INDIVIDUAL OFF EXCHANGE 2017 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
- Adult Vision Rider.
- *Plans come with the option to add Gym Access
- 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 Rehabilitation Therapy	35 Visits PBP
OT, PT, ST Outpatient Habilitation Therapy	35 Visits PBP
Cardiac and Pulmonary Therapy	35 Visits PBP
Chiropractic Care	26 Visits PBP
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

An Independent Licensee of the Blue Cross and Blue Shield Association

Individual Off Exchange 2017 — HMO Plans			
	Plan Name	In-Network CYD / Coins / OOP	In-Network PCP / Spec
Platinum	Gym Access IND Essential Plus Platinum HMO 65	$0 / 85% / $1,500 (Med) & $1,500 (Drug)	$20 / $35
Platinum	Gym Access IND Platinum HMO BC 1941	$0 / 80% / $2,000	$10 / $20
Platinum	Gym Access IND Platinum HMO 4000	$0 / 80% / $4,000	$20 / $40
Platinum	Gym Access IND Platinum HMO 91	$250 / 90% / $2,500	$15 / $30
Platinum	Gym Access IND Platinum HMO 92	$500 / 90% / $2,500	$15 / $30
Platinum	IND Platinum HMO BC 5841	$800 / 90% / $2,500	$15 / $20
Gold	Gym Access IND Gold HMO BC 5651	$0 / 60% / $3,200	$25 / $60
Gold	Gym Access IND Essential Plus Gold HMO 63	$1,250 / 80% / $4,750	$20 / $50
Gold	IND Gold HMO 4500	$1,500 / 90% / $4,500	$25 / $35
Gold	Gym Access IND Gold HMO 5500	$2,000 / 80% / $5,500	$20 / $35
Silver	Gym Access IND Essential Plus Silver HMO 53	$2,500 / 70% / $7,150	$40 / $65
Silver	IND Silver Standardized HMO 1	$3,500 / 80% / $7,150	$30 / $65
Silver	Gym Access IND Silver HMO 6400	$5,000 / 80% / $6,400	$30 / $75
Silver	IND Silver HMO BC 7741	$6,500 / 60% / $7,150	$55 / CYD + $85
Silver	Gym Access IND Silver HMO 6600	$5,500 / 80% / $6,600	$20 / $40
Silver	Gym Access IND Silver HMO BC 0941	$5,600 (Med) $3,000 (Drug) / 60% / $7,150	$50 / $100
Bronze	IND Essential Plus Bronze HMO 41	$4,500 / 40% / $6,950	CYD + Coins
Bronze	IND Bronze Standardized HMO 2	$6,650 / 50% / $7,150	CYD + Coins
Bronze	Gym Access IND Bronze HMO BC 3841	$6,700 / 50% / $6,850	$50 / $85
Catastrophic	Gym Access IND Catastrophic Essential Plus HMO 36	$7,150 / 100% / $7,150	CYD
Silver	IND Silver HMO H.S.A 2000/6450*	$2,000 / 20% / $6,450	CYD + Coins
Bronze	Gym Access IND Bronze HMO H.S.A 5500/6550	$5,500 / 70% / $6,550	CYD + Coins
Bronze	Gym Access IND Bronze HMO H.S.A 6000/6550	$6,000 / 90% / $6,550	CYD + Coins
Individual Off Exchange 2017 – POS and Triple Option Plans			
Platinum	Gym Access IND Platinum POS BC 1941	$0 / 80% / $2,000	$10 / $20
Platinum	Gym Access IND Platinum POS 4000	$0 / 80% / $4,000	$20 / $40
Platinum	Gym Access IND Platinum POS BC 5841	$800 / 90% / $2,500	$15 / $20
Gold	Gym Access IND Gold POS BC 5651	$0 / 60% / $3,200	$25 / $60
Gold	Gym Access IND Gold POS 5500	$2,000 / 80% / $5,500	$20 / $35
Silver	Gym Access IND Essential Plus Silver POS 54	$2,500 / 70% / $7,150	$40 / $65
Silver	Gym Access IND Silver POS BC 7741	$6,500 / 60% / $7,150	$55 / CYD + $85
Silver	Gym Access IND Silver POS BC 0941	$5,600 (Med) $3,000 (Drug) / 60% / $7,150	$50 / $100
Bronze	Gym Access IND Bronze Essential Plus POS 42	$4,500 / 45% / $7,000	CYD + Coins
Bronze	Gym Access IND Bronze POS BC 3841	$6,700 / 50% / $6,850	$50 / $85
Catastrophic	Gym Access IND Catastrophic Essential Plus POS 37	$7,150 / 100% / $7,150	CYD
Bronze	IND Bronze POS H.S.A 5500/6550*	$5,500 / 70% / $6,550	CYD + Coins
Bronze	IND Bronze POS H.S.A 6000/6550*	$6,000 / 90% / $6,550	CYD + Coins
Platinum	IND Platinum Triple Option 82*	$0 / 85% / $3,000	$20 / $35
Gold	IND Gold Triple Option 29*	$1,600 / 90% / $3,200 (Med) $1,000 (Drug)	$20 / $35

