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			
Metal	**Plan Name**	**In-Network CYD / Coins / OOP**	**In-Network PCP / Spec**
Platinum	IND Essential Plus Platinum HMO 65	$0 / 85% / $1,500 (Med) & $1,500 (Drug)	$20 / $35
Platinum	IND Platinum HMO BC 1941	$0 / 80% / $2,000	$10 / $20
Platinum	IND Platinum HMO 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

Florida Health Care Plans

An Independent Licensee of the Blue Cross and Blue Shield Association

INDIVIDUAL 2016 — HMO Plans

Cost Sharing		IND Essential Plus Platinum HMO 65	IND Platinum HMO BC 1941	IND Platinum HMO 4000
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$0 / $0	$0 / $0
	Out-of-Network	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	15%	20%	20%
	Out-of-Network	N/A	N/A	N/A
Medical Out-of-Pocket Maximum	In-Network	$1,500 / $3,000	$2,000 / $4,000	$4,000 / $8,000
(Per Person / Family Aggregate)	Out-of-Network	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$20 Copay	$10 Copay	$20 Copay
	Specialist	$35 Copay	$20 Copay	$40 Copay
	Allergy Injections	15% Coinsurance	20% Coinsurance	20% Coinsurance
	Medical Pharmacy (Does not include immunizations)	15% Coinsurance	20% Coinsurance	20% Coinsurance
	Out of Network	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$75 Copay	$75 Copay	$150 Copay
Urgent Care Centers	In-Network and Out-of-Network	$60 Copay	$50 Copay	$60 Copay
Independent Diagnostic Testing Facility/Provider's Office				
	Allergy Testing	$0	$10 Copay	$0
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$0	$75 Copay	$0
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$0	$150 Copay	$100 Copay
	Out-of-Network	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	$0	$0	$0
Provider Services at Hospital	Inpatient	$0	$0	$0
	Outpatient	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	15% Coinsurance	$200 Copay	$250 Copay
Provider Services at ASC	In-Network	$0	$0	$0
	Out-of-Network	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 Copay
	Out-of-Network	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	15% Coinsurance	$300 Copay	$250 Copay
	Out-of-Network	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$15 Copay	$20 Copay	$40 Copay
	Out-of-Network	N/A	N/A	N/A
Prescription Drugs*	Deductible (per person / family aggregate)	$0	Integrated with Medical	Integrated with Medical
	Out of Pocket Maximum (per person / family aggregate)	$1,500 / $3,000	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
	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

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	N/A
Coinsurance (Amount member pays)	In-Network	10%	10%	10%
	Out-of-Network	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$3,000 / $6,000	$3,000 / $6,000	$2,500 / $5,000
	Out-of-Network	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$20 Copay	$20 Copay	$15 Copay ($0 visits 1-3)
	Specialist	$35 Copay	$35 Copay	$20 Copay
	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	$150 Copay	$100 Copay	DED + Coins
Urgent Care Centers	In-Network and Out-of-Network	$50 Copay	$50 Copay	$50 Copay
Independent Diagnostic Testing Facility/Provider's Office				
	Allergy Testing	$35 Copay	$35 Copay	DED + Coins
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$35 Copay	$35 Copay	DED + Coins
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$150 Copay	$150 Copay	DED + Coins
	Out-of-Network	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	$0	$0	DED + Coins
Provider Services at Hospital	Inpatient	$0	DED + Coins	DED + Coins
	Outpatient	DED + Coins	$0	DED + Coins
	Out-of-Network	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	DED + Coins	$250 Copay	DED + Coins
Provider Services at ASC	In-Network	DED + Coins	$0	DED + Coins
	Out-of-Network	N/A	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	N/A
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	$400 Copay	DED + Coins
	Out-of-Network	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$20 Copay	DED + Coins	$20 Copay
	Out-of-Network	N/A	N/A	N/A
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 / 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
	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

