INDIVIDUAL ON 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 On Exchange 2016 — HMO Plans | | | | | |
|---|--|--|---------------|--|--|
| | | In-Network | In-Network | | |
| Metal | Plan Name | CYD / Coins / OOP | 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 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 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 | | |
| 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 On | Exchange 2016 – POS 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 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 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 | | |

INDIVIDUAL 2016 — HMO Plans
Page 2 of 18

| Cost Sharing | IND Essential Plus Platinum HMO 65 | IND Platinum HMO BC 1941 | IND Platinum HMO 4000 |
|---|---|-----------------------------|--|
| Medical Deductible (Per Person / Family Aggregate) In-Netwo | rk \$0 / \$0 | \$0 / \$0 | \$0 / \$0 |
| Out-of-Netwo | | N/A | N/A |
| Coinsurance (Amount member pays) In-Netwo | | 20% | 20% |
| Out-of-Netwo | | N/A | N/A |
| Medical Out-of-Pocket Maximum In-Netwo | rk \$1,500 / \$3,000 | \$2,000 / \$4,000 | \$4,000 / \$8,000 |
| (Per Person / Family Aggregate) Out-of-Netwo | | N/A | N/A |
| Physician Office Services Primary Care Offi | ce \$20 Copay | \$10 Copay | \$20 Copay |
| Speciali | st \$35 Copay | \$20 Copay | \$40 Copay |
| Allergy Injectio | | 20% Coinsurance | 20% Coinsurance |
| Medical Pharmacy (Does not include immunization | | 20% Coinsurance | 20% Coinsurance |
| Out of Netwo | rk N/A | N/A | N/A |
| Emergency Room Facility Services In-Network ar | od . | \$75.Q | 4450.0 |
| (per visit; copay waived if admitted) Out-of-Netwo | rk \$75 Copay | \$75 Copay | \$150 Copay |
| Urgent Care Centers In-Network and Out-of-Netwo | rk \$60 Copay | \$50 Copay | \$60 Copay |
| Independent Diagnostic Testing Facility/Provider's Office | * · · · · · · · · · · · · · · · · · · · | , to copy | The sepantial se |
| Allergy Testin | ng \$0 | \$10 Copay | \$0 |
| X-Rays / Ultrasounds / Diagnostic Services (other than A | | \$75 Copay | \$0 |
| Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medici | ne) \$0 | \$150 Copay | \$100 Copay |
| Out-of-Netwo | | N/A | N/A |
| Independent Clinical Lab In-Netwo | | \$0 | \$0 |
| Out-of-Netwo | | N/A | N/A |
| Provider Services at ER In-Network at | nd \$0 | # 0 | \$0 |
| Out-of-Netwo | rK [· | \$0 | |
| Provider Services at Hospital Inpatie | | \$0 | \$0 |
| Outpatie | nt \$0 | \$0 | \$0 |
| Out-of-Netwo | rk N/A | N/A | N/A |
| Ambulatory Surgical Center Facility (ASC) In-Netwo | rk 15% Coinsurance | \$200 Copay | \$250 Copay |
| Provider Services at ASC In-Netwo | rk \$0 | \$0 | \$0 |
| Out-of-Netwo | rk N/A | N/A | N/A |
| Inpatient Hospital Facility Services (peradmission) In-Netwo | rk \$250 per day (\$1,250 Max) | \$350 per day (\$1,050 Max) | \$250 Copay |
| Out-of-Netwo | rk N/A | N/A | N/A |
| Outpatient Hospital Facility Services(surgical)(per visit) In-Netwo | rk 15% Coinsurance | \$300 Copay | \$250 Copay |
| Out-of-Netwo | rk N/A | N/A | N/A |
| Chiropractic Care (per visit) In-Netwo | rk \$15 Copay | \$20 Copay | \$40 Copay |
| Out-of-Netwo | rk N/A | N/A | N/A |
| Prescription Drugs* Deductible (per person / family aggrega | | Integrated with Medical | Integrated with Medical |
| Out of Pocket Maximum (per person / family aggregation | te) \$1,500 / \$3,000 | Integrated with Medical | Integrated with Medical |
| Preventive Medication | | \$0 | \$0 |
| Preferred Generic / Non Preferred Gene | | \$3 / \$10 | \$3 / \$10 |
| Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectab | | \$30 / \$55 / 20% / 20% | \$30 / \$55 / 20% / 20% |
| Mail-Order (Specialty/Self-Injectable not Availa | | \$6 / \$27 / \$87 / \$162 | \$6 / \$27 / \$87 / \$162 |
| Out-of-Netwo | rk 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

INDIVIDUAL 2016 — HMO Plans
Page 3 of 18

| Cost Sharing | IND Platinum HMO 91 | IND Platinum HMO 92 | IND Platinum HMO BC 5841 |
|--|---------------------|--------------------------------|-----------------------------|
| Medical Deductible (Per Person / Family Aggregate) In-Network | \$250 / \$750 | \$500 / \$1,000 | \$800 / \$1,600 |
| Out-of-Network | | N/A | N/A |
| Coinsurance (Amount member pays) In-Network | | 10% | 10% |
| Out-of-Network | | N/A | N/A |
| Medical Out-of-Pocket Maximum In-Network | \$3,000 / \$6,000 | \$3,000 / \$6,000 | \$2,500 / \$5,000 |
| (Per Person / Family Aggregate) Out-of-Network | | N/A | N/A |
| Physician Office Services Primary Care Office | | \$20 Copay | \$15 Copay (\$0 visits 1-3) |
| | \$35 Copay | \$35 Copay | \$20 Copay |
| Allergy Injections | DED + Coins | DED + Coins | DED + Coins |
| Medical Pharmacy (Does not include immunizations) | | DED + Coins | DED + Coins |
| Out of Network | N/A | N/A | N/A |
| Emergency Room Facility Services In-Network and | \$150 Copay | \$100 Copay | DED + Coins |
| (per visit; copay waived if admitted) Out-of-Network | | фго О | φ.c. Ο |
| Urgent Care Centers In-Network and Out-of-Network | \$50 Coрау | \$50 Copay | \$50 Copay |
| Independent Diagnostic Testing Facility/Provider's Office Allergy Testing | \$35 Conav | \$35 Copay | DED + Coins |
| X-Rays / Ultrasounds / Diagnostic Services (other than AIS) | | \$35 Copay | DED + Coins |
| Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine) | | \$150 Copay | DED + Coins |
| Out-of-Network | | N/A | N/A |
| Independent Clinical Lab In-Network | | \$0 | \$0 |
| Out-of-Network | | N/A | N/A |
| Provider Services at ER In-Network and | | \$0 | DED + Coins |
| Provider Services at Hospital Out-of-Network Inpatient | | DED + Coins | DED + Coins |
| | DED + Coins | \$0 | DED + Coins DED + Coins |
| Out-of-Network | | N/A | N/A |
| | DED + Coins | \$250 Copay | DED + Coins |
| | DED + Coins | \$0 | DED + Coins |
| Out-of-Network | | N/A | N/A |
| Inpatient Hospital Facility Services (per admission) In-Network | \$250 Copay | DED + Coins | DED + Coins |
| Out-of-Network | | N/A | N/A |
| 1 1 7 7 7 | DED + Coins | \$400 Copay | DED + Coins |
| Out-of-Network | | N/A | N/A |
| | \$20 Copay | DED + Coins | \$20 Copay |
| Prescription Drugs* Out-of-Network Deductible (per person / family aggregate) | | N/A \$0 | N/A \$0 |
| Out of Pocket Maximum (per person / family aggregate) | | মূত Integrated with Medical | Integrated with Medical |
| Preventive Medications | | \$0 | \$0 |
| Preferred Generic / Non Preferred Generic | 1 2 | \$3 / \$10 | \$3 / \$10 |
| Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable | | \$30 / \$55 / 20% / 20% | \$30 / \$55 / 20% / 20% |
| Mail-Order (Specialty/Self-Injectable not Available) | | \$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/members/plansAndBenefits/2016-exchange-formulary.pdf

