Plans

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-615-4022** (TTY: **1-800-955-8770**).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-615-4022 (TTY: 1-800-955-8770).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-615-4022 (TTY: 1-800-955-8770).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-615-4022 (TTY: 1-800-955-8770).

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 1-877-615-4022（TTY：1-800-955-8770）

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-615-4022 (ATS : 1-800-955-8770).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-615-4022 (TTY: 1-800-955-8770).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-615-4022 (телетайп: 1-800-955-8770).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-615-4022 (رقم هاتف الصم والبكم: 1-800-955-8770).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-615-4022 (TTY: 1-800-955-8770).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-615-4022 (TTY: 1-800-955-8770).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-615-4022 (TTY: 1-800-955-8770)번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-615-4022 (TTY: 1-800-955-8770).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-615-4022 (TTY: 1-800-955-8770).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-615-4022 (TTY: 1-800-955-8770).

Large Group POS
Health Benefit Plan VCSB – LT6

Florida Health Care Plans

Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Medical Benefits Deductible (EM DED[1]) (PBP[2]) (DED is the amount the member is responsible for before FHCP pays)	$2,700 per person $5,400 per family	$4,500 per person $9,000 per family
Prescription Drug Benefits Deductible (DED[1]) (PBP[2]) (DED is the amount the member is responsible for before FHCP pays)	$0 per person $0 per family	Not Covered
Coinsurance (Coinsurance is the percentage the member pays for services)	10% of Allowed Amount	50% of Allowed Amount
Out-of-Pocket Maximum (EM OOPM[3]) (PBP[2]) (OOPM includes DED, Coinsurance, Copayments and Prescription Drugs)	$6,000 per person $12,000 per family	$10,000 per person $20,000 per family
Office Services		
Physician Office Services (per visit) Primary Care Office Specialist	 $35 Copay $50 Copay	 Deductible + 50% Deductible + 50%
Maternity (Office Cost Share for initial visit only. Delivery charges are separate) Primary Care Physician Specialist	 $35 Copay $50 Copay	 Deductible + 50% Deductible + 50%
Allergy Injections (per visit) Primary Care Physician Specialist	 $10 Copay $10 Copay	 Deductible + 50% Deductible + 50%
Medical Pharmacy: 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. Prior authorization is required. Preferred Medications Non-Preferred Medications	 Deductible + 10% Deductible + 10%	 Deductible + 50% Deductible + 50%
Important: The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the Office Services and/or Outpatient Facility Cost Share. Medical Pharmacy does not include immunizations, allergy injections or Services covered through the pharmacy program. Please refer to your Certificate of Coverage for a description of Medical Pharmacy.		
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, Blood Work and Immunizations	$0	Deductible + 50%
Mammogram Screening	$0	Deductible + 50%
Bone Density Screening	$0	Deductible + 50%
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0	Deductible + 50%
Emergency Medical Care		
Urgent Care Centers (per visit)	10% Coinsurance	10% Coinsurance
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)	Deductible + 10%	In-Network Deductible + 10%
Ambulance Services	Deductible + 10%	In-Network Deductible + 10%

EM DED[1] = Deductible is Embedded. A covered member's family deductible costs are capped at the individual deductible amount on the family plan.
PBP[2] = Per Benefit Period
EM OOPM[3] = Out-of-Pocket Maximum is Embedded: A covered family member's out-of-pocket costs are capped at the individual out-of-pocket maximum amount on the family plan.
Note: Out-of-Network services may be subject to balance billing.

Florida Health Care Plans is an Independent Licensee of the Blue Cross and Blue Shield Association.

Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Outpatient Diagnostic and Therapeutic Services - services with an asterisk * require prior authorization. Charges are per visit/test.		
Independent Diagnostic Testing Facility/Provider's Office		
Allergy Testing	$0	Deductible + 50%
X-rays and Ultrasounds	$50 Copay	Deductible + 50%
Diagnostic Services (except AIS)	$50 Copay	Deductible + 50%
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	Deductible + 10%	Deductible + 50%
*Radiation Therapy	$50 Copay	Deductible + 50%
Independent Clinical Lab (diagnostic testing of blood and specimens)	$0	Deductible + 50%
Outpatient Hospital Facility Services (per visit)		
X-rays and Ultrasounds	Deductible + 10%	Deductible + 50%
Diagnostic Services (except AIS)	Deductible + 10%	Deductible + 50%
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	Deductible + 10%	Deductible + 50%
*Radiation Therapy	$50 Copay	Deductible + 50%
Important: Diagnostic or therapeutic services rendered in physician offices, testing centers or other outpatient locations that are owned and operated by a hospital system are considered by the hospital system to be departments of the hospital. As a result, FHCP will be billed by the hospital for such services, and the member's outpatient hospital benefit will be applied to these claims. FHCP's Provider Directories and online Provider Search application provides information regarding which provider offices are actually hospital outpatient departments. Members should contact FHCP's cost estimation center to determine if having the diagnostic test or service performed in a hospital or hospital owned facility will result in higher cost sharing.		
Delivery / Hospital / Surgical - * all services require prior authorization		
*Ambulatory Surgical Center Facility (ASC)	Deductible + 10%	Deductible + 50%
*Birthing Center	Deductible + 10%	Deductible + 50%
*Outpatient Hospital Facility Services (surgical) (per visit)	Deductible + 10%	Deductible + 50%
*Inpatient Hospital Facility (per admit)	Deductible + 10%	Deductible + 50%
Mental Health / Substance Dependency - services with an asterisk * require prior authorization		
*Inpatient Hospitalization Facility Services (per admit)	Deductible + 10%	Deductible + 50%
Outpatient Facility Service (per visit)	$50 Copay	Deductible + 50%
*Partial Hospitalization (per admit)	Deductible + 10%	Deductible + 50%
*Residential/Rehabilitation Facility (per day)	$50 Copay	Deductible + 50%
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)	Deductible + 10%	In-Network Deductible + 10%
Provider Services at Hospital/Crisis Unit		
Primary Care Physician / Specialist	Deductible + 10%	Deductible + 50%
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician / Specialist	Deductible + 10%	Deductible + 50%
Outpatient Office Visit		
Primary Care Physician	$35 Copay	Deductible + 50%
Specialist	$50 Copay	Deductible + 50%
Other Provider Services		
Provider Services at ER	Deductible + 10%	In-Network Deductible + 10%
Provider Services at Hospital / Birthing Center		
Inpatient/Outpatient	Deductible + 10%	Deductible + 50%
Provider Services at an Ambulatory Surgical Center (ASC)	Deductible + 10%	Deductible + 50%

Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Other Special Services - services with an asterisk * require prior authorization		
Combined Limit for Outpatient Occupational, Physical and Speech Therapy (per visit)	$50 Copay	Deductible + 50%
Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit)	$50 Copay	Deductible + 50%
Chiropractic Care (per visit)	$50 Copay	Deductible + 50%
*Durable Medical Equipment	Deductible + 10%	Deductible + 50%
*Prosthetics and Medical Brace Device	Deductible + 10%	Deductible + 50%
*Home Health Care (per visit)	Deductible + 10%	Deductible + 50%
*Skilled Nursing Facility (per day)	Deductible + 10%	Deductible + 50%
Hospice	Deductible + 10%	Deductible + 50%
Hearing Exam (Audiologist/Specialist)	$50 Copay	Deductible + 50%
Telehealth Services Medical Visit Mental Health/Behavioral Health Visit	 $10 Copay $30 Copay	 Not Covered Not Covered
Diabetes Care Management		
Diabetes Outpatient Self-Management Education	$0	Not Covered
Glucometer (2 per year)	$0	Not Covered
Annual Complete Diabetic Eye Exam (Optometrist/Ophthalmologist)	$35/$50 Copay	Deductible + 50%
50 Test Strips (per box)	$10 Copay	Not Covered
Lancets (per box)	$4 Copay	Not Covered

*Prior Authorization is Required: There are certain medical services, supplies and medications for which members are required to obtain Prior Authorization before receiving. If you don't obtain prior authorization from FHCP, you will have to pay the entire cost of the service, supply or medication. Before receiving a service, supply or medication you should visit www.fhcp.com or call toll-free 1-877-615-4022 to see if prior authorization is required.

