

 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, <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.fhcp.com or call 1-877-615-4022 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network providers</u> : \$5,600 Individual / \$11,200 Family <u>Out-of-network providers</u> : Not covered	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and generic prescription drug coverage	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes, \$3000 individual / \$3000 family for brand and specialty prescription drug coverage.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>Network providers</u> : \$7,150 Individual / \$14,300 Family <u>Out-of-network providers</u> : Not covered	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.fhcp.com/find-providers/physician or call 1-877-615-4022 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$50 Copay	Not covered	Cost Shares reflect services from non-Indian Health Care providers . Additional cost share may apply for Allergy Shots, Injections and Infusions.
	Specialist visit	\$100 Copay	Not covered	Cost Shares reflect services from non-Indian Health Care providers . Additional cost share may apply for Allergy Shots, Injections and Infusions.
	Preventive care/screening/immunization	No Charge	Not covered	Preventive Colonoscopy (age 50+) 1 every 10 years. High Risk Colonoscopy 1 every 2 years. You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab work: \$20 Copay X-ray: \$50 Copay	Not covered	Cost Shares reflect services from non-Indian Health Care providers . Prior approval required. Your benefits / services may be denied. Tests in hospitals, or facilities owned and operated by hospitals, may have higher cost share.
	Imaging (CT/PET scans, MRIs)	\$400 Copay	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.fhcp.com/qhp-2020	Generic drugs – Preferred / Non-Preferred	\$3 Copay / \$10 Copay	Not covered	Cost Shares reflect services from non-Indian Health Care providers . 31 Days per Benefit Period. Available at FHCP and Walgreen's Pharmacies Only. Up to 93 day Mail Order available through FHCP Only.
	Preferred brand drugs	<u>Deductible</u> + \$30 Copay	Not covered	
	Non-preferred brand drugs	<u>Deductible</u> + \$55 Copay	Not covered	
	Specialty drugs – Preferred / Non-Preferred	<u>Deductible</u> + 40% <u>Coinsurance</u> / <u>Deductible</u> + 50% <u>Coinsurance</u>	Not covered	Cost Shares reflect services from non-Indian Health Care providers . 31 Days per Benefit Period. Available at FHCP pharmacies only.
If you have	Facility fee (e.g., ambulatory)	Deductible + \$350 Copay /	Not covered	Cost Shares reflect services from non-Indian

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/qhp-ind-2020.pdf>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
outpatient surgery	surgery center / outpatient hospital facility)	Deductible + \$500 Copay		Health Care <u>providers</u> . Pre-certification/pre-authorization of coverage required for non-emergency outpatient surgical care. Your benefits / services may be denied.
	Physician/surgeon fees	No Charge after <u>Deductible</u>	Not covered	Cost Shares reflect services from non-Indian Health Care <u>providers</u> . Prior approval required. Your benefits / services may be denied.
If you need immediate medical attention	Emergency room care	<u>Deductible</u> + \$400 Copay	<u>Deductible</u> + \$400 Copay	Cost Shares reflect services from non-Indian Health Care <u>providers</u> . Waived if admitted.
	Emergency medical transportation	\$400 Copay	\$400 Copay	Cost Shares reflect services from non-Indian Health Care <u>providers</u> .
	Urgent care	\$100 Copay	\$100 Copay	Cost Shares reflect services from non-Indian Health Care <u>providers</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>Deductible</u> + \$600 Copay per stay	Not covered	Cost Shares reflect services from non-Indian Health Care <u>providers</u> . Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
	Physician/surgeon fees	No Charge	Not covered	Cost Shares reflect services from non-Indian Health Care <u>providers</u> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$100 Copay	Not covered	Cost Shares reflect services from non-Indian Health Care <u>providers</u> .
	Inpatient services	<u>Deductible</u> + \$600 Copay per stay	Not covered	Cost Shares reflect services from non-Indian Health Care <u>providers</u> . Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
If you are pregnant	Office visits	\$100 Copay	Not covered	Cost Shares reflect services from non-Indian Health Care <u>providers</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery	No Charge	Not covered	Cost Shares reflect services from non-Indian

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/ghp-ind-2020.pdf>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	professional services			Health Care <u>providers</u> . Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
	Childbirth/delivery facility services	<u>Deductible</u> + \$600 Copay	Not covered	Cost Shares reflect services from non-Indian Health Care <u>providers</u> . Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
If you need help recovering or have other special health needs	Home health care	No Charge	Not covered	20 Days per Benefit Period. Prior authorization is required.
	Rehabilitation services	\$100 Copay	Not covered	Cost Shares reflect services from non-Indian Health Care <u>providers</u> . 35 Visits per Benefit Period. Includes Physical Therapy, Speech Therapy and Occupational Therapy.
	Habilitation services	\$100 Copay	Not covered	Cost Shares reflect services from non-Indian Health Care <u>providers</u> . 35 Visits per Benefit Period. Includes Physical Therapy, Speech Therapy and Occupational Therapy.
	Skilled nursing care	\$15 Copay per Day	Not covered	Cost Shares reflect services from non-Indian Health Care <u>providers</u> . 60 Days per Benefit Period. Prior authorization is required.
	Durable medical equipment	No Charge	Not covered	Prior approval required.
	Hospice services	No Charge	Not covered	-----none-----
If your child needs dental or eye care	Children's eye exam	\$10 Copay	Not covered	Cost Shares reflect services from non-Indian Health Care <u>providers</u> . 1 Visit per Year.
	Children's glasses	\$25 Copay	Not covered	Cost Shares reflect services from non-Indian Health Care <u>providers</u> . 1 Item per Year.
	Children's dental check-up	Not covered	Not covered	

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/ghp-ind-2020.pdf>

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|-----------------------|--|--|
| • Acupuncture | • Hearing aids | • Private-duty nursing |
| • Bariatric surgery | • Infertility treatment | • Routine eye care (Adult) |
| • Cosmetic surgery | • Long-term care | • Routine foot care unless for treatment of diabetes |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Dental care (Child) | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care

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 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. 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 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 Benefits Security Administration at 1-866-444-EBSA (3272) or 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.

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 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.

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/qhp-ind-2020.pdf>

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, kwijigo holne' 1-877-615-4022.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)																																											
■ The <u>plan's</u> overall <u>deductible</u>	\$5600	■ The <u>plan's</u> overall <u>deductible</u>	\$5600	■ The <u>plan's</u> overall <u>deductible</u>	\$5600																																										
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■ <u>Other copayment</u>	\$50	■ <u>Other coinsurance</u>	0%	■ <u>Other coinsurance</u>	\$400																																										
<p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> <u>Specialist office visits (prenatal care)</u> Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests (ultrasounds and blood work)</u> <u>Specialist visit (anesthesia)</u> 		<p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> <u>Primary care office visits (including disease education)</u> <u>Diagnostic tests (blood work)</u> <u>Prescription drugs</u> <u>Durable medical equipment (glucose meter)</u> 		<p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> <u>Emergency room care (including medical supplies)</u> <u>Diagnostic test (x-ray)</u> <u>Durable medical equipment (crutches)</u> <u>Rehabilitation services (physical therapy)</u> 																																											
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900																																										
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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.

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>.

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).