Small Group Triple Option Plan
Health Benefit Plan 683

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

Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Medical Benefits Deductible (DED[1]) (PBP[2]) (DED is the amount the member is responsible for before FHCP pays)	Opt. 1: $0 Person / $0 Family Opt. 2: $250 Person/$500 Family	Opt. 3: $500 Person / $1,000 Family
Drug Benefits Deductible (DED[1]) (PBP[2]) (DED is the amount the member is responsible for before FHCP pays)	Opt 1: $0 Person/ $0 Family. Opt 2: N/A	N/A
Coinsurance (Coinsurance is the percentage the member pays for services)	Opt. 1: 15% of Allowed Amount Opt. 2: 20% of Allowed Amount	Opt. 3: 40% of Allowed Amount
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance and Copayments) Pharmacy Not Included	Opt. 1: $1,500 Person/$3,000 Family Opt. 2: $1,500 Person/$3,000 Family	Opt. 3: $3,000 Person / $6,000 Family
Office Services		
Physician Office Services (per visit)		
Primary Care Office	Opt. 1 $10 Copay Opt. 2 $15 Copay	Opt. 3 Deductible + 40%
Specialist	Opt. 1 $20 Copay Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%
Maternity (Cost Share for initial visit only)		
Primary Care Physician	Opt. 1 $10 Copay Opt. 2 $15 Copay	Opt. 3 Deductible + 40%
Specialist	Opt. 1 $20 Copay Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%
Allergy Injections (per visit)		
Primary Care Physician	Opt. 1 $0 Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%
Specialist	Opt. 1 $0 Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%
Medical Pharmacy - Physician-Administered Medications including but not limited to: *Therapeutic Injections *Infusions *Chemotherapy Dialysis Drugs	Opt. 1 $0 Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under the *medical* benefit. *Prior Authorization is required.		
Preventive Care		
Routine Adult & Child Preventive Services and Wellness Services	Opt. 1 & 2 $10/$15 Copay - PCP Opt. 1 & 2 $20/Deductible + 20% - SP	Opt. 3 Deductible + 40%
Immunizations and Blood Work	Opt. 1 & 2 $0	Opt. 3 Deductible + 40%
Mammogram Screening	Opt. 1 & 2 $0	Opt. 3 Deductible + 40%
Bone Density Screening	Opt. 1 & 2 $0	Opt. 3 Deductible + 40%
Colonoscopy (Routine for age 50+ then frequency schedule applies)	Opt. 1 & 2 $0	Opt. 3 Deductible + 40%
Emergency Medical Care		
Urgent Care Centers (per visit)	Opt. 1 $25 Copay Opt. 2 N/A	Opt. 3 $25 Copay
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit) (waived if admitted)	Opt. 1 $60 Copay Opt. 2 N/A	Opt. 3 $60 Copay
Ambulance Services	Opt. 1 $25 Copay Opt. 2 N/A	Opt. 3 $25 Copay

