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/qhp-ind-2020.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.cciio.cms.gov or call 1-877-615-4022 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: **$2900** per person | **$5800** per group. Out of network: **$5000** per person | **$10000** per group. Does not apply to preventive care.	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 generic prescription drug coverage.	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 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?	In Network: **$8150** per person | **$16300** per group. Out of Network: **$8000** per person |**$16000** per group.	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 and balance-billed charges 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 **http://www.fhcp.com/findproviders/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 don't need a referral to see a specialist.	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		Limitation, 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	$40 Copay	50% Coinsurance after deductible	Additional cost share may apply for Allergy Shots, Injections and Infusions.
	Specialist visit	$65 Copay	50% Coinsurance after deductible	Additional cost share may apply for Allergy Shots, Injections and Infusions.
	Preventive care/ screening/ immunization	No Charge	50% Coinsurance after deductible	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance after deductible	50% Coinsurance after deductible	-----None-----
	Imaging(CT/PET scans, MRIs)	30% Coinsurance after deductible	50% Coinsurance after deductible	Prior authorization is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.fhcp.com/qhp-2020	Generic Drugs - Preferred / Non-Preferred	$3/$10 Copay	Not covered	31 Days per Benefit Period. Available at FHCP and Select In-Network Walgreen's Pharmacies Only. Up to 93 day Mail Order available through FHCP Only. Refer to the schedule of benefits for cost sharing at Walgreen's pharmacy.
	Preferred brand drugs	$30 Copay after deductible	Not covered	31 Days per Benefit Period. Available at FHCP and Select In-Network Walgreen's Pharmacies Only. Up to 93 day Mail Order available through FHCP Only. Refer to the schedule of benefits for cost sharing at Walgreen's pharmacy.
	Non-preferred brand drugs	$55 Copay after deductible	Not covered	31 Days per Benefit Period. Available at FHCP and Select In-Network Walgreen's Pharmacies Only. Up to 93 day Mail Order available through FHCP Only. Refer to the schedule of benefits for cost sharing at Walgreen's pharmacy.
	Specialty drugs - Preferred / Non-Preferred	40%/50% Coinsurance after deductible	Not covered	31 Days per Benefit Period. Available at FHCP Pharmacy Only. Mail Order not available.

For more information about limitations and exceptions, see the plan or policy document at www.fhcp.com/documents/coc/qhp-ind-2020.pdf

Common Medical Event	Services You May Need	What You will Pay		Limitation, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after deductible	50% Coinsurance after deductible	Prior authorization is required.
	Physician/surgeon fees	30% Coinsurance after deductible	50% Coinsurance after deductible	Prior authorization is required.
If you need immediate medical attention	Emergency room care	30% Coinsurance after deductible	30% Coinsurance after In-Network deductible	-----None-----
	Emergency Medical transportation	30% Coinsurance after deductible	30% Coinsurance after In-Network deductible	-----None-----
	Urgent Care	$75 Copay	$75 Copay	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after deductible	50% Coinsurance after deductible	Pre-certification/pre-authorization of coverage required for non-emergency admissions.
	Physician/surgeon fees	30% Coinsurance after deductible	50% Coinsurance after deductible	Prior approval required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$65 Copay	50% Coinsurance after deductible	-----None-----
	Inpatient services	30% Coinsurance after deductible	50% Coinsurance after deductible	Pre-certification/pre-authorization of coverage required for non-emergency admissions.
If you are pregnant	Office visits	$65 Copay	50% Coinsurance after deductible	-----None-----
	Childbirth/delivery professional services	30% Coinsurance after deductible	50% Coinsurance after deductible	Pre-certification/pre-authorization of coverage required for non-emergency admissions.
	Childbirth/delivery facility services	30% Coinsurance after deductible	50% Coinsurance after deductible	Pre-certification/pre-authorization of coverage required for non-emergency admissions.

For more information about limitations and exceptions, see the plan or policy document at www.fhcp.com/documents/coc/qhp-ind-2020.pdf

Common Medical Event	Services You May Need	What You will Pay		Limitation, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	50% Coinsurance after deductible	20 Days per Benefit Period. Prior authorization is required.
	Rehabilitation services	$65 Copay	50% Coinsurance after deductible	35 Visit(s) per Benefit Period. Includes Physical Therapy, Speech Therapy and Occupational Therapy.
	Habilitation services	$65 Copay	50% Coinsurance after deductible	35 Visit(s) per Benefit Period. Includes Physical Therapy, Speech Therapy and Occupational Therapy.
	Skilled nursing care	30% Coinsurance after deductible	50% Coinsurance after deductible	60 Days per Benefit Period. Prior authorization is required.
	Durable medical equipment	30% Coinsurance	50% Coinsurance after deductible	Prior authorization is required.
	Hospice services	30% Coinsurance after deductible	50% Coinsurance after deductible	-----None-----
If your child needs dental or eye care	Children's eye exam	$10 Copay	Not Covered	1 Visit(s) per Year
	Children's glasses	$25 Copay	Not Covered	1 Item(s) per Year
	Children's dental check-up	Not covered	Not covered	-----None-----

Excluded Services & Other Covered Services

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Routine eye care (Adult)
- Weight loss programs
- Abortion with the Exception of Limited Services

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

- Chiropractic care

For more information about limitations and exceptions, see the plan or policy document at www.fhcp.com/documents/coc/qhp-ind-2020.pdf

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 wwww.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 Benefit 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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the 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.——————————

For more information about limitations and exceptions, see the plan or policy document at www.fhcp.com/documents/coc/qhp-ind-2020.pdf

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	$2,900
Specialist copayment	$65
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE even includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery facility Services
Diagnostic test (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,900
Copayments	$1,230
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,190**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,900
Specialist copayment	$65
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,900
Copayments	$1,490
Coinsurance	$40
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,490**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,900
Specialist copayment	$65
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$970
Copayments	$460
Coinsurance	$420
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,850**

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

Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

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.

Florida Health Care Plans

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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)**

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).