

Amount Member Pays

Schedule of Benefits for Covered Services	In-Network	Out-of-Network
Financial Features		
Medical Benefits Deductible (DED <sup>1</sup> ) (PBP <sup>2</sup> )	\$1,000 per person	N/A
(DED is the amount the member is responsible for before FHCP pays)	\$2,000 per family	
Drug Benefits Deductible (DED <sup>1</sup> ) (PBP <sup>2</sup> ) (DED is the amount the member is responsible for before FHCP pays)	\$0 per person	N/A
	\$0 per family	N1/A
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of Allowed Amount	N/A
Out-of-Pocket Maximum (PBP)	\$5,000 per person	N/A
(Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Pharmacy)	\$10,000 per family	N/A
Office Services		
Physician Office Services (per visit)		
Primary Care Office	\$30 Copay	N/A
Specialist	\$50 Copay	N/A
Maternity (Cost Share for initial visit only)		
Primary Care Physician	\$30 Copay	N/A
Specialist	\$50 Copay	N/A
Allergy Injections (per visit)		
Primary Care Physician	Deductible + 20%	N/A
Specialist	Deductible + 20%	N/A
Medical Pharmacy - Physician-Administered Medications including but not limited to:		
*Therapeutic Injections	Deductible + 20%	N/A
*Infusions	Deductible + 20%	N/A
*Chemotherapy Dialysis Drugs	Deductible + 20% Deductible + 20%	N/A N/A
Physician-Administered Medications – These medications require the administration to be p ordered by a provider and administered in an office or outpatient setting. Physician-Adminis *Prior Authorization is required. Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, Blood Work and		
Immunizations	\$0	N/A
	֥	
Mammogram Screening	\$0	N/A
	ψΟ	
Bone Density Screening	\$0	N/A
bone bensity screening	ΦΟ	N/A
Colonoscopy (Routine for age 50+ then frequency schedule applies)	\$0	N/A
coordscopy (routine for age our mennequency schedule applies)	ΨŪ	
Emergency Medical Care		
Urgent Care Centers (per visit)	Deductible + 20%	Deductible + 20%
bigen care centers (per visit)		Deddelible + 2070
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)	Deductible + 20%	Deductible + 20%
Ambulance Services	Deductible + 20%	Deductible + 20%
1 DED Doductible		·

