

INDIVIDUAL OFF EXCHANGE 2016 PLANS

Plan Features for all Plans

- Preventive Adult and Child Wellness Services for all plans: \$0.
- 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 Benefits (see last page).
- All plans come with Option to purchase Gym Access, Adult Dental and Adult Vision Riders.
- Pediatric Dental is not a covered benefit. A separate dental plan should be offered and the appropriate waiver signed.

Benefit Maximums for all Plans	
Home Health Care	20 Visits PBP
Skilled Nursing/Rehabilitation Facility	60 Days PBP
OT, PT, ST Outpatient Therapy	35 Visits PBP
Cardiac and Pulmonary Therapy	35 Visits PBP
Chiropractic Care	26 Visits PBP
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.



Individual Off Exchange 2016 — HMO Plans			
Metal	Plan Name	In-Network CYD / Coins / OOP	In-Network PCP / Spec
Platinum	IND Essential Plus Platinum HMO 65	\$0 / 85% / \$1,500 (Med) & \$1,500 (Drug)	\$20 / \$35
Platinum	IND Platinum HMO BC 1941	\$0 / 80% / \$2,000	\$10 / \$20
Platinum	IND Platinum HMO 3000	\$0 / 80% / \$3,000	\$20 / \$30
Platinum	IND Platinum HMO 4000	\$0 / 80% / \$4,000	\$20 / \$40
Platinum	IND Platinum HMO 91	\$250 / 90% / \$3,000	\$20 / \$35
Platinum	IND Platinum HMO 92	\$500 / 90% / \$3,000	\$20 / \$35
Platinum	IND Platinum HMO BC 5841	\$800 / 90% / \$2,500	\$15 / \$20
Gold	IND Gold HMO BC 5651	\$0 / 60% / \$3,000	\$25 / \$60
Gold	IND Essential Plus Gold HMO 63	\$1,000 / 80% / \$2,500 (Med) \$2,000 (Drug)	CYD + 20%
Gold	IND Essential Plus Gold HMO 22	\$1,700 / 90% / \$3,400 (Med) \$1,000 (Drug)	\$20 / \$35
Gold	IND Gold HMO 4500	\$1,500 / 90% / \$4,500	\$25 / \$35
Gold	IND Gold HMO 5000	\$1,500 / 80% / \$5,000	\$20 / \$30
Gold	IND Gold HMO 5500	\$2,000 / 80% / \$5,500	\$20 / \$35
Silver	IND Essential Plus Silver HMO 53	\$1,700 (Med) \$400 (Drug) / 60% / \$4,300 (Med) \$1,500 (Drug)	CYD + Coins
Silver	IND Silver HMO 6400	\$5,000 / 80% / \$6,400	\$30 / \$75
Silver	IND Silver HMO BC 7741	\$5,200 / 70% / \$6,850	\$75 / \$100
Silver	IND Silver HMO 6600	\$5,500 / 80% / \$6,600	\$20 / \$40
Silver	IND Silver HMO BC 0941	\$5,500 (Med) \$3,000 (Drug) / 60% / \$6,850	\$125 / \$180
Bronze	IND Essential Plus Bronze HMO 41	\$4,500 / 40% / \$6,800	CYD + Coins
Bronze	IND Bronze HMO BC 3841	\$6,700 / 50% / \$6,850	\$50 / \$85
Bronze	IND Bronze HMO 6850	\$6,850 / 100% / \$6,850	CYD
Catastrophic	IND Catastrophic Essential Plus HMO 36	\$6,850 / 100% / \$6,850	CYD
Silver	IND Silver HMO H.S.A 2000/6450	\$2,000 / 20% / \$6,450	CYD + Coins
Bronze	IND Bronze HMO H.S.A 4700/6450	\$4,700 / 70% / \$6,450	CYD + Coins
Bronze	IND Bronze HMO H.S.A 6000/6450	\$6,000 / 90% / \$6,450	CYD + Coins
Individual Off Exchange 2016 – POS and Triple Option Plans			
Platinum	IND Essential Plus Platinum POS 66	\$0 / 85% / \$1,000 (Med) \$500 (Drug)	\$20 / \$35
Platinum	IND Platinum POS BC 1941	\$0 / 80% / \$2,000	\$10 / \$20
Platinum	IND Platinum POS 3000	\$0 / 80% / \$3,000	\$20 / \$30
Platinum	IND Platinum POS 4000	\$0 / 80% / \$4,000	\$20 / \$40
Platinum	IND Platinum POS BC 5841	\$800 / 90% / \$2,500	\$15 / \$20
Gold	IND Gold POS BC 5651	\$0 / 60% / \$3,000	\$25 / \$60
Gold	IND Gold POS 5000	\$1,500 / 80% / \$5,000	\$20 / \$30
Gold	IND Essential Plus Gold POS 64	\$1,600 (Med) \$0 (Drug) / 90% / \$3,500 (Med) \$2,000 (Drug)	\$25 / \$40
Gold	IND Gold POS 5500	\$2,000 / 80% / \$5,500	\$20 / \$35
Silver	IND Essential Plus Silver POS 54	\$2,000 (Med) \$400 (Drug) / 70% / \$4,300 (Med) \$2,350 (Drug)	CYD + Coins
Silver	IND Silver POS BC 7741	\$5,200 / 70% / \$6,850	\$75 / \$100
Silver	IND Silver POS BC 0941	\$5,500 (Med) \$3,000 (Drug) / 60% / \$6,850	\$125 / \$180
Bronze	IND Bronze Essential Plus POS 42	\$4,500 / 45% / \$6,800	CYD + Coins
Bronze	IND Bronze POS BC 3841	\$6,700 / 50% / \$6,850	\$50 / \$85
Catastrophic	IND Catastrophic Essential Plus POS 37	\$6,850 / 100% / \$6,850	CYD
Silver	IND Silver POS H.S.A 2000/6450	\$2,000 / 80% / \$6,450	CYD + Coins
Bronze	IND Bronze POS H.S.A 4700/6450	\$4,700 / 70% / \$6,450	CYD + Coins
Bronze	IND Bronze POS H.S.A 6000/6450	\$6,000 / 90% / \$6,450	CYD + Coins
Platinum	IND Platinum Triple Option 27	\$0 / 85% / \$1,250 (Med) \$500 (Drug)	\$10 / \$20
Gold	IND Gold Triple Option 29	\$1,500 / 90% / \$3,000 (Med) \$550 (Drug)	10% / CYD + 10%

