FHCP 2024 Small Group – BNN Plans

Plan Features for all Plans

- Preventive Adult and Child Wellness Services for all plans $0.
- Preferred Fitness Certificate (Gym Access)
- Prescription Generic oral contraceptives are covered at no cost to the member.
- Out-of-Pocket Maximum includes: Deductible, Copayments, Coinsurance and Rx.
- All plans come with Pediatric Vision Care and Pediatric Dental Care Benefits (see last page).
- All plans come with option to purchase Adult Vision Rider.
- Available to groups headquartered in Brevard County, FL.

Yellow Highlighting = Increased 2024 Cost Share
Green Highlighting = Decreased 2024 Cost Share

Benefit Maximums for all Plans	
Home Health Care	20 Visits PBP
Skilled Nursing/Rehabilitation Facility	60 Days PBP
OT, PT, ST Outpatient Rehabilitation Therapy	35 Visits PBP
OT, PT, ST Outpatient Habilitation Therapy	35 Visits PBP
Cardiac and Pulmonary Therapy	35 Visits PBP
Chiropractic Care	26 Visits PBP
Behavioral Health Residential Facility	60 Days PBP

PBP=Per Benefit Period

Florida Health Care Plans is an Independent Licensee of the Blue Cross and Blue Shield Association. This matrix is only a partial description of the many benefits and services provided or authorized by Florida Health Care Plans. This matrix does not constitute a Contract.

Florida Health Care Plans®
An Independent Licensee of the Blue Cross and Blue Shield Association

Small Group Off Exchange 2024 — HMO Plans			
Metal	Plan Name	In-Network CYD / Coins / OOP	In-Network PCP / Spec
Platinum	Gym Access SMAG Platinum HMO OA BNN 4630 PD7	$0 (Med)/ $0 (Drug) / 10% / $3,000	$15 / $30
Platinum	Gym Access SMAG Platinum HMO OA BNN 4730 PD9	$0 (Med) / $0 (Drug) / 20% / $2,500	$10 / $25
Platinum	Gym Access SMAG Platinum HMO OA BNN 4830 PE1	$0 / 20% / $2,500	$15 / $35
Platinum	Gym Access SMAG Platinum HMO OA BNN 4930 PE2	$500 (Med) $0 (Drug) / 20% / $3,000	$25 / $45
Gold	Gym Access SMAG Gold HMO OA BNN 3630 PD2	$0 / 20% / $7,300	$30 / $50
Gold	Gym Access SMAG Gold HMO OA BNN 3730 PD4	$2,500 / 20% / $5,600	$20 / $35
Gold	Gym Access SMAG Gold HMO OA BNN 3830 PD5	$1,500 / 30% / $6,000	$10 / $60
Gold	Gym Access SMAG Gold HMO OA BNN 3930 PD6	$3,000 (Med) / $0 (Drug) / 10% / $7,300	$30 / $60
Silver	Gym Access SMAG Silver HMO OA BNN 2830 PC9	$2,500 / 40% / $8,500	$20 / $55
Silver	Gym Access SMAG Silver HMO OA BNN 2630 PC6	$3,000 / 30% / $9,000	$35 / $65
Silver	Gym Access SMAG Silver HMO OA BNN 2730 PC7	$0 (Med) / $250 (Drug) / 50% / $8,900	$25 / $60
Silver	Gym Access SMAG Silver HMO OA BNN 2930 PD1	$3,000 / 50% / $9,100	$45 / $90
Bronze	Gym Access SMAG Bronze HMO OA BNN 1630 PC1	$4,500 / 30% / $9,450	$45 / $80
Bronze	Gym Access SMAG Bronze HMO OA BNN 1730 PC2	$0 (Med) / $2,500 (Drug) / 50% / $9,450	$50 / $85
Bronze	Gym Access SMAG Bronze HMO OA BNN 1830 PC4	$6,000 / 50% / $9,200	$20 / $80
Bronze – H.S.A.	Gym Access SMAG Bronze HMO OA H.S.A. BNN 1930 PC5	$7,500 / NA / $7,500	CYD
Small Group Off Exchange 2024 – POS Plans			
Platinum	Gym Access SMAG Platinum HMO OA BNN 4630 POS PD8	$0 / 10% / $3,000	$15 / $30
Gold	Gym Access SMAG Gold HMO OA BNN POS 3630 PD3	$0 / 20% / $7,300	$30 / $50
Silver	Gym Access SMAG Silver HMO OA BNN POS 2730 PC8	$0 (Med) / $250 (Drug) / 50% / $8,900	$25 / $60
Bronze	Gym Access SMAG Bronze HMO OA BNN POS 1730 PC3	$0 (Med) / $2,500 (Drug) / 50% / $9,450	$50 / $85