INDIVIDUAL 2016 — HMO Plans
Page 4 of 18

| Cost Sharing | IND Gold HMO BC 5651 | IND Essential Plus Gold HMO 63 | IND Gold HMO 5500 |
|--|-----------------------------|--------------------------------|-----------------------------|
| Madical Dadustillaria | | M4 000 / M0 000 | f0 000 /f4 000 |
| Medical Deductible (Per Person / Family Aggregate) In-Network | | \$1,000 / \$2,000 | \$2,000 / \$4,000 |
| Out-of-Network Coinsurance (Amount member pays) In-Network | N/A 409/ | N/A 20% | N/A 20% |
| Coinsurance (Amount member pays) In-Network Out-of-Network | | N/A | N/A |
| | \$3,000 / \$6,000 | \$2,500 / \$5,000 | \$5,500 / \$11,000 |
| | | N/A | N/A |
| (Per Person / Family Aggregate) Out-of-Network Physician Office Services Primary Care Office | | DED + Coins | \$20 Copay |
| | \$60 Copay | DED + Coins | \$35 Copay |
| | 20% Coinsurance*** | DED + Coins | 20% Coinsurance |
| Medical Pharmacy (Does not include immunizations) | 20% Coinsurance*** | DED + Coins | 20% Coinsurance |
| Out of Network | N/A | N/A | N/A |
| Emergency Room Facility Services In-Network and | | | |
| (per visit; copay waived if admitted) Out-of-Network | | DED + Coins | \$200 Copay |
| Urgent Care Centers In-Network and Out-of-Network | | DED + Coins | \$75 Copay |
| Independent Diagnostic Testing Facility/Provider's Office | | | |
| Allergy Testing | \$10 Copay | DED + Coins | \$0 |
| X-Rays / Ultrasounds / Diagnostic Services (other than AIS) | | DED + Coins | \$0 |
| Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine | | DED + Coins | \$100 Copay |
| Out-of-Network | | N/A | N/A |
| Independent Clinical Lab In-Network | | DED + Coins | \$0 |
| Out-of-Network | N/A | N/A | N/A |
| Provider Services at ER In-Network and Out-of-Network | \$0 | DED + Coins | \$0 |
| Provider Services at Hospital Inpatient | · I | DED + Coins | \$0 |
| Outpatient | | DED + Coins | DED + Coins |
| Out-of-Network | | N/A | N/A |
| | \$400 Copay | DED + Coins | DED + Coins |
| Provider Services at ASC In-Network | | DED + Coins | DED + Coins |
| Out-of-Network | | N/A | N/A |
| | \$600 per day (\$1,800 Max) | DED + Coins | \$250 per day (\$1,250 Max) |
| Out-of-Network | | N/A | N/A |
| Outpatient Hospital Facility Services(surgical)(per visit) In-Network | \$450 Copay | DED + Coins | DED + Coins |
| Out-of-Network | N/A | N/A | N/A |
| | \$60 Copay | 20% Coinsurance | \$35 Copay |
| Out-of-Network | | N/A | N/A |
| Prescription Drugs* Deductible (per person / family aggregate) | | \$0 | \$0 |
| Out of Pocket Maximum (per person / family aggregate) | | \$2,000 / \$4,000 | 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 / 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 |
| 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 ****Coinsurance value indicated applies.

INDIVIDUAL 2016 — HMO Plans
Page 5 of 18

| Cost Sharing | IND Essential Plus Silver | IND Essential Plus Silver | IND Essential Plus Silver | IND Essential Plus Silver |
|---|---|---------------------------|---------------------------|---------------------------|
| | <u>HMO 53</u> | HMO 53 – 73% CSR | HMO 53 – 87% CSR | HMO 53 – 94% CSR |
| Medical Deductible (Per Person / Family Aggregate) In-Network | \$1,700 / \$3,400 | \$1,650 / \$3,300 | \$250 / \$500 | \$50 / \$100 |
| Out-of-Network | | N/A | N/A | N/A |
| Coinsurance (Amount member pays) In-Network | 40% | 40% | 40% | 25% |
| Out-of-Network | | N/A | N/A | N/A |
| | \$4,300 / \$8,600 | \$3,700 / \$7,400 | \$1,000/ \$2,000 | \$500 / \$1,000 |
| Per Person / Family Aggregate) Out-of-Network | | N/A | N/A | N/A |
| Physician Office Services Primary Care Office | | DED + Coins | DED + Coins | DED + Coins |
| | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | DED + 20% Coins*** | DED + 20% Coins*** | DED + 20% Coins*** | DED + 20% Coins*** |
| Medical Pharmacy (Does not include immunizations) | | DED + 20% Coins*** | DED + 20% Coins*** | DED + 20% Coins*** |
| Out of Network | | N/A | N/A | N/A |
| Emergency Room Facility Services In-Network and | | | | |
| per visit; copay waived if admitted) Out-of-Network | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Jrgent Care Centers In-Network and Out-of-Network | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| ndependent Diagnostic Testing Facility/Provider's Office | DLD + COIIIS | DED + Collis | DED 1 GOINS | DLD + Collis |
| Allergy Testing | DED + Coins | 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 |
| | | | DED + Coins | |
| • | DED + Coins | DED + Coins | | DED + Coins |
| Out-of-Network | | N/A | N/A | N/A |
| 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 | DED + Coins |
| Outpatient | DED + Coins | DED + Coins | DED + Coins | 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 + Coins | DED + Coins |
| Provider Services at ASC In-Network | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Out-of-Network | N/A | N/A | N/A | N/A |
| npatient Hospital Facility Services (per admission) In-Network | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Out-of-Network | N/A | N/A | N/A | N/A |
| | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Out-of-Network | N/A | N/A | N/A | N/A |
| | 40% Coinsurance | 40% Coinsurance | 40% Coinsurance | 25% Coinsurance |
| Out-of-Network | N/A | N/A | N/A | N/A |
| | | \$250 / \$500 | \$150 / \$300 | \$25 / \$50 |
| Prescription Drugs* Deductible (per person / family aggregate) | | 14 | \$750 / \$4 500 | \$250 / \$500 |
| | | \$1,400 / \$2,800 | \$750 / \$1,500 | φ230 / φ300 |
| Prescription Drugs* Deductible (per person / family aggregate) Out of Pocket Maximum (per person / family aggregate) Preventive Medications | \$1,500 / \$3,000 | \$1,400 / \$2,800 \$0 | \$0 | \$0 |
| Out of Pocket Maximum (per person / family aggregate) | \$1,500 / \$3,000 \$0 | | | |
| Out of Pocket Maximum (per person / family aggregate) Preventive Medications Preferred Generic / Non Preferred Generic | \$1,500 / \$3,000 \$0 \$3** / \$10** | \$0 \$3** / \$10** | \$0 \$3** / \$10** | \$0 \$3** / \$10** |
| Out of Pocket Maximum (per person / family aggregate) Preventive Medications | \$1,500 / \$3,000 \$0 \$3** / \$10** \$30**/\$55**/20%**/20%** | \$0 | \$0 | \$0 |

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.

