FHCP – Volusia, Flagler, Brevard, Seminole & St. Johns

Plan Features for all Plans

- Preventive Adult and Child Wellness Services for all plans $0.
- Preferred Fitness Certificate (Gym Access)
- Prescription Generic oral contraceptives are covered at no cost to the member.
- Out-of-Pocket Maximum includes: Deductible, Copayments, Coinsurance and Rx.
- All plans come with Pediatric Vision Care and Pediatric Dental Care Benefits (see last page).
- All plans come with option to purchase Adult Vision Rider.

New 2024 Plans in **Bold Red**
Yellow Highlighting = Increased 2024 Cost Share
Green Highlighting = Decreased 2024 Cost Share

Benefit Maximums for all Plans	
Home Health Care	20 Visits PBP
Skilled Nursing/Rehabilitation Facility	60 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
Behavioral Health Residential Facility	60 Days PBP

PBP=Per Benefit Period

Florida Health Care Plans is an Independent Licensee of the Blue Cross and Blue Shield Association. This matrix is only a partial description of the many benefits and services provided or authorized by Florida Health Care Plans. This matrix does not constitute a Contract.

Florida Health Care Plans®
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Small Group Off Exchange 2024 — HMO Plans			
Metal	Plan Name	In-Network CYD / Coins / OOP	In-Network PCP / Specialist
Platinum	Gym Access SMAG Essential Plus Platinum HMO V65	$0 / 15% / $2,000 (Med) & $2,000 (Drug)	$20 / $35
Platinum	Gym Access SMAG Platinum HMO 3000 P10	$0 / 20% / $3,000	$20 / $30
Platinum	Gym Access SMAG Platinum HMO 4010 P12	$0 / 20% / $1,900	$20 / $40
Platinum	Gym Access SMAG Platinum HMO P91	$0 (Med) $0 (Drug) / 10% / $2,500	$15 / $30
Platinum	Gym Access SMAG Platinum HMO P92	$0 (Med) $0 (Drug) / 10% / $3,200	$15 / $30
Gold	Gym Access SMAG Gold HMO P90	$0 (Med) $0 (Drug) / 20% / $8,000	$30 / $50
Gold – H.S.A.	Gym Access SMAG Gold HMO H.S.A. 9010 PA3	$1,750 / 10% / $4,900	CYD + Coins
Gold	Gym Access SMAG Gold HMO 4500 P29	$2,550 / 10% / $5,000	$25 / $35
Gold	Gym Access SMAG Gold HMO 55001 P08	$2,800 (Med) $100 (Drug) / 20% / $7,500	$20 / $35
Gold	Gym Access SMAG Gold HMO P93	$1,500 (Med) $0 (Drug) / 20% / $7,900	$25 / $40
Gold	Gym Access SMAG Gold HMO P95	$3,000 (Med) $0 (Drug) / 10% / $7,500	$30 / $60
Gold	Gym Access SMAG Gold HMO 142009 PA7	$0 / 50% / $8,200	$40 / $60
Silver	Gym Access SMAG Silver HMO OA 0227 PB1	$0 (Med) / $3,500 (Drug) / 45% / $8,700	$30 / $50
Silver – H.S.A.	Gym Access SMAG Silver HMO H.S.A. 2566 P22	$3,250 / 20% / $7,500	CYD + Coins
Silver	Gym Access SMAG Silver HMO 1560 PA4	$4,000 (Med) $0 (Drug) / 50% / $9,200	$40 / $60
Silver	Gym Access SMAG Silver HMO 0526 PA5	$4,500 (Med) $500 (Drug) / 20% / $8,900	$30 / $60
Silver	Gym Access SMAG Silver HMO 99 P99	$5,300 (Med) $50 (Drug) / 20% / $9,350	$40 / $60
Silver	Gym Access SMAG Silver HMO 4 P04	$6,000 (Med) $0 (Drug) / 30% / $9,450	$35 / $55
Silver	Gym Access SMAG Silver HMO 3 P03	$2,500 (Med) $0 (Drug) / 50% / $9,450	$30 / $75
Bronze	Gym Access SMAG Bronze HMO OA 1211 PB2	$0 (Med) / $2,500 (Drug) / 50% / $9,450	$50 / $85
Bronze – H.S.A.	Gym Access SMAG Bronze HMO H.S.A. 5065 P24	$6,300 / 30% / $7,500	CYD + Coins
Bronze – H.S.A.	Gym Access SMAG Bronze HMO H.S.A. 6060 P26	$7,500 / 100% / $7,500	CYD
Bronze	Gym Access SMAG Bronze HMO 1 P01	$7,000 / 50% / $9,300	$60 / $90
Bronze	Gym Access SMAG Bronze HMO 2 P02	$6,000 / 50% / $9,450	$65 / $120
Bronze	Gym Access SMAG Bronze HMO OA 0318 PB3	$6,000 / 50% / $9,200	$15 / $85
Small Group Off Exchange 2024 – POS Plans			
Platinum	**Gym Access SMAG Essential Plus Platinum POS 65 P43**	**$0 / 15% / $2,000 (Med) & $2,000 (Drug)**	**$20 / $35**
Platinum	Gym Access SMAG Platinum POS P88	$0 / 15% / $3,000	$20 / $35
Platinum	Gym Access SMAG Platinum POS 3000 P11	$0 / 20% / $3,000	$20 / $30
Platinum	Gym Access SMAG Platinum POS 4010 P13	$0 / 20% / $1,900	$20 / $40
Gold	**Gym Access SMAG Gold POS 90 P44**	**$0 (Med) $0 (Drug) / 20% / $8,000**	**$30 / $50**
Gold	**Gym Access SMAG Gold POS 4500 P40**	**$2,550 / 10% / $5,000**	**$25 / $35**
Gold	Gym Access SMAG Gold POS 55001 P09	$2,800 (Med) $100 (Drug) / 20% / $7,500	$20 / $35
Silver	**Gym Access SMAG Silver POS OA 0227 P42**	**$0 (Med) / $3,500 (Drug) / 45% / $8,700**	**$30 / $50**
Silver – H.S.A.	Gym Access SMAG Silver POS H.S.A 2566 P23	$3,250 / 20% / $7,500	CYD + Coins
Silver – H.S.A.	Gym Access SMAG HDHP Silver POS P98 (H.S.A.)	$3,250 / 30% / $6,500	CYD + Coins
Bronze	**Gym Access SMAG Bronze POS OA 1211 P41**	**$0 (Med) / $2,500 (Drug) / 50% / $9,450**	**$50 / $85**
Bronze – H.S.A.	Gym Access SMAG Bronze POS H.S.A. 5065 P25	$6,300 / 30% / $7,500	CYD + Coins
Bronze – H.S.A.	Gym Access SMAG Bronze POS 6060 H.S.A. P27	$7,500 / 100% / $7,500	CYD
Bronze	Gym Access SMAG Bronze POS 1042 PA2	$5,500 / 50% / $9,400	$40 / $75
***Small Group Off Exchange 2024 – Triple Option Plans**			
Platinum	Gym Access SMAG Platinum Triple Option M82	$0 / 15% / $3,000	$20 / $35
Gold	Gym Access SMAG Gold Triple Option M29	$2,000 (Med) $0 (Drug) / 10% / $4,700 (Med) $1,000 (Drug)	$20 / $35

