Gym Access SMAG Silver POS HSA 2566
Health Benefit Plan P23

Florida Health Care Plans

Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Medical Essential Health Benefits Deductible (NEM DED[1]) (PBP[2]) (DED is the amount the member is responsible for before FHCP pays)	$2,600 per person $5,200 per family[1]	$4,000 per person $8,000 per family[1]
Prescription Drug Essential Health Benefits Deductible (NEM 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)	20% of Allowed Amount	30% of Allowed Amount
Essential Health Benefits Out-of-Pocket Maximum (EM OOPM[3]) (PBP[2]) (OOPM includes DED, Coinsurance, Copayments and Prescription Drugs)	$6,900 per person $13,800 per family[3]	$10,000 per person $20,000 per family[3]
Office Services		
Physician Office Services (per visit) Primary Care Office Specialist	 Deductible + 20% Deductible + 20%	 Deductible + 30% Deductible + 30%
Maternity (Office Cost Share for initial visit only. Delivery charges are separate) Primary Care Physician Specialist	 Deductible + 20% Deductible + 20%	 Deductible + 30% Deductible + 30%
Allergy Injections (per visit) Primary Care Physician Specialist	 Deductible + 20% Deductible + 20%	 Deductible + 30% Deductible + 30%
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	 Deductible + 40% Deductible + 50%	 Deductible + 30% Deductible + 30%
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 pharmacy 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	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)	Deductible + 20%	In-Network Deductible + 20%
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)	Deductible + 20%	In-Network Deductible + 20%
Ambulance Services	Deductible + 20%	In-Network Deductible + 20%

[1] NEM DED = Deductible is Non-Embedded: If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
[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.

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

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	Deductible + 20%	Deductible + 30%
X-rays and Ultrasounds	Deductible + 20%	Deductible + 30%
Diagnostic Services (except AIS)	Deductible + 20%	Deductible + 30%
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	Deductible + 20%	Deductible + 30%
*Radiation Therapy	Deductible + 20%	Deductible + 30%
Independent Clinical Lab (diagnostic testing of blood and specimens)	Deductible + 20%	Deductible + 30%
Outpatient Hospital Facility Services (per visit)		
X-rays and Ultrasounds	Deductible + 20%	Deductible + 30%
Diagnostic Services (except AIS)	Deductible + 20%	Deductible + 30%
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	Deductible + 20%	Deductible + 30%
*Radiation Therapy	Deductible + 20%	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.		
Delivery / Hospital / Surgical - * all services require prior authorization		
*Ambulatory Surgical Center Facility (ASC)	Deductible + 20%	Deductible + 30%
*Birthing Center	Deductible + 20%	Deductible + 30%
*Outpatient Hospital Facility Services (surgical) (per visit)	Deductible + 20%	Deductible + 30%
*Inpatient Hospital Facility (per admit)	Deductible + 20%	Deductible + 30%
Mental Health / Substance Dependency - services with an asterisk * require prior authorization		
*Inpatient Hospitalization Facility Services (per admit)	Deductible + 20%	Deductible + 30%
Outpatient Facility Service (per visit)	Deductible + 20%	Deductible + 30%
*Partial Hospitalization (per admit)	Deductible + 20%	Deductible + 30%
*Residential/Rehabilitation Facility (per day)	Deductible + 20%	Deductible + 30%
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit)	Deductible + 20%	In-Network Deductible + 20%
Provider Services at Hospital/Crisis Unit		
Primary Care Physician / Specialist	Deductible + 20%	Deductible + 30%
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician / Specialist	Deductible + 20%	Deductible + 30%
Outpatient Office Visit		
Primary Care Physician	Deductible + 20%	Deductible + 30%
Specialist	Deductible + 20%	Deductible + 30%
Other Provider Services		
Provider Services at ER	Deductible + 20%	In-Network Deductible + 20%
Provider Services at Hospital/Birthing Center		
Inpatient	Deductible + 20%	Deductible + 30%
Outpatient	Deductible + 20%	Deductible + 30%
Provider Services at an Ambulatory Surgical Center (ASC)	Deductible + 20%	Deductible + 30%

Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Other Special Services - services with an asterisk * require prior authorization		
Combined Limit for Outpatient Occupational, Physical and Speech Therapy (per visit)	Deductible + 20%	Deductible + 30%
Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit)	Deductible + 20%	Deductible + 30%
Chiropractic Care (per visit)	Deductible + 20%	Deductible + 30%
*Durable Medical Equipment	Deductible + 20%	Deductible + 30%
*Prosthetics and Medical Brace Device	Deductible + 20%	Deductible + 30%
*Home Health Care (per visit)	Deductible + 20%	Deductible + 30%
*Skilled Nursing Facility (per day)	Deductible + 20%	Deductible + 30%
Hospice	Deductible + 20%	Deductible + 30%
Hearing Exam (Audiologist/Specialist)	Deductible + 20%	Deductible + 30%
Telehealth Services Medical Visit Mental Health/Behavioral Health Visit	 Deductible + $10 Copay Deductible + $30 Copay	 Not Covered 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)	Deductible + 20%	Deductible + 30%
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	Network Pharmacy (1 month supply)		Mail Order (3 month supply)
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.			
	FHCP	Walgreens	FHCP Only
Generic Drugs Preventive (e.g., oral contraceptives) Preferred Generic Non Preferred Generic	 $0 Deductible + $3 Copay Deductible + $10 Copay	 Not Covered Deductible + $15 Copay Deductible + $20 Copay	 $0 Deductible + $6 Copay Deductible + $27 Copay
Preferred Brand Drugs	Deductible + $30 Copay	Deductible + $40 Copay	Deductible + $87 Copay
Non-Preferred Brand Drugs	Deductible + $55 Copay	Deductible + $65 Copay	Deductible + $162 Copay
Specialty Drugs (Prior authorization is required)			
Preferred Specialty	Deductible + 40%	Not Covered	Not Covered
Non Preferred Specialty	Deductible + 50%	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 Services	$0	

Wellness Certificate	
Fitness Center Access	Covered

Benefit Maximums – Combined Limit In-Network and Out-of-Network	
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.

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

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
PO Box 9910
Daytona Beach, FL 32120-0910
Phone: 1-844-219-6137
TTY: 1-800-955-8770
Fax: 386-676-7149
Email: rights@fhcp.com

You can file a 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.

Florida Health Care Plans

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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).

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