

Amount Member 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)	\$8,700 per person \$17,400 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)	Integrated with Medical	N/A
Coinsurance (Coinsurance is the percentage the member pays for services)	N/A	N/A
Essential Health Benefits Out-of-Pocket Maximum (EM OOPM ³) (PBP ²) (OOPM includes DED, Coinsurance, Copayments and Prescription Drugs)	\$8,700 per person \$17,400 per family	N/A
Office Services		
Physician Office Services (per visit) Primary Care Office Specialist	\$0 Visits 1-2 then Deductible remaining visits Deductible	N/A N/A
Maternity (Office Cost Share for initial visit only. Delivery charges are separate) Primary Care Physician Specialist	Deductible Deductible	N/A N/A
Allergy Injections (per visit) Primary Care Physician Specialist	Deductible Deductible	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 Non-Preferred Medications	Deductible Deductible	N/A N/A
Important: The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and Share. Medical Pharmacy does not include immunizations, allergy injections or Services covered th 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
Colonoscopy (Routine for age 45+ then frequency schedule applies)	\$0	N/A
Emergency Medical Care		
Urgent Care Centers (per visit)	\$75 Copay	\$75 Copay
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)	Deductible	Deductible
Ambulance Services	Deductible	Deductible

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

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

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.



Amount Member Pays

Outpatient Diagnostic and Therapeutic Services - services with an asterisk * require prior authorization. Charges are per visit/test. Independent Diagnostic Testing Facility/Provider's Office N/A Allery Testing Deductible N/A Zrays and Ultrasounds Deductible N/A Taddiation Therapy Deductible N/A Independent Clinical Lab (diagnostic testing of blood and specimens) Deductible N/A Outpatient Hospital Facility Services (per visit) Deductible N/A X-rays and Ultrasounds Deductible N/A Diagnostic Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Deductible N/A Packation Therapy Deductible N/A Tradiation Therapy Deductible N/A Important Diagnostic creates rendered in anyacian offices, testing creates or other outpactern to catabate and operated by a hospital visit no be diagnostic test rendered in anyacian offices, testing creates applicatos provider search applicatos provide search applicatos provider search applicatos thesopital applicatos provider search applicatos provid	Schedule of Benefits for Covered Services	In-Network	Out-of-Network
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	Provider Services at an Ambulatory Surgical Center (ASC)	Deductible	N/A

Gym Access IND Bronze HMO 1340 Health Benefit Plan K3A



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	N/A
Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit)	Deductible	N/A
Chiropractic Care (per visit)	Deductible	N/A
*Durable Medical Equipment Motorized Wheelchair All Other	Deductible Deductible	N/A N/A
*Prosthetics and Medical Brace Device	Deductible	N/A
*Home Health Care (per visit)	Deductible	N/A
*Skilled Nursing Facility (per day)	Deductible	N/A
Hospice	Deductible	N/A
Hearing Exam (Audiologist/Specialist)	Deductible	N/A
Telehealth Services General Medicine visit rendered by a designated Telehealth Services Provider Mental Health/Behavioral Health visit rendered by a designated Telehealth Services Provider	\$0 \$30 Copay	N/A 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)	Deductible	N/A
50 Test Strips (per box)	\$10 Copay	N/A
Lancets (per box)	\$4 Copay	N/A

*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

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 <u>www.fhcp.com</u> 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)	\$0	Not Covered	\$0
Preferred Generic	\$4 Copay	\$15 Copay	\$9 Copay
Non Preferred Generic	\$30 Copay	\$40 Copay	\$87 Copay
Preferred Brand Drugs	Deductible	Deductible	Deductible
Non-Preferred Brand Drugs	Deductible	Deductible	Deductible
Specialty Drugs (Prior authorization is required)			
Preferred Specialty	Deductible	Not Covered	Not Covered
Non Preferred Specialty	Deductible	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

Pediatric Vision

Network Provider Out-of-Network Provider

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. Not Covered Eyeglass Exam (1x per year) \$10 Copay 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) Not Covered \$25 Copay Eye Infection, Visual Disturbances, etc. (per exam) \$10 Copay Not Covered Note: Anything over the allowance will not go toward your out-of-pocket maximum. 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.