Cost Sharing		Gym Access SMAG Essential Plus Platinum HMO 65	Gym Access SMAG Platinum HMO 3000	Gym Access SMAG Platinum HMO 4010	Gym Access SMAG Platinum HMO 91	Gym Access SMAG Platinum HMO 92
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$0 / $0	$0 / $0	$0 / $0	$0 / $0
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	15%	20%	20%	10%	10%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$2,000 / $4,000	$3,000 / $6,000	$1,900 / $3,800	$2,500 / $5,000	$3,200 / $6,400
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$20 Copay	$20 Copay	$20 Copay	$15 Copay	$15 Copay
	Specialist	$35 Copay	$30 Copay	$40 Copay	$30 Copay	$30 Copay
	Allergy Injections	15% Coinsurance	20% Coinsurance	20% Coinsurance	10% Coinsurance	10% Coinsurance
Medical Pharmacy Preferred/Non-Preferred (Does not include immunizations)		40% / 50% Coinsurance	40% / 50% Coinsurance	40% / 50% Coinsurance	40% / 50% Coinsurance	40% / 50% Coinsurance
	Out of Network	N/A	N/A	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$100 Copay	$100 Copay	$150 Copay	$150 Copay	$100 Copay
Urgent Care Centers	In-Network and Out-of-Network	$60 Copay	$50 Copay	$50 Copay	$50 Copay	$50 Copay
Independent Diagnostic Testing Facility/ Provider's Office						
	Allergy Testing	$0	$0	$0	$35 Copay	$20 Copay
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$10 Copay	$0	$25 Copay	$35 Copay	$20 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$50 Copay	$75 Copay	$100 Copay	$100 Copay	$75 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$0	$0	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	$0	$0	$0	$0	$0
Provider Services at Hospital	Inpatient	$0	$0	$0	$0	$0
	Outpatient	$0	$0	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	$200 Copay	$200 Copay	$250 Copay	$200 Copay	$250 Copay
Provider Services at ASC	In-Network	$0	$0	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	$250 per day ($1,250 Max)	$200 per day ($600 Max)	$250 per day ($750 Max)	$250 per day ($750 Max)	$300 per day ($900 Max)
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	$250 Copay	$400 Copay	$500 Copay	$400 Copay	$400 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$15 Copay	$20 Copay	$40 Copay	$20 Copay	$20 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Prescription Drugs*	Drug Deductible (per person / family aggregate)	$0 / $0	Integrated with Medical	Integrated with Medical	$0 / $0	$0 / $0
	Out of Pocket Maximum (per person / family aggregate)	$2,000 / $4,000	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0	$0	$0
	Preferred Generic / Non-Preferred Generic	$3 / $10	$3 / $10	$3 / $10	$3 / $10	$3 / $10
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/						

Cost Sharing		Gym Access SMAG Gold HMO 90	Gym Access SMAG Gold HMO H.S.A. 9010 Non-embedded DED & Embedded OOP	Gym Access SMAG Gold HMO 4500	Gym Access SMAG Gold HMO 55001
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$1,750 / $3,500	$2,550 / $5,100	$2,800 / $5,600
	Out-of-Network	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	20%	10%	10%	20%
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$8.000 / $16,000	$4,900 / $9,800	$5,000 / $10,000	$7,500 / $15,000
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$30 Copay	Deductible + 10%	$25 Copay	$20 Copay
	Specialist	$50 Copay	Deductible + 10%	$35 Copay	$35 Copay
	Allergy Injections	20% Coinsurance	Deductible + 10%	10% Coinsurance	20% Coinsurance
	Medical Pharmacy Preferred/Non-Preferred (Does not include immunizations)	40% / 50% Coinsurance	DED + 40% / DED + 50%	40% / 50% Coinsurance	DED + 40% / DED + 50%
	Out of Network	N/A	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$350 Copay	Deductible + 10%	Deductible + 10%	$200 Copay
Urgent Care Centers	In-Network and Out-of-Network	$50 Copay	Deductible + 10%	$75 Copay	$75 Copay
Independent Diagnostic Testing Facility/ Provider's Office					
	Allergy Testing	$0	Deductible + 10%	$0	$0
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$50 Copay	Deductible + 10%	Deductible + 10%	$30 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$250 Copay	Deductible + 10%	Deductible + 10%	$150 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$20 Copay	Deductible + 10%	$25 Copay	$20 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	$0	Deductible + 10%	Deductible + 10%	$0
Provider Services at Hospital	Inpatient	$0	Deductible + 10%	$0	Deductible + 20%
	Outpatient	$50 Copay	Deductible + 10%	Deductible + 10%	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	$300 Copay	Deductible + 10%	Deductible + 10%	Deductible + 20%
Provider Services at ASC	In-Network	$50 Copay	Deductible + 10%	Deductible + 10%	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	$300 per day ($1,500 Max)	Deductible + 10%	$250 per day ($750 Max)	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	$500 Copay	Deductible + 10%	Deductible + 10%	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$30 Copay	Deductible + 10%	$35 Copay	$35 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs*	Drug Deductible (per person / family aggregate)	$0 / $0	Integrated with Medical	Integrated with Medical	$100 / $200
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0	$0
	Preferred Generic / Non-Preferred Generic	$3 / $10	DED + $3 / DED + $10	$3 / $10	$3 / $10
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$30 / $55 / 40% / 50%	DED + $30 / DED + $55 / DED + 40% / DED + 50%	$30 / $55 / 40% / 50%	$30 / $55 / DED + 40% / DED + 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $27 / $87 / $162	DED + $6 / DED + $27 / DED + $87 / DED + $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

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H.S.A Compatible Plans – refer to the schedule of benefits for embedding information.