INDIVIDUAL 2017 — HMO Plans

Cost Sharing		Gym Access IND Essential Plus Platinum HMO 65	Gym Access IND Platinum HMO BC 1941	Gym Access IND Platinum HMO 4000	Gym Access IND Platinum HMO 91
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$0 / $0	$0 / $0	$250 / $500
	Out-of-Network	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	15%	20%	20%	10%
	Out-of-Network	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	$4,000 / $8,000	$2,500 / $5,000
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$20 Copay	$10 Copay	$20 Copay	$15 Copay
	Specialist	$35 Copay	$20 Copay	$40 Copay	$30 Copay
	Allergy Injections	15% Coinsurance	20% Coinsurance	20% Coinsurance	DED + Coins
	Medical Pharmacy (Does not include immunizations)	15% Coinsurance	20% Coinsurance	20% Coinsurance	DED + 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	$100 Copay	$100 Copay	$150 Copay	$150 Copay
Urgent Care Centers	In-Network and Out-of-Network	$60 Copay	$50 Copay	$60 Copay	$50 Copay
Independent Diagnostic Testing Facility/Provider's Office					
	Allergy Testing	$0	$10 Copay	$0	$35 Copay
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$10 Copay	$75 Copay	$0	$35 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$50 Copay	$150 Copay	$100 Copay	$150 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$0	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	$0	$0	$0	$0
Provider Services at Hospital	Inpatient	$0	$0	$0	$0
	Outpatient	$0	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	$400 Copay	$200 Copay	$250 Copay	$200 Copay
Provider Services at ASC	In-Network	$0	$0	$0	$0
	Out-of-Network	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)	$250 per day ($750 Max)	$250 per day ($750 Max)
	Out-of-Network	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	$500 Copay	$300 Copay	$500 Copay	$400 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$15 Copay	$20 Copay	$40 Copay	$20 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs*	Deductible (per person / family aggregate)	$0	$0	$0	$0
	Out of Pocket Maximum (per person / family aggregate)	$1,500 / $3,000	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0	$0
	Preferred Generic / Non Preferred Generic	$3 / $10	$3 / $10	$3 / $10	$3 / $10
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	$30 / $55 / 50% / 50%	$30 / $55 / 50% / 50%	$30 / $55 / 50% / 50%	$30 / $55 / 50% / 50%
	Mail-Order (Specialty/Self-Injectable not Available)	$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

* Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at http://www.fhcp.com/qhp-2017

