Small Group HDHP POS (HSA Compatible)
Health Benefit Plan S67

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)	$5,000 per person $10,000 per family	$6,000 per person $12,000 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)	40% of Allowed Amount	50% of Allowed Amount
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Pharmacy)	$6,000 per person $12,000 per family	$6,000 per person $12,000 per family
Office Services		
Physician Office Services (per visit)		
Primary Care Office	Deductible + 40%	Deductible
Specialist	Deductible + 40%	Deductible
Maternity (Cost Share for initial visit only)		
Primary Care Physician	Deductible + 40%	Deductible
Specialist	Deductible + 40%	Deductible
Allergy Injections (per visit)		
Primary Care Physician	Deductible + 40%	Deductible
Specialist	Deductible + 40%	Deductible
Medical Pharmacy - Physician-Administered Medications including but not limited to:		
*Therapeutic Injections	Deductible + 40%	Deductible
*Infusions	Deductible + 40%	Deductible
*Chemotherapy	Deductible + 40%	Deductible
Dialysis Drugs	Deductible + 40%	Deductible
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, Wellness Services, Blood Work and Immunizations	$0	Deductible
Mammogram Screening	$0	Deductible
Bone Density Screening	$0	Deductible
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0	Deductible
Emergency Medical Care		
Urgent Care Centers (per visit)	Deductible + 40%	In-Network Deductible + 40%
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)	Deductible + 40%	In-Network Deductible + 40%
Ambulance Services	Deductible + 40%	In-Network Deductible + 40%

[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.

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	Deductible + 40%	Deductible
X-rays and Ultrasounds	Deductible + 40%	Deductible
Diagnostic Services (except AIS)	Deductible + 40%	Deductible
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	Deductible + 40%	Deductible
Independent Clinical Lab (diagnostic testing of blood and specimens)	Deductible + 40%	Deductible
Outpatient Hospital Facility Services (per visit)		
X-rays and Ultrasounds	Deductible + 40%	Deductible
Diagnostic Services (except AIS)	Deductible + 40%	Deductible
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	Deductible + 40%	Deductible
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)	Deductible + 40%	Deductible
*Outpatient Hospital Facility Services (surgical) (per visit)	Deductible + 40%	Deductible
*Inpatient Hospital Facility (per admit)	Deductible + 40%	Deductible
Mental Health / Substance Dependency – services with an asterisk * require prior authorization		
*Inpatient Hospitalization Facility Services (per admit)	Deductible + 40%	Deductible
Outpatient Hospitalization Facility Service (per visit)	Deductible + 40%	Deductible
*Partial Hospitalization (per admit)	Deductible + 40%	Deductible
*Residential/Rehabilitation Facility (per day)	Deductible + 40%	Deductible
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)	Deductible + 40%	In-Network Deductible + 40%
Provider Services at Hospital/Crisis Unit Primary Care Physician / Specialist	Deductible + 40%	Deductible
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician / Specialist	Deductible + 40%	Deductible
Outpatient Office Visit		
Primary Care Physician	Deductible + 40%	Deductible
Specialist	Deductible + 40%	Deductible
Other Provider Services		
Provider Services at ER	Deductible + 40%	In-Network Deductible + 40%
Provider Services at Hospital		
Inpatient	Deductible + 40%	Deductible
Outpatient	Deductible + 40%	Deductible
Provider Services at an Ambulatory Surgical Center (ASC)	Deductible + 40%	Deductible

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)	Deductible + 40%	Deductible
Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit)	Deductible + 40%	Deductible
Chiropractic Care (per visit)	Deductible + 40%	Deductible
*Durable Medical Equipment	Deductible + 40%	Deductible
*Prosthetics and Medical Brace Device	Deductible + 40%	Deductible
*Home Health Care (per visit)	Deductible + 40%	Deductible
*Skilled Nursing Facility (per day)	Deductible + 40%	Deductible
Hospice	Deductible + 40%	Deductible
Hearing Exam (Audiologist/Specialist)	Deductible + 40%	Deductible
*Radiation (per visit)	Deductible + 40%	Deductible
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
Annual Complete Diabetic Eye Exam (Optometrist/Ophthalmologist)	Deductible + 40%	Deductible
50 Test Strips /Sensors (per box)	$10 Copay	Deductible
Lancets (per box)	$10 Copay	Deductible

*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			
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			
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

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 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.

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 go toward your out-of-pocket maximum.	
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.