

# Large Group HMO Health Benefit Plan TH1

## Schedule of Benefits for Covered Services

Amount Member Pays  
In-Network      Out-of-Network

| Financial Features                                                                                                                                                                                                                                                                                                                                                                                |                                           |                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------|
| <b>Medical Benefits Deductible</b> (EM DED <sup>1</sup> ) (PBP <sup>2</sup> )<br>(DED is the amount the member is responsible for before FHCP pays)                                                                                                                                                                                                                                               | \$2,500 per person<br>\$5,000 per family  | Not Covered                |
| <b>Prescription Drug Benefits Deductible</b> (EM DED <sup>1</sup> ) (PBP <sup>2</sup> )<br>(DED is the amount the member is responsible for before FHCP pays)                                                                                                                                                                                                                                     | \$0 per person<br>\$0 per family          | Not Covered                |
| <b>Coinsurance</b><br>(Coinsurance is the percentage the member pays for services)                                                                                                                                                                                                                                                                                                                | 20% of Allowed Amount                     | Not Covered                |
| <b>Out-of-Pocket Maximum</b> (EM OOPM <sup>3</sup> ) (PBP <sup>2</sup> )<br>(OOPM includes DED, Coinsurance, Copayments and Prescription Drugs)                                                                                                                                                                                                                                                   | \$5,500 per person<br>\$11,000 per family | Not Covered                |
| Office Services                                                                                                                                                                                                                                                                                                                                                                                   |                                           |                            |
| <b>Physician Office Services</b> (per visit)<br>Primary Care<br>Specialist                                                                                                                                                                                                                                                                                                                        | \$20 Copay<br>\$35 Copay                  | Not Covered<br>Not Covered |
| <b>Maternity</b> (Office Cost Share for initial visit only. Delivery charges are separate)<br>Primary Care<br>Specialist                                                                                                                                                                                                                                                                          | \$20 Copay<br>\$35 Copay                  | Not Covered<br>Not Covered |
| <b>Allergy Injections</b> (per visit)<br>Primary Care<br>Specialist                                                                                                                                                                                                                                                                                                                               | 20% Coinsurance<br>20% Coinsurance        | Not Covered<br>Not Covered |
| <b>Medical Pharmacy:</b> Medications administered by a health care provider in an office or outpatient setting. Includes chemotherapy, infusions, dialysis, therapeutic injections and other medications ordered and administered by a provider. Prior authorization is required.<br>Preferred Medications<br>Non-Preferred Medications                                                           | 15% Coinsurance<br>25% Coinsurance        | Not Covered<br>Not Covered |
| 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 prescription drug program. Please refer to your Certificate of Coverage for a description of Medical Pharmacy. |                                           |                            |
| Preventive Care                                                                                                                                                                                                                                                                                                                                                                                   |                                           |                            |
| <b>Routine Adult &amp; Child Preventive Services, Wellness Services, Blood Work and Immunizations</b>                                                                                                                                                                                                                                                                                             | \$0                                       | Not Covered                |
| <b>Mammogram Screening</b>                                                                                                                                                                                                                                                                                                                                                                        | \$0                                       | Not Covered                |
| <b>Bone Density / Osteoporosis Screening</b>                                                                                                                                                                                                                                                                                                                                                      | \$0                                       | Not Covered                |
| <b>Colonoscopy</b> (Routine for age 45+)                                                                                                                                                                                                                                                                                                                                                          | \$0                                       | Not Covered                |
| Emergency Medical Care                                                                                                                                                                                                                                                                                                                                                                            |                                           |                            |
| <b>Urgent Care Centers</b> (per visit)                                                                                                                                                                                                                                                                                                                                                            | \$75 Copay                                | \$75 Copay                 |
| <b>Hospital Emergency Room or Stand-Alone Emergency Facility Services</b> (per visit)<br>(waived if admitted)                                                                                                                                                                                                                                                                                     | \$200 Copay                               | \$200 Copay                |
| <b>Ambulance Services</b>                                                                                                                                                                                                                                                                                                                                                                         | \$150 Copay                               | \$150 Copay                |

<sup>1</sup> EM DED = Deductible is Embedded: A covered member's family deductible costs are capped at the individual deductible amount on the family plan.

<sup>2</sup> PBP = Per Benefit Period

<sup>3</sup> EM OOPM = 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.