<sup>1</sup> DED = Deductible

<sup>2</sup> PBP = Per Benefit Period

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



Dutpatient Diagnostic Services - services with an asterisk * require prior authorization         N/A           Allergy Testing         S0         N/A           X-rays and Ultrasounds         Deductible + 20%         N/A           Diagnostic Services (except AIS)         Deductible + 20%         N/A           -Advanced Imaging Services (accept AIS)         Deductible + 20%         N/A           -X-rays and Ultrasounds         Deductible + 20%         N/A           Duppatient Hospital Facility Services (per visit)         S0         N/A           X-rays and Ultrasounds         Deductible + 20%         N/A           Diagnostic Services (except AIS)         Deductible + 20%         N/A           -Advanced Imaging Services (restrict reduced in physician office, testing conters or other outpatient notes in automater numpatient notes in a back and concert Hospital Services reduced in physician office, testing conters or other outpatient notes in automater numpatient notes in a back and concert HOP - social station center to determine 1 having the diagnostic test or sorke particle notes in automater numpatient notes in automater numpatient notes in a back and oncert in a baspital or notes in automater numpatient notes in a back and oncert in a baspital or notes in automater numpatient notes in a back and oncert in a baspital or notes in automater numpatient notes in a back and oncert in a baspital or notes in automater numpatient notes in a back and oncert in a baspital or notes in automater numpatient notes in automater numpatient notes in automater numpatient numpatient notes in automater numpatient notes in automa			ember Pays
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Allergy Testing     \$0     N/A       Microy Testing     Deductible + 20%     N/A       Market Strength     Deductible + 20%     N/A       Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)     Deductible + 20%     N/A       Independent Clinical Lab (Idaposite testing of blood and specimens)     50     N/A       Dupptient Hospital Facility Services (per visit)     Deductible + 20%     N/A       Xrays and Ultrasounds     Deductible + 20%     N/A       Diagnostic Services (except AIS)     Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)     Deductible + 20%     N/A       Advanced Imaging Services (except AIS)     Advanced Imaging Services (except AIS)     N/A     Deductible + 20%     N/A       Advanced Imaging Services (and phylocater office testing corters or other to opticate testing corters or other testing testing testing testing testing corters or other to opticate testing testi		1	
X-ray <sup>®</sup> and Ulfrasounds     Deductible + 20%     N/A       Diagnostic Services (except AIS)     N/A       Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)     Deductible + 20%     N/A       Outpatient Hospital Facility Services (per visit)     X-rays and Ulfrasounds     Deductible + 20%     N/A       Diagnostic Services (except AIS)     Deductible + 20%     N/A     Deductible + 20%     N/A       Varians and Ulfrasounds     Deductible + 20%     N/A     Deductible + 20%     N/A       Varians and Ulfrasounds     Deductible + 20%     N/A     Deductible + 20%     N/A       Varians and Ulfrasounds     Deductible + 20%     N/A     Deductible + 20%     N/A       Varians and Ulfrasounds     Deductible + 20%     N/A     Deductible + 20%     N/A       Important: Diagnositic Services rendered in physician offices, testing centers or other outpatient bicclones that are owned and operated by a hospital system are considered by the hospital for such service, and the member's outpatient bipatie dealth office and outpatient bipatient bipatient bipatient and the physician center to delemine I howing the charany and center hospital section services require prior authorization     N/A       Variance Call Section Services requires require prior authorization     N/A     N/A       Variantel Hospital Facility Services (per visit)     Deductible + 20%     N/A       Variantel Hospital Facility Services (per visit)     Deductible + 20%	ndependent Diagnostic Testing Facility/Provider's Office		
X-ray <sup>5</sup> and Ulfrasounds     Deductible + 20%     N/A       Diagnostic Services (except AIS)     Deductible + 20%     N/A       Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)     Deductible + 20%     N/A       Arays and Ulfrasounds     S0     N/A       Diagnostic Services (except AIS)     Peductible + 20%     N/A       Arays and Ulfrasounds     Deductible + 20%     N/A       Diagnostic Services (except AIS)     Deductible + 20%     N/A       Advanced Imaging Services (except AIS)     Deductible + 20%     N/A       Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)     Deductible + 20%     N/A       Important: Diagnosic to threapeatic services sendered in physician ottoes, testing centers or other outpatient bicclons that are owned and operated by a hospital system are considered by the hospital for such services, and the nucleat and operated by a hospital system are considered by the hospital for such services performed in a hospital or hospital exact and the patient provide and the system are considered by the positial system are activated by the positial system are considered by the positial system are activated by the positial system are acordised by the positial system are activated by the positial system	Alleray Testina	\$0	N/A
"Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)     Deductible + 20%     N/A       Independent Clinical Lab (diagnostic testing of blood and specimens)     S0     N/A       Duptatient Hospital Facility Services (per visit)     Deductible + 20%     N/A       Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)     Deductible + 20%     N/A       Important: Diagnostic Services (except AIS)     Deductible + 20%     N/A       Important: Diagnostic or threspetic 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 for such services, part the member soupation thospital or such services performed in a hospital or hospital ovalue offices are outpatient to construct by the hospital for such services performed in a hospital or hospital ovalue duplated by the post offices are outpatient to construct by the hospital for such services performed in a hospital or hospital owned exclety outpatient to be obtained on the physician orbits to identifie the service performed in a hospital or hospital owned exclety outpatient to be obtained on the physician orbits to identifie the service performed in a hospital or hospital owned exclety outpatient to be obtained on the physician orbits to identifie the service performed in a hospital or hospital work provider (files and by the physician orbits is the service performed in a hospital or hospital owned exclety outpatient to be obtained on the physician orbits is the service performed in a hospital facility services (surgical) (per visit)     Deductible + 20%     N/A       'Inpatient Hospital Facility Services (surgical) (per visit)     Deductible + 20%     N/A		Deductible + 20%	
independent Clinical Lab (diagnostic testing of blood and specimens)       \$0       N/A         Outpatient Hospital Facility Services (per visit)       Deductible + 20%       N/A         X-rays and Utrasounds       Deductible + 20%       N/A         Important: Diagnostic or therapeutic services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)       Deductible + 20%       N/A         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 occursed by the hospital or service sand the chrospital or service sadpatent hospital by the objetal or service performed in a hospital by a testing to other services are outpatient locations that are owned and operated by a hospital outpatient in the objetal or service performed in a hospital or service performed in a hospital or service performed in a hospital or service or service of the services (surgical) (per visit)       Deductible + 20%       N/A         Outpatient Hospital Facility Services (surgical) (per visit)       Deductible + 20%       N/A         Provider Bacility Services (surgical) (per visit)       Deductible + 20%       N/A         Outpatient Hospital Facility Services (per admit)       Deductible + 20%       N/A         Provider Bacility Services (per visit)       S50 Copay       N/A         Outpatient Hospital Facility Services (per visit)       Deductible + 20%       N/A         Partial Hospitalization Facility Services (per visit)       Deductible + 20%       N/A <td></td> <td></td> <td></td>			
Dutpatient Hospital Facility Services (per visit)         Deductible + 20%         NA           Diagnostic Services (ACCP) A(S)         Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)         Deductible + 20%         NA           Important: Diagnostic services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)         Deductible + 20%         NA           Important: Diagnostic services readress of online Provider Directions and online Provider Services and the memory and penated by a hospital service service performed in a hospital service with an envore scance of the provider Directions and online Provider Services and the memory and penated by a hospital service is a devine Provider Directions and online Provider Services and the memory and penated by a hospital service with an envore of facility will result is bridler cost-sharing.         NA           Hospital / Surgical - * all services require prior authorization         Deductible + 20%         NA           'Outpatient Hospital Facility Services (surgical) (per visit)         Deductible + 20%         NA           'Inpatient Hospital Facility Services (per admit)         Deductible + 20%         NA           'Inpatient Hospitalization facility Services (per admit)         Deductible + 20%         NA           'Inpatient Hospitalization (per visit)         Deductible + 20%         NA           'Inpatient Hospitalization facility Services (per admit)         Deductible + 20%         NA           'Inpatient Hospitalization (per admit)         Deductible + 20%         NA			
