

Amount Member Pays

		lember Pays
Schedule of Benefits for Covered Services	In-Network	Out-of-Network
Financial Features		
Medical Essential Health Benefits Deductible (EM DED ¹) (PBP ²) (DED is the amount the member is responsible for before FHCP pays)	\$3,400 per person \$6,800 per family	N/A
Prescription Drug Essential Health Benefits Deductible (EM DED ¹) (PBP ²) (DED is the amount the member is responsible for before FHCP pays)	\$3,000 per person \$3,000 per family	N/A
Coinsurance (Coinsurance is the percentage the member pays for services)	40% of Allowed Amount	N/A
Essential Health Benefits Out-of-Pocket Maximum (EM OOPM ³) (PBP ²) (OOPM includes DED, Coinsurance, Copayments and Prescription Drugs)	\$6,950 per person \$13,900 per family	N/A
Office Services		
Physician Office Services (per visit) Primary Care Office Specialist	\$15 Copay \$30 Copay	N/A N/A
Maternity (Office Cost Share for initial visit only. Delivery charges are separate) Primary Care Physician Specialist	\$15 Copay \$30 Copay	N/A N/A
Allergy Injections (per visit) Primary Care Physician Specialist	Deductible + 40% Deductible + 40%	N/A N/A
Medical Pharmacy: Medications administered by a health care provider in an office or outpatient setting. Includes chemotherapy, infusions, therapeutic injections and other medications ordered and administered by a provider. Prior authorization is required. Preferred Medications	Deductible + 40%	N/A
Non-Preferred Medications Important: The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only a Cost Share. Medical Pharmacy does not include immunizations, allergy injections or Services cov Certificate of Coverage for a description of Medical Pharmacy.		
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
	\$0	N/A
Colonoscopy (Routine for age 45+ then frequency schedule applies)	Ф О	
	ΦU	
Emergency Medical Care	\$0 \$100 Copay	\$100 Copay
Emergency Medical Care Urgent Care Centers (per visit) Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)		

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.

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

Gym Access IND Silver HMO BC 0941 73% Health Benefit Plan Q70



Outpatient Diagnostic and Therapeutic Services - services with an asterisk * require prior authorization. Charges are per visit/test. Independent Diagnostic Testing Facility/Provider's Office \$10 Copay N/A Alergy Testing \$10 Copay N/A X-rays and Ultrasounds \$50 Copay N/A Pagnostic Services (except AIS) \$50 Copay N/A *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) \$400 Copay N/A *Radiation Therapy N/A N/A Outpatient Hospital Facility Services (per visit) Deductible + 40% N/A X-rays and Ultrasounds Deductible + 40% N/A Diagnostic Services (except AIS) N/A N/A *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Deductible + 40% N/A *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Deductible + 40% N/A *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Deductible + 40% N/A *Modator Therapy Deductible + 40% N/A N/A *Bordied by the hospital system to be degarments of the hospital for strate on theospital for strate on thospital anot thospital product bere datas, PHOP Provide Theorita		Amount M	ember Pays
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Gym Access IND Silver HMO BC 0941 73% Health Benefit Plan Q70



Amount Member Pays

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) \$30 Copay N/A Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit) \$30 Copay N/A \$30 Copay Chiropractic Care (per visit) N/A *Durable Medical Equipment Motorized Wheelchair \$500 Copay N/A All Other \$0 N/A *Prosthetics and Medical Brace Device \$0 N/A *Home Health Care (per visit) \$0 N/A *Skilled Nursing Facility (per day) \$15 Copay N/A N/A Hospice \$0 Hearing Exam (Audiologist/Specialist) \$30 Copay N/A **Telehealth Services** General Medicine visit rendered by a designated Telehealth Services Provider \$0 N/A Mental Health/Behavioral Health visit rendered by a designated Telehealth Services Provider \$30 Copay N/A **Diabetes Care Management Diabetes Outpatient Self-Management Education** \$0 N/A Glucometer (2 per year) \$0 N/A Annual Complete Diabetic Eye Exam (Optometrist/Ophthalmologist) N/A \$15 / \$30 Copay N/A 50 Test Strips (per box) \$10 Copay N/A Lancets (per box) \$4 Copay

*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.

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 Pharmacy 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 \$10 Copay	Not Covered \$15 Copay \$20 Copay	\$0 \$6 Copay \$27 Copay	
Preferred Brand Drugs	Deductible + \$30 Copay	Deductible + \$40 Copay	Deductible + \$87 Copay	
Non-Preferred Brand Drugs	Deductible + \$55 Copay	Deductible + \$65 Copay	Deductible + \$162 Copay	
Specialty Drugs (Prior authorization is required)				
Preferred Specialty	Deductible + 40%	Not Covered	Not Covered	
Non Preferred Specialty	Deductible + 50%	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 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.



Amount Member Pays

Schedule of Benefits for Covered Services

Network Provider Out-of-Netwo

Out-of-Network Provider

Pediatric Vision		
Network Provider Services: The services listed below must be received from a Netw the service (except in certain situations such as emergencies). Members should log or locate a Network Provider near them.		
Eyeglass Exam (1x per year)	\$10 Copay	Not Covered
Eyeglasses (includes frames & lenses - single vision, bifocal, trifocal or lenticular)	\$25 Copay	Not Covered
Contact Lenses Exam (1x per year) (Instead of eyeglass exam)	\$50 Copay	Not Covered
Contact Lenses (2 boxes, 1x per year) (Instead of eyeglasses)	\$25 Copay	Not Covered
Eye Infection, Visual Disturbances, etc. (per exam)	\$10 Copay	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	

Wellness Certificate	
Fitness Center Access	Covered

Benefit Maximums	
Home Health Care	20 Visits 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
Skilled Nursing/Rehabilitation Facility	60 Days PBP
Behavioral Health Residential Facility	60 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.
- For a list of network providers, please visit <u>https://www.fhcp.com/our-provider-network</u> 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.