Cost Sharing		Gym Access SMAG Platinum HMO OA BNN 4630	Gym Access SMAG Platinum HMO OA BNN 4730	Gym Access SMAG Platinum HMO OA BNN 4830	Gym Access SMAG Platinum HMO OA BNN 4930
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$0 / $0	$0 / $0	$500 / $1,000
	Out-of-Network	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	10%	20%	20%	20%
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$3,000 / $6,000	$2,500 / $5,000	$2,500 / $5,000	$3,000 / $6,000
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$15 Copay	$10 Copay	$15 Copay	$25 Copay
	Specialist	$30 Copay	$25 Copay	$35 Copay	$45 Copay
	Allergy Injections	$10 Copay	$10 Copay	$10 Copay	$10 Copay
	Medical Pharmacy Preferred/Non-Preferred (Does not include immunizations)	40% / 50% Coinsurance	40% / 50% Coinsurance	40% / 50% Coinsurance	40% / 50% Coinsurance
	Out of Network	N/A	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$100 Copay	$150 Copay	$500 Copay	$250 Copay
Urgent Care Centers	In-Network and Out-of-Network	$50 Copay	$40 Copay	$50 Copay	$60 Copay
Independent Diagnostic Testing Facility/ Provider's Office					
	Allergy Testing	$0	$0	$0	$0
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$30 Copay	$25 Copay	$35 Copay	$30 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$75 Copay	$100 Copay	$350 Copay	$150 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$0	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	$0	$0	$0	$0
Provider Services at Hospital	Inpatient	$0	$0	$0	Deductible + 20%
	Outpatient	$0	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	$250 Copay	$250 Copay	$350 Copay	$300 Copay
Provider Services at ASC	In-Network	$0	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission/stay)	In-Network	$250 per day ($750 Max)	$350 per day ($1,050 Max)	$1,000 Copay	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	$400 Copay	$350 Copay	$500 Copay	$400 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$30 Copay	$25 Copay	$35 Copay	$25 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs	Drug Deductible (per person / family aggregate)	$0 / $0	$0 / $0	Integrated with Medical	$0 / $0
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0	$0
	Preferred Generic / Non-Preferred Generic	$3 / $10	$3 / $10	$3 / $10	$3 / $10
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/