Cost Sharing		IND Essential Plus Platinum HMO 65	IND Platinum HMO BC 1941	IND Platinum HMO 3000	IND Platinum HMO 4000	IND Platinum HMO 91
Medical Deductible (Per Person / Family Aggregate)	In-Network	\$0 / \$0	\$0 / \$0	\$0 / \$0	\$0 / \$0	\$250 / \$750
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	15%	20%	20%	20%	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	\$1,500 / \$3,000	\$2,000 / \$4,000	\$3,000 / \$6,000	\$4,000 / \$8,000	\$3,000 / \$6,000
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	\$20 Copay	\$10 Copay	\$20 Copay	\$20 Copay	\$20 Copay
	Specialist	\$35 Copay	\$20 Copay	\$30 Copay	\$40 Copay	\$35 Copay
	Allergy Injections	15% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance	DED + Coins
	Medical Pharmacy (Does not include immunizations) Out of Network	15% Coinsurance N/A	20% Coinsurance N/A	20% Coinsurance N/A	20% Coinsurance N/A	DED + Coins N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	\$75 Copay	\$75 Copay	\$100 Copay	\$150 Copay	\$150 Copay
	In-Network and Out-of-Network	\$60 Copay	\$50 Copay	\$50 Copay	\$60 Copay	\$50 Copay
Independent Diagnostic Testing Facility/Provider's Office	Allergy Testing	\$0	\$10 Copay	\$0	\$0	\$35 Copay
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	\$0	\$75 Copay	\$0	\$0	\$35 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	\$0	\$150 Copay	\$100 Copay	\$100 Copay	\$150 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	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network	15% Coinsurance	\$200 Copay	\$200 Copay	\$250 Copay	DED + Coins
	In-Network	\$0	\$0	\$0	\$0	DED + Coins
	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)	\$350 per day (\$1,050 Max)	\$200 Copay	\$250 Copay	\$250 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	15% Coinsurance	\$300 Copay	\$400 Copay	\$250 Copay	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	\$15 Copay	\$20 Copay	\$20 Copay	\$40 Copay	\$20 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Prescription Drugs* 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/Specialty/Self-Injectable Mail-Order (Specialty/Self-Injectable not Available) Out-of-Network		\$0 \$1,500 / \$3,000 \$0 \$3 / \$10 \$30 / \$55 / 20% / 20% \$6 / \$27 / \$87 / \$162 Not Covered	Integrated with Medical Integrated with Medical \$0 \$3 / \$10 \$30 / \$55 / 20% / 20% \$6 / \$27 / \$87 / \$162 Not Covered	Integrated with Medical Integrated with Medical \$0 \$3 / \$10 \$30 / \$55 / 20% / 20% \$6 / \$27 / \$87 / \$162 Not Covered	Integrated with Medical Integrated with Medical \$0 \$3 / \$10 \$30 / \$55 / 20% / 20% \$6 / \$27 / \$87 / \$162 Not Covered	\$0 Integrated with Medical \$0 \$3 / \$10 \$30 / \$55 / 20% / 20% \$6 / \$27 / \$87 / \$162 Not Covered

* Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at <http://www.fhcp.com/members/plansAndBenefits/2016-exchange-formulary.pdf>

