

In 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)	\$3,700 per person \$7,400 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)	\$750 per person \$1,500 per family	Not Covered
Coinsurance (Coinsurance is the percentage the member pays for services)	20% 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)	\$7,250 per person \$14,500 per family	Not Covered
Office Services		
Physician Office Services (per visit) Primary Care Office Specialist	\$30 Copay \$65 Copay	Not Covered Not Covered
Maternity (Office Cost Share for initial visit only. Delivery charges are separate) Primary Care Physician Specialist	\$30 Copay \$65 Copay	Not Covered Not Covered
Allergy Injections (per visit) Primary Care Physician Specialist	20% Coinsurance 20% Coinsurance	Not Covered Not Covered
 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 Important: The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and Cost Share. Medical Pharmacy does not include immunizations, allergy injections or Services cove Certificate of 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 Screening	\$0	Not Covered
Colonoscopy (Routine for age 45+)	\$0	Not Covered
Emergency Medical Care		
Urgent Care Centers (per visit)	\$75 Copay	\$75 Copay
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)	Deductible + 20%	Deductible + 20%
Ambulance Services	Deductible + 20%	Deductible + 20%

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.



X-rays Dec Diagnostic Services (except AIS) Dec *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Dec *Radiation Therapy \$65 Independent Clinical Lab (diagnostic testing of blood and specimens) Dec Outpatient Hospital Facility Services (per visit) X-rays and Ultrasounds Dec X-rays and Ultrasounds Dec Dec Madvanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Dec *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Dec *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Dec *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Dec *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Dec *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Dec *Radiation Therapy Dec Tradiation Therapy Important: Diagnostic or therapeutic services rendered in physician offices, testing centers or other outpattent toospital facility will result in bigher cost sharing. Dec Delivery / Hospital / Surgical - *all services require prior authorization Provider Search application provides informatioutpatient departments. Members should contact FHCP's cost estimation center to determine if having the diagnostit facility will result	eductible + 20% eductible + 20% eductible + 20% eductible + 20% 5 Copay eductible + 20% eductible + 20% eductible + 20% eductible + 20% eductible + 20% ductible + 20% ductible + 20% ductible + 20% ductible + 20%	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered y a hospital system are s outpatient hospital benefit as are actually hospital
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Outpatient Office Visit		
	luctible + 20%	Viat Coverad
	Сорау	Not Covered
Other Provider Services Provider Services at ER Dedu	Сорау	Not Covered
Provider Services at Hospital/Birthing Center	Сорау Сорау	
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Provider Services at an Ambulatory Surgical Center (ASC) Dedu	Copay Copay Juctible + 20%	Not Covered Deductible + 20%

Gym Access IND Silver Standardized HMO 1 73% Health Benefit Plan Q1C



Amount Member Pays Schedule of Benefits for Covered Services In-Network Out-of-Network Other Special Services - services with an asterisk * require prior authorization \$65 Copay Combined Limit for Outpatient Occupational, Physical and Speech Therapy (per visit) Not Covered *Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit) \$65 Copay Not Covered Chiropractic Care (per visit) \$65 Copay Not Covered *Durable Medical Equipment Motorized Wheelchair 20% Coinsurance Not Covered All Other 20% Coinsurance Not Covered *Prosthetics and Medical Brace Device Not Covered 20% Coinsurance *Home Health Care (per visit) 20% Coinsurance Not Covered *Skilled Nursing Facility (per day) Not Covered Deductible + 20% Hospice 20% Coinsurance Not Covered Hearing Exam (Audiologist/Specialist) \$65 Copay Not Covered **Telehealth Services** General Medicine visit rendered by a designated Telehealth Services Provider \$0 Not Covered Mental Health/Behavioral Health visit rendered by a designated Telehealth Services Provider \$30 Copay Not Covered **Diabetes Care Management Diabetes Outpatient Self-Management Education** \$0 Not Covered \$0 Not Covered Glucometer (2 per year) Annual Complete Diabetic Eye Exam (Optometrist/Ophthalmologist) Not Covered \$30 / \$65 Copay 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. 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 Pharmacy to locate a Network Provider pharmacy. Mail Order is only available through FHCP Pharmacy. **Network Pharmacy** Mail Order (1 month supply) (3 month supply) FHCP Walgreens **FHCP Only** Generic Drugs Preventive (e.g., oral contraceptives) \$0 Not Covered \$0 Preferred Generic \$3 Copav \$6 Copay \$15 Copav Non Preferred Generic \$15 Copay \$25 Copay \$42 Copay **Preferred Brand Drugs** Deductible + \$50 Copay Deductible + \$60 Copay Deductible + \$147 Copay

 Non-Preferred Brand Drugs
 Deductible + \$100 Copay
 Deductible + \$110 Copay
 Deductible + \$297 Copay

 Specialty Drugs (Prior authorization is required)

 Preferred Specialty
 Deductible + 30%
 Not Covered
 Not Covered

 Non Preferred Specialty
 Deductible + 40%
 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

Out-of-Network Provider

Pediatric Vision		
Network Provider Services: The services listed below must be received from a Net the service (except in certain situations such as emergencies). Members should log o 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.