INDIVIDUAL 2017 — HMO Plans

Cost Sharing		Gym Access IND Platinum HMO 92	IND Platinum HMO BC 5841	Gym Access IND Gold HMO BC 5651	Gym Access IND Essential Plus Gold HMO 63
Medical Deductible (Per Person / Family Aggregate)	In-Network	$500 / $1,000	$800 / $1,600	$0 / $0	$1,250 / $2,500
	Out-of-Network	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	10%	10%	40%	20%
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$2,500 / $5,000	$2,500 / $5,000	$3,200 / $6,400	$4,750 / $9,500
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$15 Copay	$15 Copay ($0 visits 1-3)	$25 Copay	$20 Copay
	Specialist	$30 Copay	$20 Copay	$60 Copay	$50 Copay
	Allergy Injections	DED + Coins	10% Coinsurance	40% Coinsurance	DED + Coins
	Medical Pharmacy (Does not include immunizations)	DED + Coins	10% Coinsurance	40% Coinsurance	DED + 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	$100 Copay	DED + Coins	$350 Copay	DED + $250 Copay
Urgent Care Centers	In-Network and Out-of-Network	$50 Copay	$50 Copay	$65 Copay	$65 Copay
Independent Diagnostic Testing Facility/Provider's Office					
	Allergy Testing	$35 Copay	DED + Coins	$10 Copay	DED + Coins
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$35 Copay	DED + Coins	$100 Copay	DED + Coins
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$150 Copay	DED + Coins	$250 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
Provider Services at Hospital	Inpatient	$0	$0	$0	DED + Coins
	Outpatient	$0	DED + Coins	$0	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	$250 Copay	DED + Coins	$400 Copay	DED + Coins
Provider Services at ASC	In-Network	$0	DED + Coins	$0	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	$300 per day ($900 Max)	DED + Coins	$600 per day ($1,800 Max)	DED + Coins
	Out-of-Network	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
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$20 Copay	$20 Copay	$60 Copay	20% Coinsurance
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs*	Deductible (per person / family aggregate)	$0	$0	$0	$0
	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	$3 / $10	$3 / $10	$3 / $10
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	$30 / $55 / 50% / 50%	$30 / $55 / 50% / 50%	$30 / $55 / 50% / 50%	$30 / $75 / 30% / 30%
	Mail-Order (Specialty/Self-Injectable not Available)	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $222
	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/qhp-2017

INDIVIDUAL 2017 — HMO Plans

Cost Sharing		IND Gold HMO 4500	Gym Access IND Gold HMO 5500	Gym Access IND Essential Plus Silver HMO 53	IND Silver Standardized HMO 1	Gym Access IND Silver HMO 6400
Medical Deductible (Per Person / Family Aggregate)	In-Network	$1,500 / $3,000	$2,000 / $4,000	$2,500 / $5,000	$3,500 / $7,000	$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%	30%	20%	20%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum	In-Network	$4,500 / $9,000	$5,500 / $11,000	$7,150 / $14,300	$7,150 / $14,300	$6,400 / $12,800
(Per Person / Family Aggregate)	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$25 Copay	$20 Copay	$40 Copay	$30 Copay	$30 Copay
	Specialist	$35 Copay	$35 Copay	$65 Copay	$65 Copay	$75 Copay
	Allergy Injections	10% Coinsurance	20% Coinsurance	DED + Coins	20% Coinsurance	20% Coinsurance
Medical Pharmacy (Does not include immunizations)		10% Coinsurance	20% Coinsurance	DED + Coins	20% Coinsurance	20% 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	DED + Coins	$200 Copay	DED + Coins	DED + $400 Copay	$500 Copay
Urgent Care Centers	In-Network and Out-of-Network	$75 Copay	$75 Copay	$75 Copay	$75 Copay	$100 Copay
Independent Diagnostic Testing Facility/Provider's Office						
	Allergy Testing	$0	$0	DED + Coins	DED + Coins	$0
X-Rays / Ultrasounds / Diagnostic Services (other than AIS)		DED + Coins	$0	DED + Coins	DED + Coins	$50 Copay
Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)		DED + Coins	$100 Copay	DED + Coins	DED + Coins	$250 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$0	$0	DED + Coins	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	DED + Coins	DED + Coins	$0
Provider Services at Hospital	Inpatient	$0	$0	DED + Coins	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)	In-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Provider Services at ASC	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 per day ($750 Max)	$250 per day ($1,250 Max)	DED + Coins	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	$35 Copay	$65 Copay	$65 Copay	$40 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Prescription Drugs*	Deductible (per person / family aggregate)	$0	$0	Integrated with Medical	$0	$0
	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 / $15	$3 / $10
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	$30 / $55 / 50% / 50%	$30 / $55 / 50% / 50%	$30**/ $55**/ 50%**/ 50%**	$50 / $100 / 40% / $40%	$30 / $55 / 50% / 50%
	Mail-Order (Specialty/Self-Injectable not Available)	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87**/ $162**	$6 / $42 / $147 / $297	$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/qhp-2017 **Copay applies after deductible is met.

