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 (see last page)
- All plans come with option to purchase Adult Vision Rider.
- Pediatric Dental is not a covered benefit. A separate dental plan should be offered and the appropriate waiver signed.

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

PBP=Per Benefit Period

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

An Independent Licensee of the Blue Cross and Blue Shield Association

Individual Off Exchange 2020 — HMO Plans			
Metal	Plan Name	In-Network CYD / Coins / OOP	In-Network PCP / Spec
Platinum	Gym Access IND Platinum HMO BC 1941 K38	$0 / 80% / $2,000	$10 / $20
Platinum	Gym Access IND Essential Plus Platinum HMO Y65	$0 / 85% / $2,000 (Med) & $2,000 (Drug)	$20 / $35
Platinum	Gym Access IND Platinum HMO 4000 K12	$0 / 80% / $4,000	$20 / $40
Platinum	Gym Access IND Platinum HMO K91	$250 (Med) $0 (Drug) / 90% / $2,500	$15 / $30
Platinum	Gym Access IND Platinum HMO K92	$500 (Med) $0 (Drug) / 90% / $3,000	$15 / $30
Platinum	Gym Access IND Platinum HMO BC 5841 K34	$800 (Med) $0 (Drug) / 90% / $2,500	$15 / $20
Gold	Gym Access IND Gold HMO BC 5651 K30	$0 / 60% / $5,800	$25 / $60
Gold	Gym Access IND Essential Plus Gold HMO Y63	$1,600 (Med) $0 (Drug) / 80% / $5,000	$20 / $50
Gold – H.S.A	Gym Access IND Gold HMO H.S.A 9010 K6A	$1,500 / 90% / $4,000	CYD + Coins
Gold	Gym Access IND Gold HMO 4500 K29	$2,200 / 90% / $4,500	$25 / $35
Gold	Gym Access IND Gold HMO 5500 K08	$2,500 (Med) $500 (Drug) / 80% / $5,500	$20 / $35
Silver – H.S.A	Gym Access IND Silver HMO H.S.A 2500/6650 K22	$2,500 / 80% / $6,650	CYD + Coins
Silver	Gym Access IND Essential Plus Silver HMO Y53	$2,900 / 70% / $8,150	$40 / $65
Silver	Gym Access IND Silver HMO 1560 K7A	$3,000 (Med) $0 (Drug) / 50% / $8,150	$40 / $60
Silver	Gym Access IND Silver HMO 0526 K8A	$3,500 (Med) $500 (Drug) / 80% / $7,900	$30 / $60
Silver	Gym Access IND Silver Standardized HMO 1 K1A	$3,800 (Med) $700 (Drug) / 80% / $8,150	$30 / $65
Silver	Gym Access IND Silver HMO 1120 K9A	$4,000 (Med) $1,100 (Drug) / 70% / $8,150	$35 / $65
Silver	Gym Access IND Silver HMO K99	$4,600 (Med) $250 (Drug) / 80% / $8,150	$40 / $60
Silver	Gym Access IND Silver HMO 4 K04	$5,200 (Med) $250 (Drug) / 70% / $8,150	$30 / $55
Silver	Gym Access IND Silver HMO 5 K05	$5,500 / 50% / $7,350	$35 / $60
Silver	Gym Access IND Silver HMO BC 0941 K68	$5,600 (Med) $3,000 (Drug) / 60% / $7,150	$50 / $100
Silver	IND Silver HMO BC 7741 K78	$6,000 / 60% / $7,300	$55 / $100
Bronze	Gym Access IND Bronze HMO 1041 K4A	$4,700 / 50% / $8,150	$50 / $75
Bronze – H.S.A	Gym Access IND Bronze HMO H.S.A 5000/6550 K24	$5,000 / 70% / $6,550	CYD + Coins
Bronze – H.S.A	Gym Access IND Bronze HMO H.S.A 6000/6000 K26	$6,000 / 100% / $6,000	CYD
Bronze	Gym Access IND Bronze HMO BC 3841 K64	$6,400 / 50% / $8,000	$35 / $65
Bronze	Gym Access IND Bronze Standardized HMO K2A	$6,650 / 60% / $7,600	$35 / $75
Bronze	Gym Access IND Bronze HMO 1340 K3A	$8,150 / 100% / $8,150	CYD
Catastrophic	Gym Access IND Catastrophic Essential Plus HMO Y36	$8,150 / 100% / $8,150	CYD
Individual Off Exchange 2020 – POS Plans			
Platinum	Gym Access IND Platinum POS BC 1941 K40	$0 / 80% / $2,000	$10 / $20
Platinum	Gym Access IND Platinum POS 4000 K13	$0 / 80% / $4,000	$20 / $40
Platinum	Gym Access IND Platinum POS BC 5841 K36	$800 (Med) $0 (Drug) / 90% / $2,500	$15 / $20
Gold	Gym Access IND Gold POS BC 5651 K32	$0 / 60% / $5,800	$25 / $60
Gold	Gym Access IND Gold POS 5500 K09	$2,500 (Med) $500 (Drug) / 80% / $5,500	$20 / $35
Silver	Gym Access IND Essential Plus Silver POS Y54	$2,900 / 70% / $8,150	$40 / $65
Silver	Gym Access IND Silver POS 1120 KA1	$4,000 (Med) $1,100 (Drug) / 70% / $8,150	$35 / $65
Silver	Gym Access IND Silver POS BC 0941 K73	$5,600 (Med) $3,000 (Drug) / 60% / $7,150	$50 / $100
Silver	Gym Access IND Silver POS BC 7741 K83	$6,000 / 60% / $7,300	$55 / $100
Bronze	Gym Access IND Bronze POS 1042 K5A	$5,000 / 50% / $8,150	$40 / $65
Bronze – H.S.A	Gym Access IND Bronze POS H.S.A 5000/6550 K25	$5,000 / 70% / $6,550	CYD + Coins
Bronze – H.S.A	Gym Access IND Bronze POS H.S.A 6000/6000 K27	$6,000 /100% / $6,000	CYD
Bronze	Gym Access IND Bronze POS BC 3841 K66	$6,400 / 50% / $8,000	$35 / $65
Catastrophic	Gym Access IND Catastrophic Essential Plus POS Y37	$8,150 / 100% / $8,150	CYD
Individual Off Exchange 2020 – Triple Option Plans			
Platinum	Gym Access IND Platinum Triple Option Z82	$0 / 85% / $3,000	$20 / $35