Cost Sharing		IND Platinum HMO 92	IND Platinum HMO BC 5841	IND Gold HMO BC 5651	IND Essential Plus Gold HMO 63	IND Essential Plus Gold HMO 22
Medical Deductible (Per Person / Family Aggregate)	In-Network	\$500 / \$1,000	\$800 / \$1,600	\$0 / \$0	\$1,000 / \$2,000	\$1,700 / \$3,400
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	10%	10%	40%	20%	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	\$3,000 / \$6,000	\$2,500 / \$5,000	\$3,000 / \$6,000	\$2,500 / \$5,000	\$3,400 / \$6,800
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	\$20 Copay	\$15 Copay (\$0 visits 1-3)	\$25 Copay	DED + Coins	\$20 Copay
	Specialist	\$35 Copay	\$20 Copay	\$60 Copay	DED + Coins	\$35 Copay
	Allergy Injections	DED + Coins	DED + Coins	20% Coinsurance***	DED + Coins	DED + 20% Coins***
	Medical Pharmacy (Does not include immunizations)	DED + Coins	DED + Coins	20% Coinsurance***	DED + Coins	DED + 20% Coins***
	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	DED + Coins	\$350 Copay	DED + Coins	DED + Coins
	In-Network and Out-of-Network	\$50 Copay	\$50 Copay	\$65 Copay	DED + Coins	DED + Coins
Independent Diagnostic Testing Facility/Provider's Office	Allergy Testing	\$35 Copay	DED + Coins	\$10 Copay	DED + Coins	DED + Coins
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	\$35 Copay	DED + Coins	\$100 Copay	DED + Coins	DED + Coins
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	\$150 Copay	DED + Coins	\$100 Copay	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	\$0	\$0	\$0	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	\$0	DED + Coins	\$0	DED + Coins	DED + Coins
	Provider Services at Hospital	Inpatient	DED + Coins	DED + Coins	\$0	DED + Coins
Outpatient		\$0	DED + Coins	\$0	DED + Coins	DED + Coins
Out-of-Network		N/A	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network	\$250 Copay	DED + Coins	\$400 Copay	DED + Coins	DED + Coins
	In-Network	\$0	DED + Coins	\$0	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	DED + Coins	DED + Coins	\$600 per day (\$1,800 Max)	DED + Coins	\$200 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	\$400 Copay	DED + Coins	\$450 Copay	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	DED + Coins	\$20 Copay	\$60 Copay	20% Coinsurance	\$20 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Prescription Drugs*	Deductible (per person / family aggregate)	\$0	\$0	\$0	\$0	\$0
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical	\$2,000 / \$4,000	\$1,000 / \$1,500
	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/Specialty/Self-Injectable	\$30 / \$55 / 20% / 20%	\$30 / \$55 / 20% / 20%	\$30 / \$55 / 20% / 20%	\$30 / \$55 / 20% / 20%	\$30 / \$55 / 20% / 20%
	Mail-Order (Specialty/Self-Injectable 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	

* Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at <http://www.fhcp.com/members/plansAndBenefits/2016-exchange-formulary.pdf> ***Coinsurance value indicated applies.

Cost Sharing		IND Gold HMO 4500	IND Gold HMO 5000	IND Gold HMO 5500	IND Essential Plus Silver HMO 53	IND Silver HMO 6400
Medical Deductible (Per Person / Family Aggregate)	In-Network	\$1,500 / \$3,000	\$1,500 / \$3,000	\$2,000 / \$4,000	\$1,700 / \$3,400	\$5,000 / \$10,000
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	10%	20%	20%	40%	20%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	\$4,500 / \$9,000	\$5,000 / \$10,000	\$5,500 / \$11,000	\$4,300 / \$8,600	\$6,400 / \$12,800
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	\$25 Copay	\$20 Copay	\$20 Copay	DED + Coins	\$30 Copay
	Specialist	\$35 Copay	\$30 Copay	\$35 Copay	DED + Coins	\$75 Copay
	Allergy Injections	20% Coinsurance***	20% Coinsurance	20% Coinsurance	DED + 20% Coins***	20% Coinsurance
	Medical Pharmacy (Does not include immunizations)	20% Coinsurance***	20% Coinsurance	20% Coinsurance	DED + 20% Coins***	20% Coinsurance
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	N/A	N/A	N/A	N/A	N/A
		DED + Coins	\$150 Copay	\$200 Copay	DED + Coins	\$500 Copay
Urgent Care Centers	In-Network and Out-of-Network	\$75 Copay	\$75 Copay	\$75 Copay	DED + Coins	\$100 Copay
Independent Diagnostic Testing Facility/Provider's Office	Allergy Testing	\$0	\$0	\$0	DED + Coins	\$0
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	DED + Coins	\$0	\$0	DED + Coins	\$50 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	DED + Coins	\$150 Copay	\$100 Copay	DED + Coins	\$250 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	\$0	\$0	\$0	DED + Coins	\$0
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	DED + Coins	\$0	\$0	DED + Coins	\$0
Provider Services at Hospital	Inpatient	\$0	DED + Coins	\$0	DED + Coins	\$0
	Outpatient	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	In-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	\$250 Copay	DED + Coins	\$250 per day (\$1,250 Max)	DED + Coins	\$500 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	\$35 Copay	\$30 Copay	\$35 Copay	40% Coinsurance	\$40 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Prescription Drugs*	Deductible (per person / family aggregate)	\$0	\$0	\$0	\$400 / \$800	\$0
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical	\$1,500 / \$3,000	Integrated with Medical
	Preventive Medications	\$0	\$0	\$0	\$0	\$0
	Preferred Generic / Non Preferred Generic	\$3 / \$10	\$3 / \$10	\$3 / \$10	\$3** / \$10**	\$10 / \$15
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	\$30 / \$55 / 20% / 20%	\$30 / \$55 / 20% / 20%	\$30 / \$55 / 20% / 20%	\$30**/\$55**/20%**/20%**	\$30 / \$55 / 20% / 20%
	Mail-Order (Specialty/Self-Injectable not Available)	\$6 / \$27 / \$87 / \$162	\$6 / \$27 / \$87 / \$162	\$6 / \$27 / \$87 / \$162	\$6**/\$27**/ \$87**/ \$162**	\$27 / \$42 / \$87 / \$162
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

* Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at <http://www.fhcp.com/members/plansAndBenefits/2016-exchange-formulary.pdf> **Copay applies after deductible is met.