X-rays and Ultrasounds       Deductible + 20%       N/A         Diagnostic services (except AIS)       Peductible + 20%       N/A         Temportant: Diagnostic or therapeutic services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)       Deductible + 20%       N/A         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 As a result, PACP with be billed by the hospital for such services, and the members outpatient hospital outpatient departments. Members shuld contact FHCP's cost estimation center to determine if howing the diagnostic ies or service performed in a hospital outpatient departments. Members shuld contact FHCP's cost estimation center to determine if howing the diagnostic ies or service performed in a hospital outpatient departments. Members shuld contact FHCP's cost estimation center to determine if howing the diagnostic ies or service performed in a hospital outpatient departments. Members shuld contact FHCP's cost estimation center to determine if howing the diagnostic ies or service performed in a hospital outpatient departments. Members shuld contact FHCP's cost estimation center to determine if howing the diagnostic ies or service performed in a hospital outpatient departments. Members shuld contact FHCP's cost estimation center to determine if howing the diagnostic ies or service performation regardly shall be additive.         Hospital / Surgical - 1 all services (surgical) (per visit)       Deductible + 20%       N/A         "Impatient Hospital Facility Services (surgical) (per visit)       Deductible + 20%       N/A         "Inpatient Hospital/Surgical on Facility Services	ndependent Clinical Lab (diagnostic testing of blood and specimens)	\$0	N/A
Diagnostic Services (except AIS)     NA       "Advanced imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)     Deductible + 20%     N/A       Important: Diagnostic or therapeutic services rendered in physician offices, testing centers or other aupatient locations that are owned and operated by a hospital system are considered by in hospital base to be departments or the hospital as a new to be particular to the hospital as a new to be particular of the hospital as a new to be particular of the hospital as a new to be particular of the hospital as a new to be particular of the hospital as a new to be particular of the hospital as a new to be particular of the hospital as a new to hospital abordit or hosp	Outpatient Hospital Facility Services (per visit)		
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Important: Diagnatic or therapeutic services rendered in physician offices, lesting centers or other outpatient locations that are owned and operated by a hospital system or considered by the hospital system or the hospital As a result, FHCP will be tilled by the hospital system or considered by the hospital system or the hospital As a result, FHCP will be tilled by the hospital or such systems, and the member's outpatient hospital benefit will be applied to hese claims. FHCPs Novide Directories search application provides information regarding which provides roles are actually hospital and one Provider Search application provides information regarding which provides are actually hospital and one Provider Search application provides information regarding which provide roles are actually hospital and one Provider Search application provides information regarding which provide roles are actually hospital and one Provider Search application provides information regarding which provide provides information regarding which provide roles are actually hospital and one Provider Search application provides information regarding which provide roles are actually hospital and one Provide search application provides information regarding which provide roles are actually hospital and provide information in the spital is a result. FHCP will be applied to the spital is a result of the spital is and spital is a result of the spital is and spita			
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be appled to these claims. FHCPs Provider Directories and online Provider Search application provides information regarding which provider offices are actually hospital outpatient departments. Wembers should contact FHCPs cost estimation center to determine If having the diagnostic test or service performed in a hospital or hospital or thospital velt patient is higher cost sharing.  Ambulatory Surgical Center Facility (ASC) Deductible + 20% N/A  Outpatient Hospital Facility Services (surgical) (per visit) Deductible + 20% N/A  Inpatient Hospital Facility (per admit) Deductible + 20% N/A  Mental Health / Substance Dependency - services with an asterisk * require prior authorization  Inpatient Hospital Facility Services (per admit) Deductible + 20% N/A  Partial Hospitalization Facility Services (per admit) Deductible + 20% N/A  Partial Hospitalization (per admit) Sto Copay N/A  Partial Hospitalization (per admit) Deductible + 20% N/A  Partial Hospitalization (per admit) Sto Copay N/A  Partial Hospitalization (per admit) Deductible + 20% N/A  Partial Hospitalization (per admit) Deductible + 20% N/A  Partial Hospitalization (per admit) Deductible + 20% N/A  Partial Hospitalization (per admit) Sto Copay N/A  Provider Services at Hospital/Crisis Unit Primary Care Physician / Specialist Deductible + 20% N/A  Duptatient Office Visit Primary Care Physician / Specialist Duptatient Office, Hospital and ER Primary Care Physician / Specialist Duptatient Office Visit Privater Services at ER Provider Services at Hospital Inpati	Important: Diagnostic or therapeutic services rendered in physician offices, testing centers or other outpatient loc	cations that are owned and operated b	y a hospital system are