Cost Sharing		Gym Access IND Platinum HMO BC 1941	Gym Access IND Essential Plus Platinum HMO 65	Gym Access IND Platinum HMO 4000	Gym Access IND Platinum HMO 91	Gym Access IND Platinum HMO 92
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$0 / $0	$0 / $0	$250 / $500	$500 / $1,000
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	20%	15%	20%	10%	10%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$2,000 / $4,000	$2,000 / $4,000	$4,000 / $8,000	$2,500 / $5,000	$3,000 / $6,000
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$10 Copay	$20 Copay	$20 Copay	$15 Copay	$15 Copay
	Specialist	$20 Copay	$35 Copay	$40 Copay	$30 Copay	$30 Copay
	Allergy Injections	20% Coinsurance	15% Coinsurance	20% Coinsurance	10% Coinsurance	10% Coinsurance
Medical Pharmacy preferred/non-preferred (Does not include immunizations)		40%/50% Coinsurance	40%/50% Coinsurance	40%/50% Coinsurance	40%/50% Coinsurance	40/50% Coinsurance
	Out of Network	N/A	N/A	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$125 Copay	$100 Copay	$150 Copay	$150 Copay	$100 Copay
Urgent Care Centers	In-Network and Out-of-Network	$50 Copay	$60 Copay	$60 Copay	$50 Copay	$50 Copay
Independent Diagnostic Testing Facility/ Provider's Office						
	Allergy Testing	$10 Copay	$0	$0	$35 Copay	$20 Copay
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$75 Copay	$10 Copay	$0	$35 Copay	$20 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$100 Copay	$50 Copay	$100 Copay	$100 Copay	$75 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$0	$0	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	$0	$0	$0	$0	$0
Provider Services at Hospital	Inpatient	$0	$0	$0	$0	$0
	Outpatient	$0	$0	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	$200 Copay	$400 Copay	$250 Copay	$200 Copay	$250 Copay
Provider Services at ASC	In-Network	$0	$0	$0	$0	$0
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	$350 per day ($1,050 Max)	$250 per day ($1,250 Max)	$250 per day ($750 Max)	$250 per day ($750 Max)	$300 per day ($900 Max)
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical) (per visit)	In-Network	$300 Copay	$500 Copay	$500 Copay	$400 Copay	$400 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$20 Copay	$15 Copay	$40 Copay	$20 Copay	$20 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Prescription Drugs	Drug Deductible (per person / family aggregate)	Integrated with Medical	$0 / $0	Integrated with Medical	$0 / $0	$0 / $0
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	$2,000 / $4,000	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0	$0	$0
	Preferred Generic / Non Preferred Generic	$3 / $10	$3 / $10	$3 / $10	$3 / $10	$3 / $10
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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

Cost Sharing		Gym Access IND Platinum HMO BC 5841	Gym Access IND Gold HMO BC 5651	Gym Access IND Essential Plus Gold HMO 63	Gym Access IND Gold HMO H.S.A 9010	Gym Access IND Gold HMO 4500
Medical Deductible (Per Person / Family Aggregate)	In-Network	$800 / $1,600	$0 / $0	$1,600 / $3,200	$1,500 / $3,000	$2,200 / $4,400
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	10%	40%	20%	10%	10%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$2,500 / $5,000	$5,800 / $11,600	$5,000 / $10,000	$4,000 / $8,000	$4,500 / $9,000
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$0 Visits 1-3, then $15 Copay	$25 Copay	$20 Copay	Deductible + 10%	$25 Copay
	Specialist	$20 Copay	$60 Copay	$50 Copay	Deductible + 10%	$35 Copay
	Allergy Injections	10% Coinsurance	40% Coinsurance	20% Coinsurance	Deductible + 10%	10% Coinsurance
Medical Pharmacy preferred/non-preferred (Does not include immunizations)		40%/50% Coinsurance	20%/30% Coinsurance	20%/30% Coinsurance	DED + 40%/DED + 50%	40%/50% Coinsurance
	Out of Network	N/A	N/A	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	Deductible + 10%	$350 Copay	Deductible + 20%	Deductible + 10%	Deductible + 10%
Urgent Care Centers	In-Network and Out-of-Network	$50 Copay	$65 Copay	$60 Copay	Deductible + 10%	$75 Copay
Independent Diagnostic Testing Facility/ Provider's Office						
	Allergy Testing	Deductible + 10%	$10 Copay	Deductible + 20%	Deductible + 10%	$0
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	Deductible + 10%	$100 Copay	Deductible + 20%	Deductible + 10%	Deductible + 10%