Cost Sharing		Gym Access SMAG Gold HMO OA BNN 3630	Gym Access SMAG Gold HMO OA BNN 3730	Gym Access SMAG Gold HMO OA BNN 3830	Gym Access SMAG Gold HMO OA BNN 3930
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$2,500 / $5,000	$1,500 / $3,000	$3,000 / $6,000
	Out-of-Network	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	20%	20%	30%	10%
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$7,300 / $14,600	$5,600 / $11,200	$6,000 / $12,000	$7,300 / $14,600
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$30 Copay	$20 Copay	$10 Copay	$30 Copay
	Specialist	$50 Copay	$35 Copay	$60 Copay	$60 Copay
	Allergy Injections	$10 Copay	$10 Copay	$10 Copay	10% Coinsurance
	Medical Pharmacy Preferred/Non-Preferred (Does not include immunizations)	40% / 50% Coinsurance	40% / 50% Coinsurance	20% / 30% Coinsurance	40% / 50% Coinsurance
	Out of Network	N/A	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$350 Copay	Deductible + 20%	$600 Copay	$300 Copay
Urgent Care Centers	In-Network and Out-of-Network	$50 Copay	$50 Copay	$50 Copay	$100 Copay
Independent Diagnostic Testing Facility/ Provider's Office					
	Allergy Testing	$0	$0	$0	$0
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$50 Copay	$50 Copay	$50 Copay	$35 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$250 Copay	$350 Copay	$400 Copay	$150 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$25 Copay	$25 Copay	$25 Copay	$10 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	$0	Deductible + 20%	$0	$0
Provider Services at Hospital	Inpatient	$50 Copay	$0	Deductible + 30%	Deductible + 10%
	Outpatient	$50 Copay	Deductible + 20%	Deductible + 30%	$60 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	$300 Copay	Deductible + 20%	Deductible + 30%	$350 Copay
Provider Services at ASC	In-Network	$50 Copay	Deductible + 20%	Deductible + 30%	$60 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission/stay)	In-Network	$350 per day ($1,750 Max)	$250 per day ($1,250 Max)	Deductible + 30%	Deductible + 10%
	Out-of-Network	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	$500 Copay	Deductible + 20%	Deductible + 30%	$500 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$30 Copay	$35 Copay	$10 Copay	$30 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs	Drug Deductible (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical	$0 / $0
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0	$0
	Preferred Generic / Non-Preferred Generic	$3 / $10	$3 / $10	$3 / $10	$3 / $10
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%	$40 / $75 / 20% / 30%	$30 / $55 / 40% / 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $117 / $222	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/					