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 it higher cost sharing.         Hospital / Surgical -* all services require prior authorization       Deductible + 20%       N/A         'Ambulatory Surgical Center Facility (ASC)       Deductible + 20%       N/A         'Outpatient Hospital Facility Services (surgical) (per visit)       Deductible + 20%       N/A         'Inpatient Hospital Facility (per admit)       Deductible + 20%       N/A         Mental Health / Substance Dependency - services with an asterisk * require prior authorization       N/A         'Inpatient Hospitalization Facility Services (per admit)       Deductible + 20%       N/A         Outpatient Facility Service (per visit)       S50 Copay       N/A         'Partial Hospitalization (per admit)       Deductible + 20%       N/A         'Residential/Rehabilitation Facility(per day)       Deductible + 20%       N/A         Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)       Deductible + 20%       N/A         Primary Care Physician / Specialist       Deductible + 20%       N/A         Primary Care Physician / Specialist       Deductible + 20%       N/A         Outpatient Office Visit       S30 Copay       N/A         Primary Care Physician / Specialist       S30			
Hospital / Surgical - * all services require prior authorization       Deductible + 20%       N/A         'Ambulatory Surgical Center Facility (ASC)       Deductible + 20%       N/A         'Outpatient Hospital Facility Services (surgical) (per visit)       Deductible + 20%       N/A         'Inpatient Hospital Facility (per admit)       Deductible + 20%       N/A         Wental Health / Substance Dependency - services with an asterisk * require prior authorization       N/A         'Inpatient Hospitalization Facility Services (per admit)       Deductible + 20%       N/A         Outpatient Facility Service (per visit)       S50 Copay       N/A         'Partial Hospitalization (per admit)       Deductible + 20%       N/A         'Residential/Rehabilitation Facility (per day)       Deductible + 20%       N/A         'Residential/Rehabilitation Facility (per day)       Deductible + 20%       N/A         'Porvider Services at Hospital/Crisis Unit       Deductible + 20%       N/A         Provider Services at Locations other than Office, Hospital and ER       Primary Care Physician / Specialist       N/A         Outpatient Office Visit       Primary Care Physician / Specialist       N/A       N/A         Outpatient Office Visit       Primary Care Physician / Specialist       N/A       N/A         Provider Services at ER       Deductible + 20%       N/A <td>departments. Members should contact FHCP's cost estimation center to determine if having the diagnostic test or</td> <td></td> <td></td>	departments. Members should contact FHCP's cost estimation center to determine if having the diagnostic test or		
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Inpatient Hospital Facility (per admit)       Deductible + 20%       N/A         Mental Health / Substance Dependency - services with an asterisk * require prior authorization       N/A         Inpatient Hospitalization Facility Services (per admit)       Deductible + 20%       N/A         Outpatient Facility Service (per visit)       \$50 Copay       N/A         'Partial Hospitalization (per admit)       Deductible + 20%       N/A         'Partial Hospitalization Facility(per day)       Deductible + 20%       N/A         'Residential/Rehabilitation Facility(per day)       Deductible + 20%       N/A         Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)       Deductible + 20%       N/A         Provider Services at Hospital/Crisis Unit       Deductible + 20%       N/A         Primary Care Physician / Specialist       Deductible + 20%       N/A         Poutpatient Office Visit       Deductible + 20%       N/A         Primary Care Physician / Specialist       Deductible + 20%       N/A         Outpatient Office Visit       \$30 Copay       N/A         Primary Care Physician       \$30 Copay       N/A         Specialist       Deductible + 20%       N/A         Other Provider Services at ER       Deductible + 20%       Deductible + 20%         Provider Services at Hospital In	Ambulatory Surgical Center Facility (ASC)	Deductible + 20%	N/A