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

# Large Group HMO Health Benefit Plan TH1

| Schedule of Benefits for Covered Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Amount Member Pays                                                           |                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | In-Network                                                                   | Out-of-Network                                           |
| <b>Outpatient Diagnostic and Therapeutic Services - services with an asterisk * require prior authorization. Charges are per visit/test.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                              |                                                          |
| <b>Independent Diagnostic Facility/Provider's Office</b><br>Allergy Testing<br>X-rays and Ultrasounds<br>Diagnostic Services (except AIS)<br>*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | \$0<br>\$30 Copay<br>\$30 Copay<br>\$150 Copay                               | Not Covered<br>Not Covered<br>Not Covered<br>Not Covered |
| <b>*Therapeutic Services</b> - <i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, hyperbaric oxygen therapy and radiation oncology.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 25% Coinsurance                                                              | Not Covered                                              |
| <b>Independent Clinical Lab</b> (diagnostic testing of blood and specimens)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | \$0                                                                          | Not Covered                                              |
| <b>Outpatient Hospital Facility Services</b> (per visit)<br>Lab Services<br>X-rays and Ultrasounds<br>Diagnostic Services (except AIS)<br>*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Deductible + 20%<br>Deductible + 20%<br>Deductible + 20%<br>Deductible + 20% | Not Covered<br>Not Covered<br>Not Covered<br>Not Covered |
| <b>*Therapeutic Services</b> - <i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, hyperbaric oxygen therapy and radiation oncology.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 25% Coinsurance                                                              | Not Covered                                              |
| <b>Important:</b> 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. Therapeutic services will incur separate charges for the facility service, physician fee and medical pharmacy. 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. |                                                                              |                                                          |
| <b>Delivery / Hospital / Surgical -*all services require prior authorization</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                              |                                                          |
| <b>*Ambulatory Surgical Center Facility (ASC)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Deductible + 20%                                                             | Not Covered                                              |
| <b>*Birthing Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Deductible + 20%                                                             | Not Covered                                              |
| <b>*Outpatient Hospital Facility Services</b> (per visit)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Deductible + 20%                                                             | Not Covered                                              |
| <b>*Inpatient Hospital Facility</b> (per admit)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Deductible + 20%                                                             | Not Covered                                              |
| <b>Mental Health / Substance Dependency-- services with an asterisk * require prior authorization</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                              |                                                          |
| <b>Outpatient Office Visit</b><br>Primary Care<br>Specialist<br>Group Therapy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$20 Copay<br>\$35 Copay<br>\$0                                              | Not Covered<br>Not Covered<br>Not Covered                |
| <b>*Inpatient Hospital Facility</b> (per admit)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Deductible + 20%                                                             | Not Covered                                              |
| <b>*Partial Hospitalization</b> (per day)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Deductible + 20%                                                             | Not Covered                                              |
| <b>*Outpatient Facility Service</b> (per day)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$10 Copay                                                                   | Not Covered                                              |
| <b>*Residential/Rehabilitation Facility</b> (per day)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | \$10 Copay                                                                   | Not Covered                                              |
| <b>Other Provider Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                              |                                                          |
| <b>Provider Services at ER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | \$0                                                                          | \$0                                                      |
| <b>Provider Services at Hospital /Birthing Center</b><br>Inpatient<br>Outpatient                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Deductible + 20%<br>Deductible + 20%                                         | Not Covered<br>Not Covered                               |
| <b>Provider Services at an Ambulatory Surgical Center (ASC)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Deductible + 20%                                                             | Not Covered                                              |
| <b>Provider Services at Locations other than Office, Hospital and ER</b><br>Primary Care<br>Specialist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$20 Copay<br>\$35 Copay                                                     | Not Covered<br>Not Covered                               |

**Large Group HMO  
Health Benefit Plan TH1**

**Schedule of Benefits for Covered Services**

Amount Member Pays  
In-Network      Out-of-Network

| <b>Other Special Services – services with an asterisk * require prior authorization</b>                                                                                                                   |                                    |                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------|
| <b>Combined Limit for Outpatient Occupational, Physical and Speech Therapy</b> (per visit)                                                                                                                | \$35 Copay                         | Not Covered                |
| <b>*Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy</b> (per visit)                                                                                                            | \$35 Copay                         | Not Covered                |
| <b>Chiropractic Care</b> (per visit)                                                                                                                                                                      | \$35 Copay                         | Not Covered                |
| <b>*Durable Medical Equipment</b><br>Motorized Wheelchair<br>All Other                                                                                                                                    | 20% Coinsurance<br>20% Coinsurance | Not Covered<br>Not Covered |
| <b>*Prosthetics and Medical Brace Device</b>                                                                                                                                                              | 20% Coinsurance                    | Not Covered                |
| <b>*Home Health Care</b> (per day)                                                                                                                                                                        | 20% Coinsurance                    | Not Covered                |
| <b>*Skilled Nursing Facility</b> (per day)                                                                                                                                                                | \$10 Copay                         | Not Covered                |
| <b>Hospice</b> (per day)                                                                                                                                                                                  | 20% Coinsurance                    | Not Covered                |
| <b>*Enteral Formulas</b>                                                                                                                                                                                  | 20% Coinsurance                    | Not Covered                |
| <b>Telehealth Services</b><br>General Medicine visit rendered by a designated Telehealth Services Provider<br>Mental Health/Behavioral Health visit rendered by a designated Telehealth Services Provider | \$0<br>\$30 Copay                  | Not Covered<br>Not Covered |
| <b>Diabetes Care Management</b>                                                                                                                                                                           |                                    |                            |
| <b>Diabetes Outpatient Self-Management Education</b>                                                                                                                                                      | \$0                                | Not Covered                |
| <b>Glucometer</b> (2 per year)                                                                                                                                                                            | \$0                                | Not Covered                |
| <b>50 Test Strips</b> (per box)                                                                                                                                                                           | \$10 Copay                         | Not Covered                |
| <b>Lancets</b> (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](http://www.fhcp.com) or call toll-free 1-877-615-4022 to see if prior authorization is required.