Cost Sharing		Gym Access SMAG Silver HMO OA BNN 2630	Gym Access SMAG Silver HMO OA BNN 2730	Gym Access SMAG Silver HMO OA BNN 2830	Gym Access SMAG Silver HMO OA BNN 2930
Medical Deductible (Per Person / Family Aggregate)	In-Network Out-of-Network	$3,000 / $6,000 N/A	$0 / $0 N/A	$2,500 / $5,000 N/A	$3,000 / $6,000 N/A
Coinsurance (Amount member pays)	In-Network Out-of-Network	30% N/A	50% N/A	40% N/A	50% N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network Out-of-Network	$9,000 / $18,000 N/A	$8,900 / $17,800 N/A	$8,500 / $17,000 N/A	$9,100 / $18,200 N/A
Physician Office Services	Primary Care Office Specialist Allergy Injections Medical Pharmacy Preferred/Non-Preferred (Does not include immunizations) Out of Network	$35 Copay $65 Copay 30% Coinsurance DED + 50% / DED + 50% N/A	$25 Copay $60 Copay 50% Coinsurance 50% / 50% Coinsurance N/A	$20 Copay $55 Copay 40% Coinsurance DED + 45% / DED + 45% N/A	$45 Copay $90 Copay $10 Copay 20% / 30% Coinsurance N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	Deductible + 30%	$800 Copay	Deductible + 40%	Deductible + 50%
Urgent Care Centers	In-Network and Out-of-Network	$65 Copay	$60 Copay	$55 Copay	$75 Copay
Independent Diagnostic Testing Facility/ Provider's Office					
	Allergy Testing X-Rays / Ultrasounds / Diagnostic Services (other than AIS) Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine) Out-of-Network	$0 $65 Copay $850 Copay N/A	$0 $60 Copay $650 Copay N/A	40% Coinsurance Deductible Deductible N/A	$45 Copay $100 Copay Deductible + 50% N/A
Independent Clinical Lab	In-Network Out-of-Network	$15 Copay N/A	$25 Copay N/A	Deductible N/A	$30 Copay N/A
Provider Services at ER	In-Network and Out-of-Network	Deductible + 30%	$0	Deductible + 40%	Deductible + 50%
Provider Services at Hospital	Inpatient Outpatient Out-of-Network	Deductible + 30% Deductible + 30% N/A	$0 $60 Copay N/A	Deductible + 40% Deductible + 40% N/A	Deductible + 50% Deductible + 50% N/A
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network In-Network Out-of-Network	Deductible + 30% Deductible + 30% N/A	$1,000 Copay $60 Copay N/A	Deductible + 40% Deductible + 40% N/A	Deductible + 50% Deductible + 50% N/A
Inpatient Hospital Facility Services (per admission/stay)	In-Network Out-of-Network	Deductible + 30% N/A	$2,000 per day ($6,000 Max) N/A	Deductible + 40% N/A	Deductible + 50% N/A
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network Out-of-Network	Deductible + 30% N/A	$2,000 Copay N/A	Deductible + 40% N/A	Deductible + 50% N/A
Chiropractic Care (per visit)	In-Network Out-of-Network	$35 Copay N/A	$25 Copay N/A	$20 Copay N/A	$45 Copay N/A
Prescription Drugs	Drug Deductible (per person / family aggregate) Out of Pocket Maximum (per person / family aggregate) Preventive Medications Preferred Generic / Non-Preferred Generic Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty Mail-Order (Pref. Specialty/NP Specialty not Available) Out-of-Network	Integrated with Medical Integrated with Medical $0 $4 / $30 $200 / DED + 50% / DED + 50% / DED + 50% $9 / $87 / $597/ DED + 50% Not Covered	$250 / $500 Integrated with Medical $0 $4 / $30 $100 / DED + 50% / DED + 50% / DED + 50% $9 / $87 / $297 / DED + 50% Not Covered	Integrated with Medical Integrated with Medical $0 $4 / $35 DED + 35% / DED + 40% / DED + 45% / DED + 45% $9 / $102 / DED + 35% / DED + 40% Not Covered	Integrated with Medical Integrated with Medical $0 $3 / $10 $40 / $75 / 20% / 30% $6 / $27 / $117 / $222 Not Covered
Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/					

Cost Sharing		Gym Access SMAG Bronze HMO OA BNN 1630	Gym Access SMAG Bronze OA BNN 1730	Gym Access SMAG Bronze HMO OA BNN 1830	Gym Access SMAG Bronze HMO H.S.A. OA BNN 1930 Embedded
Medical Deductible (Per Person / Family Aggregate)	In-Network	$4,500 / $9,000	$0 / $0	$6,000 / $12,000	$7,500 / $15,000
	Out-of-Network	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	30%	50%	50%	N/A
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$9,450 / $18,900	$9,450 / $18,900	$9,200 / $18,400	$7,500 / $15,000
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$45 Copay	$50 Copay	$20 Copay	Deductible
	Specialist	$80 Copay	$85 Copay	$80 Copay	Deductible
	Allergy Injections	30% Coinsurance	50% Coinsurance	50% Coinsurance	Deductible
	Medical Pharmacy Preferred/Non-Preferred (Does not include immunizations)	DED + 50% / DED + 50%	50% / 50% Coinsurance	DED + 45% / DED + 45%	Deductible
	Out of Network	N/A	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	Deductible + 30%	$1,000 Copay	Deductible + 50%	Deductible
Urgent Care Centers	In-Network and Out-of-Network	$75 Copay	$85 Copay	$80 Copay	Deductible
Independent Diagnostic Testing Facility/ Provider's Office					
	Allergy Testing	$0	$0	50% Coinsurance	Deductible
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$80 Copay	$85 Copay	Deductible	Deductible
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$1,000 Copay	$900 Copay	Deductible	Deductible
	Out-of-Network	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$40 Copay	$40 Copay	Deductible	Deductible
	Out-of-Network	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	Deductible + 30%	$0	Deductible + 50%	Deductible
Provider Services at Hospital	Inpatient	Deductible + 30%	$0	Deductible + 50%	Deductible
	Outpatient	Deductible + 30%	$85 Copay	Deductible + 50%	Deductible
	Out-of-Network	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	Deductible + 30%	$1,500 Copay	Deductible + 50%	Deductible
Provider Services at ASC	In-Network	Deductible + 30%	$85 Copay	Deductible + 50%	Deductible
	Out-of-Network	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission/stay)	In-Network	Deductible + 30%	$2,500 per day ($7,500 Max)	Deductible + 50%	Deductible
	Out-of-Network	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	Deductible + 30%	$2,000 Copay	Deductible + 50%	Deductible
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$45 Copay	$50 Copay	$20 Copay	Deductible
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs	Drug Deductible (per person / family aggregate)	Integrated with Medical	$2,500 / $5,000	Integrated with Medical	Integrated with Medical
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0	$0
	Preferred Generic / Non-Preferred Generic	$4 / $35	$4 / $35	$4 / $35	DED / DED
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$200 / DED + 50% / DED + 50% / DED + 50%	$200 / DED + 50% / DED + 50% / DED + 50%	DED + 35% / DED + 40% / DED + 45% / DED + 45%	DED / DED / DED / DED
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$9 / $102 / $597 / DED + 50%	$9 / $102 / $597 / DED + 50%	$9 / $102 / DED + 35% / DED + 40%	DED / DED / DED / DED
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/ H.S.A Compatible Plans – refer to the schedule of benefits for embedding information.