Wental Health / Substance Dependency - services with an asterisk * require prior authorization         "Inpatient Hospitalization Facility Services (per admit)       Deductible + 20%       N/A         Dutpatient Facility Service (per visit)       \$50 Copay       N/A         "Partial Hospitalization (per admit)       Deductible + 20%       N/A         "Residential/Rehabilitation Facility (per day)       Deductible + 20%       N/A         "Residential/Rehabilitation Facility (per day)       Deductible + 20%       N/A         "Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)       Deductible + 20%       Deductible + 20%         Provider Services at Hospital/Crisis Unit       Primary Care Physician / Specialist       Deductible + 20%       N/A         Provider Services at Locations other than Office, Hospital and ER       Primary Care Physician / Specialist       Deductible + 20%       N/A         Outpatient Office Visit       \$30 Copay       N/A       N/A         Primary Care Physician       \$30 Copay       N/A         Specialist       Deductible + 20%       N/A         Other Provider Services at ER       Deductible + 20%       Deductible + 20%         Provider Services at Hospital Inpatient/Outpatient       Deductible + 20%       N/A	*Outpatient Hospital Facility Services (surgical) (per visit)	Deductible + 20%	N/A
Inpatient Hospitalization Facility Services (per admit)       Deductible + 20%       N/A         Outpatient Facility Service (per visit)       \$50 Copay       N/A         'Partial Hospitalization (per admit)       Deductible + 20%       N/A         'Residential/Rehabilitation Facility(per day)       Deductible + 20%       N/A         Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)       Deductible + 20%       Deductible + 20%         Provider Services at Hospital/Crisis Unit       Deductible + 20%       N/A         Primary Care Physician / Specialist       Deductible + 20%       N/A         Provider Services at Locations other than Office, Hospital and ER       Deductible + 20%       N/A         Primary Care Physician / Specialist       Deductible + 20%       N/A         Outpatient Office Visit       \$30 Copay       N/A         Primary Care Physician       \$30 Copay       N/A         Other Provider Services at ER       Deductible + 20%       Deductible + 20%         Provider Services at Hospital Inpatient/Outpatient       Deductible + 20%       Deductible + 20%         N/A       Sto Copay       N/A       Sto Copay       N/A	*Inpatient Hospital Facility (per admit)	Deductible + 20%	N/A
Dutpatient Facility Service (per visit)       \$50 Copay       N/A         Partial Hospitalization (per admit)       Deductible + 20%       N/A         'Residential/Rehabilitation Facility(per day)       Deductible + 20%       N/A         Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)       Deductible + 20%       Deductible + 20%         Provider Services at Hospital/Crisis Unit       Primary Care Physician / Specialist       Deductible + 20%       N/A         Provider Services at Locations other than Office, Hospital and ER       Primary Care Physician / Specialist       N/A         Primary Care Physician / Specialist       Deductible + 20%       N/A         Outpatient Office Visit       Primary Care Physician / Specialist       N/A         Outpatient Office Visit       \$30 Copay       N/A         Primary Care Physician       \$30 Copay       N/A         Outpatient Office Visit       \$30 Copay       N/A         Provider Services at ER       Deductible + 20%       Deductible + 20%         Provider Services at Hospital       Deductible + 20%       Deductible + 20%         Provider Services at Hospital       Deductible + 20%       N/A	Mental Health / Substance Dependency - services with an asterisk $^{\star}$ require prior authors	orization	
Partial Hospitalization (per admit)       Deductible + 20%       N/A         'Residential/Rehabilitation Facility(per day)       Deductible + 20%       N/A         Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)       Deductible + 20%       Deductible + 20%         Provider Services at Hospital/Crisis Unit       Deductible + 20%       N/A         Provider Services at Locations other than Office, Hospital and ER       Deductible + 20%       N/A         Provider Services at Locations other than Office, Hospital and ER       Deductible + 20%       N/A         Outpatient Office Visit       Deductible + 20%       N/A         Primary Care Physician / Specialist       Deductible + 20%       N/A         Outpatient Office Visit       S30 Copay       N/A         Provider Services at ER       Deductible + 20%       N/A         Provider Services at Hospital Inpatient/Outpatient       Deductible + 20%       Deductible + 20%         N/A       Specialist       Deductible + 20%       N/A	*Inpatient Hospitalization Facility Services (per admit)	Deductible + 20%	N/A
'Residential/Rehabilitation Facility(per day)       Deductible + 20%       N/A         Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)       Deductible + 20%       Deductible + 20%         Provider Services at Hospital/Crisis Unit Primary Care Physician / Specialist       Deductible + 20%       N/A         Provider Services at Locations other than Office, Hospital and ER Primary Care Physician / Specialist       Deductible + 20%       N/A         Outpatient Office Visit Primary Care Physician Specialist       S30 Copay       N/A         Other Provider Services at ER       Deductible + 20%       N/A         Provider Services at Hospital Inpatient/Outpatient       Deductible + 20%       N/A	Outpatient Facility Service (per visit)	\$50 Copay	N/A