***Coinsurance value indicated applies.

Cost Sharing		IND Silver HMO BC 7741	IND Silver HMO 6600	IND Silver HMO BC 0941	IND Essential Plus Bronze HMO 41
Medical Deductible (Per Person / Family Aggregate)	In-Network	\$5,200 / \$10,400	\$5,500 / \$11,000	\$5,500 / \$11,000	\$4,500 / \$9,000
	Out-of-Network	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	30%	20%	40%	60%
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	\$6,850 / \$13,700	\$6,600 / \$13,200	\$6,850 / \$13,700	\$6,800 / \$13,600
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services Medical Pharmacy (Does not include immunizations)	Primary Care Office	\$75 Copay (\$0 visits 1-2)	\$20 Copay	\$125 Copay	DED + Coins
	Specialist	\$100 Copay	\$40 Copay	\$180 Copay	DED + Coins
	Allergy Injections	DED + 20% Coins***	DED + Coins	DED + 20% Coins***	DED + 20% Coins***
	Out of Network	DED + 20% Coins***	DED + Coins	DED + 20% Coins***	DED + 20% Coins***
	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	\$600 Copay	DED + Coins	DED + \$400 Copay	DED + Coins
	In-Network and Out-of-Network	\$160 Copay	DED + Coins	DED + \$100 Copay	DED + Coins
Independent Diagnostic Testing Facility/Provider's Office X-Rays / Ultrasounds / Diagnostic Services (other than AIS) Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	Allergy Testing	\$10 Copay	\$0	\$10 Copay	DED + Coins
	Out-of-Network	\$10 Copay	DED + Coins	\$50 Copay	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	\$400 Copay	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	\$0	\$0	\$0	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	\$0	DED + Coins	\$0	DED + Coins
	Inpatient	DED + Coins	DED + Coins	\$0	DED + Coins
Provider Services at Hospital	Outpatient	DED + Coins	DED + Coins	\$0	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
	Out-of-Network	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network	DED + Coins	DED + Coins	DED + \$350 Copay	DED + Coins
	In-Network	DED + Coins	DED + Coins	\$0	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	DED + Coins	DED + Coins	DED + \$600 Copay	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED + Coins	DED + \$500 Copay	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	\$100 Copay	DED + Coins	\$180 Copay	60% Coinsurance
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs* Out of Pocket Maximum (per person / family aggregate) Preventive Medications Preferred Generic / Non Preferred Generic Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable Mail-Order (Specialty/Self-Injectable not Available)	Deductible (per person / family aggregate)	Integrated with Medical	\$1,000 / \$2,000	\$3,000 / \$3,000	Integrated with Medical
	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	\$10 / \$15	\$3 / \$10	\$3** / \$10**
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	\$30**/\$55**/20%**/20%**	\$30** / \$55** / 20%** / 20%**	\$30**/\$55**/20%**/20%**	\$30**/\$55**/20%**/20%**
	Mail-Order (Specialty/Self-Injectable not Available)	\$6 / \$27 / \$87** / \$162**	\$27 / \$42 / \$87** / \$162**	\$6 / \$27 / \$87** / \$162**	\$6**/\$27** / \$87** / \$162**
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	

* Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at <http://www.fhcp.com/members/plansAndBenefits/2016-exchange-formulary.pdf> **Copay applies after deductible is met.

***Coinsurance value indicated applies.

Cost Sharing		IND Bronze HMO BC 3841	IND Bronze HMO 6850	IND Catastrophic Essential Plus HMO 36
Medical Deductible (Per Person / Family Aggregate)	In-Network	\$6,700 / \$13,400	\$6,850 / \$13,700	\$6,850 / \$13,700
	Out-of-Network	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	50%	N/A	N/A
	Out-of-Network	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	\$6,850 / \$13,700	\$6,850 / \$13,700	\$6,850 / \$13,700
	Out-of-Network	N/A	N/A	N/A
Physician Office Services	Primary Care Office	\$50 Copay (\$0 visits 1-3)	DED (\$40 Copay visits 1-3)	DED (\$0 Copay visits 1-3)
	Specialist	\$85 Copay	DED	DED
	Allergy Injections	20% Coinsurance	DED	DED
	Medical Pharmacy (Does not include immunizations)	20% Coinsurance	DED	DED
	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	DED + Coins	DED	DED
Urgent Care Centers	In-Network and Out-of-Network	\$125 Copay	DED	DED
Independent Diagnostic Testing Facility/Provider's Office	Allergy Testing	\$10 Copay	DED	DED
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	DED + Coins	DED	DED
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	DED + Coins	DED	DED
	Out-of-Network	N/A	N/A	N/A
Independent Clinical Lab	In-Network	DED + Coins	DED	DED
	Out-of-Network	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	DED + Coins	DED	DED
Provider Services at Hospital	Inpatient	DED	DED	DED
	Outpatient	DED + Coins	DED	DED
	Out-of-Network	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network	DED + Coins	DED	DED
	In-Network	DED + Coins	DED	DED
	Out-of-Network	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	DED + \$150 Copay	DED	DED
	Out-of-Network	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED	DED
	Out-of-Network	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	\$85 Copay	DED	DED
	Out-of-Network	N/A	N/A	N/A
Prescription Drugs*	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	\$3 / \$10	\$15 / \$20	DED / DED
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	\$30**/\$55**/20%**/20%**	DED / DED / DED / DED	DED / DED / DED / DED
	Mail-Order (Specialty/Self-Injectable not Available)	\$6 / \$27 / \$87** / \$162**	\$42 / \$57 / DED / DED	DED / DED / DED / DED
	Out-of-Network	Not Covered	Not Covered	Not Covered

* Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at <http://www.fhcp.com/members/plansAndBenefits/2016-exchange-formulary.pdf> **Copay applies after deductible is met.