Cost Sharing		Gym Access SMAG Gold HMO 93	Gym Access SMAG Gold HMO 95	Gym Access SMAG Gold HMO 142009
Medical Deductible (Per Person / Family Aggregate)	In-Network	$1,500 / $3,000	$3,000 / $6,000	$0 / $0
	Out-of-Network	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	20%	10%	50%
	Out-of-Network	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$7,900 / $15,800	$7,500 / $15,000	$8,200 / $16,400
	Out-of-Network	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$25 Copay	$30 Copay	$40 Copay
	Specialist	$40 Copay	$60 Copay	$60 Copay
	Allergy Injections	20% Coinsurance	Deductible + 10%	50% Coinsurance
	Medical Pharmacy Preferred/Non-Preferred (Does not include immunizations)	40% / 50% Coinsurance	40% / 50% Coinsurance	40% / 50% Coinsurance
	Out of Network	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$200 Copay	$200 Copay	$350 Copay
Urgent Care Centers	In-Network and Out-of-Network	$50 Copay	$100 Copay	$80 Copay
Independent Diagnostic Testing Facility/ Provider's Office				
	Allergy Testing	$0	$0	$0
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$25 Copay	$35 Copay	$25 Copay
	Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	$150 Copay	$125 Copay	$250 Copay
	Out-of-Network	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$15 Copay	$10 Copay	$10 Copay
	Out-of-Network	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	$0	$0	$0
Provider Services at Hospital	Inpatient	Deductible + 20%	Deductible + 10%	$0
	Outpatient	$40 Copay	$60 Copay	$60 Copay
	Out-of-Network	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	$250 Copay	$350 Copay	$750 Copay
Provider Services at ASC	In-Network	$40 Copay	$60 Copay	$60 Copay
	Out-of-Network	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	Deductible + 20%	Deductible + 10%	$1,500 Copay
	Out-of-Network	N/A	N/A	N/A
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	$350 Copay	$500 Copay	$950 Copay
	Out-of-Network	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$40 Copay	$30 Copay	$40 Copay
	Out-of-Network	N/A	N/A	N/A
Prescription Drugs*	Drug Deductible (per person / family aggregate)	$0 / $0	$0 / $0	Integrated with Medical
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0
	Preferred Generic / Non-Preferred Generic	$3 / $10	$3 / $10	$3 / $10
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered
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Cost Sharing		Gym Access SMAG Silver HMO OA 0227	Gym Access SMAG Silver HMO HSA 2566 Non-embedded DED & Embedded OOP	Gym Access SMAG Silver HMO 1560	Gym Access SMAG Silver HMO 0526
Medical Deductible (Per Person / Family Aggregate)	In-Network Out-of-Network	$0 / $0 N/A	$3,250 / $6,500 N/A	$4,000 / $8,000 N/A	$4,500 / $9,000 N/A
Coinsurance (Amount member pays)	In-Network Out-of-Network	45% N/A	20% N/A	50% N/A	20% N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network Out-of-Network	$8,700 / $17,400 N/A	$7,500 / $15,000 N/A	$9,200 / $18,400 N/A	$8,900 / $17,800 N/A
Physician Office Services	Primary Care Office Specialist Allergy Injections Medical Pharmacy Preferred/Non-Preferred (Does not include immunizations) Out of Network	$30 Copay $50 Copay 45% Coinsurance 45% / 45% Coinsurance N/A	Deductible + 20% Deductible + 20% Deductible + 20% DED + 40% / DED + 50% N/A	$40 Copay $60 Copay 50% Coinsurance 40% / 50% Coinsurance N/A	$30 Copay $60 Copay 20% Coinsurance DED + 50% / DED + 50% N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$300 Copay	Deductible + 20%	Deductible + 50%	Deductible + 20%
Urgent Care Centers	In-Network and Out-of-Network	$75 Copay	Deductible + 20%	$75 Copay	$75 Copay
Independent Diagnostic Testing Facility/ Provider's Office					
	Allergy Testing X-Rays / Ultrasounds / Diagnostic Services (other than AIS) Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine) Out-of-Network	$10 Copay $40 Copay $200 Copay N/A	Deductible + 20% Deductible + 20% Deductible + 20% N/A	50% Coinsurance Deductible Deductible + 50% N/A	20% Coinsurance Deductible Deductible + 20% N/A
Independent Clinical Lab	In-Network Out-of-Network	$20 Copay N/A	Deductible + 20% N/A	Deductible + 50% N/A	Deductible + 20% N/A
Provider Services at ER	In-Network and Out-of-Network	$0	Deductible + 20%	Deductible + 50%	Deductible + 20%
Provider Services at Hospital	Inpatient Outpatient Out-of-Network	$0 $50 Copay N/A	Deductible + 20% Deductible + 20% N/A	Deductible + 50% Deductible + 50% N/A	Deductible + 20% Deductible + 20% N/A
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network In-Network Out-of-Network	$1,000 Copay $50 Copay N/A	Deductible + 20% Deductible + 20% N/A	Deductible + 50% Deductible + 50% N/A	Deductible + 20% Deductible + 20% N/A
Inpatient Hospital Facility Services (per admission)	In-Network Out-of-Network	$2,000 per day ($8,000 Max) N/A	Deductible + 20% N/A	Deductible + 50% N/A	Deductible + 20% N/A
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network Out-of-Network	$1,500 Copay N/A	Deductible + 20% N/A	Deductible + 50% N/A	Deductible + 20% N/A
Chiropractic Care (per visit)	In-Network Out-of-Network	$30 Copay N/A	Deductible + 20% N/A	$40 Copay N/A	$30 Copay N/A
Prescription Drugs*	Drug Deductible (per person / family aggregate) Out of Pocket Maximum (per person / family aggregate) Preventive Medications Preferred Generic / Non-Preferred Generic Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty Mail-Order (Pref. Specialty/NP Specialty not Available) Out-of-Network	$3,500 / $7,000 Integrated with Medical $0 $4 / $35 DED + 35% / DED + 40% / DED + 45% / DED + 45% $9 / $102 / DED + 35% / DED + 40% Not Covered	Integrated with Medical Integrated with Medical $0 DED + $3 / DED + $10 DED + $30 / DED + $55 / DED + 40% / DED + 50% DED + $6 / DED + $27 / DED + $87 / DED + $162 Not Covered	$0 / $0 Integrated with Medical $0 $3 / $10 $30 / $55 / 40% / 50% $6 / $27 / $87 / $162 Not Covered	$500 / $1,000 Integrated with Medical $0 $4 / $18 DED + $65 / DED + 50% / DED + 50% / DED + 50% $9 / $51 / DED + $192 / DED + 50% Not Covered
Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/ H.S.A Compatible Plans – refer to the schedule of benefits for embedding information					

