



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](http://www.cciio.cms.gov) or call 1-877-615-4022 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In Network: \$8150 per person   \$16300 per group. Out of Network: Not Applicable. Does not apply to preventive care.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, Preventive Care.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In Network: \$8150 per person   \$16300 per group. Out of Network: Not Applicable.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, and out-of-network services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.fhcp.com/findproviders/physician">http://www.fhcp.com/findproviders/physician</a> or call 1 (877) 615-4022 for a list of network providers.	This <a href="#">plan</a> uses a <a href="#">provider</a> network. You will pay less if you use a <a href="#">provider</a> 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 <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an out-of-network <a href="#">provider</a> for some services (such as lab work). Check with your provider before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes, a referral is required.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



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)	
<b>If you visit a health care <a href="#">provider's office or clinic</a></b>	Primary care visit to treat an injury or illness	No Charge Visits 1-3, then No Charge after deductible	Not Covered	3 In-Network PCP visits at \$0 cost sharing before deductible and/or cost sharing applies. Additional cost share may apply for Allergy Shots, Injections and Infusions.
	<a href="#">Specialist</a> visit	No Charge after deductible	Not Covered	Additional cost share may apply for Allergy Shots, Injections and Infusions.
	<a href="#">Preventive care/ screening/ immunization</a>	No Charge	Not Covered	-----None-----
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge after deductible	Not Covered	-----None-----
	Imaging(CT/PET scans, MRIs)	No Charge after deductible	Not Covered	Prior authorization is required.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.fhcp.com/qhp-2020">http://www.fhcp.com/qhp-2020</a>	Generic Drugs	No Charge 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.
	Preferred brand drugs	No Charge 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	No Charge 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	No Charge 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](http://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)	No Charge after deductible	Not Covered	Prior authorization is required.
	Physician/surgeon fees	No Charge after deductible	Not Covered	Prior authorization is required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	No Charge after deductible	No Charge after deductible	----None----
	<a href="#">Emergency Medical transportation</a>	No Charge after deductible	No Charge after deductible	----None----
	<a href="#">Urgent Care</a>	No Charge after deductible	No Charge after deductible	----None----
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	Not Covered	Pre-certification/pre-authorization of coverage required for non-emergency admissions.
	Physician/surgeon fees	No Charge after deductible	Not Covered	Prior approval required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after deductible	Not Covered	----None----
	Inpatient services	No Charge after deductible	Not Covered	Pre-certification/pre-authorization of coverage required for non-emergency admissions.
If you are pregnant	Office visits	No Charge after deductible	Not Covered	----None----
	Childbirth/delivery professional services	No Charge after deductible	Not Covered	Pre-certification/pre-authorization of coverage required for non-emergency admissions.
	Childbirth/delivery facility services	No Charge after deductible	Not Covered	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](http://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	<a href="#">Home health care</a>	No Charge after deductible	Not Covered	20 Days per Benefit Period. Prior authorization is required.
	<a href="#">Rehabilitation services</a>	No Charge after deductible	Not Covered	35 Visit(s) per Benefit Period. Includes Physical Therapy, Speech Therapy and Occupational Therapy.
	<a href="#">Habilitation services</a>	No Charge after deductible	Not Covered	35 Visit(s) per Benefit Period. Includes Physical Therapy, Speech Therapy and Occupational Therapy.
	<a href="#">Skilled nursing care</a>	No Charge after deductible	Not Covered	60 Days per Benefit Period. Prior authorization is required.
	<a href="#">Durable medical equipment</a>	No Charge after deductible	Not Covered	Prior authorization is required.
	<a href="#">Hospice services</a>	No Charge after deductible	Not Covered	----None----
If your child needs dental or eye care	Children's eye exam	No Charge after deductible	Not Covered	1 Visit(s) per Year
	Children's glasses	No Charge after deductible	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](http://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](http://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](http://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](http://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](http://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](http://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, kwijjigo holne 1-877-615-4022.

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—————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](http://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](#) \$8,150
- [Specialist copayment](#) 100%
- Hospital (facility) [copayment](#) 100%
- Other [coinsurance](#) 100%

#### 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	\$8,150
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,210</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$8,150
- [Specialist copayment](#) 100%
- Hospital (facility) [copayment](#) 100%
- Other [coinsurance](#) 100%

#### 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	\$5,460
Copayments	\$340
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$5,860</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$8,150
- [Specialist copayment](#) 100%
- Hospital (facility) [copayment](#) 100%
- Other [coinsurance](#) 100%

#### 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	\$1,900
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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](mailto: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>.



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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).

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