Gym Access IND Silver POS BC 7741 94%
Health Benefit Plan Q87

Florida Health Care Plans
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Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Medical Essential Health Benefits Deductible (DED[1]) (PBP[2]) (DED is the amount the member is responsible for before FHCP pays)	$0 per person $0 per family	$2,000 per person $4,000 per family
Drug Essential Health Benefits Deductible (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)	25% of Allowed Amount	30% of Allowed Amount
Essential Health Benefits Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Pharmacy)	$1,250 per person $2,500 per family	$4,000 per person $8,000 per family
Office Services		
Physician Office Services (per visit) Primary Care Office Specialist	$0 Copay Visits 1-3, then $1 Copay remaining visits $10 Copay	 Deductible + 30% Deductible + 30%
Maternity (Cost Share for initial visit only) Primary Care Physician Specialist	 $1 Copay $10 Copay	 Deductible + 30% Deductible + 30%
Allergy Injections (per visit) Primary Care Physician Specialist	 25% Coinsurance 25% Coinsurance	 Deductible + 30% Deductible + 30%
Medical Pharmacy - Physician-Administered Medications including but not limited to: *Therapeutic Injections *Infusions *Chemotherapy Dialysis Drugs	 25% Coinsurance 25% Coinsurance 25% Coinsurance 25% Coinsurance	 Deductible + 30% Deductible + 30% Deductible + 30% Deductible + 30%
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under the *medical* benefit. *Prior Authorization is required.		
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, Blood Work and Immunizations	$0	Deductible + 30%
Mammogram Screening	$0	Deductible + 30%
Bone Density Screening	$0	Deductible + 30%
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0	Deductible + 30%
Emergency Medical Care		
Urgent Care Centers (per visit)	$25 Copay	$25 Copay
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit) (waived if admitted)	$100 Copay	$100 Copay
Ambulance Services	25% Coinsurance	25% Coinsurance

[1] DED = Deductible
[2] PBP = Per Benefit Period
Note: Out-of-Network services may be subject to balance billing.

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Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Outpatient Diagnostic Services - services with an asterisk * require prior authorization		
Independent Diagnostic Testing Facility/Provider's Office		
Allergy Testing	$4 Copay	Deductible + 30%
X-rays and Ultrasounds	$4 Copay	Deductible + 30%
Diagnostic Services (except AIS)	$4 Copay	Deductible + 30%
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	25% Coinsurance	Deductible + 30%
Independent Clinical Lab (diagnostic testing of blood and specimens)	$0	Deductible + 30%
Outpatient Hospital Facility Services (per visit)		
X-rays and Ultrasounds	25% Coinsurance	Deductible + 30%
Diagnostic Services (except AIS)	25% Coinsurance	Deductible + 30%
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	25% Coinsurance	Deductible + 30%
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.		
Hospital / Surgical - *all services require prior authorization		
*Ambulatory Surgical Center Facility (ASC)	25% Coinsurance	Deductible + 30%
*Outpatient Hospital Facility Services (surgical) (per visit)	25% Coinsurance	Deductible + 30%
*Inpatient Hospital Facility (per admit)	25% Coinsurance	Deductible + 30%
Mental Health / Substance Dependency - services with an asterisk * require prior authorization		
*Inpatient Hospitalization Facility Services (per admit)	25% Coinsurance	Deductible + 30%
Outpatient Facility Service (per visit)	$10 Copay	Deductible + 30%
*Partial Hospitalization (per admit)	25% Coinsurance	Deductible + 30%
*Residential/Rehabilitation Facility (per day)	25% Coinsurance	Deductible + 30%
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	25% Coinsurance	Deductible + 30%
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician / Specialist	25% Coinsurance	Deductible + 30%
Outpatient Office Visit		
Primary Care Physician	$1 Copay	Deductible + 30%
Specialist	$10 Copay	Deductible + 30%
Other Provider Services		
Provider Services at ER	$0	$0
Provider Services at Hospital		
Inpatient	25% Coinsurance	Deductible + 30%
Outpatient	25% Coinsurance	Deductible + 30%
Provider Services at an Ambulatory Surgical Center (ASC)	25% Coinsurance	Deductible + 30%

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	Deductible + 30%
Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit)	$10 Copay	Deductible + 30%
Chiropractic Care (per visit)	$10 Copay	Deductible + 30%
*Durable Medical Equipment	$0	Deductible + 30%
*Prosthetics and Medical Brace Device	$0	Deductible + 30%
*Home Health Care (per visit)	$0	Deductible + 30%
*Skilled Nursing Facility (per day)	25% Coinsurance	Deductible + 30%
Hospice	$0	Deductible + 30%
Hearing Exam (Audiologist/Specialist)	$10 Copay	Deductible + 30%
*Radiation (per visit)	25% Coinsurance	Deductible + 30%
Telehealth Services (PCP/Specialist)	$10/$30 Copay	Not Covered
Diabetes Care Management		
Diabetes Outpatient Self-Management Education	$0	Not Covered
Glucometer	$0	Deductible + 30%
Annual Complete Diabetic Eye Exam (Optometrist/Ophthalmologist)	$10 Copay	Deductible + 30%
50 Test Strips /Sensors (per box)	$10 Copay	Deductible + 30%
Lancets (per box)	$10 Copay	Deductible + 30%

*Prior Authorization is Required: There are certain medical services for which members are required to obtain Prior Authorization before receiving that service. If you don't obtain prior authorization from FHCP, you will have to pay the entire cost of the service. Before a specialty or testing appointment you should visit www.fhcp.com or call toll-free 1-877-615-4022 to see if prior authorization is required.

Any one individual in a covered family can satisfy the individual out-of-pocket maximum for your plan. The entire family amount can be satisfied by any or all of the other covered dependents.

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 Provider/Facility 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	$0 Copay	$15 Copay	$0 Copay
Non Preferred Generic	$2 Copay	$15 Copay	$3 Copay
Preferred Brand Drugs	$10 Copay	$20 Copay	$27 Copay
Non-Preferred Brand Drugs	$25 Copay	$35 Copay	$72 Copay
Specialty Drugs (Prior authorization is required)			
Preferred Specialty	15% Coinsurance	Not Covered	Not Covered
Non Preferred Specialty	25% Coinsurance	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.

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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	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.
- 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.

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Discrimination is Against the Law

Florida Health Care Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Florida Health Care Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Health Care Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Health Care Plans : 1-877-615-4022

If you believe that Florida Health Care Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Florida Health Care Plans, Civil Rights Coordinator, 1340 Ridgewood Avenue, Holly Hill, FL 32117. Phone: 1-844-219-6137, TTY: 1-800-955-8770. Fax: 386-676-7149, Email: rights@fhcp.com.

You can file grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-615-4022. (TTY: 1-800-955-8770)**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-615-4022** (TTY: **1-800-955-8770**).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-615-4022 (TTY: 1-800-955-8770).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-615-4022 (TTY: 1-800-955-8770).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-615-4022 (TTY: 1-800-955-8770).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-615-4022（TTY：1-800-955-8770）

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-615-4022 (ATS : 1-800-955-8770).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-615-4022 (TTY: 1-800-955-8770).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-615-4022 (телетайп: 1-800-955-8770).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-615-4022 (رقم هاتف الصم والبكم: 1-800-955-8770).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-615-4022 (TTY: 1-800-955-8770).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-615-4022 (TTY: 1-800-955-8770).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-615-4022 (TTY: 1-800-955-8770)번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-615-4022 (TTY: 1-800-955-8770).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-615-4022 (TTY: 1-800-955-8770).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-615-4022 (TTY: 1-800-955-8770).