Cost Sharing		Gym Access SMAG Silver HMO 99	Gym Access SMAG Silver HMO 4	Gym Access SMAG Silver HMO 3
Medical Deductible (Per Person / Family Aggregate)	In-Network	$5,300 / $10,600	$6,000 / $12,000	$2,500 / $5,000
	Out-of-Network	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	20%	30%	50%
	Out-of-Network	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$9,350 / $18,700	$9,450 / $18,900	$9,450 / $18,900
	Out-of-Network	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$40 Copay	$35 Copay	$30 Copay
	Specialist	$60 Copay	$55 Copay	$75 Copay
	Allergy Injections	20% Coinsurance	30% Coinsurance	50% Coinsurance
	Medical Pharmacy Preferred/Non-Preferred (Does not include immunizations)	40% / 50% Coinsurance	40% / 50% Coinsurance	40% / 50% Coinsurance
	Out of Network	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	Deductible + 20%	Deductible + 30%	$1,000 Copay
Urgent Care Centers	In-Network and Out-of-Network	$75 Copay	$85 Copay	$85 Copay
Independent Diagnostic Testing Facility/ Provider's Office				
	Allergy Testing	Deductible + 20%	$0	$0
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	Deductible	$60 Copay	$150 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	Deductible + 20%	$500 Copay	$850 Copay
	Out-of-Network	N/A	N/A	N/A
Independent Clinical Lab	In-Network	Deductible + 20%	$50 Copay	$50 Copay
	Out-of-Network	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	Deductible + 20%	Deductible + 30%	$0
Provider Services at Hospital	Inpatient	Deductible + 20%	Deductible + 30%	$0
	Outpatient	Deductible + 20%	Deductible + 30%	Deductible + 50%
	Out-of-Network	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	Deductible + 20%	Deductible + 30%	Deductible + 50%
Provider Services at ASC	In-Network	Deductible + 20%	Deductible + 30%	Deductible + 50%
	Out-of-Network	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	Deductible + 20%	Deductible + 30%	$2,000 per day ($8,000 Max)
	Out-of-Network	N/A	N/A	N/A
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	Deductible + 20%	Deductible + 30%	Deductible + 50%
	Out-of-Network	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$60 Copay	$30 Copay	$60 Copay
	Out-of-Network	N/A	N/A	N/A
Prescription Drugs*	Drug Deductible (per person / family aggregate)	$50 / $100	$0 / $0	$0 / $0
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0
	Preferred Generic / Non-Preferred Generic	$3 / $10	$3 / $10	$3 / $10
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$30 / $55 / DED + 40% / DED + 50%	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered
Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/				

Cost Sharing		Gym Access SMAG Bronze HMO OA 1211	Gym Access SMAG Bronze HMO H.S.A. 5065 Embedded DED & OOP	Gym Access SMAG Bronze HMO H.S.A. 6060 Embedded DED & OOP
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$6,300 / $12,600	$7,500 / $15,000
	Out-of-Network	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	50%	30%	100%
	Out-of-Network	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$9,450 / $18,900	$7,500 / $15,000	$7,500 / $15,000
	Out-of-Network	N/A	N/A	N/A
Physician Office Services				
	Primary Care Office	$50 Copay	Deductible + 30%	Deductible
	Specialist	$85 Copay	Deductible + 30%	Deductible
	Allergy Injections	50% Coinsurance	Deductible + 30%	Deductible
	Medical Pharmacy Preferred/Non-Preferred (Does not include immunizations)	50% / 50% Coinsurance	DED + 40% / DED + 50%	Deductible / Deductible
	Out of Network	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$1,000 Copay	Deductible + 30%	Deductible
Urgent Care Centers	In-Network and Out-of-Network	$85 Copay	Deductible + 30%	Deductible
Independent Diagnostic Testing Facility/ Provider's Office				
	Allergy Testing	$0	Deductible + 30%	Deductible
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$100 Copay	Deductible + 30%	Deductible
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$850 Copay	Deductible + 30%	Deductible
	Out-of-Network	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$50 Copay	Deductible + 30%	Deductible
	Out-of-Network	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	$0	Deductible + 30%	Deductible
Provider Services at Hospital	Inpatient	$0	Deductible + 30%	Deductible
	Outpatient	$85 Copay	Deductible + 30%	Deductible
	Out-of-Network	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	$1,000 Copay	Deductible + 30%	Deductible
Provider Services at ASC	In-Network	$85 Copay	Deductible + 30%	Deductible
	Out-of-Network	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	$3,000 Copay	Deductible + 30%	Deductible
	Out-of-Network	N/A	N/A	N/A
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	$2,000 Copay	Deductible + 30%	Deductible
	Out-of-Network	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$50 Copay	Deductible + 30%	Deductible
	Out-of-Network	N/A	N/A	N/A
Prescription Drugs*	Drug Deductible (per person / family aggregate)	$2,500 / $5,000	Integrated with Medical	Integrated with Medical
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0
	Preferred Generic / Non-Preferred Generic	$4 / $35	DED + $3 / DED + $10	DED / DED
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$200 / DED + 50% / DED + 50% / DED + 50%	DED + $30 / DED + $55 / DED + 40% / DED + 50%	DED / DED / DED / DED
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$9 / $102 / $597 / DED + 50%	DED + $6 / DED + $27 / DED + $87 / DED + $162	DED / DED / DED / DED
	Out-of-Network	Not Covered	Not Covered	Not Covered