INDIVIDUAL 2016 — HMO Plans
Page 6 of 18

| Cost Sharing | IND Silver HMO 6400 | <u>IND Silver HMO</u> 6400 – 73% CSR | IND Silver HMO 6400 – 87% CSR | IND Silver HMO 6400 – 94% CSR |
|---|--|---|----------------------------------|----------------------------------|
| Medical Deductible (Per Person / Family Aggregate) In-N | letwork \$5,000 / \$10,000 | \$4,200 / \$8,400 | \$750 / \$1,500 | \$150 / \$300 |
| | letwork N/A | N/A | N/A | N/A |
| Coinsurance (Amount member pays) In-N | letwork 20% | 20% | 20% | 20% |
| | letwork N/A | N/A | N/A | N/A |
| | letwork \$6,400 / \$12,800 | \$5,200 / \$10,400 | \$1,500/ \$3,000 | \$500 / \$1,000 |
| | letwork N/A | N/A | N/A | N/A |
| , , , , | e Office \$30 Copay | \$30 Copay | \$20 Copay | \$20 Copay |
| | ecialist \$75 Copay | \$75 Copay | \$40 Copay | \$40 Copay |
| | ections 20% Coinsurance | 20% Coinsurance | 20% Coinsurance | 20% Coinsurance |
| Medical Pharmacy (Does not include immu | | 20% Coinsurance | 20% Coinsurance | 20% Coinsurance |
| | Network N/A | N/A | N/A | N/A |
| Emergency Room Facility Services In-Netwo | ork and | | | |
| (per visit; copay waived if admitted) Out-of-N | | \$500 Copay | \$250 Copay | \$250 Copay |
| Urgent Care Centers In-Network and Out-of-N | | \$100 Copay | \$100 Copay | \$100 Copay |
| ndependent Diagnostic Testing Facility/Provider's Office | etwork \$100 Copay | у тоо Сорау | у 100 Сорау | утоо Сорау |
| | Testing \$0 | \$0 | \$0 | \$0 |
| X-Rays / Ultrasounds / Diagnostic Services (othe | | \$50 Copay | \$40 Copay | \$40 Copay |
| Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear | | \$250 Copay | \$150 Copay | \$150 Copay |
| | Network N/A | N/A | N/A | N/A |
| | | | | |
| · | Network \$0 | \$0 | \$0 | \$0 N/A |
| Out-oi-in | letwork N/A | N/A | N/A | N/A |
| Provider Services at ER In-Netwo | ork and so | \$0 | \$0 | \$0 |
| Out-01-N | IEIWOIK | | · | • |
| | patient \$0 | \$0 DED : Online | \$0 | \$0 DED : Online |
| | patient DED + Coins letwork N/A | DED + Coins | DED + Coins N/A | DED + Coins N/A |
| | | N/A | | |
| | letwork DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | etwork DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | letwork N/A | N/A | N/A | N/A |
| | letwork \$500 Copay | \$500 Copay | \$500 Copay | \$500 Copay |
| | letwork N/A | N/A | N/A | N/A |
| | letwork DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | letwork N/A | N/A | N/A | N/A |
| | letwork \$40 Copay | \$40 Copay | \$40 Copay | \$40 Copay |
| | letwork N/A | N/A | N/A | N/A |
| Prescription Drugs* Deductible (per person / family a | | \$0 | \$0 | \$0 |
| Out of Pocket Maximum (per person / family a | | Integrated with Medical | Integrated with Medical | Integrated with Medical |
| Preventive Med | i i | \$0 \$10 / \$15 | \$0 | \$0 |
| Preferred Generic / Non Preferred G | | 1 ' | \$10 / \$15 | \$10 / \$15 |
| Preferred Brand/Non-Preferred Brand/Specialty/Self-Inj | | \$30 / \$55 / 20% / 20% | \$30 / \$55 / 20% / 20% | \$30 / \$55 / 20% / 20% |
| | ot Available) \$27 / \$42 / \$87 / \$162 | \$27 / \$42 / \$87 / \$162 | \$27 / \$42 / \$87 / \$162 | \$27 / \$42 / \$87 / \$162 |
| Out-ot-N | letwork 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

| Cost Sharing | | IND Silver HMO BC 7741 | IND Silver HMO BC 7741 | IND Silver HMO BC 7741 | IND Silver HMO BC 774 |
|--|--------------------------------------|------------------------------|-----------------------------------|-----------------------------|----------------------------|
| | | | 73% CSR | 87% CSR | 94% CSR |
| Medical Deductible (Per Person / Family Aggregate) | In-Network | \$5,200 / \$10,400 | \$4,300 / \$8,600 | \$0 / \$0 | \$0 / \$0 |
| | Out-of-Network | | N/A | N/A | N/A |
| Coinsurance (Amount member pays) | In-Network | 30% | 30% | 30% | 30% |
| | Out-of-Network | | N/A | N/A | N/A |
| | | | | | |
| Medical Out-of-Pocket Maximum | | \$6,850 / \$13,700 | \$4,500 / \$9,000 N/A | \$2,250 / \$4,500 N/A | \$900 / \$1,800 |
| , , , | out-of-Network | | | l . | N/A |
| Physician Office Services Prima | ry Care Office | \$75 Copay (\$0 visits 1-2) | \$65 Copay (\$0 visits 1-2) | \$10 Copay (\$0 visits 1-2) | \$5 Copay (\$0 visits 1-2) |
| Alla | Specialist | \$100 Copay | \$85 Copay | \$25 Copay | \$10 Copay |
| | | DED + 20% Coins*** | DED + 20% Coins*** | 20% Coinsurance*** | 20% Coinsurance*** |
| Medical Pharmacy (Does not incl | lude immunizations) | DED + 20% Coins*** | DED + 20% Coins*** | 20% Coinsurance*** | 20% Coinsurance*** |
| | Out of Network | N/A | N/A | N/A | N/A |
| 9 , | -Network and | \$600 Copay | \$600 Copay | \$600 Copay | \$100 Copay |
| | ut-of-Network | . , | | , , | . , |
| Urgent Care Centers In-Network and O | ut-of-Network | \$160 Copay | \$100 Copay | \$35 Copay | \$25 Copay |
| Independent Diagnostic Testing Facility/Provider's Offi | | | | | |
| A | Allergy Testing | \$10 Copay | \$10 Copay | \$10 Copay | \$10 Copay |
| X-Rays / Ultrasounds / Diagnostic Service | CES (other than AIS) | \$10 Copay | \$10 Copay | \$10 Copay | \$10 Copay |
| Advanced Imaging Services (AIS)(MRI, MRA, PET, CT | | | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| | Out-of-Network | | N/A | N/A | N/A |
| ndependent Clinical Lab | In-Network | \$0 | \$0 | \$0 | \$0 |
| | ut-of-Network | 1.5 | N/A | N/A | N/A |
| | | | | | |
| Tovider Gervices at Erk | n-Network and Out-of-Network | \$0 | \$0 | \$0 | \$0 |
| Provider Services at Hospital | Inpatient | DED + Coins | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| | | DED + Coins | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| C | Out-of-Network | | N/A | N/A | N/A |
| Ambulatory Surgical Center Facility (ASC) | | DED + Coins | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| Provider Services at ASC | | DED + Coins | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| | Out-of-Network | | N/A | N/A | N/A |
| | | DED + Coins | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| npatient Hospital Facility Services (per admission) | Out-of-Network | | N/A | N/A | N/A |
| Outpatient Hospital Facility Services(surgical)(per visit) | | DED + Coins | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| | Out-of-Network | | N/A | N/A | N/A |
| Chiropractic Care (per visit) | | \$100 Copay | \$85 Copay | \$25 Copay | \$10 Copay |
| | Out-of-Network | | N/A | N/A | N/A |
| | | Integrated with Medical | Integrated with Medical | \$0 / \$0 | \$0 / \$0 |
| Out of Pocket Maximum (per person | | | Integrated with Medical | Integrated with Medical | Integrated with Medical |
| | n / family aggregate) ve Medications | | \$0 | \$0 | \$0 |
| Preferred Generic / Non Pref | | | \$3 / \$10 | \$3 / \$10 | \$3/ \$10 |
| | | 1.7 | | | |
| Preferred Brand/Non-Preferred Brand/Specialty/ | | | \$30** / \$55** / 20%** / 20%** | \$30 / \$55 / 20% / 20% | \$30 / \$55 / 20% / 20% |
| | | \$6 / \$27 / \$87**/ \$162** | \$6** / \$27** / \$87** / \$162** | \$6 / \$27 / \$87 / \$162 | \$6 / \$27 / \$87 / \$162 |
| | Out-of-Network | INOT 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.