Cost Sharing		IND Gold HMO BC 5651	IND Essential Plus Gold HMO 63	IND Gold HMO 5500
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$1,000 / $2,000	$2,000 / $4,000
	Out-of-Network	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	40%	20%	20%
	Out-of-Network	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$3,000 / $6,000	$2,500 / $5,000	$5,500 / $11,000
	Out-of-Network	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$25 Copay	DED + Coins	$20 Copay
	Specialist	$60 Copay	DED + Coins	$35 Copay
	Allergy Injections	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 (per visit; copay waived if admitted)	In-Network and Out-of-Network	$350 Copay	DED + Coins	$200 Copay
Urgent Care Centers	In-Network and Out-of-Network	$65 Copay	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)	$100 Copay	DED + Coins	$0
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$100 Copay	DED + Coins	$100 Copay
	Out-of-Network	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$0	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	$0	DED + Coins	$0
	Outpatient	$0	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A
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	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	$600 per day ($1,800 Max)	DED + Coins	$250 per day ($1,250 Max)
	Out-of-Network	N/A	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
Chiropractic Care (per visit)	In-Network	$60 Copay	20% Coinsurance	$35 Copay
	Out-of-Network	N/A	N/A	N/A
Prescription Drugs*	Deductible (per person / family aggregate)	$0	$0	$0
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	$2,000 / $4,000	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
	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

Cost Sharing		IND Essential Plus Silver HMO 53	IND Essential Plus Silver HMO 53 – 73% CSR	IND Essential Plus Silver HMO 53 – 87% CSR	IND Essential Plus Silver 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	N/A
Coinsurance (Amount member pays)	In-Network	40%	40%	40%	25%
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$4,300 / $8,600	$3,700 / $7,400	$1,000/ $2,000	$500 / $1,000
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Specialist	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Allergy Injections	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***	DED + 20% Coins***
	Out of Network	N/A	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Urgent Care Centers	In-Network and Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
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	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	DED + Coins	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
Inpatient 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
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	40% Coinsurance	40% Coinsurance	40% Coinsurance	25% Coinsurance
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs*	Deductible (per person / family aggregate)	$400 / $800	$250 / $500	$150 / $300	$25 / $50
	Out of Pocket Maximum (per person / family aggregate)	$1,500 / $3,000	$1,400 / $2,800	$750 / $1,500	$250 / $500
	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**/20%**/20%**	$30** / $55** / 20%** / 20%**	$30**/$55**/20%**/20%**	$30**/$55**/20%**/20%**
	Mail-Order (Specialty/Self-Injectable not Available)	$6**/$27**/ $87**/ $162**	$6** / $27** / $87** / $162**	$6 / $27 / $87**/ $162**	$6**/$27**/ $87**/ $162**
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

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

***Coinsurance value indicated applies.

Cost Sharing		IND Silver HMO 6400	IND Silver HMO 6400 – 73% CSR	IND Silver HMO 6400 – 87% CSR	IND Silver HMO 6400 – 94% CSR
Medical Deductible (Per Person / Family Aggregate)	In-Network	$5,000 / $10,000	$4,200 / $8,400	$750 / $1,500	$150 / $300
	Out-of-Network	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	20%	20%	20%	20%
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$6,400 / $12,800	$5,200 / $10,400	$1,500/ $3,000	$500 / $1,000
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$30 Copay	$30 Copay	$20 Copay	$20 Copay
	Specialist	$75 Copay	$75 Copay	$40 Copay	$40 Copay
	Allergy Injections	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance
	Medical Pharmacy (Does not include immunizations)	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance
	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	$500 Copay	$500 Copay	$250 Copay	$250 Copay
Urgent Care Centers	In-Network and Out-of-Network	$100 Copay	$100 Copay	$100 Copay	$100 Copay
Independent Diagnostic Testing Facility/Provider's Office					
	Allergy Testing	$0	$0	$0	$0
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$50 Copay	$50 Copay	$40 Copay	$40 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$250 Copay	$250 Copay	$150 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	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
Inpatient Hospital Facility Services (per admission)	In-Network	$500 Copay	$500 Copay	$500 Copay	$500 Copay
	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 + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$40 Copay	$40 Copay	$40 Copay	$40 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)	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0	$0
	Preferred Generic / Non Preferred Generic	$10 / $15	$10 / $15	$10 / $15	$10 / $15
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	$30 / $55 / 20% / 20%	$30 / $55 / 20% / 20%	$30 / $55 / 20% / 20%	$30 / $55 / 20% / 20%
	Mail-Order (Specialty/Self-Injectable not Available)	$27 / $42 / $87 / $162	$27 / $42 / $87 / $162	$27 / $42 / $87 / $162	$27 / $42 / $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

