

Gym Access SMAG Silver HMO OA 0227 Health Benefit Plan PB1	An Independent Licensee of the Blue Cross and Blue Shield Association	
	Amount Mer	
Schedule of Benefits for Covered Services	In-Network	Out-of-Network
Financial Features		
Medical Essential Health Benefits Deductible (EM DED ¹) (PBP ²)	\$0 per person	Not Covered
(DED is the amount the member is responsible for before FHCP pays) Prescription Drug Essential Health Benefits Deductible (EM DED ¹) (PBP ²)	\$0 per family \$3,500 per person	Not Covered
(DED is the amount the member is responsible for before FHCP pays)	\$7,000 per family	
Coinsurance (Coinsurance is the percentage the member pays for services)	45% of Allowed Amount	Not Covered
Essential Health Benefits Out-of-Pocket Maximum (EM OOPM ³) (PBP ²)	\$8,700 per person	Not Covered
(OOPM includes DED, Coinsurance, Copayments and Prescription Drugs)	\$17,400 per family	
Office Services		
Physician Office Services (per visit)		
Primary Care	\$30 Copay	Not Covered Not Covered
Specialist	\$50 Copay	Not Covered
Maternity (Office Cost Share for initial visit only. Delivery charges are separate) Primary Care	\$30 Copay	Not Covered
Specialist	\$50 Copay	Not Covered
Allergy Injections (per visit)		
Primary Care	45% Coinsurance	Not Covered
Specialist	45% Coinsurance	Not Covered
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	45% Coinsurance	Not Covered
Non-Preferred Medications	45% Coinsurance	Not Covered
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 t Coverage for a description of Medical Pharmacy.	ddition to the Office Services and/c he prescription drug program. Plea	r Outpatient Facility Cost ase refer to your Certificate of
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, Blood Work and Immunizations	\$0	Not Covered
Mammogram Screening	\$0	Not Covered
Bone Density / Osteoporosis Screening	\$0	Not Covered
Colonoscopy (Routine for age 45+)	\$0	Not Covered
Emergency Medical Care		
Urgent Care Centers (per visit)	\$75 Copay	\$75 Copay
Hospital Emergency Room or Stand-Alone Emergency Facility Services (per visit) (waived if admitted)	\$300 Copay	\$300 Copay
Ambulance Services	\$300 Copay	\$300 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.