INDIVIDUAL 2016 — HMO Plans

Page 8 of 18

| Cost Sharing | IND Silver HMO 6600 | IND Silver HMO 6600 | IND Silver HMO 6600 | IND Silver HMO 6600 |
|--|--------------------------------------|---|---------------------------------|----------------------------------|
| | | 73% CSR | 87% CSR | 94% CSR |
| | work \$5,500 / \$11,000 | \$4,500 / \$9,000 | \$650 / \$1,300 | \$150 / \$300 |
| Out-of-Net | | N/A | N/A | N/A |
| 1 7 7 | vork 20% | 20% | 20% | 20% |
| Out-of-Net | vork N/A | N/A | N/A | N/A |
| Medical Out-of-Pocket Maximum In-Net | vork \$6,600 / \$13,200 | \$5,200 / \$10,400 | \$1,450/ \$2,900 | \$500 / \$1,000 |
| (Per Person / Family Aggregate) Out-of-Net | | N/A | N/A | N/A |
| | ffice \$20 Copay | \$20 Copay | \$20 Copay | \$20 Copay |
| | alist \$40 Copay | \$40 Copay | \$40 Copay | \$40 Copay |
| | ons DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Medical Pharmacy (Does not include immuniza | | DED + Coins | DED + Coins | DED + Coins |
| Out of Net | | N/A | N/A | N/A |
| Emergency Room Facility Services In-Network | and DED 0: | 555 0 1 | 555 6 : | 555 0 : |
| (per visit; copay waived if admitted) Out-of-Netv | | 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 Te | stina \$0 | \$0 | \$0 | \$0 |
| X-Rays / Ultrasounds / Diagnostic Services (other tha | | DED + Coins | DED + Coins | DED + Coins |
| Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Me | | DED + Coins | DED + Coins | DED + Coins |
| Out-of-Net | | N/A | N/A | N/A |
| | vork \$0 | \$0 | \$0 | \$0 |
| Out-of-Net | T. | N/A | N/A | N/A |
| | | | | |
| Out-of-Net | and DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | ient DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | ient DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Out-of-Net | | N/A | N/A | N/A |
| | vork DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | vork DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Out-of-Net | | N/A | N/A | N/A |
| | vork DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Out-of-Net | | N/A | N/A | N/A |
| | vork DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Out-of-Net | | N/A | N/A | N/A |
| | vork DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Out-of-Net | | N/A | N/A | N/A |
| Prescription Drugs* Deductible (per person / family aggr | | \$500 / \$1,000 | \$200 / \$400 | \$50 / \$100 |
| Out of Pocket Maximum (per person / family agg | | Integrated with Medical | Integrated with Medical | Integrated with Medical |
| Preventive Medica | | \$0 | \$0 | \$0 |
| Preferred Generic / Non Preferred Ger | eric \$10 / \$15 | \$10 / \$15 | \$10 / \$15 | \$10 / \$15 |
| Preferred Brand/Non-Preferred Brand/Specialty/Self-Inject | able \$30** / \$55** / 20%** / 20%** | \$30** / \$55** / 20%** / 20%** | \$30** / \$55** / 20%** / 20%** | \$30** / \$55** / 20%** / 20%* |
| Mail-Order (Specialty/Self-Injectable not Av | | \$27 / \$42 / \$87** / \$162** | \$27 / \$42 / \$87** / \$162** | \$27 / \$42 / \$87** / \$162** |
| ` ' ' | work Not Covered | Not Covered | Not Covered | Not Covered |
| Proventive Medications and Dy Liste are available in the EUCD Evaluate | | 1 | | capilias often deductible is mot |

^{*} 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 Plans

Page 9 of 18

| Cost Sharing | IND Silver HMO BC 0941 | IND Silver HMO BC 0941 | IND Silver HMO BC 0941 | Page IND Silver HMO BC 094 |
|---|------------------------|------------------------------|-----------------------------|----------------------------|
| | | 73% CSR | 87% CSR | 94% CSR |
| Medical Deductible (Per Person / Family Aggregate) In-Network | \$5,500 / \$11,000 | \$4,000 / \$8,000 | \$0 / \$0 | \$0 / \$0 |
| Out-of-Network | | N/A | N/A | N/A |
| Coinsurance (Amount member pays) In-Network | | 40% | 40% | 20% |
| Out-of-Network | N/A | N/A | N/A | N/A |
| Medical Out-of-Pocket Maximum In-Network | \$6,850 / \$13,700 | \$5,200 / \$10,400 | \$2,000 / \$4,000 | \$1,000 / \$2,000 |
| Per Person / Family Aggregate) Out-of-Network | | N/A | N/A | N/A |
| Physician Office Services Primary Care Office | \$125 Copay | \$85 Copay | \$10 Copay (\$0 Visits 1-3) | \$5 Copay (\$0 Visits 1-3) |
| | \$180 Copay | \$150 Copay | \$25 Copay | \$10 Copay |
| | DED + 20% Coins*** | DED + 20% Coins*** | 20% Coinsurance*** | 20% Coinsurance |
| Medical Pharmacy (Does not include immunizations) | | DED + 20% Coins*** | 20% Coinsurance*** | 20% Coinsurance |
| Out of Network | N/A | N/A | N/A | N/A |
| Emergency Room Facility Services In-Network and | | | 4000.0 | 450.0 |
| per visit; copay waived if admitted) Out-of-Network | DED + \$400 Copay | DED + \$400 Copay | \$200 Copay | \$50 Copay |
| Irgent Care Centers In-Network and Out-of-Network | DED + \$100 Copay | DED + \$100 Copay | \$30 Copay | \$10 Copay |
| ndependent Diagnostic Testing Facility/Provider's Office | | | | |
| Allergy Testing | \$10 Copay | \$10 Copay | \$10 Copay | \$10 Copay |
| X-Rays / Ultrasounds / Diagnostic Services (other than AIS) | | \$50 Copay | \$25 Copay | \$25 Copay |
| Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine) | | \$400 Copay | \$125 Copay | \$50 Copay |
| Out-of-Network | | N/A | N/A | N/A |
| ndependent Clinical Lab In-Network | | \$0 | \$0 | \$0 |
| Out-of-Network | N/A | N/A | N/A | N/A |
| Provider Services at ER In-Network and | 60 | \$0 | \$0 | ¢Ω |
| Out-of-Network | \$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 |
| | DED + \$350 Copay | DED + \$350 Copay | \$200 Copay | \$100 Copay |
| Provider Services at ASC In-Network | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network | | N/A | N/A | N/A |
| npatient Hospital Facility Services (peradmission) In-Network | DED + \$600 Copay | DED + \$600 Copay | \$400 Copay | \$300 Copay |
| Out-of-Network | | N/A | N/A | N/A |
| | DED + \$500 Copay | DED + \$500 Copay | \$300 Copay | \$200 Copay |
| Out-of-Network | | N/A | N/A | N/A |
| | \$180 Copay | \$150 Copay | \$25 Copay | \$10 Copay |
| Out-of-Network | | N/A | N/A | N/A |
| Prescription Drugs* Deductible (per person / family aggregate) | | \$3,000 / \$3,000 | 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 | | \$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% |
| Mail-Order (Specialty/Self-Injectable not Available | | \$6 / \$27 / \$87**/ \$162** | \$6 / \$27 / \$87 / \$162 | \$6 / \$27 / \$87 / \$162 |
| | | | | |

^{*} 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.

