Large Group HMO
Health Benefit Plan T28

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)	$250 per person $500 per family	N/A
Drug Benefits Deductible (DED[1]) (PBP[2]) (DED is the amount the member is responsible for before FHCP pays)	$0 per person $0 per family	N/A
Coinsurance (Coinsurance is the percentage the member pays for services)	N/A	N/A
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Pharmacy)	$2,000 per person $4,000 per family	N/A
Office Services		
Physician Office Services (per visit) Primary Care Office Specialist	 $20 Copay $35 Copay	 N/A N/A
Maternity (Cost Share for initial visit only) Primary Care Physician Specialist	 $20 Copay $35 Copay	 N/A N/A
Allergy Injections (per visit) Primary Care Physician Specialist	 $0 $0	 N/A N/A
Medical Pharmacy - Physician-Administered Medications including but not limited to Therapeutic Injections, Infusions, Chemotherapy and Dialysis Drugs.	5% Coinsurance	N/A
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.		
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, Blood Work and Immunizations	$0	N/A
Mammogram Screening	$0	N/A
Bone Density Screening	$0	N/A
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0	N/A
Emergency Medical Care		
Urgent Care Centers (per visit)	$75 Copay	$75 Copay
Emergency Room Facility Services (per visit) (waived if admitted)	$250 Copay	$250 Copay
Ambulance Services	$100 Copay	$100 Copay

[1] DED = Deductible
[2] PBP = Per Benefit Period

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Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility/Provider's Office		
Allergy Testing	$0	N/A
X-rays and Ultrasounds	$20 Copay	N/A
Diagnostic Services (except AIS)	$20 Copay	N/A
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$175 Copay	N/A
Independent Clinical Lab (diagnostic testing of blood and specimens)	$0	N/A
Outpatient Hospital Facility Services (per visit)		
Blood Work	$0	N/A
X-rays and Ultrasounds	$20 Copay	N/A
Diagnostic Services (except AIS)	$20 Copay	N/A
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$175 Copay	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 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.		
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	$200 Copay	N/A
Outpatient Hospital Facility Services (surgical) (per visit)	$200 Copay	N/A
Inpatient Hospital Facility (per admit)	Deductible + $250 Copay/Day (Days 1-5)	N/A
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit)	Deductible + $250 Copay/Day (Days 1-5)	N/A
Outpatient Facility Service (per visit)	$35 Copay	N/A
Partial Hospitalization (per admit)	Deductible + $125 Copay/Day (Days 1-5)	N/A
Residential/Rehabilitation Facility (per day)	$50 Copay	N/A
Emergency Room Facility Services (per visit)	$250 Copay	$250 Copay
Provider Services at Hospital/Crisis Unit		
Primary Care Physician / Specialist	$0	N/A
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician / Specialist	$0	N/A
Outpatient Office Visit		
Primary Care Physician	$20 Copay	N/A
Specialist	$35 Copay	N/A
Other Provider Services		
Provider Services at ER	$0	$0
Provider Services at Hospital		
Inpatient /Outpatient	$0	N/A
Provider Services at an Ambulatory Surgical Center (ASC)	$0	N/A

Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Other Special Services		
Combined Limit for Outpatient Occupational, Physical and Speech Therapy (per visit)	$15 Copay	N/A
Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit)	$15 Copay	N/A
Chiropractic Care (per visit)	$15 Copay	N/A
Durable Medical Equipment	15% Coinsurance	N/A
Prosthetics and Medical Brace Device	$0	N/A
Home Health Care (per visit)	$15 Copay	N/A
Skilled Nursing Facility (per day)	$50 Copay	N/A
Hospice	$0	N/A
Hearing Exam (Audiologist/Specialist)	$0	N/A
Radiation (per visit)	$35 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)	$20 / $35 Copay	N/A
50 Test Strips /Sensors (per box)	$10 Copay	N/A
Lancets (per box)	$10 Copay	N/A

Important: 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 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; meaning any one individual in the family can satisfy the individual out-of-pocket maximum. 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 Preventive (e.g., oral contraceptives) Preferred Generic Non Preferred Generic	 $0 $3 Copay $12 Copay	 Not Covered $20 Copay $20 Copay	 $0 $6 Copay $33 Copay
Preferred Brand Drugs	$35 Copay	$40 Copay	$102 Copay
Non-Preferred Brand Drugs	$60 Copay	$65 Copay	$177 Copay
Specialty and Self-Injectable Drugs (Prior authorization is required)	$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. 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.			

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Amount Member Pays - Network Provider

Schedule of Benefits for Covered Services

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
Cardiac and Pulmonary Therapy	20 Visits PBP
Chiropractic Care	20 Visits PBP
Skilled Nursing/Rehabilitation Facility	20 Days PBP
Behavioral Health Residential Facility	20 Days PBP

Additional Benefits and Features

- To find out more about their benefits and/or treatment options, members are encouraged to call the Member Services Department at 1-877-615-4022. This can help them save time and money.
- Members have online access to view their health benefit plan information as well as self-service tools through the Member Portal at www.fhcp.com.

This is not an insurance contract or Benefit Booklet. This Benefit Schedule is only a partial description of the many benefits and services provided or authorized by Florida Health Care Plans. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Health Care Plans Certificate of Coverage; its terms prevail.