Large Group HMO
Health Benefit Plan TS3

Florida Health Care Plans
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Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Medical Benefits Deductible (EM DED[1]) (PBP[2]) (DED is the amount the member is responsible for before FHCP pays)	$750 per person $1,500 per family	Not Covered
Prescription Drug Benefits Deductible (EM DED[1]) (PBP[2]) (DED is the amount the member is responsible for before FHCP pays)	$0 per person $0 per family	Not Covered
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of Allowed Amount	Not Covered
Out-of-Pocket Maximum (EM OOPM[3]) (PBP[2]) (OOPM includes DED, Coinsurance, Copayments and Prescription Drugs)	$5,000 per person $10,000 per family	Not Covered
Office Services		
Physician Office Services (per visit) Primary Care Specialist	 $30 Copay $50 Copay	 Not Covered Not Covered
Maternity (Office Cost Share for initial visit only. Delivery charges are separate) Primary Care Specialist	 $30 Copay $50 Copay	 Not Covered Not Covered
Allergy Injections (per visit) Primary Care Specialist	 $10 Copay $10 Copay	 Not Covered Not Covered
Medical Pharmacy: Medications administered by a health care provider in an office or outpatient setting. Includes chemotherapy, infusions, dialysis, therapeutic injections and other medications ordered and administered by a provider. Prior authorization is required. Preferred Medications Non-Preferred Medications	 20% Coinsurance 20% Coinsurance	 Not Covered Not Covered
Important: The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the Office Services and/or Outpatient Facility Cost Share. Medical Pharmacy does not include immunizations, allergy injections or Services covered through the prescription drug program. Please refer to your Certificate of Coverage for a description of Medical Pharmacy.		
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, Blood Work and Immunizations	$0	Not Covered
Mammogram Screening	$0	Not Covered
Bone Density / Osteoporosis Screening	$0	Not Covered
Colonoscopy (Routine for age 45+)	$0	Not Covered
Emergency Medical Care		
Urgent Care Centers (per visit)	$65 Copay	$65 Copay
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit) (waived if admitted)	$250 Copay	$250 Copay
Ambulance Services	Deductible + 20%	Deductible + 20%

[1] EM DED = Deductible is Embedded: A covered member's family deductible costs are capped at the individual deductible amount on the family plan.
[2] PBP = Per Benefit Period
[3] EM OOPM = Out-of-Pocket Maximum is Embedded: A covered family member's out-of-pocket costs are capped at the individual out-of-pocket maximum amount on the family plan.

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Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Outpatient Diagnostic and Therapeutic Services - services with an asterisk * require prior authorization. Charges are per visit/test.		
Independent Diagnostic Facility/Provider's Office		
Allergy Testing	$50 Copay	Not Covered
X-rays and Ultrasounds	$50 Copay	Not Covered
Diagnostic Services (except AIS)	$50 Copay	Not Covered
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$250 Copay	Not Covered
***Therapeutic Services -** *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, hyperbaric oxygen therapy and radiation oncology.*	20% Coinsurance	Not Covered
Independent Clinical Lab (diagnostic testing of blood and specimens)	$0	Not Covered
Outpatient Hospital Facility Services (per visit)		
Lab Services	$25 Copay	Not Covered
X-rays and Ultrasounds	$300 Copay	Not Covered
Diagnostic Services (except AIS)	$300 Copay	Not Covered
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$500 Copay	Not Covered
***Therapeutic Services -** *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, hyperbaric oxygen therapy and radiation oncology.*	20% Coinsurance	Not Covered
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. Therapeutic services will incur separate charges for the facility service, physician fee and medical pharmacy. 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.		
Delivery / Hospital / Surgical -*all services require prior authorization		
***Ambulatory Surgical Center Facility (ASC)**	$300 Copay	Not Covered
***Birthing Center**	$500 Copay	Not Covered
***Outpatient Hospital Facility Services** (per visit)	$500 Copay	Not Covered
***Inpatient Hospital Facility** (per admit)	$300 Copay/Day ($1,500 Maximum, Days 1-5)	Not Covered
Mental Health / Substance Dependency– services with an asterisk * require prior authorization		
Outpatient Office Visit		
Primary Care	$30 Copay	Not Covered
Specialist	$50 Copay	Not Covered
Group Therapy	$0	Not Covered
***Inpatient Hospital Facility** (per admit)	$300 Copay/Day ($1,500 Maximum, Days 1-5)	Not Covered
***Partial Hospitalization**	$150 Copay/Day ($750 Maximum, Days 1-5)	Not Covered
***Outpatient Facility Service** (per day)	Deductible + 20%	Not Covered
***Residential/Rehabilitation Facility** (per day)	Deductible + 20%	Not Covered
Other Provider Services		
Provider Services at ER	$0	$0
Provider Services at Hospital /Birthing Center		
Inpatient	$0	Not Covered
Outpatient	$0	Not Covered
Provider Services at an Ambulatory Surgical Center (ASC)	$0	Not Covered
Provider Services at Locations other than Office, Hospital and ER		
Primary Care	$30 Copay	Not Covered
Specialist	$50 Copay	Not Covered