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H.S.A Compatible Plans – refer to the schedule of benefits for embedding information

Cost Sharing		Gym Access SMAG Bronze HMO 1	Gym Access SMAG Bronze HMO 2	Gym Access SMAG Bronze HMO OA 0318
Medical Deductible (Per Person / Family Aggregate)	In-Network	$7,000 / $14,000	$6,000 / $12,000	$6,000 / $12,000
	Out-of-Network	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	50%	50%	50%
	Out-of-Network	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$9,300 / $18,600	$9,450 / $18,900	$9,200 / $18,400
	Out-of-Network	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$60 Copay	$65 Copay	$15 Copay
	Specialist	$90 Copay	$120 Copay	$85 Copay
	Allergy Injections	50% Coinsurance	50% Coinsurance	50% Coinsurance
	Medical Pharmacy Preferred/Non-Preferred (Does not include immunizations)	DED + 50% / DED + 50%	DED + 45% / DED + 45%	DED + 45% / DED + 45%
	Out of Network	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	Deductible + 50%	$1,000 Copay	Deductible + 50%
Urgent Care Centers	In-Network and Out-of-Network	$85 Copay	$100 Copay	$100 Copay
Independent Diagnostic Testing Facility/ Provider's Office				
	Allergy Testing	$0	$0	Deductible + 50%
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	Deductible	$150 Copay	Deductible
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	Deductible + 50%	$1,000 Copay	Deductible + 50%
	Out-of-Network	N/A	N/A	N/A
Independent Clinical Lab	In-Network	Deductible	$50 Copay	Deductible
	Out-of-Network	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	Deductible + 50%	$0	Deductible + 50%
Provider Services at Hospital	Inpatient	Deductible + 50%	$0	Deductible + 50%
	Outpatient	Deductible + 50%	$120 Copay	Deductible + 50%
	Out-of-Network	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	Deductible + 50%	$2,000 Copay	Deductible + 50%
Provider Services at ASC	In-Network	Deductible + 50%	$120 Copay	Deductible + 50%
	Out-of-Network	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	Deductible + $150 Copay	$2,500 per day ($7,500 Max)	Deductible + 50%
	Out-of-Network	N/A	N/A	N/A
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	Deductible + 50%	$2,500 Copay	Deductible + 50%
	Out-of-Network	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$40 Copay	$65 Copay	$85 Copay
	Out-of-Network	N/A	N/A	N/A
Prescription Drugs*	Drug Deductible (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0
	Preferred Generic / Non-Preferred Generic	$4 / $18	$4 / $35	$4 / $35
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	DED + $65 / DED + 50% / DED + 50% / DED + 50%	DED + 35% / DED + 40% / DED + 45% / DED + 45%	DED + 35% / DED + 40% / DED + 45% / DED + 45%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$9 / $51 / DED + $192 / DED + 50%	$9 / $102 / DED + 35% / DED + 40%	$9 / $102 / DED + 35% / DED + 40%
	Out-of-Network	Not Covered	Not Covered	Not Covered
Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/				

Cost Sharing		Gym Access SMAG Essential Plus Platinum POS 85	Gym Access SMAG Platinum POS 88	Gym Access SMAG Platinum POS 3000	Gym Access SMAG Platinum POS 4010
Medical Deductible (Per Person / Family Aggregate)	In-Network Out-of-Network	$0 / $0 $3,000 / $6,000	$0 / $0 $250 / $750	$0 / $0 $500 / $1,000	$0 / $0 $500 / $1,000
Coinsurance (Amount member pays)	In-Network Out-of-Network	15% 30%	15% 20%	20% 30%	20% 30%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network Out-of-Network	$2,000 / $4,000 $6,000 / $12,000	$3,000 / $6,000 $4,500 / $9,000	$3,000 / $6,000 $6,000 / $12,000	$1,900 / $3,800 $8,000 / $16,000
Physician Office Services	Primary Care Office Specialist Allergy Injections Medical Pharmacy preferred/non-preferred (Does not include immunizations) Out of Network	$20 Copay $35 Copay 15% Coinsurance 40% / 50% Coinsurance Deductible + 30%	$20 Copay $35 Copay 15% Coinsurance 40% / 50% Coinsurance Deductible + 20%	$20 Copay $30 Copay 20% Coinsurance 40% / 50% Coinsurance Deductible + 30%	$20 Copay $40 Copay 20% Coinsurance 40% / 50% Coinsurance Deductible + 30%
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$100 Copay	$125 Copay	$100 Copay	$150 Copay
Urgent Care Centers	In-Network and Out-of-Network	$60 Copay	$50 Copay	$50 Copay	$50 Copay
Independent Diagnostic Testing Facility/ Provider's Office					
	Allergy Testing	$0	$35 Copay	$0	$0
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$10 Copay	$35 Copay	$0	$25 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$50 Copay	$100 Copay	$75 Copay	$100 Copay
	Out-of-Network	Deductible + 30%	Deductible + 20%	Deductible + 30%	Deductible + 30%
Independent Clinical Lab	In-Network Out-of-Network	$0 Deductible + 30%	$0 Deductible + 20%	$0 Deductible + 30%	$0 Deductible + 30%
Provider Services at ER	In-Network and Out-of-Network	$0	$0	$0	$0
Provider Services at Hospital	Inpatient Outpatient Out-of-Network	$0 $0 Deductible + 30%	$0 $0 Deductible + 20%	$0 $0 Deductible + 30%	$0 $0 Deductible + 30%
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network In-Network Out-of-Network	$200 Copay $0 Deductible + 30%	$200 Copay $0 Deductible + 20%	$200 Copay $0 Deductible + 30%	$250 Copay $0 Deductible + 30%
Inpatient Hospital Facility Services (per admission)	In-Network Out-of-Network	$250 per day ($1,250 Max) Deductible + 30%	$200 per day ($1,000 Max) Deductible + 20%	$200 per day ($600 Max) Deductible + 30%	$250 per day ($750 Max) Deductible + 30%
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network Out-of-Network	$250 Copay Deductible + 30%	$300 Copay Deductible + 20%	$400 Copay Deductible + 30%	$500 Copay Deductible + 30%
Chiropractic Care (per visit)	In-Network Out-of-Network	$15 Copay Deductible + 30%	$20 Copay Deductible + 20%	$20 Copay Deductible + 30%	$40 Copay Deductible + 30%
Prescription Drugs*	Drug Deductible (per person / family aggregate) Out of Pocket Maximum (per person / family aggregate) Preventive Medications Preferred Generic / Non-Preferred Generic Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty Mail-Order (Pref. Specialty/NP Specialty not Available) Out-of-Network	$0 / $0 $2,000 / $4,000 $0 $3 / $10 $30 / $55 / 40% / 50% $6 / $27 / $87 $162 Not Covered	Integrated with Medical Integrated with Medical $0 $3 / $10 $30 / $55 / 40% / 50% $6 / $27 / $87 / $162 Not Covered	Integrated with Medical Integrated with Medical $0 $3 / $10 $30 / $55 / 40% / 50% $6 / $27 / $87 / $162 Not Covered	Integrated with Medical Integrated with Medical $0 $3 / $10 $30 / $55 / 40% / 50% $6 / $27 / $87 / $162 Not Covered
Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/					