Cost Sharing		IND Silver HMO BC 7741	IND Silver HMO BC 7741 73% CSR	IND Silver HMO BC 7741 87% CSR	IND Silver HMO BC 7741 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	N/A
Coinsurance (Amount member pays)	In-Network	30%	30%	30%	30%
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$6,850 / $13,700	$4,500 / $9,000	$2,250 / $4,500	$900 / $1,800
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary 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)
	Specialist	$100 Copay	$85 Copay	$25 Copay	$10 Copay
	Allergy 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	N/A	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$600 Copay	$600 Copay	$600 Copay	$100 Copay
Urgent Care Centers	In-Network and Out-of-Network	$160 Copay	$100 Copay	$35 Copay	$25 Copay
Independent Diagnostic Testing Facility/Provider's Office					
	Allergy Testing	$10 Copay	$10 Copay	$10 Copay	$10 Copay
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$10 Copay	$10 Copay	$10 Copay	$10 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	DED + Coins	DED + Coins	30% Coinsurance	30% Coinsurance
	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	DED + Coins	DED + Coins	30% Coinsurance	30% Coinsurance
	Outpatient	DED + Coins	DED + Coins	30% Coinsurance	30% Coinsurance
	Out-of-Network	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	DED + Coins	DED + Coins	30% Coinsurance	30% Coinsurance
Provider Services at ASC	In-Network	DED + Coins	DED + Coins	30% Coinsurance	30% Coinsurance
	Out-of-Network	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	DED + Coins	DED + Coins	30% Coinsurance	30% Coinsurance
	Out-of-Network	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED + Coins	30% Coinsurance	30% Coinsurance
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$100 Copay	$85 Copay	$25 Copay	$10 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs*	Deductible (per person / family aggregate)	Integrated with Medical	Integrated with Medical	$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**/20%**/20%**	$30** / $55** / 20%** / 20%**	$30 / $55 / 20% / 20%	$30 / $55 / 20% / 20%
	Mail-Order (Specialty/Self-Injectable not Available)	$6 / $27 / $87**/ $162**	$6** / $27** / $87** / $162**	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

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

INDIVIDUAL 2016 — HMO Plans

Cost Sharing		IND Silver HMO 6600	IND Silver HMO 6600 73% CSR	IND Silver HMO 6600 87% CSR	IND Silver HMO 6600 94% CSR
Medical Deductible (Per Person / Family Aggregate)	In-Network	$5,500 / $11,000	$4,500 / $9,000	$650 / $1,300	$150 / $300
	Out-of-Network	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	20%	20%	20%	20%
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$6,600 / $13,200	$5,200 / $10,400	$1,450/ $2,900	$500 / $1,000
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$20 Copay	$20 Copay	$20 Copay	$20 Copay
	Specialist	$40 Copay	$40 Copay	$40 Copay	$40 Copay
	Allergy Injections	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Medical Pharmacy (Does not include immunizations)	DED + Coins	DED + Coins	DED + Coins	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	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Urgent Care Centers	In-Network and Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Independent Diagnostic Testing Facility/Provider's Office					
	Allergy Testing	$0	$0	$0	$0
	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	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	DED + Coins	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
Inpatient 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
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs*	Deductible (per person / family aggregate)	$1,000 / $2,000	$500 / $1,000	$200 / $400	$50 / $100
	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	$10 / $15	$10 / $15	$10 / $15	$10 / $15
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	$30** / $55** / 20%** / 20%**	$30** / $55** / 20%** / 20%**	$30** / $55** / 20%** / 20%**	$30** / $55** / 20%** / 20%**
	Mail-Order (Specialty/Self-Injectable not Available)	$27 / $42 / $87** / $162**	$27 / $42 / $87** / $162**	$27 / $42 / $87** / $162**	$27 / $42 / $87** / $162**
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

