Gym Access SMAG Platinum Triple Option 82
Health Benefit Plan M82

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)	Opt. 1: $0 Person / $0 Family Opt. 2: $250 Person / $500 Family	Opt. 3: $500 Person / $1,000 Family
Prescription Drug Essential Health Benefits Deductible (EM DED[1]) (PBP[2]) (DED is the amount the member is responsible for before FHCP pays)	Opt. 1: $0 Person / $0 Family Opt. 2: Not Covered	Not Covered
Coinsurance (Coinsurance is the percentage the member pays for services)	Opt. 1: 15% of Allowed Amount Opt. 2: 30% of Allowed Amount	Opt. 3: 50% of Allowed Amount
Essential Health Benefits Out-of-Pocket Maximum (EM OOPM[3]) (PBP[2]) (OOPM includes DED, Coinsurance, Copayments and Prescription Drugs)	Opt. 1: $3,000 Person / $6,000 Family Opt. 2: $4,000 Person / $8,000 Family	Opt. 3: $6,000 Person / $12,000 Family
Office Services		
Physician Office Services (per visit)		
Primary Care Office	Opt. 1 $20 Copay Opt. 2 $30 Copay	Opt. 3 Deductible + 50%
Specialist	Opt. 1 $35 Copay Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
Maternity (Office Cost Share for initial visit only. Delivery charges are separate)		
Primary Care Physician	Opt. 1 $20 Copay Opt. 2 $30 Copay	Opt. 3 Deductible + 50%
Specialist	Opt. 1 $35 Copay Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
Allergy Injections (per visit)		
Primary Care Physician	Opt. 1 15% Coinsurance Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
Specialist	Opt. 1 15% Coinsurance Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
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	Opt. 1 40% Coinsurance Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
Non-Preferred Medications	Opt. 1 50% Coinsurance Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
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	Opt. 1 & 2 $0	Opt. 3 Deductible + 50%
Mammogram Screening	Opt. 1 & 2 $0	Opt. 3 Deductible + 50%
Bone Density Screening	Opt. 1 & 2 $0	Opt. 3 Deductible + 50%
Colonoscopy (Routine for age 45+)	Opt. 1 & 2 $0	Opt. 3 Deductible + 50%
Emergency Medical Care		
Urgent Care Centers (per visit)	Opt. 1 & 2 $60 Copay	Opt. 3 $60 Copay
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit) (waived if admitted)	Opt. 1 & 2 $100 Copay	Opt. 3 $100 Copay
Ambulance Services	Opt. 1 & 2 $100 Copay	Opt. 3 $100 Copay

[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.
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	Amount Member Pays 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 X-rays and Ultrasounds Diagnostic Services (except AIS)	Opt. 1 $10 Copay Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	Opt. 1 $50 Copay Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
*Radiation Therapy	Opt. 1 15% Coinsurance Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
Independent Clinical Lab (diagnostic testing of blood and specimens)	Opt. 1 $0 Opt. 2 Not Covered	Opt. 3 Deductible + 50%
Outpatient Hospital Facility Services (per visit) X-rays and Ultrasounds Diagnostic Services (except AIS) *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) *Radiation Therapy	Opt. 1 15% Coinsurance Opt. 2 Not Covered	Opt. 3 Deductible + 50%
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)**	Opt. 1 $200 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 50%
***Birthing Center**	Opt. 1 $400 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 50%
***Outpatient Hospital Facility Services** (surgical) (per visit)	Opt. 1 $400 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 50%
***Inpatient Hospital Facility** (per admit)	Opt. 1 $250 Copay/Day ($1,250 Maximum, Days 1-5) Opt. 2 Not Covered	Opt. 3 Deductible + 50%
Mental Health / Substance Dependency – services with an asterisk* require prior authorization		
***Inpatient Hospitalization Facility Services** (per admit)	Opt. 1 $250 Copay/Day ($1,250 Maximum, Days 1-5) Opt. 2 Not Covered	Opt. 3 Deductible + 50%
Outpatient Facility Service (per visit)	Opt. 1 $35 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 50%
***Partial Hospitalization** (per admit)	Opt. 1 $125 Copay/Day ($625 Maximum, Days 1-5) Opt. 2 Not Covered	Opt. 3 Deductible + 50%
***Residential/Rehabilitation Facility** (per day)	Opt. 1 $50 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 50%
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit) (waived if admitted)	Opt. 1 $100 Copay Opt. 2 $100 Copay	Opt. 3 $100 Copay
Provider Services at Hospital/Crisis Unit Primary Care Physician / Specialist	Opt. 1 $0 Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician / Specialist	Opt. 1 $0 Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
Outpatient Office Visit Primary Care Physician Specialist	Opt. 1 $20 Copay Opt. 2 $30 Copay Opt. 1 $35 Copay Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50% Opt. 3 Deductible + 50%