[1] DED = Deductible
[2] PBP = Per Benefit Period
Note: Out-of-Network services may be subject to balance billing.
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Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Outpatient Diagnostic Services - services with an asterisk * require prior authorization		
Independent Diagnostic Testing Facility/Provider's Office Allergy Testing X-rays and Ultrasounds Diagnostic Services (except AIS) *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	Opt. 1 $0 Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%
Independent Clinical Lab (diagnostic testing of blood and specimens)	Opt. 1 $0 Opt. 2 Not Covered	Opt. 3 Deductible + 40%
Outpatient Hospital Facility Services (per visit) X-rays and Ultrasounds Diagnostic Services (except AIS) *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	Opt. 1 $0 Opt. 2 Not Covered	Opt. 3 Deductible + 40%
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.		
Hospital / Surgical – *all services require prior authorization		
*Ambulatory Surgical Center Facility (ASC)	Opt. 1 $0 Opt. 2 Not Covered	Opt. 3 Deductible + 40%
*Outpatient Hospital Facility Services (surgical) (per visit)	Opt. 1 $0 Opt. 2 Not Covered	Opt. 3 Deductible + 40%
*Inpatient Hospital Facility (per admit)	Opt. 1 $200 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 40%
Mental Health / Substance Dependency – services with an asterisk * require prior authorization		
*Inpatient Hospitalization Facility Services (per admit)	Opt. 1 $200 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 40%
Outpatient Facility Service (per visit)	Opt. 1 $15 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 40%
*Partial Hospitalization (per admit)	Opt. 1 $100 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 40%
*Residential/Rehabilitation Facility (per day)	Opt. 1 $10 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 40%
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit) (waived if admitted)	Opt. 1 $60 Copay Opt. 2 N/A	Opt. 3 $60 Copay
Provider Services at Hospital/Crisis Unit Primary Care Physician / Specialist	Opt. 1 $0 Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician / Specialist	Opt. 1 $0 Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%
Outpatient Office Visit Primary Care Physician Specialist – Mental Health Specialist – Substance Dependency	 Opt. 1 $10 Copay Opt. 2 $15 Copay Opt. 1 $20 Copay Opt. 2 Deductible + 20% Opt. 1 $15 Copay Opt. 2 Deductible + 20%	 Opt. 3 Deductible + 40% Opt. 3 Deductible + 40% Opt. 3 Deductible + 40%
Other Provider Services		
Provider Services at ER	Opt. 1 $0 Opt. 2 N/A	Opt. 3 $0
Provider Services at Hospital Inpatient / Outpatient	Opt. 1 $0 Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%
Provider Services at an Ambulatory Surgical Center (ASC)	Opt. 1 $0 Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%

Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Other Special Services – services with an asterisk * require prior authorization		
Combined Limit for Outpatient Occupational, Physical and Speech Therapy (per visit)	Opt. 1 $15 Copay Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%
Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit)	Opt. 1 $15 Copay Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%
Chiropractic Care (per visit)	Opt. 1 $10 Copay Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%
*Durable Medical Equipment	Opt. 1 15% Coinsurance Opt. 2 Not Covered	Opt. 3 Deductible + 40%
*Prosthetics and Medical Brace Device	Opt. 1 $0 Opt. 2 Not Covered	Opt. 3 Deductible + 40%
*Home Health Care (per visit)	Opt. 1 $0 Opt. 2 Not Covered	Opt. 3 Deductible + 40%
*Skilled Nursing Facility (per day)	Opt. 1 $10 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 40%
Hospice	Opt. 1 $0 Opt. 2 Not Covered	Opt. 3 Deductible + 40%
Hearing Exam (Audiologist/Specialist)	Opt. 1 $0 Opt. 2 Deductible + 20%	Opt. 3 Deductible + 40%
*Radiation (per visit)	Opt. 1 $0 Opt 2 Deductible + 20%	Opt. 3 Deductible + 40%
Telehealth Services (PCP/Specialist)	Opt. 1 $10/$30 Copay Opt. 2 N/A	Not Covered
Diabetes Care Management		
Diabetes Outpatient Self-Management Education	Opt.1 $0 Opt. 2 Not Covered	Opt. 3 Not Covered
Glucometer	Opt.1 $0 Opt. 2 Not Covered	Opt. 3 Deductible + 40%
Annual Complete Diabetic Eye Exam (Optometrist/Ophthalmologist)	Opt. 1 $10/$20 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 40%
50 Test Strips/Sensors (per box)	Opt.1 $10 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 40%
Lancets (per box)	Opt.1 $10 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 40%

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

The family out-of-pocket maximum amount is embedded. Any one individual in the covered family can satisfy the individual out-of-pocket maximum for your plan. The entire family amount can be satisfied by any or all of the other covered dependents.

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 Provider/Facility 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	FHCP Only
Generic Drugs			
Preferred Generic	$3 Copay	$15 Copay	$6 Copay
Non Preferred Generic	$10 Copay	$15 Copay	$27 Copay
Preferred Brand Drugs	$30 Copay	$35 Copay	$87 Copay

Schedule of Benefits for Covered Services	Amount Member Pays		
Non-Preferred Brand Drugs	$55 Copay	$60 Copay	$162 Copay
Specialty Drugs (Prior authorization is required)			
Preferred Specialty	$100 Copay	Not Covered	Not Covered
Non Preferred Specialty	$100 Copay	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.			

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	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
OT, PT, ST Outpatient Habilitation Therapy	Not Covered
Cardiac and Pulmonary Outpatient 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 insurance issuer believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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.