Cost Sharing		Gym Access SMAG Gold POS 80	Gym Access SMAG Gold POS 4500	Gym Access SMAG Gold POS 55001	Gym Access SMAG Silver POS OA 0227	Gym Access SMAG Silver POS HSA 2566 Non-embedded DED & Embedded OOP
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$2,550 / $5,100	$2,800 / $5,600	$0 / $0	$3,250 / $6,500
	Out-of-Network	$1,000 / $2,000	$4,000 / $8,000	$4,000 / $8,000	$500 / $1,000	$4,000 / $8,000
Coinsurance (Amount member pays)	In-Network	20%	10%	20%	45%	20%
	Out-of-Network	30%	30%	30%	50%	30%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$8,000 / $16,000	$5,000 / $10,000	$7,500 / $15,000	$8,700 / $17,400	$7,500 / $15,000
	Out-of-Network	$10,000 / $20,000	$8,000 / $16,000	$8,000 / $16,000	$10,000 / $20,000	$10,000 / $20,000
Physician Office Services	Primary Care Office	$30 Copay	$25 Copay	$20 Copay	$30 Copay	Deductible + 20%
	Specialist	$50 Copay	$35 Copay	$35 Copay	$50 Copay	Deductible + 20%
	Allergy Injections	20% Coinsurance	10% Coinsurance	20% Coinsurance	45% Coinsurance	Deductible + 20%
	Medical Pharmacy preferred/non-preferred (Does not include immunizations)	40% / 50% Coinsurance	40% / 50% Coinsurance	DED + 40% / DED + 50%	45% / 45% Coinsurance	DED + 40% / DED + 50%
	Out of Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 50%	Deductible + 30%
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$350 Copay	INN Deductible[1] + 10%	$200 Copay	$300 Copay	INN Deductible[1] + 20%
Urgent Care Centers	In-Network and Out-of-Network	$50 Copay	$75 Copay	$75 Copay	$75 Copay	INN Deductible[1] + 20%
Independent Diagnostic Testing Facility/ Provider's Office						
	Allergy Testing	$0	$0	$0	$10 Copay	Deductible + 20%
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$50 Copay	Deductible + 10%	$30 Copay	$40 Copay	Deductible + 20%
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$250 Copay	Deductible + 10%	$150 Copay	$200 Copay	Deductible + 20%
	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 50%	Deductible + 30%
Independent Clinical Lab	In-Network	$20 Copay	$25 Copay	$20 Copay	$20 Copay	Deductible + 20%
	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 50%	Deductible + 30%
Provider Services at ER	In-Network and Out-of-Network	$0	INN Deductible[1] + 10%	$0	$0	INN Deductible[1] + 20%
Provider Services at Hospital	Inpatient	$0	$0	Deductible + 20%	$0	Deductible + 20%
	Outpatient	$50 Copay	Deductible + 10%	Deductible + 20%	$50 Copay	Deductible + 20%
	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 50%	Deductible + 30%
Ambulatory Surgical Center Facility	In-Network	$300 Copay	Deductible + 10%	Deductible + 20%	$1,000 Copay	Deductible + 20%
(ASC)	In-Network	$50 Copay	Deductible + 10%	Deductible + 20%	$50 Copay	Deductible + 20%
Provider Services at ASC	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 50%	Deductible + 30%
Inpatient Hospital Facility Services (per admission)	In-Network	$300 per day ($1,500 Max)	$250 per day ($750 Max)	Deductible + 20%	$2,000 per day ($8,000 Max)	Deductible + 20%
	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 50%	Deductible + 30%
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	$500 Copay	Deductible + 10%	Deductible + 20%	$1,500 Copay	Deductible + 20%
	Out-of-Network	Deductible + 20%	Deductible + 30%	Deductible + 30%	Deductible + 50%	Deductible + 30%
Chiropractic Care (per visit)	In-Network	$30 Copay	$35 Copay	$35 Copay	$30 Copay	Deductible + 20%
	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 50%	Deductible + 30%
Prescription Drugs*	Drug Deductible (per person / family aggregate)	$0 / $0	Integrated with Medical	$100 / $200	$3,500 / $7,000	Integrated with Medical
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0	$0	$0
	Preferred Generic / Non-Preferred Generic	$3 / $10	$3 / $10	$3 / $10	$4 / $35	DED + $3 / DED + $10
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%	$30 / $55 / DED + 40% / DED + 50%	DED + 35% / DED + 40% / DED + 45% / DED + 45%	DED + $30 / DED + $55 / DED + 40% / DED + 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$9 / $102 / DED + 35% / DED + 40%	DED + $6 / DED + $27 / DED + $87 / DED + $162
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/

[1] INN = In-Network Deductible + Coinsurance (if applicable) applies.

H.S.A Compatible Plans – refer to the schedule of benefits for embedding information.