INDIVIDUAL 2017 — HMO Plans

Cost Sharing		IND Silver HMO BC 7741	Gym Access IND Silver HMO 6600	Gym Access IND Silver HMO BC 0941	IND Essential Plus Bronze HMO 41
Medical Deductible (Per Person / Family Aggregate)	In-Network	$6,500 / $13,000	$5,500 / $11,000	$5,600 / $11,200	$4,500 / $9,000
	Out-of-Network	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	40%	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	$7,150 / $14,300	$6,600 / $13,200	$7,150/ $14,300	$6,950 / $13,900
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$55 Copay ($0 visits 1-2)	$20 Copay	$50 Copay	DED + Coins
	Specialist	DED + $85 Copay	$40 Copay	$100 Copay	DED + Coins
	Allergy Injections	DED + Coins	DED + Coins	DED + Coins	DED + 50% Coins***
	Medical Pharmacy (Does not include immunizations)	DED + Coins	DED + Coins	DED + Coins	DED + 50% 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	DED + $600 Copay	DED + Coins	DED + $400 Copay	DED + Coins
Urgent Care Centers	In-Network and Out-of-Network	$160 Copay	DED + Coins	$100 Copay	DED + Coins
Independent Diagnostic Testing Facility/Provider's Office					
	Allergy Testing	$4 Copay	$0	$10 Copay	DED + Coins
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$4 Copay	DED + Coins	$50 Copay	DED + Coins
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	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	$25 Copay	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	Deductible	DED + Coins	$0	DED + Coins
Provider Services at Hospital	Inpatient	DED + Coins	DED + Coins	$0	DED + Coins
	Outpatient	DED + Coins	DED + Coins	Deductible	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	DED + Coins	DED + Coins	DED + $350 Copay	DED + Coins
Provider Services at ASC	In-Network	DED + Coins	DED + Coins	Deductible	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	$85 Copay	DED + Coins	$100 Copay	60% Coinsurance
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs*	Deductible (per person / family aggregate)	$0	$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 / $15	$3 / $10	$3 / $10	$3** / $10**
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	$50 / $100 / 40% / 40%	$30** / $55** / 50%** / 50%**	$30** / $55** / 50%** / 50%**	$30**/ $55**/ 50%**/ 50%**
	Mail-Order (Specialty/Self-Injectable not Available	$6 / $42 / $147 / $297	$6 / $27 / $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/qhp-2017 **Copay applies after deductible is met. ***Coinsurance value indicated applies.

INDIVIDUAL 2017 — HMO Plans

Cost Sharing		IND Bronze Standardized HMO 2	Gym Access IND Bronze HMO BC 3841	Gym Access IND Catastrophic Essential Plus HMO 36
Medical Deductible (Per Person / Family Aggregate)	In-Network	$6,650 / $13,300	$6,700 / $13,400	$7,150 / $14,300
	Out-of-Network	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	50%	50%	N/A
	Out-of-Network	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$7,150 / $14,300	$6,850 / $13,700	$7,150 / $14,300
	Out-of-Network	N/A	N/A	N/A
Physician Office Services	Primary Care Office	DED + Coins ($45 visits 1-3)	$50 Copay ($0 visits 1-3)	DED ($0 Copay visits 1-3)
	Specialist	DED + Coins	$85 Copay	DED
	Allergy Injections	50% Coinsurance	50% Coinsurance	DED
	Medical Pharmacy (Does not include immunizations)	50% Coinsurance	50% Coinsurance	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 + Coins	DED
Urgent Care Centers	In-Network and Out-of-Network	DED + Coins	$125 Copay	DED
Independent Diagnostic Testing Facility/Provider's Office				
	Allergy Testing	DED + Coins	$10 Copay	DED
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	DED + Coins	DED + Coins	DED
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	DED + Coins	DED + Coins	DED
	Out-of-Network	N/A	N/A	N/A
Independent Clinical Lab	In-Network	DED + Coins	DED + Coins	DED
	Out-of-Network	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	DED + Coins	DED + Coins	DED
Provider Services at Hospital	Inpatient	DED	DED	DED
	Outpatient	DED + Coins	DED + Coins	DED
	Out-of-Network	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	DED + Coins	DED + Coins	DED
Provider Services at ASC	In-Network	DED + Coins	DED + Coins	DED
	Out-of-Network	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	DED + Coins	DED + $150 Copay	DED
	Out-of-Network	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED + Coins	DED
	Out-of-Network	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	50% Coinsurance	$85 Copay	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	$4 / $35	$4 / $18	DED / DED
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	35%** / 40%** / 45%**/ 45%**	$65**/ 50%**/ 50%**/ 50%**	DED / DED / DED / DED
	Mail-Order (Specialty/Self-Injectable not Available)	$9 / $102 / 35%** / 40%**	$9 / $51 / $192**/ 50%**	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/qhp-2017**Copay applies after deductible is met.