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	Deductible + 10%	$250 Copay	Deductible + 20%	Deductible + 10%	Deductible + 10%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$0	$20 Copay	Deductible + 20%	Deductible + 10%	$10 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	Deductible + 10%	$0	Deductible + 20%	Deductible + 10%	Deductible + 10%
Provider Services at Hospital	Inpatient	$0	$0	Deductible + 20%	Deductible + 10%	$0
	Outpatient	Deductible + 10%	$0	Deductible + 20%	Deductible + 10%	Deductible + 10%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	Deductible + 10%	$400 Copay	Deductible + 20%	Deductible + 10%	Deductible + 10%
Provider Services at ASC	In-Network	Deductible + 10%	$0	Deductible + 20%	Deductible + 10%	Deductible + 10%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	Deductible + 10%	$600 per day ($1,800 Max)	Deductible + 20%	Deductible + 10%	$250 per day ($750 Max)
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical) (per visit)	In-Network	Deductible + 10%	$450 Copay	Deductible + 20%	Deductible + 10%	Deductible + 10%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$20 Copay	$60 Copay	20% Coinsurance	Deductible + 10%	$35 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Prescription Drugs	Drug Deductible (per person / family aggregate)	$0 / $0	Integrated with Medical	$0 / $0	Integrated with Medical	Integrated with Medical
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0	$0	$0
	Preferred Generic / Non Preferred Generic	$3 / $10	$3 / $10	$3 / $10	DED + $3 / DED + $10	$3 / $10
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$30 / $55 / 40% / 50%	$40 / $75 / 20% / 30%	$40 / $75 / 20% / 30%	DED + $30 / DED + $55 / DED + 40% / DED + 50%	$30 / $55 / 40% / 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $27 / $87 / $162	$6 / $27 / $117 / $222	$6 / $27 / $117 / $222	DED + $6 / DED + $27 / DED + $87 / DED + $162	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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Cost Sharing		Gym Access IND Gold HMO 5500	Gym Access IND Silver HMO H.S.A 2500/6650	Gym Access IND Essential Plus Silver HMO 53	Gym Access IND Silver HMO 1560	Gym Access IND Silver HMO 0526
Medical Deductible (Per Person / Family Aggregate)	In-Network	$2,500 / $5,000	$2,500 / $5,000	$2,900 / $5,800	$3,000 / $6,000	$3,500 / $7,000
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	20%	20%	30%	50%	20%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$5,500 / $11,000	$6,650 / $13,300	$8,150 / $16,300	$8,150 / $16,300	$7,900 / $15,800
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$20 Copay	Deductible + 20%	$40 Copay	$40 Copay	$30 Copay
	Specialist	$35 Copay	Deductible + 20%	$65 Copay	$60 Copay	$60 Copay
	Allergy Injections	20% Coinsurance	Deductible + 20%	Deductible + 30%	50% Coinsurance	20% Coinsurance
	Medical Pharmacy preferred/non-preferred (Does not include immunizations)	DED + 40%/DED + 50%	DED + 40%/DED + 50%	DED + 40%/DED + 50%	40%/50% Coinsurance	DED + 50%/DED + 50%
	Out of Network	N/A	N/A	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$200 Copay	Deductible + 20%	Deductible + 30%	Deductible + 50%	Deductible + 20%
Urgent Care Centers	In-Network and Out-of-Network	$75 Copay	Deductible + 20%	$75 Copay	$75 Copay	$75 Copay
Independent Diagnostic Testing Facility/ Provider's Office						
	Allergy Testing	$0	Deductible + 20%	Deductible + 30%	50% Coinsurance	20% Coinsurance
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$30 Copay	Deductible + 20%	Deductible + 30%	Deductible + 50%	Deductible + 20%
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$150 Copay	Deductible + 20%	Deductible + 30%	Deductible + 50%	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$10 Copay	Deductible + 20%	Deductible + 30%	Deductible + 50%	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	$0	Deductible + 20%	Deductible + 30%	Deductible + 50%	Deductible + 20%
Provider Services at Hospital	Inpatient	Deductible + 20%	Deductible + 20%	Deductible + 30%	Deductible + 50%	Deductible + 20%
	Outpatient	Deductible + 20%	Deductible + 20%	Deductible + 30%	Deductible + 50%	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	Deductible + 20%	Deductible + 20%	Deductible + 30%	Deductible + 50%	Deductible + 20%