INDIVIDUAL 2016 – HMO HDHP PLANS WITH H.S.A. COMPATIBILITY

Cost Sharing		IND Silver HMO H.S.A. 2000/6450	IND Bronze HMO H.S.A. 4700/6450	IND Bronze HMO H.S.A. 6000/6450
Medical Deductible (Per Person / Family Aggregate)	In-Network	\$2,000 / \$4,000	\$4,700 / \$9,400	\$6,000 / \$12,000
	Out-of-Network	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	20%	30%	10%
	Out-of-Network	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	\$6,450 / \$12,900	\$6,450 / \$12,900	\$6,450 / \$12,900
	Out-of-Network	N/A	N/A	N/A
Physician Office Services	Primary Care Office	DED + Coins	DED + Coins	DED + Coins
	Specialist	DED + Coins	DED + Coins	DED + Coins
	Allergy Injections	DED + Coins	DED + 20% Coins***	DED + Coins
	Medical Pharmacy (Does not include immunizations)	DED + Coins	DED + 20% Coins***	DED + Coins
	Out of Network	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network			
Urgent Care Centers	In-Network and Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Independent Diagnostic Testing Facility/Provider's Office	Allergy Testing	DED + Coins	DED + Coins	DED + Coins
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	DED + Coins	DED + Coins	DED + Coins
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A
Independent Clinical Lab	In-Network	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network			
Provider Services at ER	In-Network and Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Provider Services at Hospital	Inpatient	DED + Coins	DED + Coins	DED + Coins
	Outpatient	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network	DED + Coins	DED + Coins	DED + Coins
	In-Network	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A
Prescription Drugs*	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	\$10** / \$15**	\$10** / \$15**	\$10** / \$15**
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	\$30**/\$55**/20%**/20%**	\$30**/\$55**/20%**/20%**	\$30**/\$55**/20%**/20%**
	Mail-Order (Specialty/Self-Injectable not Available)	\$27**/\$42**/\$87**/\$162**	\$27**/\$42**/\$87**/\$162**	\$27**/\$42**/\$87**/\$162**
	Out-of-Network	Not Covered	Not Covered	Not Covered

* Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at <http://www.fhcp.com/members/plansAndBenefits/2016-exchange-formulary.pdf> **Copay applies after deductible is met.

***Coinsurance value indicated applies. **H.S.A. Compatible Plans** - Each member covered under the contract must meet their individual deductible up to the family deductible amount, then coinsurance (%) may apply.

Cost Sharing		IND Essential Plus Platinum POS 66	IND Platinum POS BC 1941	IND Platinum POS 3000	IND Platinum POS 4000	IND Platinum POS BC 5841
Medical Deductible (Per Person / Family Aggregate)	In-Network	\$0 / \$0	\$0 / \$0	\$0 / \$0	\$0 / \$0	\$800 / \$1,600
	Out-of-Network	\$500 / \$1,000	\$500 / \$1,000	\$500 / \$1,000	\$500 / \$1,000	\$1,600 / \$3,200
Coinsurance (Amount member pays)	In-Network	15%	20%	20%	20%	10%
	Out-of-Network	30%	30%	30%	30%	30%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	\$1,000 / \$2,000	\$2,000 / \$4,000	\$3,000 / \$6,000	\$4,000 / \$8,000	\$2,500 / \$5,000
	Out-of-Network	\$2,000 / \$4,000	\$4,000 / \$8,000	\$6,000 / \$12,000	\$8,000 / \$16,000	\$5,000 / \$10,000
Physician Office Services	Primary Care Office	\$20 Copay	\$10 Copay	\$20 Copay	\$20 Copay	\$15 Copay (\$0 visits 1-3)
	Specialist	\$35 Copay	\$20 Copay	\$30 Copay	\$40 Copay	\$20 Copay
	Allergy Injections	15% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance	DED + Coins
	Medical Pharmacy (Does not include immunizations)	15% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance	DED + Coins
	Out of Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	15% Coinsurance	\$75 Copay	\$100 Copay	\$150 Copay	INN DED + Coins ¹
Urgent Care Centers	In-Network and Out-of-Network	15% Coinsurance	\$50 Copay	\$50 Copay	\$60 Copay	\$50 Copay
Independent Diagnostic Testing Facility/Provider's Office	Allergy Testing	15% Coinsurance	\$10 Copay	\$0	\$0	DED + Coins
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	15% Coinsurance	\$75 Copay	\$0	\$0	DED + Coins
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	15% Coinsurance	\$150 Copay	\$100 Copay	\$100 Copay	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Independent Clinical Lab	In-Network	15% Coinsurance	\$0	\$0	\$0	\$0
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Provider Services at ER	In-Network and Out-of-Network	15% Coinsurance	\$0	\$0	\$0	INN DED + Coins ¹
Provider Services at Hospital	Inpatient	15% Coinsurance	\$0	\$0	\$0	DED + Coins
	Outpatient	15% Coinsurance	\$0	\$0	\$0	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network	15% Coinsurance	\$200 Copay	\$200 Copay	\$250 Copay	DED + Coins
	In-Network	15% Coinsurance	\$0	\$0	\$0	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Inpatient Hospital Facility Services (per admission)	In-Network	15% Coinsurance	\$350 per day (\$1,050 Max)	\$200 Copay	\$250 Copay	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	15% Coinsurance	\$300 Copay	\$400 Copay	\$250 Copay	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Chiropractic Care (per visit)	In-Network	15% Coinsurance	\$20 Copay	\$20 Copay	\$40 Copay	\$20 Copay
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Prescription Drugs*	Deductible (per person / family aggregate)	\$0	Integrated with Medical	Integrated with Medical	Integrated with Medical	\$0
	Out of Pocket Maximum (per person / family aggregate)	\$500 / \$1,000	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/Specialty/Self-Injectable	\$30 / \$55 / 20% / 20%	\$30 / \$55 / 20% / 20%	\$30 / \$55 / 20% / 20%	\$30 / \$55 / 20% / 20%	\$30 / \$55 / 20% / 20%
	Mail-Order (Specialty/Self-Injectable 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

* Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at <http://www.fhcp.com/members/plansAndBenefits/2016-exchange-formulary.pdf> ¹ INN – In-Network Deductible + Coinsurance Applies

Cost Sharing		IND Gold POS BC 5651	IND Gold POS 5000	IND Essential Plus Gold POS 64	IND Gold POS 5500	IND Essential Plus Silver POS 54
Medical Deductible (Per Person / Family Aggregate)	In-Network	\$0 / \$0	\$1,500 / \$3,000	\$1,600 / \$3,200	\$2,000 / \$4,000	\$2,000 / \$4,000
	Out-of-Network	\$500 / \$1,000	\$3,000 / \$6,000	\$3,200 / \$6,400	\$4,000 / \$8,000	\$5,000 / \$10,000
Coinsurance (Amount member pays)	In-Network	40%	20%	10%	20%	30%
	Out-of-Network	30%	30%	30%	30%	50%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	\$3,000 / \$6,000	\$5,000 / \$10,000	\$3,500 / \$7,000	\$5,500 / \$11,000	\$4,300 / \$8,600
	Out-of-Network	\$6,000 / \$12,000	\$10,000 / \$15,000	\$6,000 / \$12,000	\$8,000 / \$16,000	\$8,000 / \$16,000
Physician Office Services	Primary Care Office	\$25 Copay	\$20 Copay	\$25 Copay	\$20 Copay	DED + Coins
	Specialist	\$60 Copay	\$30 Copay	\$40 Copay	\$35 Copay	DED + Coins
	Allergy Injections	20% Coinsurance***	20% Coinsurance	DED + Coins	20% Coinsurance	DED + 20% Coins***
	Medical Pharmacy (Does not include immunizations)	20% Coinsurance***	20% Coinsurance	DED + Coins	20% Coinsurance	DED + 20% Coins***
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	\$350 Copay	\$150 Copay	INN DED + Coins ¹	\$200 Copay	INN DED + Coins ¹
	Urgent Care Centers	\$65 Copay	\$75 Copay	\$30 Copay	\$75 Copay	INN DED + Coins ¹
Independent Diagnostic Testing Facility/Provider's Office	Allergy Testing	\$10 Copay	\$0	DED + Coins	\$0	DED + Coins
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	\$100 Copay	\$0	DED + Coins	\$0	DED + Coins
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	\$100 Copay	\$150 Copay	DED + Coins	\$100 Copay	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Independent Clinical Lab	In-Network	\$0	\$0	DED + Coins	\$0	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Provider Services at ER	In-Network and Out-of-Network	\$0	\$0	INN DED + Coins ¹	\$0	INN DED + Coins ¹
Provider Services at Hospital	Inpatient	\$0	DED + Coins	DED + Coins	\$0	DED + Coins
	Outpatient	\$0	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Ambulatory Surgical Center Facility (ASC)	In-Network	\$400 Copay	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Provider Services at ASC	In-Network	\$0	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Inpatient Hospital Facility Services (per admission)	In-Network	\$600 per day (\$1,800 Max)	DED + Coins	DED + Coins	\$250 per day (\$1,250 Max)	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	\$450 Copay	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Chiropractic Care (per visit)	In-Network	\$60 Copay	\$30 Copay	\$25 Copay	\$35 Copay	30% Coinsurance
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Prescription Drugs*	Deductible (per person / family aggregate)	\$0	\$0	\$0	\$0	\$400 / \$800
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	\$2,000 / \$4,000	Integrated with Medical	\$2,350 / \$4,700
	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/Specialty/Self-Injectable	\$30 / \$55 / 20% / 20%	\$30 / \$55 / 20% / 20%	\$30 / \$55 / 20% / 20%	\$30 / \$55 / 20% / 20%	\$30**/\$55**/20%**/20%**
	Mail-Order (Specialty/Self-Injectable 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

Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at <http://www.fhpc.com/members/plansAndBenefits/2016-exchange-formulary.pdf> ¹ INN – In-Network Deductible + Coinsurance Applies.
 ***Coinsurance value indicated applies.