INDIVIDUAL 2017 – HMO HDHP PLANS WITH H.S.A. COMPATIBILITY

Cost Sharing		IND Silver HMO H.S.A. 2000/6450*	Gym Access IND Bronze HMO H.S.A 5500/6550	Gym Access IND Bronze HMO H.S.A 6000/6550
Medical Deductible (Per Person / Family Aggregate)	In-Network	$2,000 / $4,000	$5,500 / $11,000	$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	$6,550 / $13,100	$6,550 / $13,100
	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 + Coins	DED + Coins
	Medical Pharmacy (Does not include immunizations)	DED + Coins	DED + 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 Out-of-Network	DED + Coins	DED + Coins	DED + Coins
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)	In-Network	DED + Coins	DED + Coins	DED + Coins
Provider Services at ASC	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	$3** / $10**	$3** / $10**	$3** / $10**
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	$30** / $55**/ 50%** / 50%**	$30** / $55** / 50%** / 50%**	$30** / $55** / 50%** / 50%**
	Mail-Order (Specialty/Self-Injectable not Available)	$6** / $27** / $87**/ $162**	$6** / $27** / $87** / $162**	$6** / $27** / $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/qhp-2017 **Copay applies after deductible is met.

H.S.A. Compatible Plans – The maximum out-of-pocket is embedded, refer to the schedule of benefits for embedding information on the deductible.

INDIVIDUAL 2017 – POS PLANS

Cost Sharing		Gym Access IND Platinum POS BC 1941	Gym Access IND Platinum POS 4000	Gym Access IND Platinum POS BC 5841
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$0 / $0	$800 / $1,600
	Out-of-Network	$500 / $1,000	$500 / $1,000	$1,600 / $3,200
Coinsurance (Amount member pays)	In-Network	20%	20%	10%
	Out-of-Network	30%	30%	30%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$2,000 / $4,000	$4,000 / $8,000	$2,500 / $5,000
	Out-of-Network	$4,000 / $8,000	$8,000 / $16,000	$5,000 / $10,000
Physician Office Services	Primary Care Office	$10 Copay	$20 Copay	$15 Copay ($0 visits 1-3)
	Specialist	$20 Copay	$40 Copay	$20 Copay
	Allergy Injections	20% Coinsurance	20% Coinsurance	10% Coinsurance
	Medical Pharmacy (Does not include immunizations)	20% Coinsurance	20% Coinsurance	10% Coinsurance
	Out of Network	DED + Coins	DED + Coins	DED + Coins
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$100 Copay	$150 Copay	INN DED + Coins[1]
Urgent Care Centers	In-Network and Out-of-Network	$50 Copay	$60 Copay	$50 Copay
Independent Diagnostic Testing Facility/Provider's Office				
	Allergy Testing	$10 Copay	$0	DED + Coins
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$75 Copay	$0	DED + Coins
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$150 Copay	$100 Copay	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Independent Clinical Lab	In-Network	$0	$0	$0
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Provider Services at ER	In-Network and Out-of-Network	$0	$0	INN DED + Coins[1]
Provider Services at Hospital	Inpatient	$0	$0	$0
	Outpatient	$0	$0	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Ambulatory Surgical Center Facility (ASC)	In-Network	$200 Copay	$250 Copay	DED + Coins
Provider Services at ASC	In-Network	$0	$0	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Inpatient Hospital Facility Services (per admission)	In-Network	$350 per day ($1,050 Max)	$250 per day ($750 Max)	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	$300 Copay	$500 Copay	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Chiropractic Care (per visit)	In-Network	$20 Copay	$40 Copay	$20 Copay
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Prescription Drugs*	Deductible (per person / family aggregate)	$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/Specialty/Self-Injectable	$30 / $55 / 50% / 50%	$30 / $55 / 50% / 50%	$30 / $55 / 50% / 50%
	Mail-Order (Specialty/Self-Injectable not Available)	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $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/qhp-2017 [1] INN – In-Network Deductible + Coinsurance Applies