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Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Other Special Services – services with an asterisk * require prior authorization		
Combined Limit for Outpatient Occupational, Physical and Speech Therapy (per visit)	$50 Copay	Not Covered
***Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy** (per visit)	$50 Copay	Not Covered
Chiropractic Care (per visit)	Deductible + 20%	Not Covered
***Durable Medical Equipment**		
Motorized Wheelchair	Deductible + 20%	Not Covered
All Other	Deductible + 20%	Not Covered
***Prosthetics and Medical Brace Device**	Deductible + 20%	Not Covered
***Home Health Care** (per visit)	Deductible + 20%	Not Covered
***Skilled Nursing Facility** (per day)	Deductible + 20%	Not Covered
Hospice (per visit)	Deductible + 20%	Not Covered
***Enteral Formulas**	Deductible + 20%	Not Covered
Telehealth Services		
General Medicine visit rendered by a designated Telehealth Services Provider	$0	Not Covered
Mental Health/Behavioral Health visit rendered by a designated Telehealth Services Provider	$30 Copay	Not Covered
Diabetes Care Management		
Diabetes Outpatient Self-Management Education	$0	Not Covered
Glucometer (2 per year)	$0	Not Covered
50 Test Strips (per box)	$10 Copay	Not Covered
Lancets (per box)	$4 Copay	Not Covered

***Prior Authorization is Required:** There are certain medical services, supplies and medications for which **members are required to obtain Prior Authorization** before receiving. If you don't obtain prior authorization from FHCP, you will have to **pay the entire cost** of the service, supply or medication. Before receiving a service, supply or medication you should visit www.fhcp.com or call toll-free 1-877-615-4022 to see if prior authorization is required.

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 Facility/Rehabilitation Facility	20 Days PBP
Behavioral Health Residential Facility	20 Days PBP

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Schedule of Benefits for Covered Services — Amount Member Pays

Prescription Drug Program

Pharmacy Network: A Preferred Retail pharmacy is an FHCP owned and operated pharmacy. A Non-Preferred Retail Pharmacy is a participating network pharmacy that is listed in FHCP's Pharmacy Directory and is not owned and operated by FHCP. Members must use a Preferred FHCP pharmacy or a Non-Preferred Retail pharmacy 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). Mail Order is only available through FHCP Mail Order Pharmacy. Members should log into their member account at www.fhcp.com and click Find a Pharmacy to locate a Network Provider pharmacy.

	Retail Network Pharmacies (1 month supply)		**Mail Order** (3 month supply)
	Preferred - FHCP	**Non-Preferred**	**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 Usual and Customary cash price for that prescription.
FHCP Pharmacy benefit provides coverage for Generic contraceptive medications or supplies (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

Exclusive 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 Services	Not Covered

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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.
- For a list of network providers, please visit https://www.fhcp.com/our-provider-network or call 1 (877) 615-4022 to request a printed provider directory.
- 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.