Provider Services at ASC	In-Network	Deductible + 20%	Deductible + 20%	Deductible + 30%	Deductible + 50%	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	Deductible + 20%	Deductible + 20%	Deductible + 30%	Deductible + 50%	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical) (per visit)	In-Network	Deductible + 20%	Deductible + 20%	Deductible + 30%	Deductible + 50%	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$35 Copay	Deductible + 20%	$65 Copay	$40 Copay	$30 Copay
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Prescription Drugs	Drug Deductible (per person / family aggregate)	$500 / $1,000	Integrated with Medical	Integrated with Medical	$0 / $0	$500 / $1,000
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0	$0	$0
	Preferred Generic / Non Preferred Generic	$3 / $10	DED + $3 / DED + $10	$3 / $10	$3 / $10	$4 / $18
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$30 / $55 / DED + 40% / DED + 50%	DED + $30 / DED + $55 / DED + 40% / DED + 50%	DED + $30 / DED + $55 / DED + 40% / DED + 50%	$30 / $55 / 40% / 50%	DED + $65 / DED + 50% / DED + 50% / DED + 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $27 / $87 / $162	DED + $6 / DED + $27 / DED + $87 / DED + $162	$6 / $27 / DED + $87 / DED + $162	$6 / $27 / $87 / $162	$9 / $51 / DED + $192 / DED + 50%
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/ H.S.A Compatible Plans – refer to the schedule of benefits for embedding information.

Cost Sharing		Gym Access IND Silver Standardized HMO 1	Gym Access IND Silver HMO 1120	Gym Access IND Silver HMO 99
Medical Deductible (Per Person / Family Aggregate)	In-Network	$3,800 / $7,600	$4,000 / $8,000	$4,600 / $9,200
	Out-of-Network	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	20%	30%	20%
	Out-of-Network	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$8,150 / $16,300	$8,150 / $16,300	$8,150 / $16,300
	Out-of-Network	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$30 Copay	$35 Copay	$40 Copay
	Specialist	$65 Copay	$65 Copay	$60 Copay
	Allergy Injections	20% Coinsurance	30% Coinsurance	20% Coinsurance
	Medical Pharmacy preferred/non-preferred (Does not include immunizations)	DED + 30%/DED + 40%	DED + 40%/DED + 50%	DED + 40%/DED + 50%
	Out of Network	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	Deductible + 20%	$600 Copay	Deductible + 20%
Urgent Care Centers	In-Network and Out-of-Network	$75 Copay	$75 Copay	Deductible + 20%
Independent Diagnostic Testing Facility/ Provider's Office				
	Allergy Testing	Deductible + 20%	$0	Deductible + 20%
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	Deductible + 20%	$50 Copay	Deductible + 20%
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	Deductible + 20%	$500 Copay	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A
Independent Clinical Lab	In-Network	Deductible + 20%	$25 Copay	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	Deductible + 20%	$0	Deductible + 20%
Provider Services at Hospital	Inpatient	Deductible + 20%	Deductible + 30%	Deductible + 20%
	Outpatient	Deductible + 20%	Deductible + 30%	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	Deductible + 20%	Deductible + 30%	Deductible + 20%
Provider Services at ASC	In-Network	Deductible + 20%	Deductible + 30%	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	Deductible + 20%	Deductible + 30%	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical) (per visit)	In-Network	Deductible + 20%	Deductible + 30%	Deductible + 20%
	Out-of-Network	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$65 Copay	$35 Copay	$60 Copay
	Out-of-Network	N/A	N/A	N/A
Prescription Drugs	Drug Deductible (per person / family aggregate)	$700 / $1,400	$1,100 / $2,200	$250 / $500
	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 / $15	$3 / $15	$3 / $10
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	DED + $50 / DED + $100 / DED + 30% / DED + 40%	DED + 20% / DED + 30% / DED + 40% / DED + 50%	$30 / $55 / DED + 40% / DED + 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $42 / DED + $147 / DED + $297	$6 / $42 / DED + 20% / DED + 30%	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered

Cost Sharing		Gym Access IND Silver HMO 4	Gym Access IND Silver HMO 5	Gym Access IND Silver HMO BC 0941	IND Silver HMO BC 7741
Medical Deductible (Per Person / Family Aggregate)	In-Network	$5,200 / $10,400	$5,500 / $11,000	$5,600 / $11,200	$6,000 / $12,000
	Out-of-Network	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	30%	50%	40%	40%
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$8,150 / $16,300	$7,350 / $14,700	$7,150 / $14,300	$7,300 / $14,600