Cost Sharing		Gym Access SMAG Platinum POS OA BNN 4630	Gym Access SMAG Gold POS OA BNN 3630	Gym Access SMAG Silver POS OA BNN 2730	Gym Access SMAG Bronze POS OA BNN 1730
Medical Deductible (Per Person / Family Aggregate)	In-Network Out-of-Network	$0 / $0 $500 / $1,000	$0 / $0 $5,000 / $10,000	$0 / $0 $10,000 / $20,000	$0 / $0 $10,000 / $20,000
Coinsurance (Amount member pays)	In-Network Out-of-Network	10% 30%	20% 30%	50% 50%	50% 50%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network Out-of-Network	$3,000 / $6,000 $6,000 / $12,000	$7,300 / $14,600 $10,000 / $20,000	$8,900 / $17,800 $20,000 / $40,000	$9,450 / $18,900 $20,000 / $40,000
Physician Office Services	Primary Care Office Specialist Allergy Injections Medical Pharmacy preferred/non-preferred (Does not include immunizations) Out of Network	$15 Copay $30 Copay $10 Copay 40% / 50% Coinsurance Deductible + 30%	$30 Copay $50 Copay $10 Copay 40% / 50% Coinsurance Deductible + 30%	$25 Copay $60 Copay 50% Coinsurance 50% / 50% Coinsurance Deductible + 50%	$50 Copay $85 Copay 50% Coinsurance 50% / 50% Coinsurance Deductible + 50%
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$100 Copay	$350 Copay	$800 Copay	$1,000 Copay
Urgent Care Centers	In-Network and Out-of-Network	$50 Copay	$50 Copay	$60 Copay	$85 Copay
Independent Diagnostic Testing Facility/ Provider's Office					
	Allergy Testing	$0	$0	$0	$0 Copay
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$30 Copay	$50 Copay	$60 Copay	$85 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$75 Copay	$250 Copay	$650 Copay	$900 Copay
	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 50%	Deductible + 50%
Independent Clinical Lab	In-Network Out-of-Network	$0 Deductible + 30%	$25 Copay Deductible + 30%	$25 Copay Deductible + 50%	$40 Copay Deductible + 50%
Provider Services at ER	In-Network and Out-of-Network	$0	$0	$0	$0
Provider Services at Hospital	Inpatient Outpatient Out-of-Network	$0 $0 Deductible + 30%	$50 Copay $50 Copay Deductible + 30%	$0 $60 Copay Deductible + 50%	$0 $85 Copay Deductible + 50%
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network In-Network Out-of-Network	$250 Copay $0 Deductible + 30%	$300 Copay $50 Copay Deductible + 30%	$1,000 Copay $60 Copay Deductible + 50%	$1,500 Copay $85 Copay Deductible + 50%
Inpatient Hospital Facility Services (per admission/stay)	In-Network Out-of-Network	$250 per day ($750 Max) Deductible + 30%	$350 per day ($1,750 Max) Deductible + 30%	$2,000 per day ($6,000 Max) Deductible + 50%	$2,500 per day ($7,500 Max) Deductible + 50%
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network Out-of-Network	$400 Copay Deductible + 30%	$500 Copay Deductible + 30%	$2,000 Copay Deductible + 50%	$2,000 Copay Deductible + 50%
Chiropractic Care (per visit)	In-Network Out-of-Network	$30 Copay Deductible + 30%	$30 Copay Deductible + 30%	$25 Copay Deductible + 50%	$50 Copay Deductible + 30%
Prescription Drugs	Drug Deductible (per person/family aggregate) Out of Pocket Maximum (per person / family aggregate) Preventive Medications Preferred Generic / Non-Preferred Generic Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty Mail-Order (Pref. Specialty/NP Specialty not Available) Out-of-Network	$0 / $0 Integrated with Medical $0 $3 / $10 $30 / $55 / 40% / 50% $6 / $27 / $87 / $162 Not Covered	Integrated with Medical Integrated with Medical $0 $3 / $10 $30 / $55 / 40% / 50% $6 / $27 / $87 / $162 Not Covered	$250 / $500 Integrated with Medical $0 $4/ $30 $100 / DED + 50% / DED + 50% / DED + 50% $9 / $87 / $297 / DED + 50% Not Covered	$2,500 / $5,000 Integrated with Medical $0 $4 / $35 $200 / DED + 50% / DED + 50% / DED + 50% $9 / $102 / $597 / DED + 50% Not Covered
Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/					