Cost Sharing		Gym Access SMAG HDHP Silver POS 98 (H.S.A. Compatible) Non-embedded DED & Embedded OOP	Gym Access SMAG Bronze POS OA 1211	Gym Access SMAG Bronze POS H.S.A. 5065 Embedded DED & OOP	Gym Access SMAG Bronze POS H.S.A. 6060 Embedded DED & OOP	Gym Access SMAG Bronze POS 1042
Medical Deductible (Per Person / Family Aggregate)	In-Network Out-of-Network	$3,250 / $6,500 $5,000 / $10,000	$0 / $0 $4,000 / $8,000	$6,300 / $12,600 $8,000 / $16,000	$7,500 / $15,000 $8,000 / $16,000	$5,500 / $11,000 $10,000 / $20,000
Coinsurance (Amount member pays)	In-Network Out-of-Network	30% 40%	50% 50%	30% 40%	100% 30%	50% 50%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network Out-of-Network	$6,500 / $13,000 $7,000 / $14,000	$9,450 / $18,900 $12,000 / $24,000	$7,500 / $15,000 $12,000 / $24,000	$7,500 / $15,000 $16,000 / $32,000	$9,400 / $18,800 $20,000 / $40,000
Physician Office Services	Primary Care Office Specialist Allergy Injections Medical Pharmacy preferred/non-preferred (Does not include immunizations) Out of Network	Deductible + 30% Deductible + 30% Deductible + 30% DED + 40% / DED + 50% Deductible + 40%	$50 Copay $85 Copay 50% Coinsurance 50% / 50% Coinsurance Deductible + 50%	Deductible + 30% Deductible + 30% Deductible + 30% DED + 40% / DED + 50% Deductible + 40%	Deductible Deductible Deductible Deductible / Deductible Deductible + 30%	$40 Copay $75 Copay 50% Coinsurance DED + 45% / DED + 45% Deductible + 50%
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	INN Deductible[1] + 30%	$1,000 Copay	INN Deductible[1] + 30%	INN Deductible[1]	INN Deductible[1] + 50%
Urgent Care Centers	In-Network and Out-of-Network	INN Deductible[1] + 30%	$85 Copay	INN Deductible[1] + 30%	INN Deductible[1]	$100 Copay
Independent Diagnostic Testing Facility/ Provider's Office						
	Allergy Testing	Deductible + 30%	$0	Deductible + 30%	Deductible	Deductible + 50%
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	Deductible + 30%	$100 Copay	Deductible + 30%	Deductible	Deductible
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	Deductible + 30%	$850 Copay	Deductible + 30%	Deductible	Deductible + 50%
	Out-of-Network	Deductible + 40%	Deductible + 50%	Deductible + 40%	Deductible + 30%	Deductible + 50%
Independent Clinical Lab	In-Network Out-of-Network	Deductible + 30% Deductible + 40%	$50 Copay Deductible + 50%	Deductible + 30% Deductible + 40%	Deductible Deductible + 30%	Deductible Deductible + 50%
Provider Services at ER	In-Network and Out-of-Network	INN Deductible[1] + 30%	$0	INN Deductible[1] + 30%	INN Deductible[1]	INN Deductible[1] + 50%
Provider Services at Hospital	Inpatient Outpatient Out-of-Network	Deductible + 30% Deductible + 30% Deductible + 40%	$0 $85 Copay Deductible + 50%	Deductible + 30% Deductible + 30% Deductible + 40%	Deductible Deductible Deductible + 30%	Deductible + 50% Deductible + 50% Deductible + 50%
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network In-Network Out-of-Network	Deductible + 30% Deductible + 30% Deductible + 40%	$1,000 Copay $85 Copay Deductible + 50%	Deductible + 30% Deductible + 30% Deductible + 40%	Deductible Deductible Deductible + 30%	Deductible + 50% Deductible + 50% Deductible + 50%
Inpatient Hospital Facility Services (per admission)	In-Network Out-of-Network	Deductible + 30% Deductible + 40%	$3,000 Copay Deductible + 50%	Deductible + 30% Deductible + 40%	Deductible Deductible + 30%	Deductible + 50% Deductible + 50%
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network Out-of-Network	Deductible + 30% Deductible + 40%	$2,000 Copay Deductible + 50%	Deductible + 30% Deductible + 40%	Deductible Deductible + 30%	Deductible + 50% Deductible + 50%
Chiropractic Care (per visit)	In-Network Out-of-Network	Deductible + 30% Deductible + 40%	$50 Copay Deductible + 50%	Deductible + 30% Deductible + 40%	Deductible Deductible + 30%	$40 Copay Deductible + 50%
Prescription Drugs*	Drug Deductible (per person / family aggregate) Out of Pocket Maximum (per person / family aggregate) Preventive Medications Preferred Generic / Non-Preferred Generic Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty Mail-Order (Pref. Specialty/NP Specialty not Available) Out-of-Network	Integrated with Medical Integrated with Medical $0 DED + $3 / DED + $10 DED + $30 / DED + $55 / DED + 40% / DED + 50% DED + $6 / DED + $27 / DED + $87 / DED + $162 Not Covered	$2,500 / $5,000 Integrated with Medical $0 $4 / $35 $200 / DED + 50% / DED + 50% / DED + 50% $9 / $102 / $597 / DED + 50% Not Covered	Integrated with Medical Integrated with Medical $0 DED + $3 / DED + $10 DED + $30 / DED + $55 / DED + 40% / DED + 50% DED + $6 / DED + $27 / DED + $87 / DED + $162 Not Covered	Integrated with Medical Integrated with Medical $0 DED / DED DED / DED / DED / DED DED / DED / DED / DED Not Covered	Integrated with Medical Integrated with Medical $0 $4 / $35 DED + 35% / DED + 40% / DED + 45% / DED + 45% $9 / $102 / DED + 35% / DED + 40% Not Covered

Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/

[1] INN = In-Network Deductible + Coinsurance (if applicable) applies. H.S.A Compatible Plans – refer to the schedule of benefits for embedding information.