INDIVIDUAL 2016 — HMO Plans

Page 10 of 18

| Cost Sharing | IND Essential Plus | IND Bronze HMO BC 3841 | IND Bronze HMO | IND Catastrophic |
|--|---------------------------|------------------------------|-----------------------------|----------------------------|
| 14 15 15 1 (1) | Bronze HMO 41 | | 6850 | Essential Plus HMO 36 |
| | vork \$4,500 / \$9,000 | \$6,700 / \$13,400 | \$6,850 / \$13,700 | \$6,850 / \$13,700 |
| Out-of-Netv | | N/A | N/A | N/A |
| | vork 60% | 50% | N/A | N/A |
| Out-of-Netv | | N/A | N/A | N/A |
| | vork \$6,800 / \$13,600 | \$6,850 / \$13,700 | \$6,850 / \$13,700 | \$6,850 / \$13,700 |
| (Per Person / Family Aggregate) Out-of-Netv | | N/A | N/A | N/A |
| | ffice DED + Coins | \$50 Copay (\$0 visits 1-3) | DED (\$40 Copay visits 1-3) | DED (\$0 Copay visits 1-3) |
| | alist DED + Coins | \$85 Copay | DED | DED |
| | ons DED + 20% Coins*** | 20% Coinsurance | DED | DED |
| Medical Pharmacy (Does not include immuniza | tions) DED + 20% Coins*** | 20% Coinsurance | DED | DED |
| Out of Net | vork N/A | N/A | N/A | N/A |
| Emergency Room Facility Services In-Network | and DED Coins | DED Octob | DED | DED |
| (per visit; copay waived if admitted) Out-of-Netw | | DED + Coins | DED | DED |
| Urgent Care Centers In-Network and Out-of-Netw | ork DED + Coins | \$125 Copay | DED | DED |
| Independent Diagnostic Testing Facility/Provider's Office | | t and deposit | | |
| | sting DED + Coins | \$10 Copay | DED | DED |
| X-Rays / Ultrasounds / Diagnostic Services (other tha | | DED + Coins | DED | DED |
| Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Me | | DED + Coins | DED | DED |
| Out-of-Netv | | N/A | N/A | N/A |
| | vork DED + Coins | DED + Coins | DED | DED |
| Out-of-Netv | | N/A | N/A | N/A |
| Provider Services at ER In-Network | and | | | |
| Out-of-Netv | | DED + Coins | DED | DED |
| Provider Services at Hospital Inpat | ient DED + Coins | DED | DED | DED |
| | ent DED + Coins | DED + Coins | DED | DED |
| Out-of-Netv | | N/A | N/A | N/A |
| | vork DED + Coins | DED + Coins | DED | DED |
| | ork DED + Coins | DED + Coins | DED | DED |
| Out-of-Netv | | N/A | N/A | N/A |
| | vork DED + Coins | DED + \$150 Copay | DED | DED |
| Out-of-Net | | N/A | N/A | N/A |
| | vork DED + Coins | DED + Coins | DED | DED |
| Out-of-Netv | | N/A | N/A | N/A |
| Chiropractic Care (per visit) In-Net | vork 60% Coinsurance | \$85 Copay | DED | DED |
| Out-of-Netv | | N/A | N/A | N/A |
| Prescription Drugs* Deductible (per person / family aggre | | Integrated with Medical | Integrated with Medical | Integrated with Medical |
| Out of Pocket Maximum (per person / family aggre | | Integrated with Medical | Integrated with Medical | Integrated with Medical |
| Preventive Medica | | \$0 | \$0 | \$0 |
| Preferred Generic / Non Preferred Gen | | \$3 / \$10 | \$15 / \$20 | DED / DED |
| Preferred Brand/Non-Preferred Brand/Specialty/Self-Inject | | \$30**/\$55**/20%**/20%** | DED / DED / DED / DED | DED / DED / DED / DED |
| Mail-Order (Specialty/Self-Injectable not Av | | \$6 / \$27 / \$87**/ \$162** | \$42 / \$57 / DED / DED | DED / DED / DED / DED |
| iviali-Oluci (Specialty/Seit-injectable not Av | vork 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 H.S.A | IND Bronze HMO H.S.A |
|---|------------------------------|------------------------------|------------------------------|
| M. P. d D. L. et l. | I. Ni. (I | 4700/6450 | 6000/6450 |
| Medical Deductible (Per Person / Family Aggregate) | | \$4,700 / \$9,400 | \$6,000 / \$12,000 |
| Coincurance | Out-of-Network In-Network | | N/A 10% |
| Coinsurance (Amount member pays) | Out-of-Network | | N/A |
| Medical Out-of-Pocket Maximum | | \$6,450 / \$12,900 | \$6,450 / \$12,900 |
| | Out-of-Network | | N/A |
| (Per Person / Family Aggregate) Physician Office Services Pri | mary Care Office | | DED + Coins |
| Filysician Office Services Fil | | DED + Coins | DED + Coins |
| | | DED + 20% Coins*** | DED + Coins |
| Medical Pharmacy (Does no | | | DED + Coins |
| ivieutcai Friairiacy (Does no | Out of Network | INI/Δ | N/A |
| Emergency Deem Facility Convince | In-Network and | 19/7 | 11/7 |
| Emergency Room Facility Services | Out-of-Network | DED + Coins | DED + Coins |
| (per visit; copay waived if admitted) | | | |
| | d Out-of-Network | DED + Coins | DED + Coins |
| Independent Diagnostic Testing Facility/Provider's O | | | |
| | | DED + Coins | DED + Coins |
| X-Rays / Ultrasounds / Diagnostic Sel | | DED + Coins | DED + Coins |
| Advanced Imaging Services (AIS)(MRI, MRA, PET | | | DED + Coins |
| | Out-of-Network | N/A | N/A |
| Independent Clinical Lab | In-Network | DED + Coins | DED + Coins |
| | Out-of-Network | DED : GOINS | DED : OOMS |
| Provider Services at ER | In-Network and | DED + Coins | DED + Coins |
| | Out-of-Network | | |
| Provider Services at Hospital | | DED + Coins | DED + Coins |
| | | DED + Coins | DED + Coins |
| | Out-of-Network | | N/A |
| Ambulatory Surgical Center Facility (ASC) | | DED + Coins | DED + Coins |
| Provider Services at ASC | | DED + Coins | DED + Coins |
| | Out-of-Network | 1 | N/A |
| Inpatient Hospital Facility Services (per admission) | | DED + Coins | DED + Coins |
| | Out-of-Network | | N/A |
| Outpatient Hospital Facility Services(surgical)(per visit) | | DED + Coins | DED + Coins |
| | Out-of-Network | | N/A |
| Chiropractic Care (per visit) | | DED + Coins | DED + Coins |
| | Out-of-Network | | N/A |
| | | Integrated with Medical | Integrated with Medical |
| Out of Pocket Maximum (per p | | | Integrated with Medical |
| | entive Medications | | \$0 |
| Preferred Generic / Non I | | | \$10** / \$15** |
| Preferred Brand/Non-Preferred Brand/Specia | | | \$30**/\$55**/20%**/20%** |
| Mail-Order (Specialty/Se | | \$27**/\$42**/\$87**/\$162** | \$27**/\$42**/\$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/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 4000 | IND Platinum POS BC 5841 |
|---|---------------------------------------|-----------------------------|---------------------------|------------------------------|
| Medical Deductible (Per Person / Family Aggregate) In-Network | \$0 / \$0 | \$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 | 15% | 20% | 20% | 10% |
| Out-of-Network | 30% | 30% | 30% | 30% |
| Medical Out-of-Pocket Maximum In-Network | \$1,000 / \$2,000 | \$2,000 / \$4,000 | \$4,000 / \$8,000 | \$2,500 / \$5,000 |
| (Per Person / Family Aggregate) 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 | DED + Coins |
| Medical Pharmacy (Does not include immunizations | | 20% Coinsurance | 20% Coinsurance | DED + Coins |
| Out of Network | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Emergency Room Facility Services In-Network and | 15% Coinsurance | \$75 Copay | \$150 Copay | INN DED + Coins ¹ |
| (per visit; copay waived if admitted) Out-of-Network | | т о образ | ф тоо обрау | INTO DED - COMO |
| Urgent Care Centers In-Network and Out-of-Network | 15% Coinsurance | \$50 Copay | \$60 Copay | \$50 Copay |
| Independent Diagnostic Testing Facility/Provider's Office | | | | |
| Allergy Testing | 15% Coinsurance | \$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 | DED + Coins |
| Provider Services at ER In-Network and | 15% Coinsurance | \$0 | \$0 | INN DED + Coins ¹ |
| Out-of-Network | | · | · | |
| Provider Services at Hospital Inpatient | 15% Coinsurance | \$0 | \$0 | DED + Coins |
| 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 | DED + Coins |
| Inpatient Hospital Facility Services (per admission) In-Network | | \$350 per day (\$1,050 Max) | \$250 Copay | DED + Coins |
| Out-of-Network | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Outpatient Hospital Facility Services(surgical)(per visit) In-Network | 15% Coinsurance | \$300 Copay | \$250 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 | DED + Coins |
| Prescription Drugs* Deductible (per person / family aggregate) | \$0 | Integrated with Medical | | \$0 |
| Out of Pocket Maximum (per person / family aggregate) | | 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 / 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 |
| 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 1INN – In-Network Deductible + Coinsurance Applies

