

# Gym Access SMAG Gold Triple Option Essential Plus 29 Health Benefit Plan M29



Amount Member Pays  
In-Network                      Out-of-Network

## Schedule of Benefits for Covered Services

Financial Features		
<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)	Opt. 1: \$2,000 Person / \$4,000 Family Opt. 2: \$2,000 Person / \$4,000 Family	Opt. 3: \$3,000 Person / \$6,000 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)	Opt. 1: \$0 Person / \$0 Family Opt. 2: Not Applicable	Not Covered
<b>Coinsurance</b> (Coinsurance is the percentage the member pays for services)	Opt. 1: 10% of Allowed Amount Opt. 2: 20% of Allowed Amount	Opt. 3: 30% of Allowed Amount
<b>Medical Essential Health Benefits Out-of-Pocket Maximum</b> (EM OOPM <sup>3</sup> ) (PBP <sup>2</sup> ) (OOPM includes DED, Coinsurance and Copayments)	Opt. 1: \$4,700 Person / \$9,400 Family Opt. 2: \$5,000 Person / \$10,000 Family	Opt. 3: \$5,500 Person / \$11,000 Family
<b>Prescription Drug Essential Health Benefits OOP Maximum</b> (EM OOPM <sup>3</sup> ) (PBP <sup>2</sup> ) (OOPM includes DED, Coinsurance and Copayments)	Opt. 1: \$1,000 Person / \$2,000 Family Opt. 2: Not Applicable	Not Covered
Office Services		
<b>Physician Office Services</b> (per visit)		
Primary Care	Opt. 1 \$20 Copay Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%
Specialist	Opt. 1 \$35 Copay Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%
<b>Maternity</b> (Office Cost Share for initial visit only. Delivery charges are separate)		
Primary Care	Opt. 1 \$20 Copay Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%
Specialist	Opt. 1 \$35 Copay Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%
<b>Allergy Injections</b> (per visit)		
Primary Care	Opt. 1 10% Coinsurance Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%
Specialist	Opt. 1 10% Coinsurance Opt. 2 Deductible + 20%	Opt. 3 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	Opt. 1 40% Coinsurance Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%
Non-Preferred Medications	Opt. 1 50% Coinsurance Opt. 2 Deductible + 20%	Opt. 3 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		
<b>Routine Adult &amp; Child Preventive Services, Wellness Services, Blood Work and Immunizations</b>	Opt. 1 & 2 \$0	Opt. 3 Deductible + 30%
<b>Mammogram Screening</b>	Opt. 1 & 2 \$0	Opt. 3 Deductible + 30%
<b>Bone Density / Osteoporosis Screening</b>	Opt. 1 & 2 \$0	Opt. 3 Deductible + 30%
<b>Colonoscopy</b> (Routine for age 45+)	Opt. 1 & 2 \$0	Opt. 3 Deductible + 30%
Emergency Medical Care		
<b>Urgent Care Centers</b> (per visit)	Opt. 1 & 2 \$75 Copay	Opt. 3 \$75 Copay
<b>Hospital Emergency Room or Stand-Alone Emergency Facility Services</b> (per visit)	Opt. 1 & 2 Deductible + 10%	Opt. 3 In-Network Deductible + 10%
<b>Ambulance Services</b>	Opt. 1 & 2 Deductible + 10%	Opt. 3 In-Network Deductible + 10%

<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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Health Benefit Plan M29**



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**Schedule of Benefits for Covered Services**

In-Network

Out-of-Network

<b>Outpatient Diagnostic and Therapeutic Services – services with an asterisk* require prior authorization. Charges are per visit/test.</b>		
<b>Independent Diagnostic Testing Facility/Provider's Office</b> Allergy Testing X-rays and Ultrasounds Diagnostic Services (except AIS) *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	Opt. 1 Deductible + 10% Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%
<b>*Therapeutic Services</b> - Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, hyperbaric oxygen therapy and radiation oncology.	Opt. 1 50% Coinsurance Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%
<b>Independent Clinical Lab</b> (diagnostic testing of blood and specimens)	Opt. 1 Deductible + 10% Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>Outpatient Hospital Facility Services</b> (per visit) Lab Services X-rays and Ultrasounds Diagnostic Services (except AIS) *Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	Opt. 1 Deductible + 10% Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>*Therapeutic Services</b> - Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, hyperbaric oxygen therapy and radiation oncology	Opt. 1 50% Coinsurance Opt. 2 Not Covered	Opt. 3 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>	Opt. 1 Deductible + 10% Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>*Birthing Center</b>	Opt. 1 Deductible + 10% Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>*Outpatient Hospital Facility Services</b> (surgical) (per visit)	Opt. 1 Deductible + 10% Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>*Inpatient Hospital Facility</b> (per stay)	Opt. 1 \$500 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>Mental Health / Substance Dependency – services with an asterisk* require prior authorization</b>		
<b>Outpatient Office Visit</b> Primary Care Specialist Group Therapy	Opt. 1 \$20 Copay Opt. 2 Deductible + 20% Opt. 1 \$35 Copay Opt. 2 Deductible + 20% Opt. 1 \$0 Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30% Opt. 3 Deductible + 30% Opt. 3 Deductible + 30%
<b>*Inpatient Hospital Facility</b> (per stay)	Opt. 1 \$500 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>*Partial Hospitalization</b>	Opt. 1 \$250 Copay Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>Outpatient Facility Service</b> (per day)	Opt. 1 Deductible + 10% Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>*Residential/Rehabilitation Facility</b> (per day)	Opt. 1 Deductible + 10% Opt. 2 Not Covered	Opt. 3 Deductible + 30%