Schedule of Benefits for Covered Services	Amount Member Pays		
Prescription Drug Program			
Network Provider Services: A Network Provider pharmacy must be used when a member needs to have a prescription filled or the member will have to pay the full cost of the drug (except in certain situations such as emergencies). Members should log into their member account at www.fhcp.com and click Find a Pharmacy to locate a Network Provider pharmacy. Mail Order is only available through FHCP Pharmacy.			
	Network Pharmacy (1 month supply)		Mail Order (3 month supply)
	FHCP	Walgreens & Publix	FHCP Only
Generic Drugs Preventive (e.g., oral contraceptives) Preferred Generic Non Preferred Generic	 $0 $3 Copay $12 Copay	 Not Covered $12 Copay $20 Copay	 $0 $6 Copay $33 Copay
Preferred Brand Drugs	$35 Copay	$40 Copay	$102 Copay
Non-Preferred Brand Drugs	$60 Copay	$65 Copay	$177 Copay
Specialty Drugs (Prior authorization is required)			
Preferred Specialty	15% Coinsurance	Not Covered	Not Covered
Non Preferred Specialty	25% Coinsurance	Not Covered	Not Covered

If a Brand Name Prescription Drug is requested when there is a Generic Prescription Drug available, the member will be responsible for paying the Usual and Customary cash price for that prescription.

FHCP Pharmacy benefit provides coverage for Generic contraceptive medications or devices (e.g., oral contraceptives, emergency contraceptive, and diaphragms) at no cost when obtained from a pharmacy owned and operated by FHCP. FHCP's Pharmacy Benefit also covers certain preventive medications at no cost in accordance with the United States Preventative Task Force (USPSTF) Affordable Care Act A and B recommendations as long as all criteria are met and the medication is obtained from a FHCP owned and operated pharmacy.

Schedule of Benefits for Covered Services	Amount Member Pays - Network Provider
Pediatric Vision	
Network Provider Services: The services listed below must be received from a Network Provider or the member will have to pay the full cost of the service (except in certain situations such as emergencies). Members should log onto www.fhcp.com and click **Find a Provider/Facility** to locate a Network Provider near them.	
Exam	Not Covered
Eyeglass Lenses	Not Covered
Frames	Pediatric Selection: Not Covered Non-Selection: Not Covered
Contact Lenses *(Instead of eyeglasses)* Includes contact lenses, evaluation, fitting and follow up care.	Pediatric Selection: Not Covered Non-Selection: Not Covered
Note: Anything over the allowance will not count toward your out-of-pocket maximum limitation.	
Pediatric Dental	
Preventive, Basic and Major Services	Not Covered

Benefit Maximums - Combined Limit In-Network and Out-of-Network	
Home Health Care	60 Visits PBP
OT, PT, ST Outpatient Rehabilitation Therapy	20 Visits PBP
Cardiac and Pulmonary Therapy	20 Visits PBP
Chiropractic Care	20 Visits PBP
Skilled Nursing/Rehabilitation Facility	20 Days PBP
Behavioral Health Residential Facility	20 Days PBP

Additional Benefits and Features

- To find out more about their benefits and/or treatment options, members are encouraged to call the Member Services Department at 1-877-615-4022. This can help them save time and money.
- Members have online access to view their health benefit plan information as well as self-service tools through the Member Portal at www.fhcp.com.

This is not an insurance contract or Benefit Booklet. This Benefit Schedule is only a partial description of the many benefits and services provided or authorized by Florida Health Care Plans. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Health Care Plans Certificate of Coverage; its terms prevail.