| Cost Sharing | | IND Gold POS BC 5651 | IND Essential Plus Gold POS | IND Gold POS |
|--|-------------------------------|-----------------------------|------------------------------|-----------------------------|
| Cost Sharing | | <u></u> | <u>64</u> | <u>5500</u> |
| Medical Deductible (Per Person / Family Aggregate) | In-Network | \$0 / \$0 | \$1,600 / \$3,200 | \$2,000 / \$4,000 |
| , 33 3 , | Out-of-Network | | \$3,200 / \$6,400 | \$4,000 / \$8,000 |
| Coinsurance (Amount member pays) | In-Network | | 10% | 20% |
| | Out-of-Network | 30% | 30% | 30% |
| Medical Out-of-Pocket Maximum | | \$3,000 / \$6,000 | \$3,500 / \$7,000 | \$5,500 / \$11,000 |
| (Per Person / Family Aggregate) | | \$6,000 / \$12,000 | \$6,000 / \$12,000 | \$8,000 / \$16,000 |
| Physician Office Services | Primary Care Office | \$25 Copay | \$25 Copay | \$20 Copay |
| | Specialist | \$60 Copay | \$40 Copay | \$35 Copay |
| | Allergy Injections | 20% Coinsurance*** | DED + Coins | 20% Coinsurance |
| Medical Pharmacy (Doe | s not include immunizations) | 20% Coinsurance*** | DED + Coins | 20% Coinsurance |
| • , | Out of Network | DED + Coins | DED + Coins | DED + Coins |
| Emergency Room Facility Services | In-Network and | \$350 Copay | INN DED + Coins ¹ | |
| (per visit; copay waived if admitted) | Out-of-Network | \$350 Copay | INN DED + Coins | \$200 Copay |
| | and Out-of-Network | \$65 Copay | \$30 Copay | \$75 Copay |
| Independent Diagnostic Testing Facility/Provider | | | | |
| | Allergy Testing | \$10 Copay | DED + Coins | \$0 |
| X-Rays / Ultrasounds / Diagnostic | | | DED + Coins | \$0 |
| Advanced Imaging Services (AIS)(MRI, MRA, P | ET, CT & Nuclear Medicine) | \$100 Copay | DED + Coins | \$100 Copay |
| | Out-of-Network | DED + Coins | DED + Coins | DED + Coins |
| Independent Clinical Lab | In-Network | | DED + Coins | \$0 |
| | Out-of-Network | DED + Coins | DED + Coins | DED + Coins |
| Provider Services at ER | In-Network and Out-of-Network | 90 | INN DED + Coins ¹ | \$0 |
| | Out of Hotwork | | | |
| Provider Services at Hospital | Inpatient | | DED + Coins | \$0 |
| | Outpatient | | DED + Coins | DED + Coins |
| | Out-of-Network | DED + Coins | DED + Coins | DED + Coins |
| Ambulatory Surgical Center Facility (ASC) | | \$400 Copay | DED + Coins | DED + Coins |
| Provider Services at ASC | In-Network | | DED + Coins | DED + Coins |
| | Out-of-Network | DED + Coins | DED + Coins | DED + Coins |
| Inpatient Hospital Facility Services (per admission) | | \$600 per day (\$1,800 Max) | DED + Coins | \$250 per day (\$1,250 Max) |
| | Out-of-Network | | DED + Coins | DED + Coins |
| Outpatient Hospital Facility Services(surgical)(per | | \$450 Copay | DED + Coins | DED + Coins |
| | Out-of-Network | | DED + Coins | DED + Coins |
| Chiropractic Care (per visit) | | \$60 Copay | \$25 Copay | \$35 Copay |
| Description Descript | Out-of-Network | | DED + Coins | DED + Coins |
| | r person / family aggregate) | | \$0 | Dtograted with Madical |
| Out of Pocket Maximum (pe | | | \$2,000 / \$4,000 | Integrated with Medical |
| | eventive Medications | | \$0 | \$0 |
| Preferred Generic / No | | | \$3 / \$10 | \$3 / \$10 |
| Preferred Brand/Non-Preferred Brand/Spec | | | \$30 / \$55 / 20% / 20% | \$30 / \$55 / 20% / 20% |
| Mail-Order (Specialty | | \$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/members/plansAndBenefits/2016-exchange-formulary.pdf
¹ INN – In-Network Deductible + Coinsurance Applies. ***Coinsurance value indicated applies.

