

Small Group HDHP POS (HSA Compatible)
Health Benefit Plan S65



Amount Member Pays

In-Network

Out-of-Network

Schedule of Benefits for Covered Services

| Financial Features | | |
|---|--|--|
| Medical Benefits Deductible (DED ¹) (PBP ²) (DED is the amount the member is responsible for before FHCP pays) | \$2,500 per person \$5,000 per family | \$5,000 per person \$10,000 per family |
| Drug Benefits Deductible (DED ¹) (PBP ²) (DED is the amount the member is responsible for before FHCP pays) | Integrated with Medical | Not Covered |
| Coinsurance (Coinsurance is the percentage the member pays for services) | 30% of Allowed Amount | 50% of Allowed Amount |
| Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Pharmacy) | \$4,000 per person \$8,000 per family | \$6,000 per person \$12,000 per family |
| Office Services | | |
| Physician Office Services (per visit) Primary Care Office Specialist | Deductible + 30% Deductible + 30% | Deductible + 50% Deductible + 50% |
| Maternity (Cost Share for initial visit only) Primary Care Physician Specialist | Deductible + 30% Deductible + 30% | Deductible + 50% Deductible + 50% |
| Allergy Injections (per visit) Primary Care Physician Specialist | Deductible + 30% Deductible + 30% | Deductible + 50% Deductible + 50% |
| Medical Pharmacy - Physician-Administered Medications including but not limited to: *Therapeutic Injections *Infusions *Chemotherapy Dialysis Drugs | Deductible + 30% Deductible + 30% Deductible + 30% Deductible + 30% | Deductible + 50% Deductible + 50% Deductible + 50% Deductible + 50% |
| 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 <i>medical</i> benefit. *Prior authorization is required. | | |
| Preventive Care | | |
| Routine Adult & Child Preventive Services, Wellness Services, Blood Work and Immunizations | \$0 | Deductible + 50% |
| Mammogram Screening | \$0 | Deductible + 50% |
| Bone Density Screening | \$0 | Deductible + 50% |
| Colonoscopy (Routine for age 50+ then frequency schedule applies) | \$0 | Deductible + 50% |
| Emergency Medical Care | | |
| Urgent Care Centers (per visit) | Deductible + 30% | In-Network Deductible + 30% |
| Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit) | Deductible + 30% | In-Network Deductible + 30% |
| Ambulance Services | Deductible + 30% | In-Network Deductible + 30% |

¹ DED = Deductible

² PBP = Per Benefit Period

Note: Out-of-Network services may be subject to balance billing.

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

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| Schedule of Benefits for Covered Services | Amount Member Pays | |
|---|--------------------|-----------------------------|
| | In-Network | Out-of-Network |
| Outpatient Diagnostic Services – services with an asterisk * require prior authorization | | |
| Independent Diagnostic Testing Facility/Provider's Office | | |
| Allergy Testing | Deductible + 30% | Deductible + 50% |
| X-rays and Ultrasounds | Deductible + 30% | Deductible + 50% |
| Diagnostic Services (except AIS) | Deductible + 30% | Deductible + 50% |
| *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) | Deductible + 30% | Deductible + 50% |
| Independent Clinical Lab (diagnostic testing of blood and specimens) | Deductible + 30% | Deductible + 50% |
| Outpatient Hospital Facility Services (per visit) | | |
| X-rays and Ultrasounds | Deductible + 30% | Deductible + 50% |
| Diagnostic Services (except AIS) | Deductible + 30% | Deductible + 50% |
| *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) | Deductible + 30% | Deductible + 50% |
| <p>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.</p> | | |
| Hospital / Surgical - *all services require prior authorization | | |
| *Ambulatory Surgical Center Facility (ASC) | Deductible + 30% | Deductible + 50% |
| *Outpatient Hospital Facility Services (surgical) (per visit) | Deductible + 30% | Deductible + 50% |
| *Inpatient Hospital Facility (per admit) | Deductible + 30% | Deductible + 50% |
| Mental Health / Substance Dependency – services with an asterisk * require prior authorization | | |
| *Inpatient Hospitalization Facility Services (per admit) | Deductible + 30% | Deductible + 50% |
| Outpatient Hospitalization Facility Service (per visit) | Deductible + 30% | Deductible + 50% |
| *Partial Hospitalization (per admit) | Deductible + 30% | Deductible + 50% |
| *Residential/Rehabilitation Facility (per day) | Deductible + 30% | Deductible + 50% |
| Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit) | Deductible + 30% | In-Network Deductible + 30% |
| Provider Services at Hospital/Crisis Unit Primary Care Physician / Specialist | Deductible + 30% | Deductible + 50% |
| Provider Services at Locations other than Office, Hospital and ER Primary Care Physician / Specialist | Deductible + 30% | Deductible + 50% |
| Outpatient Office Visit | | |
| Primary Care Physician | Deductible + 30% | Deductible + 50% |
| Specialist | Deductible + 30% | Deductible + 50% |
| Other Provider Services | | |
| Provider Services at ER | Deductible + 30% | In-Network Deductible + 30% |
| Provider Services at Hospital | | |
| Inpatient | Deductible + 30% | Deductible + 50% |
| Outpatient | Deductible + 30% | Deductible + 50% |
| Provider Services at an Ambulatory Surgical Center (ASC) | Deductible + 30% | Deductible + 50% |

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

***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 deductible and out-of-pocket maximum amounts are non-embedded. No individual in a covered family has satisfied the deductible or out-of-pocket maximum until the entire family amount for your plan has been satisfied.

| Schedule of Benefits for Covered Services | Amount Member Pays | | |
|---|---|-------------------------|---------------------------------------|
| | Prescription Drug Program | | |
| <p>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.</p> | | | |
| | Network Pharmacy (1 month supply) | | Mail Order (3 month supply) |
| | FHCP | Walgreens | FHCP Only |
| Generic Drugs | | | |
| Preventive (e.g., oral contraceptives) | \$0 | Not Covered | \$0 |
| Preferred Generic | Deductible + \$3 Copay | Deductible + \$15 Copay | Deductible + \$6 Copay |
| Non Preferred Generic | Deductible + \$10 Copay | Deductible + \$15 Copay | Deductible + \$27 Copay |
| Preferred Brand Drugs | Deductible + \$30 Copay | Deductible + \$35 Copay | Deductible + \$87 Copay |
| Non-Preferred Brand Drugs | Deductible + \$55 Copay | Deductible + \$60 Copay | Deductible + \$162 Copay |
| Specialty Drugs (Prior authorization is required) | | | |
| Preferred Specialty | Deductible + \$125 Copay | Not Covered | Not Covered |
| Non Preferred Specialty | Deductible + \$125 Copay | Not Covered | Not Covered |
| <p>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.</p> | | | |
| <p>FHCP Pharmacy benefit provides coverage for Generic contraceptive medications or devices (e.g., oral contraceptives, emergency contraceptive, and diaphragms) at no cost when obtained from a pharmacy owned and operated by FHCP. FHCP's Pharmacy Benefit also covers certain preventive medications at no cost in accordance with the United States Preventative Task Force (USPSTF) Affordable Care Act A and B recommendations as long as all criteria are met and the medication is obtained from a FHCP owned and operated pharmacy.</p> | | | |

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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 (<i>Instead of eyeglasses</i>) 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 Therapy | 20 Visits PBP |
| Chiropractic Care | 20 Visits PBP |
| Skilled Nursing/Rehabilitation Facility | 20 Days PBP |
| Behavioral Health Residential Facility | 20 Days PBP |

Additional Benefits and Features

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

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