Cost Sharing		Gym Access SMAG Platinum Triple Option 82	Gym Access SMAG Gold Triple Option 29
Medical Deductible (Per Person / Family Aggregate)	In-Network	Opt. 1. $0 / $0; Opt. 2. $250 / $500	Opt. 1. $2,000 / $4,000; Opt. 2. $2,000 / $4,000
	Out-of-Network	Opt. 3. $500 / $1,000	Opt. 3. $3,000 / $6,000
Coinsurance (Amount member pays)	In-Network	Opt. 1. 15%; Opt. 2. 30%	Opt. 1. 10%; Opt. 2. 20%
	Out-of-Network	Opt. 3. 50%	Opt. 3. 30%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	Opt. 1. $3,000 / $6,000; Opt. 2. $4,000 / $8,000	Opt. 1. $4,700 / $9,400; Opt. 2. $5,000 / $10,000
	Out-of-Network	Opt. 3. $6,000 / $12,000	Opt. 3. $5,500 / $11,000
Physician Office Services	Primary Care Office	Opt. 1. $20 Copay; Opt. 2. $30 Copay	Opt. 1. $20 Copay; Opt. 2. Deductible + 20%
	Specialist	Opt. 1. $35 Copay; Opt. 2. Deductible + 30%	Opt. 1. $35 Copay; Opt. 2. Deductible + 20%
	Allergy Injections	Opt. 1. 15% Coinsurance; Opt. 2. Deductible + 30%	Opt. 1. 10% Coinsurance; Opt. 2. Deductible + 20%
	Medical Pharmacy preferred/non-preferred (Does not include immunizations)	Opt. 1. 40% Coinsurance/50% Coinsurance	Opt. 1. 40% Coinsurance/50% Coinsurance
		Opt. 2. Deductible + 30%/Deductible + 30%	Opt. 2. Deductible + 20%/Deductible + 20%
	Out of Network	Opt. 3. Deductible + 50%	Opt. 3. Deductible + 30%
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$100 Copay	INN Deductible[1] + 10%
Urgent Care Centers	In-Network and Out-of-Network	$60 Copay	$75 Copay
Independent Diagnostic Testing Facility/ Provider's Office			
	Allergy Testing	Opt. 1. $10 Copay; Opt. 2. Deductible + 30%	Opt. 1. Deductible + 10%; Opt. 2. Deductible + 20%
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	Opt. 1. $10 Copay; Opt. 2. Deductible + 30%	Opt. 1. Deductible + 10%; Opt. 2. Deductible + 20%
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	Opt. 1. $50 Copay; Opt. 2. Deductible + 30%	Opt. 1. Deductible + 10%; Opt. 2. Deductible + 20%
	Out-of-Network	Opt. 3. Deductible + 50%	Opt. 3. Deductible + 30%
Independent Clinical Lab	In-Network	Opt. 1. $0; Opt. 2. N/A	Opt. 1. Deductible + 10%; Opt. 2. N/A
	Out-of-Network	Opt. 3. Deductible + 50%	Opt. 3. Deductible + 30%
Provider Services at ER	In-Network and Out-of-Network	$0	INN Deductible[1] + 10%
Provider Services at Hospital	Inpatient	Opt. 1. $0; Opt. 2. Deductible + 30%	Opt. 1. $0; Opt. 2. Deductible + 20%
	Outpatient	Opt. 1. $0; Opt. 2. Deductible + 30%	Opt. 1. Deductible + 10%; Opt. 2. Deductible + 20%
	Out-of-Network	Opt. 3. Deductible + 50%	Opt. 3. Deductible + 30%
Ambulatory Surgical Center Facility (ASC)	In-Network	Opt. 1. $200 Copay; Opt. 2. N/A	Opt. 1. Deductible + 10%; Op.t 2. N/A
Provider Services at ASC	In-Network	Opt. 1. $0; Opt. 2. Deductible + 30%	Opt. 1. Deductible + 10%; Opt. 2. Deductible + 20%
	Out-of-Network	Opt. 3. Deductible + 50%	Opt. 3. Deductible + 30%
Inpatient Hospital Facility Services (per admission)	In-Network	Opt. 1. $250 per day ($1,250 Max); Opt. 2. N/A	Opt. 1. $500 Copay; Opt. 2. N/A
	Out-of-Network	Opt. 3. Deductible + 50%	Opt. 3. Deductible + 30%
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	Opt. 1. $400 Copay; Opt. 2. N/A	Opt. 1. Deductible + 10%; Opt. 2. N/A
	Out-of-Network	Opt. 3. Deductible + 50%	Opt. 3. Deductible + 30%
Chiropractic Care (per visit)	In-Network	Opt. 1. $15 Copay; Opt. 2. Deductible + 30%	Opt. 1. $20 Copay; Opt. 2. Deductible + 20%
	Out-of-Network	Opt. 3. Deductible + 50%	Opt. 3. Deductible + 30%
Prescription Drugs*	Drug Deductible (per person / family aggregate)	$0 / $0	$0 / $0
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	$1,000 / $2,000
	Preventive Medications	$0	$0
	Preferred Generic / Non-Preferred Generic	$3 / $10	$3 / $10
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered

Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/

[1] INN – Option 1 In-Network Deductible + Coinsurance Applies.

Triple Option Members have the added benefit of choosing to have their care rendered, at the point of service, by an HMO provider (Option 1), an Expanded Physician Network provider (EPN-Option 2), or a non-participating provider (Option 3).

***Triple Option plans are only available in Volusia and Flagler counties**.

Small Group 2024 – FHCP Plans – Pediatric Vision and Pediatric Dental (In-Network Services Only)

Pediatric Vision Care Costs shown below are for covered individuals who are under age 19. Benefits for pediatric vision care services are not subject to a deductible, however, frequency limits do apply.	**Amount Member Pays**
Participating In-Network Provider Services	
Eye Glass Exam (1x per year)	$10 Copay
Eye Glasses (includes frames & lenses – single vision, bifocal, trifocal or lenticular)	$25 Copay
Contact Lens Exam (1x per year in lieu of eyeglass exam)	$50 Copay
Contact Lenses (2 boxes of standard contact lenses, 1x per year in lieu of eyeglasses)	$25 Copay
Eye Exam for Infection, visual disturbances, etc.	$10 Copay

Pediatric Dental Care Costs shown below are for covered individuals who are under age 19.	**Amount Member Pays**
Participating In-Network Provider Services	
Preventive Services	**No waiting period**
Oral exams, cleaning and fluoride treatments X-rays (bitewing) Space Maintainers Sealants	$0
Basic Services	**No waiting period**
Anesthesia Emergency Treatment (Palliative Care) Fillings Extractions Minor Endodontics Minor Periodontics Minor Prosthodontics	$0
Major Services	**No waiting period**
Major Endodontics Major Periodontics Major Prosthodontics Medically Necessary Implants (Prior Authorization is required)	$0
Medically Necessary Orthodontics	**No waiting period**
Prior authorization is required	$0

Pediatric Dental benefits are administered by Florida Combined Life Insurance Company, Inc. (FCL) an independent licensee of the Blue Cross and Blue Shield Association.