| Cost Sharing | IND Essential Plus | IND Essential Plus Silver POS | IND Essential Plus Silver POS | IND Essential Plus Silver POS |
|---|------------------------------|-------------------------------|-------------------------------|-------------------------------|
| | Silver POS 54 | <u>54 – 73% CSR</u> | <u>54 – 87% CSR</u> | <u>54 – 94% CSR</u> |
| Medical Deductible (Per Person / Family Aggregate) In-Network | \$2,000 / \$4,000 | \$1,900 / \$3,800 | \$250 / \$500 | \$50 / \$100 |
| Out-of-Network | \$5,000 / \$10,000 | \$3,400 / \$6,800 | \$1,500 / \$3,000 | \$500 / \$1,000 |
| Coinsurance (Amount member pays) In-Network | 30% | 30% | 30% | 20% |
| Out-of-Network | | | | 50% |
| | \$4,300 / \$8,600 | \$3,900 / \$7,800 | \$1,100 / \$2,200 | \$500 / \$1,000 |
| (Per Person / Family Aggregate) Out-of-Network | \$8,000 / \$16,000 | | | \$2,500 / \$5,000 |
| Physician Office Services Primary Care Office | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | DED + Coins | | | DED + Coins |
| | DED + 20% Coins*** | DED + 20% Coins*** | DED + 20% Coins*** | DED + Coins |
| Medical Pharmacy (Does not include immunizations) | DED + 20% Coins*** | | | DED + Coins |
| Out of Network | | DED + Coins | DED + Coins | DED + Coins |
| Emergency Room Facility Services In-Network and | INN DED + Coins ¹ | INN DED + Coins ¹ | INN DED + Coins ¹ | INN DED + Coins ¹ |
| (per visit; copay waived if admitted) Out-of-Network | | | | |
| Urgent Care Centers In-Network and Out-of-Network | INN DED + Coins ¹ | 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 | DED + Coins |
| X-Rays / Ultrasounds / Diagnostic Services (other than AIS) | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine) | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Out-of-Network | | | | DED + Coins |
| Independent Clinical Lab In-Network | DED + Coins | | DED + Coins | DED + Coins |
| Out-of-Network | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Provider Services at ER In-Network and | INN DED + Coins ¹ | INN DED + Coins ¹ | INN DED + Coins ¹ | INN DED + Coins ¹ |
| Out-of-Network | | | | |
| | DED + Coins | | | DED + Coins |
| | DED + Coins | | | DED + Coins |
| Out-of-Network | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | DED + Coins | | | DED + Coins |
| | DED + Coins | | | DED + Coins |
| Out-of-Network | | DED + Coins | DED + Coins | DED + Coins |
| | DED + Coins | | | DED + Coins |
| Out-of-Network | | | | DED + Coins |
| | DED + Coins | | | DED + Coins |
| Out-of-Network | | | | DED + Coins |
| | 30% Coinsurance | 30% Coinsurance | | 20% Coinsurance |
| Out-of-Network | | | | DED + Coins |
| Prescription Drugs* Deductible (per person / family aggregate) | \$400 / \$800 | | | \$25 / \$50 |
| Out of Pocket Maximum (per person / family aggregate) | | | | \$250 / \$500 |
| Preventive Medications | | \$0 | \$0 | \$0 |
| Preferred Generic / Non Preferred Generic | | | | \$3** / \$10** |
| Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable | | | \$30**/\$55**/20%**/20%** | \$30**/\$55**/20%**/20%** |
| Mail-Order (Specialty/Self-Injectable not Available) | | | | \$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
¹ INN – In-Network Deductible + Coinsurance Applies. **Copay applies after deductible. ***Coinsurance value indicated applies.

Page 15 of 18 **INDIVIDUAL 2016 – POS PLANS**

| Cost Sharing | IND Silver POS BC 7741 | IND Silver POS BC 7741 73% CSR | IND Silver POS BC 7741 87% CSR | IND Silver POS BC 7741 94% CSR |
|---|---|-----------------------------------|-----------------------------------|-----------------------------------|
| Medical Deductible (Per Person / Family Aggregate) In | -Network \$5,200 / \$10,400 | \$4,300 / \$8,600 | \$0 / \$0 | \$0 / \$0 |
| | -Network \$7,000 / \$14,000 | \$6,000 / \$12,000 | \$4,000 / \$8,000 | \$2,000 / \$4,000 |
| Coinsurance (Amount member pays) | -Network 30% | 30% | 30% | 30% |
| | -Network 30% | 30% | 30% | 30% |
| | Network \$6,850 / \$13,700 | \$4,500 / \$9,000 | \$2,250 / \$4,500 | \$900 / \$1,800 |
| | -Network \$10,000 / \$20,000 | \$8,000 / \$16,000 | \$6,000 / \$12,000 | \$4,000 / \$8,000 |
| | re Office \$75 Copay (\$0 visits 1-2) | \$65 Copay (\$0 visits 1-2) | \$10 Copay (\$0 visits 1-2) | \$5 Copay (\$0 visits 1-2) |
| | Specialist \$100 Copay | \$85 Copay | \$25 Copay | \$10 Copay |
| | jections DED + 20% Coins*** | DED + 20% Coins*** | 20% Coinsurance*** | 20% Coinsurance*** |
| Medical Pharmacy (Does not include imm | nunizations) DED + 20% Coins*** | DED + 20% Coins*** | 20% Coinsurance*** | 20% Coinsurance*** |
| Out of | Network DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Emergency Room Facility Services In-Net | work and | \$600 Copay | \$600 Copay | \$100 Copay |
| (per visit; copay waived if admitted) Out-of | -Network | рооо Сорау | фооо Copay | \$100 Copay |
| Urgent Care Centers In-Network and Out-of | -Network \$160 Copay | \$100 Copay | \$35 Copay | \$25 Copay |
| ndependent Diagnostic Testing Facility/Provider's Office | | | | |
| | Testing \$10 Copay | \$10 Copay | \$10 Copay | \$10 Copay |
| X-Rays / Ultrasounds / Diagnostic Services (oth | | \$10 Copay | \$10 Copay | \$10 Copay |
| Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nucl | | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| | Network DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | -Network \$0 | \$0 | \$0 | \$0 |
| Out-of | -Network DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | | \$0 | \$0 | \$0 |
| Out-of | work and \$0 -Network | · · | l' | l' |
| r Tovider Services at Hospital | III patietit DED + Collis | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| 0 | utpatient DED + Coins | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| Out-of | -Network DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Ambulatory Surgical Center Facility (ASC) In- | Network DED + Coins | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| | Network DED + Coins | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| | -Network DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | Network DED + Coins | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| | -Network DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Outpatient Hospital Facility Services(surgical)(per visit) In | -Network DED + Coins | DED + Coins | 30% Coinsurance | 30% Coinsurance |
| | -Network DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | -Network \$100 Copay | \$85 Copay | \$25 Copay | \$10 Copay |
| Out-of | -Network DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | y aggregate) Integrated with Medical | Integrated with Medical | \$0 | \$0 |
| Out of Pocket Maximum (per person / family | | Integrated with Medical | Integrated with Medical | Integrated with Medical |
| Preventive Me | | \$0 | \$0 | \$0 |
| Preferred Generic / Non Preferred | | \$3 / \$10 | \$3 / \$10 | \$3 / \$10 |
| Preferred Brand/Non-Preferred Brand/Specialty/Self-I | | \$30**/\$55**/20%**/20%** | \$30 / \$55 / 20% / 20% | \$30 / \$55 / 20% / 20% |
| | not Available) \$6 / \$27 / \$87**/ \$162** | \$6 / \$27 / \$87**/ \$162** | \$6 / \$27 / \$87 / \$162 | \$6 / \$27 / \$87 / \$162 |
| | -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.