Cost Sharing		IND Silver POS BC 7741	IND Silver POS BC 0941	IND Bronze Essential Plus POS 42	IND Bronze POS BC 3841	IND Catastrophic Essential Plus POS 37
Medical Deductible (Per Person / Family Aggregate)	In-Network	\$5,200 / \$10,400	\$5,500 / \$11,000	\$4,500 / \$9,000	\$6,700 / \$13,400	\$6,850 / \$13,700
	Out-of-Network	\$7,000 / \$14,000	\$7,000 / \$14,000	\$10,000 / \$20,000	\$8,000 / \$16,000	\$13,500 / \$27,000
Coinsurance (Amount member pays)	In-Network	30%	40%	55%	50%	NA
	Out-of-Network	30%	40%	70%	50%	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	\$6,850 / \$13,700	\$6,850 / \$13,700	\$6,800 / \$13,600	\$6,850 / \$13,700	\$6,850 / \$13,700
	Out-of-Network	\$10,000 / \$20,000	\$10,000 / \$20,000	\$20,000 / \$40,000	\$10,000 / \$20,000	\$13,500 / \$27,000
Physician Office Services	Primary Care Office	\$75 Copay (\$0 visits 1-2)	\$125 Copay	DED + Coins	\$50 Copay (\$0 visits 1-3)	DED (\$0 Copay visits 1-3)
	Specialist	\$100 Copay	\$180 Copay	DED + Coins	\$85 Copay	DED
	Allergy Injections	DED + 20% Coins***	DED + 20% Coins***	DED + 20% Coins***	20% Coinsurance	DED
	Medical Pharmacy (Does not include immunizations)	DED + 20% Coins***	DED + 20% Coins***	DED + 20% Coins***	20% Coinsurance	DED
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	\$600 Copay	DED + \$400 Copay	INN DED + Coins ¹	INN DED + Coins ¹	INN DED ²
	In-Network and Out-of-Network	\$160 Copay	DED + \$100 Copay	INN DED + Coins ¹	\$125 Copay	INN DED ²
Independent Diagnostic Testing Facility/Provider's Office	Allergy Testing	\$10 Copay	\$10 Copay	DED + Coins	\$10 Copay	DED
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	\$10 Copay	\$50 Copay	DED + Coins	DED + Coins	DED
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	DED + Coins	\$400 Copay	DED + Coins	DED + Coins	DED
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED
Independent Clinical Lab	In-Network	\$0	\$0	DED + Coins	DED + Coins	DED
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED
Provider Services at ER	In-Network and Out-of-Network	\$0	\$0	INN DED + Coins ¹	INN DED ²	INN DED ²
Provider Services at Hospital	Inpatient	DED + Coins	\$0	DED + Coins	DED	DED
	Outpatient	DED + Coins	\$0	DED + Coins	DED + Coins	DED
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network	DED + Coins	DED + \$350 Copay	DED + Coins	DED + Coins	DED
	In-Network	DED + Coins	\$0	DED + Coins	DED + Coins	DED
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED
Inpatient Hospital Facility Services (per admission)	In-Network	DED + Coins	DED + \$600 Copay	DED + Coins	DED + \$150 Copay	DED
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED + \$500 Copay	DED + Coins	DED + Coins	DED
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED
Chiropractic Care (per visit)	In-Network	\$100 Copay	\$180 Copay	55% Coinsurance	\$85 Copay	DED
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED
Prescription Drugs*	Deductible (per person / family aggregate)	Integrated with Medical	\$3,000 / \$3,000	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	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	DED / DED
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	\$30**/\$55**/20%**/20%**	\$30**/\$55**/20%**/20%**	\$30**/\$55**/20%**/20%**	\$30**/\$55**/20%**/20%**	DED / DED / DED / DED
	Mail-Order (Specialty/Self-Injectable not Available)	\$6 / \$27 / \$87** / \$162**	\$6 / \$27 / \$87** / \$162**	\$6**/\$27** / \$87** / \$162**	\$6 / \$27 / \$87** / \$162**	DED / DED / DED / DED
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at <http://www.fhccp.com/members/plansAndBenefits/2016-exchange-formulary.pdf> **Copay applies after Deductible is met.

***Coinsurance value indicated applies. ¹ INN – In-Network Deductible + Coinsurance Applies. ²INN – In-Network Deductible Applies

Cost Sharing		IND Silver POS H.S.A. 2000/6450	IND Bronze POS H.S.A. 4700/6450	IND Bronze POS H.S.A. 6000/6450
Medical Deductible (Per Person / Family Aggregate)	In-Network	\$2,000 / \$4,000	\$4,700 / \$9,400	\$6,000 / \$12,000
	Out-of-Network	\$4,000 / \$8,000	\$8,000 / \$16,000	\$8,000 / \$16,000
Coinsurance (Amount member pays)	In-Network	20%	30%	10%
	Out-of-Network	30%	40%	30%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	\$6,450 / \$12,900	\$6,450 / \$12,900	\$6,450 / \$12,900
	Out-of-Network	\$10,000 / \$20,000	\$12,000 / \$24,000	\$16,000 / \$32,000
Physician Office Services	Primary Care Office	DED + Coins	DED + Coins	DED + Coins
	Specialist	DED + Coins	DED + Coins	DED + Coins
	Allergy Injections	DED + Coins	DED + 20% Coins***	DED + Coins
	Medical Pharmacy (Does not include immunizations)	DED + Coins	DED + 20% Coins***	DED + Coins
	Out of Network	DED + Coins	DED + Coins	DED + Coins
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and	INN DED + Coins ¹	INN DED + Coins ¹	INN DED + Coins ¹
	Out-of-Network			
Urgent Care Centers	In-Network and Out-of-Network	INN DED + Coins ¹	INN DED + Coins ¹	INN DED + Coins ¹
Independent Diagnostic Testing Facility/Provider's Office	Allergy Testing	DED + Coins	DED + Coins	DED + Coins
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	DED + Coins	DED + Coins	DED + Coins
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Independent Clinical Lab	In-Network	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Provider Services at ER	In-Network and Out-of-Network	INN DED + Coins ¹	INN DED + Coins ¹	INN DED + Coins ¹
Provider Services at Hospital	Inpatient	DED + Coins	DED + Coins	DED + Coins
	Outpatient	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Inpatient Hospital Facility Services (per admission)	In-Network	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Chiropractic Care (per visit)	In-Network	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Prescription Drugs*	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	\$10** / \$15**	\$10** / \$15**	\$10** / \$15**
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	\$30**/\$55**/20%**/20%**	\$30**/\$55**/20%**/20%**	\$30**/\$55**/20%**/20%**
	Mail-Order (Specialty/Self-Injectable not Available)	\$27**/\$42**/\$87**/\$162**	\$27**/\$42**/\$87**/\$162**	\$27**/\$42**/\$87**/\$162**
	Out-of-Network	Not Covered	Not Covered	Not Covered

* Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at <http://www.fhcp.com/members/plansAndBenefits/2016-exchange-formulary.pdf> **Copay applies after deductible is met.