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



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*Partial Hospitalization (\$8,000 Maximum, Days 1-4) *Partial Hospitalization \$500 Copay/Day (\$4,000 Maximum, Days 1-8) *Outpatient Facility Service (per day) \$50 Copay *Residential/Rehabilitation Facility (per day) \$50 Copay Vother Provider Services \$0 Provider Services at ER \$0 Provider Services at Hospital/Birthing Center \$0 Inpatient \$0 Outpatient \$0 Provider Services at an Ambulatory Surgical Center (ASC) \$50 Copay Provider Services at Locations other than Office, Hospital and ER \$30 Copay Primary Care \$30 Copay			
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*Residential/Rehabilitation Facility (per day) \$50 Copay Not Covered Other Provider Services at ER \$0 \$0 Provider Services at Hospital/Birthing Center \$0 \$0 Inpatient \$0 Not Covered Outpatient \$0 Not Covered Provider Services at an Ambulatory Surgical Center (ASC) \$50 Copay Not Covered Provider Services at Locations other than Office, Hospital and ER \$30 Copay Not Covered	*Partial Hospitalization	\$500 Copay/Day	Not Covered
Other Provider Services \$0 \$0 Provider Services at ER \$0 \$0 Provider Services at Hospital/Birthing Center \$0 Not Covered Inpatient \$0 Not Covered Outpatient \$50 Copay Not Covered Provider Services at an Ambulatory Surgical Center (ASC) \$50 Copay Not Covered Provider Services at Locations other than Office, Hospital and ER \$30 Copay Not Covered	*Outpatient Facility Service (per day)	\$50 Copay	Not Covered
Provider Services at ER\$0\$0Provider Services at Hospital/Birthing Center Inpatient\$0Not CoveredOutpatient\$0Not CoveredProvider Services at an Ambulatory Surgical Center (ASC)\$50 CopayNot CoveredProvider Services at Locations other than Office, Hospital and ER Primary Care\$30 CopayNot Covered	*Residential/Rehabilitation Facility (per day)	\$50 Copay	Not Covered
Provider Services at Hospital/Birthing Center \$0 Not Covered Inpatient \$0 Not Covered Outpatient \$50 Copay Not Covered Provider Services at an Ambulatory Surgical Center (ASC) \$50 Copay Not Covered Provider Services at Locations other than Office, Hospital and ER \$30 Copay Not Covered Primary Care \$30 Copay Not Covered	Other Provider Services		
Inpatient \$0 Not Covered Outpatient \$50 Copay Not Covered Provider Services at an Ambulatory Surgical Center (ASC) \$50 Copay Not Covered Provider Services at Locations other than Office, Hospital and ER \$30 Copay Not Covered Primary Care \$30 Copay Not Covered		\$0	\$0
Provider Services at an Ambulatory Surgical Center (ASC) \$50 Copay Not Covered Provider Services at Locations other than Office, Hospital and ER \$30 Copay Not Covered	Inpatient		
Provider Services at Locations other than Office, Hospital and ER Primary Care \$30 Copay Not Covered			
Primary Care \$30 Copay Not Covered			
specialist \$50 Copay Not Covered		\$30 Copay \$50 Copay	Not Covered Not Covered

Gym Access SMAG Silver HMO OA 0227 Health Benefit Plan PB1



Amount Member Pays Schedule of Benefits for Covered Services Out-of-Network In-Network Other Special Services - services with an asterisk * require prior authorization Combined Limit for Outpatient Occupational, Physical and Speech Therapy (per visit) \$50 Copay Not Covered *Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit) \$50 Copay Not Covered Chiropractic Care (per visit) \$30 Copay Not Covered *Durable Medical Equipment Motorized Wheelchair Not Covered 45% Coinsurance All Other 45% Coinsurance Not Covered *Prosthetics and Medical Brace Device Not Covered 45% Coinsurance *Home Health Care (per day) 45% Coinsurance Not Covered *Skilled Nursing Facility (per day) Not Covered \$50 Copay 45% Coinsurance Not Covered Hospice (per day) *Enteral Formulas 45% Coinsurance Not Covered **Telehealth Services** General Medicine visit rendered by a designated Telehealth Services Provider \$0 Not Covered Mental Health/Behavioral Health visit rendered by a designated Telehealth Services Provider \$30 Copay Not Covered **Diabetes Care Management** Diabetes Outpatient Self-Management Education \$0 Not Covered **Glucometer** (2 per year) \$0 Not Covered 50 Test Strips (per box) \$10 Copay Not Covered Not Covered Lancets (per box) \$4 Copay

*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	
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

Gym Access SMAG Silver HMO OA 0227 Health Benefit Plan PB1

Schedule of Benefits for Covered Services

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Florida

Health Care

Plans

Amount Member Pays

Amount Member Pays

Out-of-Network Provider

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) Preferred Generic Non-Preferred Generic	\$0 \$4 Copay \$35 Copay	Not Covered \$15 Copay \$45 Copay	\$0 \$9 Copay \$102 Copay	
Preferred Brand Drugs	Deductible + 35%	Deductible + 35%	Deductible + 35%	
Non-Preferred Brand Drugs	Deductible + 40%	Deductible + 40%	Deductible + 40%	
Specialty Drugs (Prior authorization is required)				
Preferred Specialty	Deductible + 45%	Not Covered	Not Covered	
Non-Preferred Specialty	Deductible + 45%	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 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 lir	nitation.	
Pediatric Dental		
Preventive, Basic and Major Services	\$0	

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 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.