INDIVIDUAL 2017 – POS PLANS

Cost Sharing		Gym Access IND Gold POS BC 5651	Gym Access IND Gold POS 5500	Gym Access IND Essential Plus Silver POS 54
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$2,000 / $4,000	$2,500 / $5,000
	Out-of-Network	$500 / $1,000	$4,000 / $8,000	$5,000 / $10,000
Coinsurance (Amount member pays)	In-Network	40%	20%	30%
	Out-of-Network	30%	30%	50%
Medical Out-of-Pocket Maximum	In-Network	$3,200 / $6,400	$5,500 / $11,000	$7,150 / $14,300
(Per Person / Family Aggregate)	Out-of-Network	$6,000 / $12,000	$8,000 / $16,000	$8,000 / $16,000
Physician Office Services	Primary Care Office	$25 Copay	$20 Copay	$40 Copay
	Specialist	$60 Copay	$35 Copay	$65 Copay
	Allergy Injections	40% Coinsurance	20% Coinsurance	DED + Coins
	Medical Pharmacy (Does not include immunizations)	40% Coinsurance	20% Coinsurance	DED + Coins
	Out of Network	DED + Coins	DED + Coins	DED + Coins
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$350 Copay	$200 Copay	INN DED + Coins[1]
Urgent Care Centers	In-Network and Out-of-Network	$65 Copay	$75 Copay	$75 Copay
Independent Diagnostic Testing Facility/Provider's Office				
	Allergy Testing	$10 Copay	$0	DED + Coins
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$100 Copay	$0	DED + Coins
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$250 Copay	$100 Copay	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Independent Clinical Lab	In-Network	$0	$0	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Provider Services at ER	In-Network and Out-of-Network	$0	$0	INN DED + Coins[1]
Provider Services at Hospital	Inpatient	$0	$0	DED + Coins
	Outpatient	$0	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Ambulatory Surgical Center Facility (ASC)	In-Network	$400 Copay	DED + Coins	DED + Coins
Provider Services at ASC	In-Network	$0	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Inpatient Hospital Facility Services (per admission)	In-Network	$600 per day ($1,800 Max)	$250 per day ($1,250 Max)	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	$450 Copay	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Chiropractic Care (per visit)	In-Network	$60 Copay	$35 Copay	$65 Copay
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Prescription Drugs*	Deductible (per person / family aggregate)	$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/Specialty/Self-Injectable	$30 / $55 / 50% / 50%	$30 / $55 / 50% / 50%	$30** / $55** / 50%** / 50%**
	Mail-Order (Specialty/Self-Injectable not Available)	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $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/qhp-2017 **Copay applies after Deductible is met. [1] INN – In-Network Deductible + Coinsurance Applies.

