

An Independent Licensee of the Blue Cross and Blue Shield Association

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)	\$9,450 per person \$18,900 per family	Not Covered
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	Not Covered
Coinsurance (Coinsurance is the percentage the member pays for services)	100% of Allowed Amount	Not Covered
Essential Health Benefits Out-of-Pocket Maximum (EM OOPM ³) (PBP ²) (OOPM includes DED, Coinsurance, Copayments and Prescription Drugs)	\$9,450 per person \$18,900 per family	Not Covered
Office Services		
Physician Office Services (per visit) Primary Care Specialist	\$0 Visits 1-3 then Deductible remaining visits Deductible	Not Covered Not Covered
Maternity (Office Cost Share for initial visit only. Delivery charges are separate) Primary Care Specialist	Deductible Deductible	Not Covered Not Covered
Allergy Injections (per visit) Primary Care Specialist	Deductible Deductible	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	Deductible	Not Covered
Non-Preferred Medications Important: The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in a Share. Medical Pharmacy does not include immunizations, allergy injections or Services covered through 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)	Deductible	Deductible
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

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.



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Amount M	ember Pays
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		Deductible	Not Covered
		Deductible	Not Covered

Gym Access IND Catastrophic Essential Plus HMO 36 Health Benefit Plan X36



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 Not Covered *Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit) Deductible Not Covered Chiropractic Care (per visit) Deductible Not Covered *Durable Medical Equipment Motorized Wheelchair Deductible Not Covered All Other Deductible Not Covered *Prosthetics and Medical Brace Device Deductible Not Covered Not Covered *Home Health Care (per day) Deductible *Skilled Nursing Facility (per day) Deductible Not Covered Hospice (per day) Deductible Not Covered *Enteral Formulas Deductible Not Covered **Telehealth Services** General Medicine visit rendered by a designated Telehealth Services Provider Deductible Not Covered Mental Health/Behavioral Health visit rendered by a designated Telehealth Services Provider Deductible 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	20 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
Skilled Nursing/Rehabilitation Facility	60 Days PBP
Behavioral Health Residential Facility	60 Days PBP



Amount Member Pays

Schedule of Benefits for Covered Services

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	Deductible	Deductible	Deductible	
Non-Preferred Generic	Deductible	Deductible	Deductible	
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 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.

	Amount Member Pays	
Schedule of Benefits for Covered Services	Network Provider	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)	Deductible	Not Covered
Eyeglasses (includes frames & lenses - single vision, bifocal, trifocal or lenticular)	Deductible	Not Covered
Contact Lenses Exam (1x per year) (Instead of eyeglass exam)	Deductible	Not Covered
Contact Lenses (2 boxes, 1x per year) (Instead of eyeglasses)	Deductible	Not Covered
Eye Infection, Visual Disturbances, etc. (per exam)	Deductible	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



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 <u>www.fhcp.com</u>.
- Value-add Programs Members 18 years of age or older, enrolled in a Florida Health Care Plans Individual plan, can earn rewards by
 participating in the FHCP Rewards program. The FHCP Reward program rewards you for being more active in your healthcare choices. Visit
 your member portal account on <u>www.fhcp.com</u> or download the FHCP Rewards app on your mobile device to learn more about the
 program, how to participate, and ways to earn and spend rewards. You can also call Member Services at 1-877-615-4022 (TRS Relay 711
 TTY: 1-800-955-8770). Limitations may apply.

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.