

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 <sup>1</sup> ) (PBP <sup>2</sup> ) (DED is the amount the member is responsible for before FHCP pays)	\$0 per person \$0 per family	\$250 per person \$500 per family
Prescription Drug Essential Health Benefits Deductible (EM DED <sup>1</sup> ) (PBP <sup>2</sup> ) (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	50% of Allowed Amount
Essential Health Benefits Out-of-Pocket Maximum (EM OOPM <sup>3</sup> ) (PBP <sup>2</sup> ) (OOPM includes DED, Coinsurance, Copayments and Prescription Drugs)	\$3,200 per person \$6,400 per family	\$6,000 per person \$12,000 per family
Office Services		
Physician Office Services (per visit) Primary Care Specialist	\$10 Copay \$20 Copay	Deductible + 50% Deductible + 50%
Maternity (Office Cost Share for initial visit only. Delivery charges are separate) Primary Care Specialist	\$10 Copay \$20 Copay	Deductible + 50% Deductible + 50%
Allergy Injections (per visit) Primary Care Specialist	10% Coinsurance 10% Coinsurance	Deductible + 50% Deductible + 50%
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 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	Deductible + 50%
Mammogram Screening	\$0	Deductible + 50%
Bone Density / Osteoporosis Screening	\$0	Deductible + 50%
Colonoscopy (Routine for age 45+)	\$0	Deductible + 50%
Emergency Medical Care		
Urgent Care Centers (per visit)	\$15 Copay	\$15 Copay
	\$100 Copay	\$100 Copay
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit) (Waived if admitted)	\$100 Copay	

<sup>1</sup> EM DED = Deductible is Embedded: A covered member's family deductible costs are capped at the individual deductible amount on the family plan.

<sup>2</sup> PBP = Per Benefit Period

<sup>3</sup> 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.

### Note: Out-of-Network services may be subject to balance billing.

Florida Health Care Plans is an Independent Licensee of the Blue Cross and Blue Shield Association.



Outpatient Diagnostic and Tharapeutic Services - services with an asterisk * require prior authorization. Charges are per visititest.           Independent Diagnostic Pacifity/Provider's Office         \$30 Copay         Deductible - 50%           Allergy Testing         \$30 Copay         Deductible - 50%           Varys and Ultrasounds         \$30 Copay         Deductible - 50%           "Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)         \$100 Copay         Deductible - 50%           "Therapeutic Services - Therapeutic restments include, but are not limited to diaptish.         10% Coinsurance         Deductible - 50%           Independent Clinical Lab (diagnostic testing of blood and specimens)         \$30 Copay         Deductible - 50%           Outpatient Hospital Facility Services (per visit)         \$30 Copay         Deductible - 50%           Lab Services - Therapeutic treatments include, but are not limited to diaptish.         10% Coinsurance         Deductible - 50%           "Therapeutic Services (except AIS)         \$30 Copay         Deductible - 50%         Deductible - 50%           "Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)         \$30 Copay         Deductible - 50%           "Therapeutic Services - therapeutic treatments include, but are not limited to diaptish.         10% Coinsurance         Deductible - 50%           "Therapeutic Services - therapeutic treatments include, but are not limited to diaptish.		An Independent Licensee	An Independent Licensee of the Blue Cross and Blue Shield Association	
Schedule of Benefits for Covered Services     In-Network     Outpatient Diagnostic and Therapeutic Services visit an asterisk * require prior authorization. Charges are per visit/test.       Allergy Testing     \$30 Copey     Deductible - 50%.       X-rays and Utrasounds     \$30 Copey     Deductible - 50%.       * Advanced Imaging Services (ASI) (MRI, MRA, PET, CT, Nuclear Med.)     \$100 Copay     Deductible - 50%.       * Therapeutic Services - merupeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous chemotherapy. Intravenous chemotherapy.     Deductible - 50%.       • Therapeutic Services (previse)     \$30 Copey     Deductible - 50%.       • Therapeutic Services - merupeutic treatments include, but are not limited to dialysis, intravenous chemotherapy. Intravenous chemotherapy.     Deductible - 50%.       • Uptatient Hospital Facility Services (per visit)     \$30 Copay     Deductible - 50%.       • Degustible - Services (except AIS)     \$30 Copay     Deductible - 50%.       • Therapeutic Services - Interapeutic treatments include, but are not limited to dialysis.     10% Coinsurance     Deductible - 50%.       • Therapeutic Services - Interapeutic treatments include, but are not limited to ratio avoid interapeutic treatments include, but are not limited to ratio avoid interapeutic treatments include, but are not limited to ratio avoid interapeutic treatments include, but are not limited to ratio avoid interapeutic treatments include, but are not limited to ratio avoid interapeutic treatments include, but are not limited to ratio avoid include avoid but and peutid by the long		Amount Member Pays		
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Mental Health / Substance Dependency - services with an asterisk * require prior authorization         Outpatient Office Visit       \$10 Copay         Primary Care       \$10 Copay         Specialist       \$10 Copay         Group Therapy       \$0         *Inpatient Hospital Facility (per admit)       \$350 Copay         *Partial Hospitalization       \$175 Copay         *Outpatient Facility Service (per day)       \$150 Copay         *Residential/Rehabilitation Facility (per day)       \$150 Copay         Other Provider Services       \$0         Provider Services at ER       \$0         Provider Services at an Ambulatory Surgical Center (ASC)       \$150 Copay       Deductible + 50%         Provider Services at Locations other than Office, Hospital and ER       \$10 Copay       Deductible + 50%         Provider Services at Locations other than Office, Hospital and ER       \$10 Copay       Deductible + 50%	*Outpatient Hospital Facility Services (per visit)			
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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
Other Special Services - services with an asterisk * require prior authorization		
Combined Limit for Outpatient Occupational, Physical and Speech Therapy (per visit)	\$10 Copay	Deductible + 50%
*Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit)	\$10 Copay	Deductible + 50%
Chiropractic Care (per visit)	\$10 Copay	Deductible + 50%
*Durable Medical Equipment Motorized Wheelchair All Other	10% Coinsurance 10% Coinsurance	Deductible + 50% Deductible + 50%
*Prosthetics and Medical Brace Device	10% Coinsurance	Deductible + 50%
*Home Health Care (per day)	10% Coinsurance	Deductible + 50%
*Skilled Nursing Facility (per day)	\$150 Copay	Deductible + 50%
Hospice (per day)	10% Coinsurance	Deductible + 50%
*Enteral Formulas	10% Coinsurance	Deductible + 50%
Telehealth Services General Medicine visit rendered by a designated Telehealth Services Provider Mental Health/Behavioral Health visit rendered by a designated Telehealth Services Provider Diabetes Care Management	\$0 \$10 Copay	Not Covered Not Covered
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 – Combined Limit In-Network and Out-of-Network		
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	



### Schedule of Benefits for Covered Services

#### Amount Member Pays

#### **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	\$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.

	Amount Member Pays	
Schedule of Benefits for Covered Services	Network Provider	Out-of-Network Provider
Pediatric Vision		
<b>Network Provider Services:</b> 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)	\$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



#### **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>.
- Members pay no out-of-pocket costs only when they receive services from an Indian health care provider or another provider with a referral
  from an Indian health care provider. The cost sharing shown is for out-of-pocket costs for services received from a non-Indian health care
  provider and services received without a referral from an Indian health care provider.
- 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.