INDIVIDUAL 2017 – POS PLANS

Cost Sharing		Gym Access IND Silver POS BC 7741	Gym Access IND Silver POS BC 0941	Gym Access IND Bronze Essential Plus POS 42	Gym Access IND Bronze POS BC 3841	Gym Access IND Catastrophic Essential Plus POS 37
Medical Deductible (Per Person / Family Aggregate)	In-Network	$6,500 / $13,000	$5,600 / $11,200	$4,500 / $9,000	$6,700 / $13,400	$7,150 / $14,300
	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	40%	40%	55%	50%	NA
	Out-of-Network	30%	40%	70%	50%	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$7,150 / $14,300	$7,150 / $14,300	$7,000 / $14,000	$6,850 / $13,700	$7,150 / $14,300
	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	$55 Copay ($0 visits 1-2)	$50 Copay	DED + Coins	$50 Copay ($0 visits 1-3)	DED ($0 Copay visits 1-3)
	Specialist	DED + $85 Copay	$100 Copay	DED + Coins	$85 Copay	DED
	Allergy Injections	DED + Coins	DED + Coins	DED + 50% Coins***	50% Coinsurance	DED
	Medical Pharmacy (Does not include immunizations)	DED + Coins	DED + Coins	DED + 50% Coins***	50% Coinsurance	DED
	Out of Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	DED + $600 Copay	DED + $400 Copay	INN DED + Coins[1]	INN DED + Coins[1]	INN DED[2]
Urgent Care Centers	In-Network and Out-of-Network	$160 Copay	$100 Copay	INN DED + Coins[1]	$125 Copay	INN DED[2]
Independent Diagnostic Testing Facility/Provider's Office						
	Allergy Testing	$4 Copay	$10 Copay	DED + Coins	$10 Copay	DED
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$4 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	$25 Copay	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	Deductible	$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	Deductible	DED + Coins	DED + Coins	DED
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins	DED
Ambulatory Surgical Center Facility (ASC)	In-Network	DED + Coins	DED + $350 Copay	DED + Coins	DED + Coins	DED
Provider Services at ASC	In-Network	DED + Coins	Deductible	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	$85 Copay	$100 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)	$0	$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 / $15	$3 / $10	$3** / $10**	$4 / $18	DED / DED
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	$50 /$100 /40% /40%	$30**/$55**/50%**/50%**	$30**/$55**/50%**/50%**	$65**/50%**/50%**/50%**	DED / DED / DED / DED
	Mail-Order (Specialty/Self-Injectable not Available)	$6 / $42 / $147 / $297	$6 / $27 / $87**/ 162**	$6**/$27**/ $87**/ $162**	$9 / $51 / $192**/ 50%**	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.fhcp.com/qhp-2017 **Copay applies after Deductible is met. [1]INN – In-Network Deductible + Coinsurance Applies.

[2]INN – In-Network Deductible Applies

INDIVIDUAL 2017 – POS HDHP PLANS WITH H.S.A. COMPATIBILITY

Cost Sharing		IND Bronze POS H.S.A. 5500/6550*	IND Bronze POS H.S.A. 6000/6550*
Medical Deductible (Per Person / Family Aggregate)	In-Network	$5,500 / $11,000	$6,000 / $12,000
	Out-of-Network	$8,000 / $16,000	$8,000 / $16,000
Coinsurance (Amount member pays)	In-Network	30%	10%
	Out-of-Network	40%	30%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$6,550 / $13,100	$6,550 / $13,100
	Out-of-Network	$12,000 / $24,000	$16,000 / $32,000
Physician Office Services	Primary Care Office	DED + Coins	DED + Coins
	Specialist	DED + Coins	DED + Coins
	Allergy Injections	DED + Coins	DED + Coins
	Medical Pharmacy (Does not include immunizations)	DED + Coins	DED + Coins
	Out of Network	DED + Coins	DED + Coins
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	INN DED + Coins[1]	INN DED + Coins[1]
Urgent Care Centers	In-Network and Out-of-Network	INN DED + Coins[1]	INN DED + Coins[1]
Independent Diagnostic Testing Facility/Provider's Office			
	Allergy Testing	DED + Coins	DED + Coins
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	DED + Coins	DED + Coins
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins
Independent Clinical Lab	In-Network	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins
Provider Services at ER	In-Network and Out-of-Network	INN DED + Coins[1]	INN DED + Coins[1]
Provider Services at Hospital	Inpatient	DED + Coins	DED + Coins
	Outpatient	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins
Ambulatory Surgical Center Facility (ASC)	In-Network	DED + Coins	DED + Coins
Provider Services at ASC	In-Network	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins
Inpatient Hospital Facility Services (per admission)	In-Network	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins
Chiropractic Care (per visit)	In-Network	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins
Prescription Drugs*	Deductible (per person / family aggregate)	Integrated with Medical	Integrated with Medical
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0
	Preferred Generic / Non Preferred Generic	$3** / $10**	$3** / $10**
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	$30** / $55** / 50%** / 50%**	$30** / $55** / 50%** / 50%**
	Mail-Order (Specialty/Self-Injectable not Available)	$6** / $27** / $87** / $162**	$6** / $27** / $87** / $162**
	Out-of-Network	Not Covered	Not Covered

* Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at http://www.fhcp.com/qhp-2017 *Copay applies after deductible is met.

H.S.A. Compatible Plans - The maximum out-of-pocket is embedded, refer to the schedule of benefits for embedding information on the deductible.