Schedule of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Other Provider Services		
Provider Services at ER	Opt. 1 & 2 $0	Opt. 3 $0
Provider Services at Hospital/Birthing Center Inpatient/Outpatient	Opt. 1 $0 Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
Provider Services at an Ambulatory Surgical Center (ASC)	Opt. 1 $0 Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
Other Special Services – services with an asterisk * require prior authorization		
Combined Limit for Outpatient Occupational, Physical and Speech Therapy (per visit)	Opt. 1 $15 Copay Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
***Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy** (per visit)	Opt. 1 $15 Copay Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
Chiropractic Care (per visit)	Opt. 1 $15 Copay Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
***Durable Medical Equipment** Motorized Wheelchair	Opt. 1 15% Coinsurance Opt. 2 Not Covered	Opt. 3 Deductible + 50%
All Other	Opt. 1 15% Coinsurance Opt. 2 Not Covered	Opt. 3 Deductible + 50%
***Prosthetics and Medical Brace Device**	Opt. 1 $0 Opt. 2 Not Covered	Opt. 3 Deductible + 50%
***Home Health Care** (per visit)	Opt. 1 $15 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 50%
***Skilled Nursing Facility** (per day)	Opt. 1 $50 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 50%
Hospice	Opt. 1 $0 Opt. 2 Not Covered	Opt. 3 Deductible + 50%
Hearing Exam (Audiologist/Specialist)	Opt. 1 $35 Copay Opt. 2 Deductible + 30%	Opt. 3 Deductible + 50%
Telehealth Services General Medicine visit rendered by a designated Telehealth Services Provider	Opt. 1 $0 Opt. 2 Not Covered	Opt. 3 Not Covered
Mental Health/Behavioral Health visit rendered by a designated Telehealth Services Provider	Opt. 1 $30 Copay Opt. 2 Not Covered	Opt. 3 Not Covered
Diabetes Care Management		
Diabetes Outpatient Self-Management Education	Opt.1 $0 / Opt. 2 Not Covered	Opt. 3 Not Covered
Glucometer (2 per year)	Opt.1 $0 / Opt. 2 Not Covered	Opt. 3 Not Covered
Annual Complete Diabetic Eye Exam (Optometrist/Ophthalmologist)	Opt.1 $20 / $35 Copay Opt.2 Deductible + 30%	Opt. 3 Deductible + 50%
50 Test Strips (per box)	Opt.1 $10 Copay / Opt. 2 Not Covered	Opt. 3 Not Covered
Lancets (per box)	Opt.1 $4 Copay / Opt. 2 Not Covered	Opt. 3 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	$3 Copay	$15 Copay	$6 Copay
Non Preferred Generic	$10 Copay	$20 Copay	$27 Copay
Preferred Brand Drugs	$30 Copay	$40 Copay	$87 Copay
Non-Preferred Brand Drugs	$55 Copay	$65 Copay	$162 Copay
Specialty Drugs (Prior authorization is required)			
Preferred Specialty	40% Coinsurance	Not Covered	Not Covered
Non Preferred Specialty	50% 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 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

Pediatric Vision	Network Provider	Out-of-Network Provider
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). Inform members to 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.
- 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.