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

INDIVIDUAL 2016 — HMO Plans

Cost Sharing		IND Silver HMO BC 0941	IND Silver HMO BC 0941 73% CSR	IND Silver HMO BC 0941 87% CSR	IND Silver HMO BC 0941 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	N/A
Coinsurance (Amount member pays)	In-Network	40%	40%	40%	20%
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$6,850 / $13,700	$5,200 / $10,400	$2,000 / $4,000	$1,000 / $2,000
	Out-of-Network	N/A	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)
	Specialist	$180 Copay	$150 Copay	$25 Copay	$10 Copay
	Allergy 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	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 + $400 Copay	DED + $400 Copay	$200 Copay	$50 Copay
Urgent Care Centers	In-Network and Out-of-Network	DED + $100 Copay	DED + $100 Copay	$30 Copay	$10 Copay
Independent 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	$50 Copay	$25 Copay	$25 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$400 Copay	$400 Copay	$125 Copay	$50 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	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	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	DED + $600 Copay	DED + $600 Copay	$400 Copay	$300 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + $500 Copay	DED + $500 Copay	$300 Copay	$200 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$180 Copay	$150 Copay	$25 Copay	$10 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs*	Deductible (per person / family aggregate)	$3,000 / $3,000	$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	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**/20%**/20%**	$30**/$55**/20%**/20%**	$30 / $55 / 20% / 20%	$30 / $55 / 20% / 20%
	Mail-Order (Specialty/Self-Injectable not Available	$6 / $27 / $87**/ $162**	$6 / $27 / $87**/ $162**	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

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

INDIVIDUAL 2016 — HMO Plans

Cost Sharing		IND Essential Plus Bronze HMO 41	IND Bronze HMO BC 3841	IND Bronze HMO 6850	IND Catastrophic Essential Plus HMO 36
Medical Deductible (Per Person / Family Aggregate)	In-Network	$4,500 / $9,000	$6,700 / $13,400	$6,850 / $13,700	$6,850 / $13,700
	Out-of-Network	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	60%	50%	N/A	N/A
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$6,800 / $13,600	$6,850 / $13,700	$6,850 / $13,700	$6,850 / $13,700
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	DED + Coins	$50 Copay ($0 visits 1-3)	DED ($40 Copay visits 1-3)	DED ($0 Copay visits 1-3)
	Specialist	DED + Coins	$85 Copay	DED	DED
	Allergy Injections	DED + 20% Coins***	20% Coinsurance	DED	DED
	Medical Pharmacy (Does not include immunizations)	DED + 20% Coins***	20% Coinsurance	DED	DED
	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 + Coins	DED + Coins	DED	DED
Urgent Care Centers	In-Network and Out-of-Network	DED + Coins	$125 Copay	DED	DED
Independent Diagnostic Testing Facility/Provider's Office					
	Allergy Testing	DED + Coins	$10 Copay	DED	DED
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	DED + Coins	DED + Coins	DED	DED
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	DED + Coins	DED + Coins	DED	DED
	Out-of-Network	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	DED + Coins	DED + Coins	DED	DED
	Out-of-Network	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	DED + Coins	DED + Coins	DED	DED
Provider Services at Hospital	Inpatient	DED + Coins	DED	DED	DED
	Outpatient	DED + Coins	DED + Coins	DED	DED
	Out-of-Network	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	DED + Coins	DED + Coins	DED	DED
Provider Services at ASC	In-Network	DED + Coins	DED + Coins	DED	DED
	Out-of-Network	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	DED + Coins	DED + $150 Copay	DED	DED
	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	DED
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	60% Coinsurance	$85 Copay	DED	DED
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs*	Deductible (per person / family aggregate)	Integrated with Medical	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
	Preventive Medications	$0	$0	$0	$0
	Preferred Generic / Non Preferred Generic	$3** / $10**	$3 / $10	$15 / $20	DED / DED
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	$30**/$55**/20%**/20%**	$30**/$55**/20%**/20%**	DED / DED / DED / DED	DED / DED / DED / DED
	Mail-Order (Specialty/Self-Injectable not Available	$6**/$27**/ $87**/ $162**	$6 / $27 / $87**/ $162**	$42 / $57 / DED / DED	DED / DED / DED / DED
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