INDIVIDUAL 2017 – POS HDHP PLANS WITH H.S.A. COMPATIBILITY

Cost Sharing		IND Platinum Triple Option 82*	IND Gold Triple Option 29*
Medical Deductible (Per Person / Family Aggregate)	In-Network	Opt 1. $0 / $0; Opt 2. $250 / $500	Opt 1. $1,600 / $3,200; 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	In-Network	Opt 1. $3,000 / $6,000; Opt 2. $4,000 / $8,000	Opt 1. $3,200 / $6,400; Opt 2. $4,000 / $8,000
(Per Person / Family Aggregate)	Out-of-Network	Opt 3. $6,000 / $12,000	Opt 3. $4,500 / $9,000
Physician Office Services	Primary Care Office	Opt 1. $20 Copay; Opt 2. $30 Copay	Opt 1. $20 Copay; Opt 2. DED + Coins
	Specialist	Opt 1. $35 Copay; Opt 2. DED + Coins	Opt 1. $35 Copay; Opt 2. DED + Coins
	Allergy Injections	Opt 1. 15% Coinsurance; Opt 2. DED + Coins	Opt 1. 10% Coinsurance; Opt 2. DED + Coins
	Medical Pharmacy (Does not include immunizations)	Opt 1. 15% Coinsurance; Opt 2. DED + Coins	Opt 1. 10% Coinsurance; Opt 2. DED + Coins
	Out of Network	Opt 3. DED + Coins	Opt 3. DED + Coins
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$100 Copay	INN DED + Coins
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. DED + Coins	Opt 1. DED + Coins; Opt 2. DED + Coins
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	Opt 1. $10 Copay; Opt 2. DED + Coins	Opt 1. DED + Coins; Opt 2. DED + Coins
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	Opt 1. $50 Copay; Opt 2. DED + Coins	Opt 1. DED + Coins; Opt 2. DED + Coins
	Out-of-Network	Opt 3. DED + Coins	Opt 3. DED + Coins
Independent Clinical Lab	In-Network	Opt 1. $0; Opt 2. N/A	Opt 1. DED + Coins; Opt 2. N/A
	Out-of-Network	Opt 3. DED + Coins	Opt 3. DED + Coins
Provider Services at ER	In-Network and Out-of-Network	$0	INN DED + Coins
Provider Services at Hospital	Inpatient	Opt 1. $0; Opt 2. DED + Coins	Opt 1. $0; Opt 2. DED + Coins
	Outpatient	Opt 1. $0; Opt 2. DED + Coins	Opt 1. DED + Coins; Opt 2. DED + Coins
	Out-of-Network	Opt 3. DED + Coins	Opt 3. DED + Coins
Ambulatory Surgical Center Facility (ASC)	In-Network	Opt 1. $0; Opt 2. DED + Coins	Opt 1. DED + Coins; Opt 2. N/A
Provider Services at ASC	In-Network	Opt 1. $0; Opt 2. DED + Coins	Opt 1. DED + Coins; Opt 2. DED + Coins
	Out-of-Network	Opt 3. DED + Coins	Opt 3. DED + Coins
Inpatient Hospital Facility Services (per admission)	In-Network	Opt 1. $250 per day ($1250 Max) Copay; Opt 2. N/A	Opt 1. $500 Copay; Opt 2. N/A
	Out-of-Network	Opt 3. DED + Coins	Opt 3. DED + Coins
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	Opt 1. $400 Copay; Opt 2. N/A	Opt 1. DED + Coins; Opt 2. N/A
	Out-of-Network	Opt 3. DED + Coins	Opt 3. DED + Coins
Chiropractic Care (per visit)	In-Network	Opt 1. $15 Copay; Opt 2. DED + Coins	Opt 1. $20 Copay; Opt 2. DED + Coins
	Out-of-Network	Opt 3. DED + Coins	Opt 3. DED + Coins
Prescription Drugs*	Deductible (per person / family aggregate)	$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/Specialty/Self-Injectable	$30 / $55 / 50% /50%	$30 / $55 / 50% /50%
	Mail-Order (Specialty/Self-Injectable not Available	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered

* Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at http://www.fhcp.com/qhp-2017

INDIVIDUAL 2017 — FHCP Plans — Pediatric Vision (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