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$30 Copay	$0 visits 1-3 then $35 Copay	$50 Copay	$55 Copay
	Specialist	$55 Copay	$60 Copay	$100 Copay	$100 Copay
	Allergy Injections	30% Coinsurance	50% Coinsurance	Deductible + 40%	Deductible + 40%
	Medical Pharmacy preferred/non-preferred (Does not include immunizations)	DED + 40%/ DED + 50%	DED + 50%/DED + 50%	DED + 40%/DED + 50%	DED + 40%/DED + 50%
	Out of Network	N/A	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	Deductible + 30%	Deductible + 50%	Deductible + $400 Copay	Deductible + $600 Copay
Urgent Care Centers	In-Network and Out-of-Network	$85 Copay	$75 Copay	$100 Copay	$160 Copay
Independent Diagnostic Testing Facility/ Provider's Office					
	Allergy Testing	$0	$0	$10 Copay	$4 Copay
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$50 Copay	$45 Copay	$50 Copay	$13 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$300 Copay	Deductible + 50%	$400 Copay	Deductible + 40%
	Out-of-Network	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	$25 Copay	$0	$20 Copay	$0
	Out-of-Network	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	Deductible + 30%	Deductible + 50%	$0	Deductible
Provider Services at Hospital	Inpatient	Deductible + 30%	Deductible + 50%	$0	Deductible + 40%
	Outpatient	Deductible + 30%	Deductible + 50%	Deductible	Deductible + 40%
	Out-of-Network	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	Deductible + 30%	Deductible + 50%	Deductible + $350 Copay	Deductible + 40%
Provider Services at ASC	In-Network	Deductible + 30%	Deductible + 50%	Deductible	Deductible + 40%
	Out-of-Network	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	Deductible + 30%	Deductible + 50%	Deductible + $600 Copay	Deductible + 40%
	Out-of-Network	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services(surgical) (per visit)	In-Network	Deductible + 30%	Deductible + 50%	Deductible + $500 Copay	Deductible + 40%
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$30 Copay	$35 Copay	$100 Copay	$85 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs	Drug Deductible (per person / family aggregate)	$250 / $500	Integrated with Medical	$3,000 / $3,000	Integrated with Medical
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0	$0
	Preferred Generic / Non Preferred Generic	$3 / $10	$4 / $18	$3 / $10	$3 / $15
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	$30 / $55 / DED + 40% / DED + 50%	DED + $65 / DED + 50% / DED + 50% / DED + 50%	DED + $30 / DED + $55 / DED + 40% / DED + 50%	DED + $50 / DED + $100 / DED + 40% / DED + 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $27 / $87 / $162	$9 / $51 / DED + $192 / DED + 50%	$6 / $27 / DED + $87 / DED + $162	$6 / $42 / DED + $147 / DED + $297
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

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Cost Sharing		Gym Access IND Bronze HMO 1041	Gym Access IND Bronze HMO H.S.A 5000/6550	Gym Access IND Bronze HMO H.S.A 6000/6000	Gym Access IND Bronze HMO BC 3841
Medical Deductible (Per Person / Family Aggregate)	In-Network	$4,700 / $9,400	$5,000 / $10,000	$6,000 / $12,000	$6,400 / $12,800
	Out-of-Network	N/A	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	50%	30%	100%	50%
	Out-of-Network	N/A	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$8,150 / $16,300	$6,550 / $13,100	$6,000 / $12,000	$8,000 / $16,000
	Out-of-Network	N/A	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$50 Copay	Deductible + 30%	Deductible	$0 visits 1-3 then $35 Copay
	Specialist	$75 Copay	Deductible + 30%	Deductible	$65 Copay
	Allergy Injections	50% Coinsurance	Deductible + 30%	Deductible	50% Coinsurance
Medical Pharmacy preferred/non-preferred	(Does not include immunizations)	DED + 40%/DED + 50%	DED + 40%/DED + 50%	Deductible/Deductible	DED + 45%/DED + 45%
	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	Deductible + 50%	Deductible + 30%	Deductible	Deductible + 50%
Urgent Care Centers	In-Network and Out-of-Network	$100 Copay	Deductible + 30%	Deductible	$125 Copay
Independent Diagnostic Testing Facility/ Provider's Office					
	Allergy Testing	Deductible + 50%	Deductible + 30%	Deductible	$10 Copay
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	Deductible + 50%	Deductible + 30%	Deductible	Deductible + 50%
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	Deductible + 50%	Deductible + 30%	Deductible	Deductible + 50%