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

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

Cost Sharing		IND Bronze HMO H.S.A 4700/6450	IND Bronze HMO H.S.A 6000/6450
Medical Deductible (Per Person / Family Aggregate)	In-Network	$4,700 / $9,400	$6,000 / $12,000
	Out-of-Network	N/A	N/A
Coinsurance (Amount member pays)	In-Network	30%	10%
	Out-of-Network	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$6,450 / $12,900	$6,450 / $12,900
	Out-of-Network	N/A	N/A
Physician Office Services	Primary Care Office	DED + Coins	DED + Coins
	Specialist	DED + Coins	DED + Coins
	Allergy Injections	DED + 20% Coins***	DED + Coins
	Medical Pharmacy (Does not include immunizations)	DED + 20% Coins***	DED + Coins
	Out of Network	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	DED + Coins	DED + Coins
Urgent Care Centers	In-Network and Out-of-Network	DED + Coins	DED + Coins
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	N/A	N/A
Independent Clinical Lab	In-Network	DED + Coins	DED + Coins
	Out-of-Network		
Provider Services at ER	In-Network and Out-of-Network	DED + Coins	DED + Coins
Provider Services at Hospital	Inpatient	DED + Coins	DED + Coins
	Outpatient	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	DED + Coins	DED + Coins
Provider Services at ASC	In-Network	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A
Chiropractic Care (per visit)	In-Network	DED + Coins	DED + Coins
	Out-of-Network	N/A	N/A
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	$10** / $15**	$10** / $15**
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	$30**/$55**/20%**/20%**	$30**/$55**/20%**/20%**
	Mail-Order (Specialty/Self-Injectable not Available)	$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.

INDIVIDUAL 2016 – POS PLANS

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	$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	$2,000 / $4,000	$4,000 / $8,000	$8,000 / $16,000	$5,000 / $10,000
Physician Office Services	Primary Care Office	$20 Copay	$10 Copay	$20 Copay	$15 Copay ($0 visits 1-3)
	Specialist	$35 Copay	$20 Copay	$40 Copay	$20 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	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	15% Coinsurance	$75 Copay	$150 Copay	INN DED + Coins[1]
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)	15% Coinsurance	$75 Copay	$0	DED + Coins
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	15% Coinsurance	$150 Copay	$100 Copay	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Independent Clinical Lab	In-Network	15% Coinsurance	$0	$0	$0
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Provider Services at ER	In-Network and Out-of-Network	15% Coinsurance	$0	$0	INN DED + Coins[1]
Provider Services at Hospital	Inpatient	15% Coinsurance	$0	$0	DED + Coins
	Outpatient	15% Coinsurance	$0	$0	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Ambulatory Surgical Center Facility (ASC)	In-Network	15% Coinsurance	$200 Copay	$250 Copay	DED + Coins
Provider Services at ASC	In-Network	15% Coinsurance	$0	$0	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Inpatient Hospital Facility Services (per admission)	In-Network	15% Coinsurance	$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	DED + Coins
Chiropractic Care (per visit)	In-Network	15% Coinsurance	$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	Integrated with Medical	$0
	Out of Pocket Maximum (per person / family aggregate)	$500 / $1,000	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 / 20% / 20%	$30 / $55 / 20% / 20%	$30 / $55 / 20% / 20%	$30 / $55 / 20% / 20%
	Mail-Order (Specialty/Self-Injectable not Available)	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
	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