INDIVIDUAL 2016 – POS PLANS Page 16 of 18

| Cost Sharing | | IND Silver POS | IND Silver POS BC 0941 | IND Silver POS BC 0941 | IND Silver POS BC 0941 |
|--|---------------------------|------------------------------------|------------------------------------|-----------------------------|----------------------------|
| Cost Sharing | | BC 0941 | 73% CSR | 87% CSR | 94% CSR |
| Medical Deductible (Per Person / Family Aggregate) | In-Network | \$5,500 / \$11,000 | \$4,000 / \$8,000 | \$0 / \$0 | \$0 / \$0 |
| | | \$7,000 / \$14,000 | \$6,000 / \$12,000 | \$3,000 / \$6,000 | \$2,000 / \$4,000 |
| Coinsurance (Amount member pays) | In-Network | | 40% | 40% | 20% |
| | -of-Network | | 40% | 40% | 20% |
| Medical Out-of-Pocket Maximum | | \$6,850 / \$13,700 | \$5,200 / \$10,400 | \$2,000 / \$4,000 | \$1,000 / \$2,000 |
| | | \$10,000 / \$20,000 | \$8,000 / \$16,000 | \$6,000 / \$12,000 | \$4,000 / \$8,000 |
| | | \$125 Copay | \$85 Copay | \$10 Copay (\$0 Visits 1-3) | \$5 Copay (\$0 Visits 1-3) |
| Timary | | \$180 Copay | \$150 Copay | \$25 Copay | \$10 Copay |
| Alleray | / Injections | DED + 20% Coins*** | DED + 20% Coins*** | 20% Coinsurance*** | 20% Coinsurance |
| Medical Pharmacy (Does not include | immunizations) | DED + 20% Coins*** | DED + 20% Coins*** | 20% Coinsurance*** | 20% Coinsurance |
| Out | of Network | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Emergency Room Facility Services In-N | letwork and | INN DED + \$400 Copay ¹ | | | |
| (per visit; copay waived if admitted) Out | -of-Network | INN DED + \$400 Copay ¹ | INN DED + \$400 Copay ¹ | \$200 Copay | \$50 Copay |
| | | INN DED + \$100 Copay ¹ | INN DED + \$100 Copay ¹ | \$30 Copay | \$10 Copay |
| Independent Diagnostic Testing Facility/Provider's Offic | е | | | | |
| Alle | rgy Testing | \$10 Copay | \$10 Copay | \$10 Copay | \$10 Copay |
| X-Rays / Ultrasounds / Diagnostic Services | (other than AIS) | \$50 Copay | \$50 Copay | \$25 Copay | \$25 Copay |
| Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & N | luclear Medicine) | \$400 Copay | \$400 Copay | \$125 Copay | \$50 Copay |
| Out- | of-Network | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Independent Clinical Lab | In-Network | \$0 | \$0 | \$0 | \$0 |
| | | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Provider Services at ER In-N | letwork and | \$0 | \$0 | \$0 | \$0 |
| Out | letwork and of-Network | Ф О | | | |
| Provider Services at Hospital | IIIPalieIII | ΨΟ | \$0 | \$0 | \$0 |
| | Outpatient | | \$0 | \$0 | \$0 |
| Out | -of-Network | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Ambulatory Surgical Center Facility (ASC) | In-Network | DED + \$350 Copay | DED + \$350 Copay | \$200 Copay | \$100 Copay |
| Provider Services at ASC | In-Network | | \$0 | \$0 | \$0 |
| | -of-Network | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Inpatient Hospital Facility Services (per admission) | | DED + \$600 Copay | DED + \$600 Copay | \$400 Copay | \$300 Copay |
| | | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| | | DED + \$500 Copay | DED + \$500 Copay | \$300 Copay | \$200 Copay |
| | | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Chiropractic Care (per visit) | | \$180 Copay | \$150 Copay | \$25 Copay | \$10 Copay |
| | | DED + Coins | DED + Coins | DED + Coins | DED + Coins |
| Prescription Drugs* Deductible (per person / f | amily aggregate) | \$3,000 / \$3,000 | \$3,000 / \$3,000 | Integrated with Medical | Integrated with Medical |
| Out of Pocket Maximum (per person / fa | | | Integrated with Medical | Integrated with Medical | Integrated with Medical |
| | Medications | | \$0 | \$0 | \$0 |
| Preferred Generic / Non Preferr | | | \$3 / \$10 | \$3 / \$10 | \$3 / \$10 |
| Preferred Brand/Non-Preferred Brand/Specialty/Se | | | \$30**/\$55**/20%**/20%** | \$30 / \$55 / 20% / 20% | \$30 / \$55 / 20% / 20% |
| Mail-Order (Specialty/Self-Injecta | | | \$6 / \$27 / \$87**/ \$162** | \$6 / \$27 / \$87 / \$162 | \$6 / \$27 / \$87 / \$162 |
| Out | | 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. 1 INN – In-Network Deductible + Copay Applies.

| INDIVIDUAL 2016 - POS PLANS | IND Bronze Essential | IND Bronze POS | IND Catastrophic |
|---|-------------------------------|-------------------------------|----------------------------|
| Cost Sharing | Plus POS 42 | BC 3841 | Essential Plus POS 37 |
| Medical Deductible (Per Person / Family Aggregate) In-Network | \$4,500 / \$9,000 | \$6,700 / \$13,400 | \$6,850 / \$13,700 |
| | \$10,000 / \$20,000 | \$8,000 / \$16,000 | \$13,500 / \$27,000 |
| | | | |
| Coinsurance (Amount member pays) In-Network | | 50% | NA |
| Out-of-Network | | 50% | N/A |
| | \$6,800 / \$13,600 | \$6,850 / \$13,700 | \$6,850 / \$13,700 |
| | \$20,000 / \$40,000 | \$10,000 / \$20,000 | \$13,500 / \$27,000 |
| | | \$50 Copay (\$0 visits 1-3) | DED (\$0 Copay visits 1-3) |
| | DED + Coins | \$85 Copay 20% Coinsurance | DED DED |
| | DED + 20% Coins*** | | |
| Medical Pharmacy (Does not include immunizations) | DED + 20% Coins*** | 20% Coinsurance | DED |
| Out of Network | | DED + Coins | DED |
| Emergency Room Facility Services In-Network and | | INN DED + Coins ¹ | INN DED ² |
| (per visit; copay waived if admitted) Out-of-Network | | 440-0 | |
| Urgent Care Centers In-Network and Out-of-Network | INN DED + Coins ¹ | \$125 Copay | INN DED ² |
| Independent Diagnostic Testing Facility/Provider's Office | | | |
| Allergy Testing | | \$10 Copay | DED |
| X-Rays / Ultrasounds / Diagnostic Services (other than AIS) | | DED + Coins | DED |
| Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine | | DED + Coins | DED |
| Out-of-Network | | DED + Coins | DED |
| · · | DED + Coins | DED + Coins | DED |
| Out-of-Network | | DED + Coins | DED |
| Provider Services at ER In-Network and | IININI DED ± COINS | INN DED ² | INN DED ² |
| Out-of-Network | | | |
| | DED + Coins | DED | DED |
| | DED + Coins | DED + Coins | DED |
| Out-of-Network | DED + Coins | DED + Coins | DED |
| 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 | | DED + Coins | DED |
| | DED + Coins | DED + \$150 Copay | DED |
| Out-of-Network | | DED + Coins | DED |
| Outpatient Hospital Facility Services(surgical)(per visit) In-Network | DED + Coins | DED + Coins | DED |
| Out-of-Network | | DED + Coins | DED |
| | 55% Coinsurance | \$85 Copay | DED |
| Out-of-Network | | DED + Coins | DED |
| 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 | DED / DED |
| Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable | | \$30**/\$55**/20%**/20%** | DED / DED / DED / DED |
| Mail-Order (Specialty/Self-Injectable not Available) | \$6**/\$27**/ \$87**/ \$162** | \$6 / \$27 / \$87**/ \$162** | 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. *Coinsurance value indicated applies. 1 INN – In-Network Deductible + Coinsurance Applies. 2 INN – In-Network Deductible Applies

| 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 | |