	Out-of-Network	N/A	N/A	N/A	N/A
Independent Clinical Lab	In-Network	Deductible + 50%	Deductible + 30%	Deductible	Deductible + 50%
	Out-of-Network	N/A	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	Deductible + 50%	Deductible + 30%	Deductible	Deductible + 50%
Provider Services at Hospital	Inpatient	Deductible + 50%	Deductible + 30%	Deductible	Deductible
	Outpatient	Deductible + 50%	Deductible + 30%	Deductible	Deductible + 50%
	Out-of-Network	N/A	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	Deductible + 50%	Deductible + 30%	Deductible	Deductible + 50%
Provider Services at ASC	In-Network	Deductible + 50%	Deductible + 30%	Deductible	Deductible + 50%
	Out-of-Network	N/A	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	Deductible + 50%	Deductible + 30%	Deductible	Deductible + $100 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	Deductible + 50%	Deductible + 30%	Deductible	Deductible + 50%
	Out-of-Network	N/A	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	$50 Copay	Deductible + 30%	Deductible	$65 Copay
	Out-of-Network	N/A	N/A	N/A	N/A
Prescription Drugs	Drug 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	DED + $3 / DED + $10	DED + $3 / DED + $10	DED / DED	$4 / $35
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	DED + $30 / DED + $55 / DED + 40% / DED + 50%	DED + $30 / DED + $55 / DED + 40% / DED + 50%	DED / DED / DED / DED	DED + 35% / DED + 40% / DED + 45% / DED + 45%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	DED + $6 / DED + $27 / DED + $87 / DED + $162	DED + $6 / DED + $27 / DED + $87 / DED + $162	DED / DED / DED / DED	$9 / $102/ DED + 35% / DED + 40%
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/ H.S.A Compatible Plans – refer to the schedule of benefits for embedding information.

Cost Sharing		Gym Access IND Bronze Standardized HMO	Gym Access IND Bronze HMO 1340	Gym Access IND Catastrophic Essential Plus HMO 36
Medical Deductible (Per Person / Family Aggregate)	In-Network	$6,650 / $13,300	$8,150 / $16,300	$8,150 / $16,300
	Out-of-Network	N/A	N/A	N/A
Coinsurance (Amount member pays)	In-Network	40%	100%	100%
	Out-of-Network	N/A	N/A	N/A
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$7,600 / $15,200	$8,150 / $16,300	$8,150 / $16,300
	Out-of-Network	N/A	N/A	N/A
Physician Office Services	Primary Care Office	$35 Copay	$0 visits 1-2 then Deductible	$0 visits 1-3 then Deductible
	Specialist	$75 Copay	Deductible	Deductible
	Allergy Injections	40% Coinsurance	Deductible	Deductible
Medical Pharmacy preferred/non-preferred	(Does not include immunizations)	DED + 45%/DED + 45%	Deductible/Deductible	Deductible/Deductible
	Out of Network	N/A	N/A	N/A
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	Deductible + 40%	Deductible	Deductible
Urgent Care Centers	In-Network and Out-of-Network	$75 Copay	Deductible	Deductible
Independent Diagnostic Testing Facility/ Provider's Office				
	Allergy Testing	Deductible + 40%	Deductible	Deductible
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	Deductible + 40%	Deductible	Deductible
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	Deductible + 40%	Deductible	Deductible
	Out-of-Network	N/A	N/A	N/A
Independent Clinical Lab	In-Network	Deductible +40%	Deductible	Deductible
	Out-of-Network	N/A	N/A	N/A
Provider Services at ER	In-Network and Out-of-Network	Deductible + 40%	Deductible	Deductible
Provider Services at Hospital	Inpatient	Deductible + 40%	Deductible	Deductible
	Outpatient	Deductible + 40%	Deductible	Deductible
	Out-of-Network	N/A	N/A	N/A
Ambulatory Surgical Center Facility (ASC)	In-Network	Deductible + 40%	Deductible	Deductible
Provider Services at ASC	In-Network	Deductible + 40%	Deductible	Deductible
	Out-of-Network	N/A	N/A	N/A
Inpatient Hospital Facility Services (per admission)	In-Network	Deductible + 40%	Deductible	Deductible
	Out-of-Network	N/A	N/A	N/A
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	Deductible + 40%	Deductible	Deductible
	Out-of-Network	N/A	N/A	N/A
Chiropractic Care (per visit)	In-Network	40% Coinsurance	Deductible	Deductible
	Out-of-Network	N/A	N/A	N/A
Prescription Drugs	Drug Deductible (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0
	Preferred Generic / Non Preferred Generic	$4 / $35	$4 / $30	DED / DED
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	DED + 35% / DED + 40% / DED + 45% / DED + 45%	DED / DED / DED / DED	DED / DED / DED / DED