Small Group 2024 – FHCP Plans – Pediatric Vision and Pediatric Dental (In-Network Services Only)

Pediatric Vision Care Costs shown below are for covered individuals who are under age 19. Benefits for pediatric vision care services are not subject to a deductible, however, frequency limits do apply.	**Amount Member Pays**
Participating In-Network Provider Services	
Eye Glass Exam (1x per year)	$10 Copay
Eye Glasses (includes frames & lenses – single vision, bifocal, trifocal or lenticular)	$25 Copay
Contact Lens Exam (1x per year in lieu of eyeglass exam)	$50 Copay
Contact Lenses (2 boxes of standard contact lenses, 1x per year in lieu of eyeglasses)	$25 Copay
Eye Exam for Infection, visual disturbances, etc.	$10 Copay

Pediatric Dental Care Costs shown below are for covered individuals who are under age 19.	**Amount Member Pays**
Participating In-Network Provider Services	
Preventive Services	**No waiting period**
Oral exams, cleaning and fluoride treatments X-rays (bitewing) Space Maintainers Sealants	$0
Basic Services	**No waiting period**
Anesthesia Emergency Treatment (Palliative Care) Fillings Extractions Minor Endodontics Minor Periodontics Minor Prosthodontics	$0
Major Services	**No waiting period**
Major Endodontics Major Periodontics Major Prosthodontics Medically Necessary Implants (Prior Authorization is required)	$0
Medically Necessary Orthodontics	**No waiting period**
Prior authorization is required	$0
Pediatric Dental benefits are administered by Florida Combined Life Insurance Company, Inc. (FCL) an independent licensee of the Blue Cross and Blue Shield Association.	