***Coinsurance value indicated applies. **H.S.A. Compatible Plans** - Each member covered under the contract must meet their individual deductible up to the family deductible amount, then coinsurance (%) may apply.

INDIVIDUAL 2016 – TRIPLE OPTION PLANS

Cost Sharing		IND Platinum Triple Option 27	IND Gold Triple Option 29
Medical Deductible (Per Person / Family Aggregate)	In-Network Out-of-Network	Opt 1. \$0 / \$0; Opt 2. \$250 / \$500 Opt 3. \$500 / \$1,000	Opt 1. \$1,500 / \$3,000; Opt 2. \$2,000 / \$4,000 Opt 3. \$3,000 / \$6,000
Coinsurance (Amount member pays)	In-Network Out-of-Network	Opt 1. 15%; Opt 2. 20% Opt 3. 40%	Opt 1. 10%; Opt 2. 20% Opt 3. 30%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network Out-of-Network	Opt 1. \$1,250 / \$2,500; Opt 2. \$2,250 / \$4,500 Opt 3. \$2,700 / \$5,400	Opt 1. \$3,000 / \$6,000; Opt 2. \$4,000 / \$8,000 Opt 3. \$4,500 / \$9,000
Physician Office Services Primary Care Office Specialist Allergy Injections Medical Pharmacy (Does not include immunizations) Out of Network		Opt 1. \$10 Copay; Opt 2. \$15 Copay Opt 1. \$20 Copay; Opt 2. DED + Coins Opt 1. 20% Coinsurance; Opt 2. DED + Coins Opt. 1 & 2: 20% Coinsurance Opt 3. DED + Coins	Opt 1. 10% Coinsurance; Opt 2. DED + Coins Opt 1. DED + Coins; Opt 2. DED + Coins Opt 1. DED + Coins; Opt 2. DED + Coins Opt 1. DED + Coins; Opt 2. DED + Coins Opt 3. DED + Coins
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	\$75 Copay	INN DED + Coins ¹
Urgent Care Centers	In-Network and Out-of-Network	\$25 Copay	INN DED + Coins ¹
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		Opt 1. \$0; Opt 2. DED + Coins Opt 1. \$0; Opt 2. DED + Coins Opt 1. \$0; Opt 2. DED + Coins Opt 3. DED + Coins	Opt 1. DED + Coins; Opt 2. DED + Coins Opt 1. DED + Coins; Opt 2. DED + Coins Opt 1. DED + Coins; Opt 2. DED + Coins Opt 3. DED + Coins
Independent Clinical Lab	In-Network Out-of-Network	Opt 1. \$0; Opt 2. N/A Opt 3. DED + Coins	Opt 1. DED + Coins; Opt 2. N/A Opt 3. DED + Coins
Provider Services at ER	In-Network and Out-of-Network	\$0	INN DED + Coins ¹
Provider Services at Hospital Inpatient Outpatient Out-of-Network		Opt 1. \$0; Opt 2. DED + Coins Opt 1. \$0; Opt 2. DED + Coins Opt 3. DED + Coins	Opt 1. \$0; Opt 2. DED + Coins Opt 1. DED + Coins; Opt 2. DED + Coins Opt 3. DED + Coins
Ambulatory Surgical Center Facility (ASC) Provider Services at ASC	In-Network In-Network Out-of-Network	Opt 1. 15% Coinsurance; Opt 2. N/A Opt 1. \$0; Opt 2. DED + Coins Opt 3. DED + Coins	Opt 1. DED + Coins; Opt 2. N/A Opt 1. DED + Coins; Opt 2. DED + Coins Opt 3. DED + Coins
Inpatient Hospital Facility Services (per admission)	In-Network Out-of-Network	Opt 1. \$200 Copay; Opt 2. N/A Opt 3. DED + Coins	Opt 1. \$200 Copay; Opt 2. N/A Opt 3. DED + Coins
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network Out-of-Network	Opt 1. 15% Coinsurance; Opt 2. N/A Opt 3. DED + Coins	Opt 1. DED + Coins; Opt 2. N/A Opt 3. DED + Coins
Chiropractic Care (per visit)	In-Network Out-of-Network	Opt 1. \$10 Copay; Opt 2. DED + Coins Opt 3. DED + Coins	Opt 1. \$20 Copay; Opt 2. DED + Coins Opt 3. DED + Coins
Prescription Drugs* 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/Specialty/Self-Injectable Mail-Order (Specialty/Self-Injectable not Available) Out-of-Network		\$0 \$500 / \$1,000 \$0 \$3 / \$10 \$30 / \$55 / 20% / 20% \$6 / \$27 / \$87 / \$162 Not Covered	\$0 \$550 / \$1,100 \$0 \$3 / \$10 \$30 / \$55 / 20% / 20% \$6 / \$27 / \$87 / \$162 Not Covered

Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at <http://www.fhcp.com/members/plansAndBenefits/2016-exchange-formulary.pdf> 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).

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