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$9 / $102 / DED + 35% / DED + 40%	$9 / $87 / DED / DED	DED / DED / DED / DED
	Out-of-Network	Not Covered	Not Covered	Not Covered

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Cost Sharing		Gym Access IND Platinum POS BC 1941	Gym Access IND Platinum POS 4000	Gym Access IND Platinum POS BC 5841	Gym Access IND Gold POS BC 5651	Gym Access IND Gold POS 5500
Medical Deductible (Per Person / Family Aggregate)	In-Network	$0 / $0	$0 / $0	$800 / $1,600	$0 / $0	$2,500 / $5,000
	Out-of-Network	$500 / $1,000	$500 / $1,000	$1,600 / $3,200	$500 / $1,000	$4,000 / $8,000
Coinsurance (Amount member pays)	In-Network	20%	20%	10%	40%	20%
	Out-of-Network	30%	30%	30%	30%	30%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$2,000 / $4,000	$4,000 / $8,000	$2,500 / $5,000	$5,800 / $11,600	$5,500 / $11,000
	Out-of-Network	$4,000 / $8,000	$8,000 / $16,000	$5,000 / $10,000	$6,000 / $12,000	$8,000 / $16,000
Physician Office Services	Primary Care Office	$10 Copay	$20 Copay	$0 visits 1-3 then $15 Copay	$25 Copay	$20 Copay
	Specialist	$20 Copay	$40 Copay	$20 Copay	$60 Copay	$35 Copay
	Allergy Injections	20% Coinsurance	20% Coinsurance	10% Coinsurance	40% Coinsurance	20% Coinsurance
Medical Pharmacy preferred/non-preferred (Does not include immunizations)		40%/50% Coinsurance	40%/50% Coinsurance	40%/50% Coinsurance	20%/30% Coinsurance	DED + 40%/DED + 50%
	Out of Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	$125 Copay	$150 Copay	INN Deductible + 10%[1]	$350 Copay	$200 Copay
Urgent Care Centers	In-Network and Out-of-Network	$50 Copay	$60 Copay	$50 Copay	$65 Copay	$75 Copay
Independent Diagnostic Testing Facility/ Provider's Office						
	Allergy Testing	$10 Copay	$0	Deductible + 10%	$10 Copay	$0
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	$75 Copay	$0	Deductible + 10%	$100 Copay	$30 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	$100 Copay	$100 Copay	Deductible + 10%	$250 Copay	$150 Copay
	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%
Independent Clinical Lab	In-Network	$0	$0	$0	$20 Copay	$10 Copay
	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%
Provider Services at ER	In-Network and Out-of-Network	$0	$0	INN Deductible + 10%[1]	$0	$0
Provider Services at Hospital	Inpatient	$0	$0	$0	$0	Deductible + 20%
	Outpatient	$0	$0	Deductible + 10%	$0	Deductible + 20%
	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%
Ambulatory Surgical Center Facility (ASC)	In-Network	$200 Copay	$250 Copay	Deductible + 10%	$400 Copay	Deductible + 20%
Provider Services at ASC	In-Network	$0	$0	Deductible + 10%	$0	Deductible + 20%
	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%
Inpatient Hospital Facility Services (per admission)	In-Network	$350 per day ($1,050 Max)	$250 per day ($750 Max)	Deductible + 10%	$600 per day ($1,800 Max)	Deductible + 20%
	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%
Outpatient Hospital Facility Services(surgical) (per visit)	In-Network	$300 Copay	$500 Copay	Deductible + 10%	$450 Copay	Deductible + 20%
	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%
Chiropractic Care (per visit)	In-Network	$20 Copay	$40 Copay	$20 Copay	$60 Copay	$35 Copay
	Out-of-Network	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%	Deductible + 30%
Prescription Drugs — Drug Deductible (per person / family aggregate)		Integrated with Medical	Integrated with Medical	$0 / $0	Integrated with Medical	$500 / $1,000
Out of Pocket Maximum (per person / family aggregate)		Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
Preventive Medications		$0	$0	$0	$0	$0
Preferred Generic / Non Preferred Generic		$3 / $10	$3 / $10	$3 / $10	$3 / $10	$3 / $10
Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty		$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%	$30 / $55 / 40% / 50%	$40 / $75 / 20% / 30%	$30 / $55 / DED + 40% / DED + 50%
Mail-Order (Pref. Specialty/NP Specialty not Available)		$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162	$6 / $27 / $117 / $222	$6 / $27 / $87 / $162
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Information on Preventive Medications, Formularies, Provider Directories and Pharmacy locations can be found online at: https://www.fhcp.com/for-members/about-your-care/ [1]-INN = In Network Deductible + Coinsurance (if applicable) applies.