INDIVIDUAL 2016 – POS PLANS

Cost Sharing		IND Gold POS BC 5651	IND Essential Plus Gold POS 64	IND Gold POS 5500
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$1,600 / $3,200	$2,000 / $4,000
	Out-of-Network	$500 / $1,000	$3,200 / $6,400	$4,000 / $8,000
Coinsurance (Amount member pays)	In-Network	40%	10%	20%
	Out-of-Network	30%	30%	30%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$3,000 / $6,000	$3,500 / $7,000	$5,500 / $11,000
	Out-of-Network	$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 (Does not include immunizations)	20% Coinsurance***	DED + Coins	20% 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	$350 Copay	INN DED + Coins[1]	$200 Copay
Urgent Care Centers	In-Network and Out-of-Network	$65 Copay	$30 Copay	$75 Copay
Independent Diagnostic Testing Facility/Provider's Office				
	Allergy Testing	$10 Copay	DED + Coins	$0
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$100 Copay	DED + Coins	$0
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$100 Copay	DED + Coins	$100 Copay
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Independent Clinical Lab	In-Network	$0	DED + Coins	$0
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins
Provider Services at ER	In-Network and Out-of-Network	$0	INN DED + Coins[1]	$0
Provider Services at Hospital	Inpatient	$0	DED + Coins	$0
	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)	DED + Coins	$250 per day ($1,250 Max)
	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	$25 Copay	$35 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	$2,000 / $4,000	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
	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.

INDIVIDUAL 2016 – POS PLANS

Cost Sharing		IND Essential Plus Silver POS 54	IND Essential Plus Silver POS 54 – 73% CSR	IND Essential Plus Silver POS 54 – 87% CSR	IND Essential Plus Silver POS 54 – 94% CSR
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%	50%	50%	50%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$4,300 / $8,600	$3,900 / $7,800	$1,100 / $2,200	$500 / $1,000
	Out-of-Network	$8,000 / $16,000	$6,800 / $13,600	$2,500 / $5,000	$2,500 / $5,000
Physician Office Services	Primary Care Office	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Specialist	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Allergy Injections	DED + 20% Coins***	DED + 20% Coins***	DED + 20% Coins***	DED + Coins
	Medical Pharmacy (Does not include immunizations)	DED + 20% Coins***	DED + 20% Coins***	DED + 20% Coins***	DED + Coins
	Out of Network	DED + Coins	DED + Coins	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]	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]	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	DED + Coins	DED + Coins	DED + Coins
Independent Clinical Lab	In-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Provider Services at ER	In-Network and Out-of-Network	INN DED + Coins[1]	INN DED + Coins[1]	INN DED + Coins[1]	INN DED + Coins[1]
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	DED + Coins	DED + Coins	DED + Coins	DED + Coins
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	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Inpatient Hospital Facility Services (per admission)	In-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Chiropractic Care (per visit)	In-Network	30% Coinsurance	30% Coinsurance	30% Coinsurance	20% Coinsurance
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Prescription Drugs*	Deductible (per person / family aggregate)	$400 / $800	$250 / $500	$150 / $300	$25 / $50
	Out of Pocket Maximum (per person / family aggregate)	$2,350 / $4,700	$1,300 / $2,600	$750 / $1,500	$250 / $500
	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**/20%**/20%**	$30**/$55**/20%**/20%**	$30**/$55**/20%**/20%**	$30**/$55**/20%**/20%**
	Mail-Order (Specialty/Self-Injectable not Available)	$6**/$27**/ $87**/ $162**	$6**/$27**/ $87**/ $162**	$6**/$27**/ $87**/ $162**	$6**/$27**/ $87**/ $162**
	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.