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)       Deductible + 20%       Deductible + 20%         Provider Services at Hospital/Crisis Unit       Deductible + 20%       N/A         Primary Care Physician / Specialist       Deductible + 20%       N/A         Provider Services at Locations other than Office, Hospital and ER       Deductible + 20%       N/A         Primary Care Physician / Specialist       Deductible + 20%       N/A         Outpatient Office Visit       Deductible + 20%       N/A         Primary Care Physician       \$30 Copay       N/A         Specialist       \$50 Copay       N/A         Other Provider Services at ER       Deductible + 20%       Deductible + 20%         Provider Services at Hospital       Deductible + 20%       N/A	*Partial Hospitalization (per admit)	Deductible + 20%	N/A
Provider Services at Hospital/Crisis Unit     Deductible + 20%     N/A       Provider Services at Locations other than Office, Hospital and ER     Deductible + 20%     N/A       Primary Care Physician / Specialist     Deductible + 20%     N/A       Outpatient Office Visit     Deductible + 20%     N/A       Primary Care Physician     \$30 Copay     N/A       Specialist     Specialist     N/A       Outpatient Office Visit     \$30 Copay     N/A       Primary Care Physician     \$30 Copay     N/A       Specialist     Deductible + 20%     N/A	*Residential/Rehabilitation Facility(per day)	Deductible + 20%	N/A
Primary Care Physician / SpecialistDeductible + 20%N/AProvider Services at Locations other than Office, Hospital and ER Primary Care Physician / SpecialistDeductible + 20%N/AOutpatient Office Visit Primary Care Physician SpecialistN/AN/AOutpatient Office Visit Primary Care Physician SpecialistN/AN/AOutpatient Office Visit Provider Services at ERN/AN/AProvider Services at Hospital Inpatient/OutpatientDeductible + 20%Deductible + 20%N/ADeductible + 20%N/AN/A	Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)	Deductible + 20%	Deductible + 20%
Provider Services at Locations other than Office, Hospital and ER       Deductible + 20%       N/A         Primary Care Physician / Specialist       Deductible + 20%       N/A         Outpatient Office Visit       \$30 Copay       N/A         Primary Care Physician       \$30 Copay       N/A         Specialist       \$50 Copay       N/A         Other Provider Services       Deductible + 20%       Deductible + 20%         Provider Services at ER       Deductible + 20%       Deductible + 20%         Provider Services at Hospital Inpatient/Outpatient       Deductible + 20%       N/A	Provider Services at Hospital/Crisis Unit		
Primary Care Physician / SpecialistDeductible + 20%N/AOutpatient Office VisitPrimary Care Physician\$30 CopayN/ASpecialist\$50 CopayN/AOther Provider Services at ERDeductible + 20%Deductible + 20%Provider Services at Hospital Inpatient/OutpatientDeductible + 20%N/A	Primary Care Physician / Specialist	Deductible + 20%	N/A
Primary Care Physician / SpecialistDeductible + 20%N/AOutpatient Office VisitPrimary Care Physician\$30 CopayN/ASpecialist\$50 CopayN/AOther Provider Services at ERDeductible + 20%Deductible + 20%Provider Services at Hospital Inpatient/OutpatientDeductible + 20%N/A	Provider Services at Locations other than Office. Hospital and ER		
Outpatient Office Visit       \$30 Copay       N/A         Primary Care Physician       \$30 Copay       N/A         Specialist       \$50 Copay       N/A         Other Provider Services       Deductible + 20%       Deductible + 20%         Provider Services at Hospital Inpatient/Outpatient       Deductible + 20%       N/A	•	Deductible + 20%	N/A
Primary Care Physician       \$30 Copay       N/A         Specialist       \$50 Copay       N/A         Other Provider Services at ER       Deductible + 20%       Deductible + 20%         Provider Services at Hospital Inpatient/Outpatient       Deductible + 20%       N/A			
Specialist       \$50 Copay       N/A         Other Provider Services       Deductible + 20%       Deductible + 20%         Provider Services at Hospital Inpatient/Outpatient       Deductible + 20%       N/A	•	\$20 Consu	NI/A
Other Provider Services     Deductible + 20%     Deductible + 20%       Provider Services at ER     Deductible + 20%     Deductible + 20%       Provider Services at Hospital Inpatient/Outpatient     Deductible + 20%     N/A	5 5	. ,	
Provider Services at ER       Deductible + 20%       Deductible + 20%         Provider Services at Hospital Inpatient/Outpatient       Deductible + 20%       N/A		\$50 Copay	N/A
Provider Services at Hospital Inpatient/Outpatient     Deductible + 20%     N/A			
Inpatient/Outpatient Deductible + 20% N/A		Deductible + 20%	Deductible + 20%
Provider Services at an Ambulatory Surgical Center (ASC) Deductible + 20% N/A		Deductible + 20%	N/A
	Provider Services at an Ambulatory Surgical Center (ASC)	Deductible + 20%	N/A