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**Schedule of Benefits for Covered Services**

In-Network

Out-of-Network

<b>Other Provider Services</b>		
<b>Provider Services at ER</b>	Opt. 1 & 2 Deductible + 10%	Opt. 3 In-Network Deductible + 10%
<b>Provider Services at Hospital/Birthing Center</b> Inpatient  Outpatient	Opt. 1 \$0 Opt. 2 Deductible + 20% Opt. 1 Deductible + 10% Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%  Opt. 3 Deductible + 30%
<b>Provider Services at an Ambulatory Surgical Center (ASC)</b>	Opt. 1 Deductible + 10% Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%
<b>Provider Services at Locations other than Office, Hospital and ER</b> Primary Care  Specialist	Opt. 1 \$20 Copay Opt. 2 Deductible + 20% Opt. 1 \$35 Copay Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%  Opt. 3 Deductible + 30%
<b>Other Special Services – services with an asterisk * require prior authorization</b>		
<b>Combined Limit for Outpatient Occupational, Physical and Speech Therapy (per visit)</b>	Opt. 1 \$35 Copay Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%
<b>Combined Limit for Outpatient Cardiac and Pulmonary Rehabilitation Therapy (per visit)</b>	Opt. 1 \$35 Copay Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%
<b>Chiropractic Care (per visit)</b>	Opt. 1 \$20 Copay Opt. 2 Deductible + 20%	Opt. 3 Deductible + 30%
<b>*Durable Medical Equipment</b> Motorized Wheelchair  All Other	Opt. 1 10% Coinsurance Opt. 2 Not Covered Opt. 1 10% Coinsurance Opt. 2 Not Covered	Opt. 3 Deductible + 30%  Opt. 3 Deductible + 30%
<b>*Prosthetics and Medical Brace Device</b>	Opt. 1 10% Coinsurance Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>*Home Health Care (per day)</b>	Opt. 1 10% Coinsurance Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>*Skilled Nursing Facility (per day)</b>	Opt. 1 Deductible + 10% Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>Hospice (per day)</b>	Opt. 1 10% Coinsurance Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>*Enteral Formulas</b>	Opt. 1 10% Coinsurance Opt. 2 Not Covered	Opt. 3 Deductible + 30%
<b>Telehealth Services</b> General Medicine visit rendered by a designated Telehealth Services Provider  Mental Health/Behavioral Health visit rendered by a designated Telehealth Services Provider	Opt. 1 \$0 Opt. 2 Not Covered Opt. 1 \$30 Copay Opt. 2 Not Covered	Opt. 3 Not Covered  Opt. 3 Not Covered

Schedule of Benefits for Covered Services	Amount Member Pays	
	In-Network	Out-of-Network
<b>Diabetes Care Management</b>		
<b>Diabetes Outpatient Self-Management Education</b>	Opt.1 \$0 / Opt. 2 Not Covered	Opt. 3 Not Covered
<b>Glucometer</b> (2 per year)	Opt.1 \$0/ Opt. 2 Not Covered	Opt. 3 Not Covered
<b>50 Test Strips</b> (per box)	Opt.1 \$10 Copay/ Opt. 2 Not Covered	Opt. 3 Not Covered
<b>Lancets</b> (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](http://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		
<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.			
	<b>Retail Network Pharmacies</b> (1 month supply)		<b>Mail Order</b> (3 month supply)
	<b>Preferred - FHCP</b>	<b>Non-Preferred</b>	<b>FHCP Only</b>
<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). Inform members to 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.		
<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

**Note:** Anything over the allowance will not count toward your out-of-pocket maximum limitation.

**Schedule of Benefits for Covered Services**

<b>Pediatric Dental</b>	
Preventive, Basic and Major Services	\$0

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

<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

**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](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.