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
	Out-of-Network	$7,000 / $14,000	$6,000 / $12,000	$4,000 / $8,000	$2,000 / $4,000
Coinsurance (Amount member pays)	In-Network	30%	30%	30%	30%
	Out-of-Network	30%	30%	30%	30%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$6,850 / $13,700	$4,500 / $9,000	$2,250 / $4,500	$900 / $1,800
	Out-of-Network	$10,000 / $20,000	$8,000 / $16,000	$6,000 / $12,000	$4,000 / $8,000
Physician Office Services	Primary 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)
	Specialist	$100 Copay	$85 Copay	$25 Copay	$10 Copay
	Allergy 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 (per visit; copay waived if admitted)	In-Network and Out-of-Network	$600 Copay	$600 Copay	$600 Copay	$100 Copay
Urgent Care Centers	In-Network and Out-of-Network	$160 Copay	$100 Copay	$35 Copay	$25 Copay
Independent Diagnostic Testing Facility/Provider's Office					
	Allergy Testing	$10 Copay	$10 Copay	$10 Copay	$10 Copay
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$10 Copay	$10 Copay	$10 Copay	$10 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	DED + Coins	DED + Coins	30% Coinsurance	30% Coinsurance
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Independent Clinical Lab	In-Network	$0	$0	$0	$0
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Provider Services at ER	In-Network and Out-of-Network	$0	$0	$0	$0
Provider Services at Hospital	Inpatient	DED + Coins	DED + Coins	30% Coinsurance	30% Coinsurance
	Outpatient	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
Provider Services at ASC	In-Network	DED + Coins	DED + Coins	30% Coinsurance	30% Coinsurance
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Inpatient Hospital Facility Services (per admission)	In-Network	DED + Coins	DED + Coins	30% Coinsurance	30% Coinsurance
	Out-of-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
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Chiropractic Care (per visit)	In-Network	$100 Copay	$85 Copay	$25 Copay	$10 Copay
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Prescription Drugs*	Deductible (per person / family aggregate)	Integrated with Medical	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
	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**/20%**/20%**	$30**/$55**/20%**/20%**	$30 / $55 / 20% / 20%	$30 / $55 / 20% / 20%
	Mail-Order (Specialty/Self-Injectable not Available)	$6 / $27 / $87**/ $162**	$6 / $27 / $87**/ $162**	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

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

INDIVIDUAL 2016 – POS PLANS

Cost Sharing		IND Silver POS BC 0941	IND Silver POS BC 0941 73% CSR	IND Silver POS BC 0941 87% CSR	IND Silver POS BC 0941 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	$7,000 / $14,000	$6,000 / $12,000	$3,000 / $6,000	$2,000 / $4,000
Coinsurance (Amount member pays)	In-Network	40%	40%	40%	20%
	Out-of-Network	40%	40%	40%	20%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$6,850 / $13,700	$5,200 / $10,400	$2,000 / $4,000	$1,000 / $2,000
	Out-of-Network	$10,000 / $20,000	$8,000 / $16,000	$6,000 / $12,000	$4,000 / $8,000
Physician Office Services	Primary Care Office	$125 Copay	$85 Copay	$10 Copay ($0 Visits 1-3)	$5 Copay ($0 Visits 1-3)
	Specialist	$180 Copay	$150 Copay	$25 Copay	$10 Copay
	Allergy 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 (per visit; copay waived if admitted)	In-Network and Out-of-Network	INN DED + $400 Copay[1]	INN DED + $400 Copay[1]	$200 Copay	$50 Copay
Urgent Care Centers	In-Network and Out-of-Network	INN DED + $100 Copay[1]	INN DED + $100 Copay[1]	$30 Copay	$10 Copay
Independent 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	$50 Copay	$25 Copay	$25 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear 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
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
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	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	$0
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Inpatient Hospital Facility Services (per admission)	In-Network	DED + $600 Copay	DED + $600 Copay	$400 Copay	$300 Copay
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + $500 Copay	DED + $500 Copay	$300 Copay	$200 Copay
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Chiropractic Care (per visit)	In-Network	$180 Copay	$150 Copay	$25 Copay	$10 Copay
	Out-of-Network	DED + Coins	DED + Coins	DED + Coins	DED + Coins
Prescription Drugs*	Deductible (per person / family aggregate)	$3,000 / $3,000	$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	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**/20%**/20%**	$30**/$55**/20%**/20%**	$30 / $55 / 20% / 20%	$30 / $55 / 20% / 20%
	Mail-Order (Specialty/Self-Injectable not Available)	$6 / $27 / $87**/ $162**	$6 / $27 / $87**/ $162**	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