Amount Member Pavs

	Amount Member Pays	
Schedule of Benefits for Covered Services	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 + 20%	N/A
Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit)	Deductible + 20%	N/A
Chiropractic Care (per visit)	Deductible + 20%	N/A
*Durable Medical Equipment	Deductible + 20%	N/A
*Prosthetics and Medical Brace Device	Deductible + 20%	N/A
*Home Health Care (per visit)	Deductible + 20%	N/A
*Skilled Nursing Facility (per day)	Deductible + 20%	N/A
Hospice	Deductible + 20%	N/A
Hearing Exam (Audiologist/Specialist)	\$50 Copay	N/A
*Radiation (per visit)	\$50 Copay	N/A
Telehealth Services (PCP/Specialist)	\$10/\$30 Copay	N/A
Diabetes Care Management		
Diabetes Outpatient Self-Management Education	\$0	N/A
Glucometer	\$0	N/A
Annual Complete Diabetic Eye Exam (Optometrist/Ophthalmologist)	\$30 / \$50 Copay	N/A
50 Test Strips /Sensors (per box)	\$10 Copay	N/A
Lancets (per box)	\$10 Copay	N/A

\*Prior Authorization is Required: There are certain medical services for which members are required to obtain 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 <u>www.fhcp.com</u> or call toll-free 1-877-615-4022 to see if prior authorization is required.

Any one individual in a 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

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) (3	
	FHCP	Walgreens	FHCP Only
Generic Drugs			
Preventive (e.g., oral contraceptives)	\$0	Not Covered	\$0
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
Non-Preferred Brand Drugs	\$55 Copay	\$60 Copay	\$162 Copay
Specialty Drugs (Prior authorization is required)			
Preferred Specialty	\$250 Copay	Not Covered	Not Covered
Non Preferred Specialty	\$250 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.

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	
<b>Network Provider Services:</b> The services listed below must be received from of the service (except in certain situations such as emergencies). Members she 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)	Pediatric Selection: Not Covered
Includes contact lenses, evaluation, fitting and follow up care.	Non-Selection: Not Covered
Note: Anything over the allowance will not count toward your out-of-pocket ma	iximum limitation.
Pediatric Dental	
Preventive, basic and major	Not Covered

Benefit Maximums	
Home Health Care	60 Visits PBP
OT, PT, ST Outpatient Rehabilitation Therapy	20 Visits PBP
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 <a href="http://www.fhcp.com">www.fhcp.com</a>.

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 [(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 분이Florida Health Care Plans에 관한 질문이 있을 경우, 귀하에게는 무료로 본인이 구사하는 언어로 도움과 정보를 받을 권리가 있습니다. 통역으로 전화 연결되려면1-877-615-4022. (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 คุณจะได้รับการช่วยเหลือและได้รับข้อมูลในภาษาของคุณโดยที่ไม่มีค่าใช้จ่ายใด ๆ 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.



# **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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, 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 <u>http://www.hhs.gov/ocr/office/file/index.html</u>.