# Gym Access IND Platinum HMO OA Standard 4450
# Health Benefit Plan QL1

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])<br>(DED is the amount the member is responsible for before FHCP pays) | $0 per person<br>$0 per family | Not Covered |
| **Prescription Drug Essential Health Benefits Deductible** (EM DED[1]) (PBP[2])<br>(DED is the amount the member is responsible for before FHCP pays) | Integrated with Medical | Not Covered |
| **Coinsurance**<br>(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])<br>(OOPM includes DED, Coinsurance, Copayments and Prescription Drugs) | $3,000 per person<br>$6,000 per family | Not Covered |
| **Office Services** | | |
| **Physician Office Services** (per visit)<br>Primary Care Office<br>Specialist | <br>$10 Copay<br>$20 Copay | <br>Not Covered<br>Not Covered |
| **Maternity** (Office Cost Share for initial visit only. Delivery charges are separate)<br>Primary Care Physician<br>Specialist | <br>$10 Copay<br>$20 Copay | <br>Not Covered<br>Not Covered |
| **Allergy Injections** (per visit)<br>Primary Care Physician<br>Specialist | <br>10% Coinsurance<br>10% Coinsurance | <br>Not Covered<br>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.<br>Preferred Medications<br>Non-Preferred Medications | <br>10% Coinsurance<br>10% Coinsurance | <br>Not Covered<br>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) | $300 Copay | Not Covered |
| **Outpatient Facility Service** (per visit) | $10 Copay | Not Covered |
| ***Partial Hospitalization** (per stay) | $150 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.