

**Gym Access SMAG Platinum POS 3000  
Health Benefit Plan P11**



Schedule of Benefits for Covered Services	Amount Member Pays	
	In-Network	Out-of-Network
<b>Financial Features</b>		
<b>Medical Essential Health Benefits Deductible</b> (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	\$500 per person \$1,000 per family
<b>Prescription Drug Essential Health Benefits Deductible</b> (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
<b>Coinsurance</b> (Coinsurance is the percentage the member pays for services)	20% of Allowed Amount	30% of Allowed Amount
<b>Essential Health Benefits Out-of-Pocket Maximum</b> (EM OOPM <sup>3</sup> ) (PBP <sup>2</sup> ) (OOPM includes DED, Coinsurance, Copayments and Prescription Drugs)	\$3,000 per person \$6,000 per family	\$6,000 per person \$12,000 per family
<b>Office Services</b>		
<b>Physician Office Services</b> (per visit) Primary Care Specialist	\$20 Copay \$30 Copay	Deductible + 30% Deductible + 30%
<b>Maternity</b> (Office Cost Share for initial visit only. Delivery charges are separate) Primary Care Specialist	\$20 Copay \$30 Copay	Deductible + 30% Deductible + 30%
<b>Allergy Injections</b> (per visit) Primary Care Specialist	20% Coinsurance 20% Coinsurance	Deductible + 30% Deductible + 30%
<b>Medical Pharmacy:</b> 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	40% Coinsurance 50% Coinsurance	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 prescription drug program. Please refer to your Certificate of Coverage for a description of Medical Pharmacy.		
<b>Preventive Care</b>		
<b>Routine Adult &amp; Child Preventive Services, Wellness Services, Blood Work and Immunizations</b>	\$0	Deductible + 30%
<b>Mammogram Screening</b>	\$0	Deductible + 30%
<b>Bone Density / Osteoporosis Screening</b>	\$0	Deductible + 30%
<b>Colonoscopy</b> (Routine for age 45+)	\$0	Deductible + 30%
<b>Emergency Medical Care</b>		
<b>Urgent Care Centers</b> (per visit)	\$50 Copay	\$50 Copay
<b>Hospital Emergency Room or Stand-Alone Emergency Facility Services</b> (per visit) (waived if admitted)	\$100 Copay	\$100 Copay
<b>Ambulance Services</b>	\$100 Copay	\$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.

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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.		
<b>Independent Diagnostic Facility/Provider's Office</b>		
Allergy Testing	\$0	Deductible + 30%
X-rays and Ultrasounds	\$0	Deductible + 30%
Diagnostic Services (except AIS)	\$0	Deductible + 30%
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	\$75 Copay	Deductible + 30%
<b>*Therapeutic Services</b> - <i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, hyperbaric oxygen therapy and radiation oncology.</i>	50% Coinsurance	Deductible + 30%
<b>Independent Clinical Lab</b> (diagnostic testing of blood and specimens)		
	\$0	Deductible + 30%
<b>Outpatient Hospital Facility Services</b> (per visit)		
Lab Services	\$25 Copay	Deductible + 30%
X-rays and Ultrasounds	\$25 Copay	Deductible + 30%
Diagnostic Services (except AIS)	\$25 Copay	Deductible + 30%
*Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	\$150 Copay	Deductible + 30%
<b>*Therapeutic Services</b> - <i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, hyperbaric oxygen therapy and radiation oncology.</i>	50% Coinsurance	Deductible + 30%
<b>Important:</b> 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. Therapeutic services will incur separate charges for the facility service, physician fee and medical pharmacy. 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.		
<b>Delivery / Hospital / Surgical - *all services require prior authorization</b>		
<b>*Ambulatory Surgical Center Facility (ASC)</b>	\$200 Copay	Deductible + 30%
<b>*Birthing Center</b>	\$400 Copay	Deductible + 30%
<b>*Outpatient Hospital Facility Services</b> (per visit)	\$400 Copay	Deductible + 30%
<b>*Inpatient Hospital Facility</b> (per admit)	\$200 Copay/Day (\$600 Maximum, Days 1-3)	Deductible + 30%
<b>Mental Health / Substance Dependency - services with an asterisk * require prior authorization</b>		
<b>Outpatient Office Visit</b>		
Primary Care	\$20 Copay	Deductible + 30%
Specialist	\$30 Copay	Deductible + 30%
Group Therapy	\$0	Deductible + 30%
<b>*Inpatient Hospital Facility</b> (per admit)	\$200 Copay/Day (\$600 Maximum, Days 1-3)	Deductible + 30%
<b>*Partial Hospitalization</b>	\$100 Copay/Day (\$300 Maximum, Days 1-3)	Deductible + 30%
<b>*Outpatient Facility Service</b> (per day)	\$50 Copay	Deductible + 30%
<b>*Residential/Rehabilitation Facility</b> (per day)	\$50 Copay	Deductible + 30%
<b>Other Provider Services</b>		
<b>Provider Services at ER</b>	\$0	\$0
<b>Provider Services at Hospital/Birthing Center</b>		
Inpatient	\$0	Deductible + 30%
Outpatient	\$0	Deductible + 30%
<b>Provider Services at an Ambulatory Surgical Center (ASC)</b>	\$0	Deductible + 30%
<b>Provider Services at Locations other than Office, Hospital and ER</b>		
Primary Care	\$20 Copay	Deductible + 30%
Specialist	\$30 Copay	Deductible + 30%