Preventive Medications and Rx Lists are available in the FHCP Exchange QHP formulary at http://www.fhcp.com/members/plansAndBenefits/2016-exchange-formulary.pdf **Copay applies after Deductible is met.
***Coinsurance value indicated applies. [1] INN – In-Network Deductible + Copay Applies.

INDIVIDUAL 2016 – POS PLANS

Cost Sharing		IND Bronze Essential Plus POS 42	IND Bronze POS BC 3841	IND Catastrophic Essential Plus POS 37
Medical Deductible (Per Person / Family Aggregate)	In-Network	$4,500 / $9,000	$6,700 / $13,400	$6,850 / $13,700
	Out-of-Network	$10,000 / $20,000	$8,000 / $16,000	$13,500 / $27,000
Coinsurance (Amount member pays)	In-Network	55%	50%	NA
	Out-of-Network	70%	50%	N/A
Medical Out-of-Pocket Maximum	In-Network	$6,800 / $13,600	$6,850 / $13,700	$6,850 / $13,700
(Per Person / Family Aggregate)	Out-of-Network	$20,000 / $40,000	$10,000 / $20,000	$13,500 / $27,000
Physician Office Services	Primary Care Office	DED + Coins	$50 Copay ($0 visits 1-3)	DED ($0 Copay visits 1-3)
	Specialist	DED + Coins	$85 Copay	DED
	Allergy Injections	DED + 20% Coins***	20% Coinsurance	DED
	Medical Pharmacy (Does not include immunizations)	DED + 20% Coins***	20% Coinsurance	DED
	Out of Network	DED + Coins	DED + Coins	DED
Emergency Room Facility Services	In-Network and	INN DED + Coins[1]	INN DED + Coins[1]	INN DED[2]
(per visit; copay waived if admitted)	Out-of-Network			
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	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	DED + Coins	DED + Coins	DED
Independent Clinical Lab	In-Network	DED + Coins	DED + Coins	DED
	Out-of-Network	DED + Coins	DED + Coins	DED
Provider Services at ER	In-Network and	INN DED + Coins[1]	INN DED[2]	INN DED[2]
	Out-of-Network			
Provider Services at Hospital	Inpatient	DED + Coins	DED	DED
	Outpatient	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 + Coins	DED
Inpatient Hospital Facility Services (per admission)	In-Network	DED + Coins	DED + $150 Copay	DED
	Out-of-Network	DED + Coins	DED + Coins	DED
Outpatient Hospital Facility Services(surgical)(per visit)	In-Network	DED + Coins	DED + Coins	DED
	Out-of-Network	DED + Coins	DED + Coins	DED
Chiropractic Care (per visit)	In-Network	55% Coinsurance	$85 Copay	DED
	Out-of-Network	DED + Coins	DED + Coins	DED
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	DED / DED
	Preferred Brand/Non-Preferred Brand/Specialty/Self-Injectable	$30**/$55**/20%**/20%**	$30**/$55**/20%**/20%**	DED / DED / DED / DED
	Mail-Order (Specialty/Self-Injectable not Available)	$6**/$27**/ $87**/ $162**	$6 / $27 / $87**/ $162**	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