| <b>Benefit Maximums</b>                                 |               |
|---------------------------------------------------------|---------------|
| <b>Home Health Care</b>                                 | 60 Days PBP   |
| <b>OT, PT, ST Outpatient Rehabilitation Therapy</b>     | 20 Visits PBP |
| <b>Cardiac and Pulmonary Therapy</b>                    | 20 Visits PBP |
| <b>Chiropractic Care</b>                                | 20 Visits PBP |
| <b>Skilled Nursing Facility/Rehabilitation Facility</b> | 20 Days PBP   |
| <b>Behavioral Health Residential Facility</b>           | 20 Days PBP   |

**Large Group HMO  
Health Benefit Plan TH1**

**Schedule of Benefits for Covered Services**

Amount Member Pays

**Prescription Drug Program**

**Pharmacy Network:** A Preferred Retail pharmacy is an FHCP owned and operated pharmacy. A Non-Preferred Retail Pharmacy is a participating network pharmacy that is listed in FHCP's Pharmacy Directory and is not owned and operated by FHCP. Members must use a Preferred FHCP pharmacy or a Non-Preferred Retail pharmacy 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). Mail Order is only available through FHCP Mail Order Pharmacy. Members should log into their member account at [www.fhcp.com](http://www.fhcp.com) and click Find a Pharmacy to locate a Network Provider pharmacy.

|                                                          | Retail Network Pharmacies<br>(1 month supply) |               | Mail Order<br>(3 month supply) |
|----------------------------------------------------------|-----------------------------------------------|---------------|--------------------------------|
|                                                          | Preferred - FHCP                              | Non-Preferred | FHCP Only                      |
| <b>Generic Drugs</b>                                     |                                               |               |                                |
| Preventive (e.g., oral contraceptives)                   | \$0                                           | Not Covered   | \$0                            |
| Preferred Generic                                        | \$3 Copay                                     | \$15 Copay    | \$6 Copay                      |
| Non-Preferred Generic                                    | \$10 Copay                                    | \$15 Copay    | \$27 Copay                     |
| <b>Preferred Brand Drugs</b>                             | \$30 Copay                                    | \$35 Copay    | \$87 Copay                     |
| <b>Non-Preferred Brand Drugs</b>                         | \$55 Copay                                    | \$60 Copay    | \$162 Copay                    |
| <b>Specialty Drugs</b> (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 supplies (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      Out-of-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](http://www.fhcp.com) and click **Find a Provider/Facility** to locate a Network Provider near them.

|                                                                                               |             |             |
|-----------------------------------------------------------------------------------------------|-------------|-------------|
| <b>Eyeglass Exam</b> (1x per year)                                                            | Not Covered | Not Covered |
| <b>Eyeglasses</b> (includes frames & lenses - single vision, bifocal, trifocal or lenticular) | Not Covered | Not Covered |
| <b>Contact Lenses Exam</b> (1x per year) <i>(Instead of eyeglass exam)</i>                    | Not Covered | Not Covered |
| <b>Contact Lenses</b> (2 boxes, 1x per year) <i>(Instead of eyeglasses)</i>                   | Not Covered | Not Covered |

**Note:** Anything over the allowance will not count toward your out-of-pocket maximum limitation.

**Pediatric Dental**

|                                             |             |
|---------------------------------------------|-------------|
| <b>Preventive, Basic and Major Services</b> | Not Covered |
|---------------------------------------------|-------------|

#### Additional Benefits and Features

- In the event the allowable rate for a service rendered is less than the Member's contractual copayment amount for that service, the member will be responsible for the lesser charge.
- 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.
- For a list of network providers, please visit <https://www.fhcp.com/our-provider-network> or call 1 (877) 615-4022 to request a printed provider directory.
- 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](http://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.