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	In-Network	Out-of-Network
<b>Other Special Services - services with an asterisk * require prior authorization</b>		
Combined Limit for Outpatient Occupational, Physical and Speech Therapy (per visit)	\$20 Copay	Deductible + 30%
*Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit)	\$20 Copay	Deductible + 30%
Chiropractic Care (per visit)	\$20 Copay	Deductible + 30%
*Durable Medical Equipment Motorized Wheelchair All Other	20% Coinsurance 20% Coinsurance	Deductible + 30% Deductible + 30%
*Prosthetics and Medical Brace Device	20% Coinsurance	Deductible + 30%
*Home Health Care (per day)	20% Coinsurance	Deductible + 30%
*Skilled Nursing Facility (per day)	\$50 Copay	Deductible + 30%
Hospice (per day)	20% Coinsurance	Deductible + 30%
*Enteral Formulas	20% Coinsurance	Deductible + 30%
Telehealth Services General Medicine visit rendered by a designated Telehealth Services Provider Mental Health/Behavioral Health visit rendered by a designated Telehealth Services Provider	\$0 \$30 Copay	Not Covered Not Covered
<b>Diabetes Care Management</b>		
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](http://www.fhcp.com) or call toll-free 1-877-615-4022 to see if prior authorization is required.

<b>Benefit Maximums – Combined Limit In-Network and Out-of-Network</b>	
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

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**Schedule of Benefits for Covered Services**

Amount Member Pays

<b>Prescription Drug Program</b>			
<b>Pharmacy Network:</b> 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 <a href="http://www.fhcp.com">www.fhcp.com</a> 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
<b>Generic Drugs</b>			
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
<b>Preferred Brand Drugs</b>	\$30 Copay	\$40 Copay	\$87 Copay
<b>Non-Preferred Brand Drugs</b>	\$55 Copay	\$65 Copay	\$162 Copay
<b>Specialty Drugs</b> (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  
Network Provider      Out-of-Network Provider

<b>Pediatric Vision</b>		
<b>Network Provider Services:</b> 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 <a href="http://www.fhcp.com">www.fhcp.com</a> and click <b>Find a Provider/Facility</b> to locate a Network Provider near them.		
	Network Provider	Out-of-Network Provider
<b>Eyeglass Exam</b> (1x per year)	\$10 Copay	Not Covered
<b>Eyeglasses</b> (includes frames & lenses - single vision, bifocal, trifocal or lenticular)	\$25 Copay	Not Covered
<b>Contact Lenses Exam</b> (1x per year) <i>(Instead of eyeglass exam)</i>	\$50 Copay	Not Covered
<b>Contact Lenses</b> (2 boxes, 1x per year) <i>(Instead of eyeglasses)</i>	\$25 Copay	Not Covered
<b>Eye Infection, Visual Disturbances, etc.</b> (per exam)	\$10 Copay	Not Covered
<b>Note:</b> Anything over the allowance will not count toward your out-of-pocket maximum limitation.		
<b>Pediatric Dental</b>		
<b>Preventive, Basic and Major Services</b>	\$0	

<b>Wellness Certificate</b>	
<b>Fitness Center Access</b>	Covered

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### 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](http://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.