Gym Access IND Platinum HMO OA Standard 4450
Health Benefit Plan KL1

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

Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays 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)	$0 per person $0 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)	10% 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)	$3,000 per person $6,000 per family	Not Covered
Office Services		
Physician Office Services (per visit)		
Primary Care Office	$10 Copay	Not Covered
Specialist	$20 Copay	Not Covered
Maternity (Office Cost Share for initial visit only. Delivery charges are separate)		
Primary Care Physician	$10 Copay	Not Covered
Specialist	$20 Copay	Not Covered
Allergy Injections (per visit)		
Primary Care Physician	10% Coinsurance	Not Covered
Specialist	10% Coinsurance	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	10% Coinsurance	Not Covered
Non-Preferred Medications	10% Coinsurance	Not Covered
Important: The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the Office Services and/or Outpatient Facility Cost Share. Medical Pharmacy does not include immunizations, allergy injections or Services covered through the prescription drug program. Please refer to your 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)	$15 Copay	$15 Copay
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit) (waived if admitted)	$100 Copay	$100 Copay
Ambulance Services	10% Coinsurance	10% Coinsurance

[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.

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Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Outpatient Diagnostic and Therapeutic Services - services with an asterisk * require prior authorization. Charges are per visit/test.		
Independent Diagnostic Testing Facility/Provider's Office		
Allergy Testing	$30 Copay	Not Covered
X-rays and Ultrasounds	$30 Copay	Not Covered
Diagnostic Services (except AIS)	$30 Copay	Not Covered
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$100 Copay	Not Covered
*Radiation Therapy	10% Coinsurance	Not Covered
Independent Clinical Lab (diagnostic testing of blood and specimens)	$30 Copay	Not Covered
Outpatient Hospital Facility Services (per visit)		
X-rays and Ultrasounds	10% Coinsurance	Not Covered
Diagnostic Services (except AIS)	10% Coinsurance	Not Covered
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	10% Coinsurance	Not Covered
*Radiation Therapy	10% Coinsurance	Not Covered
Important: Diagnostic or therapeutic services rendered in physician offices, testing centers or other outpatient locations that are owned and operated by a hospital system are considered by the hospital system to be departments of the hospital. As a result, FHCP will be billed by the hospital for such services, and the member's outpatient hospital benefit will be applied to these claims. FHCP's Provider Directories and online Provider Search application provides information regarding which provider offices are actually hospital outpatient departments. Members should contact FHCP's cost estimation center to determine if having the diagnostic test or service performed in a hospital or hospital owned facility will result in higher cost sharing.		
Delivery / Hospital / Surgical - *all services require prior authorization		
***Ambulatory Surgical Center Facility (ASC)**	$150 Copay	Not Covered
***Birthing Center**	$300 Copay	Not Covered
***Outpatient Hospital Facility Services** (surgical) (per visit)	$300 Copay	Not Covered
***Inpatient Hospital Facility** (per stay)	$350 Copay	Not Covered
Mental Health / Substance Dependency - services with an asterisk * require prior authorization		
***Inpatient Hospitalization Facility Services** (per stay)	$350 Copay	Not Covered
Outpatient Facility Service (per visit)	$10 Copay	Not Covered
***Partial Hospitalization** (per stay)	$175 Copay	Not Covered
***Residential/Rehabilitation Facility** (per stay)	$150 Copay	Not Covered
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit) (waived if admitted)	$100 Copay	$100 Copay
Provider Services at Hospital/Crisis Unit		
Primary Care Physician / Specialist	$0	Not Covered
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician / Specialist	$0	Not Covered
Outpatient Office Visit		
Primary Care Physician	$10 Copay	Not Covered
Specialist	$10 Copay	Not Covered
Other Provider Services		
Provider Services at ER	$0	$0
Provider Services at Hospital/Birthing Center		
Inpatient	$0	Not Covered
Outpatient	$150 Copay	Not Covered
Provider Services at an Ambulatory Surgical Center (ASC)	$150 Copay	Not Covered

Schedule of Benefits for Covered Services	Amount Member Pays 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)	$10 Copay	Not Covered
***Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy** (per visit)	$10 Copay	Not Covered
Chiropractic Care (per visit)	$10 Copay	Not Covered
***Durable Medical Equipment**		
Motorized Wheelchair	10% Coinsurance	Not Covered
All Other	10% Coinsurance	Not Covered
***Prosthetics and Medical Brace Device**	10% Coinsurance	Not Covered
***Home Health Care** (per visit)	10% Coinsurance	Not Covered
***Skilled Nursing Facility** (per stay)	$150 Copay	Not Covered
Hospice	10% Coinsurance	Not Covered
Hearing Exam (Audiologist/Specialist)	$20 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	$10 Copay	Not Covered
Diabetes Care Management		
Diabetes Outpatient Self-Management Education	$0	Not Covered
Glucometer (2 per year)	$0	Not Covered
Annual Complete Diabetic Eye Exam (Optometrist/Ophthalmologist)	$10 / $20 Copay	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.

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 (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	$5 Copay	$15 Copay	$12 Copay
Non Preferred Generic	$5 Copay	$15 Copay	$12 Copay
Preferred Brand Drugs	$10 Copay	$20 Copay	$27 Copay
Non-Preferred Brand Drugs	$50 Copay	$60 Copay	$147 Copay
Specialty Drugs (Prior authorization is required)			
Preferred Specialty	$150 Copay	Not Covered	Not Covered
Non Preferred Specialty	$150 Copay	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.

Schedule of Benefits for Covered Services

	Amount Member Pays	
	Network Provider	Out-of-Network Provider
Pediatric Vision		
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.		
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 https://www.fhcp.com/our-provider-network 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.