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 Average Wholesale Price (AWP) 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.

If you or someone you're helping has questions about **Florida Health Care Plans**, you have the right to get help and information in your language at no cost. To talk to an interpreter, call **1-877-615-4022. (TTY: TRS Relay 711)**

Si usted o alguien a quien ayuda tienen preguntas sobre **Florida Health Care Plans**, tienen derecho a obtener ayuda e información en su idioma de manera gratuita. Para hablar con un intérprete, llame al **1-877-615-4022. (TTY: TRS Relay 711)**

Si ou menm, oswa yon moun w ap ede, gen kesyon sou **Florida Health Care Plans** ,ou gen dwa pou jwenn enfòmasyon nan lang ou gratis. Pou ale ak yon entèprèt, rele **1-877-615-4022. (TTY: TRS Relay 711)**

Nếu quý vị, hoặc người nào đó mà quý vị đang giúp đỡ, có các thắc mắc về **Florida Health Care Plans**, quý vị có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của quý vị miễn phí. Để trao đổi với phiên dịch, hãy gọi theo số **1-877-615-4022. (TTY: TRS Relay 711)**

Se você, ou alguém que estiver a ajudar, tiver dúvidas sobre **Florida Health Care Plans**, tem o direito de obter ajuda e informações na sua língua, sem nenhumas custas. Para falar com um intérprete, ligue para **1-877-615-4022. (TTY: TRS Relay 711)**

如果您或您正協助的某人對**Florida Health Care Plans**
有疑問，您有權免費以您的語言取得本協助及資訊。如欲與口譯員交談，請致電**1-877-615-4022. (TTY: TRS Relay 711)**

Si vous ou une personne que vous aidez avez des questions au sujet de **Florida Health Care Plans**, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, veuillez appeler le **1-877-615-4022. (TTY: TRS Relay 711)**

Kung ikaw, o ang isang taong tinutulungan mo, ay may mga tanong tungkol sa **Florida Health Care Plans**, mayroon kang karapatang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang interpreter, tumawag sa **1-877-615-4022. (TTY: TRS Relay 711)**

Если у Вас или у кого-то, кому Вы помогаете, есть вопросы о программе **Florida Health Care Plans**, Вы имеет право бесплатно получить ответы в переводе на Ваш язык. Для того чтобы воспользоваться помощью устного переводчика, позвоните по телефону **1-877-615-4022. (TTY: TRS Relay 711)**

ذا كان لديك أو الشخص الذي تساعده استفسارات حول [**Florida Health Care Plans**, يحق لك تلقي المساعدة والمعلومات بلغتك مجاناً. تحدث إلى مترجم فوري، اتصل على الرقم [**1-877-615-4022. (TTY: TRS Relay 711)**].

se voi, o una persona che state aiutando, avete domande relative al **Florida Health Care Plans**, avete diritto a ottenere assistenza e informazioni gratuitamente nella vostra lingua. Per parlare con un interprete, chiamare il numero **1-877-615-4022. (TTY: TRS Relay 711)**

Falls Sie oder jemand, dem Sie helfen, irgendwelche Fragen über **Florida Health Care Plans** haben, so haben Sie Anspruch auf kostenlose Unterstützung und Informationen in Ihrer eigenen Sprache. Bitte rufen Sie uns unter der Nummer **1-877-615-4022. (TTY: TRS Relay 711)** an, um mit einem Dolmetscher/einer Dolmetscherin zu sprechen.

귀하 또는 귀하가 도와드리고 있는 분이**Florida Health Care Plans**에 관한 질문이 있을 경우, 귀하에게는 무료로 본인이 구사하는 언어로 도움과 정보를 받을 권리가 있습니다. 통역으로 전화 연결되려면**1-877-615-4022. (TTY: TRS Relay 711)** 번으로 전화해 주십시오.

Jeśli Ty lub ktoś, komu pomagasz macie pytania dotyczące **Florida Health Care Plans**, macie prawo uzyskać pomoc i informacje w swoim języku, bez żadnych kosztów. Porozmawiaj z tłumaczem, zadzwoń pod numer **1-877-615-4022. (TTY: TRS Relay 711)**

જો તમને અથવા તમે જેને મદદ કરી રહ્યાં છો તેમને **Florida Health Care Plans** વિશે કોઈ પ્રશ્નો હોય, તો તમને તમારી ભાષામાં કોઇ પણ ખર્ચ વિના મદદ અને માહિતી મેળવવાનો હક છે. દુભાષિયા સાથે વાત કરવા માટે **1-877-615-4022. (TTY: TRS Relay 711)** પર ફોન કરો.

หากคุณ หรือคนที่คุณกำลังช่วยเหลืออยู่มีคำถามเกี่ยวกับ **Florida Health Care Plans** คุณจะได้รับการช่วยเหลือและได้รับข้อมูลในภาษาของคุณโดยที่ไม่มีค่าใช้จ่ายใดๆ หากต้องการพูดคุยกับล่ามแปลภาษา โทร.
1-877-615-4022. (TTY: TRS Relay 711)

Florida Health Care Plan, Inc. d/b/a Florida Health Care Plans ("FHCP") offers health insurance coverage products. FHCP is an affiliate of Blue Cross and Blue Shield of Florida, Inc. d/b/a Florida Blue. Both companies are Independent Licensees of the Blue Cross and Blue Shield Association.

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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 Daria Siciliano, RN-BC, CCM.

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:

Daria Siciliano, RN-BC, CCM,
Manager of Member Services,
1340 Ridgewood Avenue,
Holly Hill, FL 32117.
Phone: 1-844-219-6137,
TTY: TRS Relay 711,
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, Daria Siciliano, RN-BC, CCM Manager of Member Services 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.