Cost Sharing		Gym Access IND Essential Plus Silver POS 54	Gym Access IND Silver POS 1120	Gym Access IND Silver POS BC 0941	Gym Access IND Silver POS BC 7741
Medical Deductible (Per Person / Family Aggregate)	In-Network	$2,900 / $5,800	$4,000 / $8,000	$5,600 / $11,200	$6,000 / $12,000
	Out-of-Network	$5,000 / $10,000	$5,000 / $10,000	$7,000 / $14,000	$7,000 / $14,000
Coinsurance (Amount member pays)	In-Network	30%	30%	40%	40%
	Out-of-Network	50%	40%	40%	30%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$8,150 / $16,300	$8,150 / $16,300	$7,150 / $14,300	$7,300 / $14,600
	Out-of-Network	$9,000 / $18,000	$9,000 / $18,000	$10,000 / $20,000	$10,000 / $20,000
Physician Office Services	Primary Care Office	$40 Copay	$35 Copay	$50 Copay	$55 Copay
	Specialist	$65 Copay	$65 Copay	$100 Copay	$100 Copay
	Allergy Injections	Deductible + 30%	30% Coinsurance	Deductible + 40%	Deductible + 40%
Medical Pharmacy preferred/non-preferred (Does not include immunizations)		DED + 40%/DED + 50%	DED + 40%/DED + 50%	DED + 40%/DED + 50%	DED + 40%/DED + 50%
	Out of Network	Deductible + 50%	Deductible + 40%	Deductible + 40%	Deductible + 30%
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	INN Deductible + 30%[1]	$600 Copay	INN Deductible + $400 Copay[1]	INN Deductible + $600 Copay[1]
Urgent Care Centers	In-Network and Out-of-Network	$75 Copay	$75 Copay	$100 Copay	$160 Copay
Independent Diagnostic Testing Facility/ Provider's Office					
	Allergy Testing	Deductible + 30%	$0	$10 Copay	$4 Copay
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	Deductible + 30%	$50 Copay	$50 Copay	$13 Copay
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	Deductible + 30%	$500 Copay	$400 Copay	Deductible + 40%
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 40%	Deductible + 30%
Independent Clinical Lab	In-Network	Deductible + 30%	$25 Copay	$20 Copay	$0
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 40%	Deductible + 30%
Provider Services at ER	In-Network and Out-of-Network	INN Deductible + 30%[1]	$0	$0	INN Deductible[1]
Provider Services at Hospital	Inpatient	Deductible + 30%	Deductible + 30%	$0	Deductible + 40%
	Outpatient	Deductible + 30%	Deductible + 30%	Deductible	Deductible + 40%
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 40%	Deductible + 30%
Ambulatory Surgical Center Facility (ASC)	In-Network	Deductible + 30%	Deductible + 30%	Deductible + $350 Copay	Deductible + 40%
Provider Services at ASC	In-Network	Deductible + 30%	Deductible + 30%	Deductible	Deductible + 40%
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 40%	Deductible + 30%
Inpatient Hospital Facility Services (per admission)	In-Network	Deductible + 30%	Deductible + 30%	Deductible + $600 Copay	Deductible + 40%
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 40%	Deductible + 30%
Outpatient Hospital Facility Services(surgical) (per visit)	In-Network	Deductible + 30%	Deductible + 30%	Deductible + $500 Copay	Deductible + 40%
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 40%	Deductible + 30%
Chiropractic Care (per visit)	In-Network	$65 Copay	$35 Copay	$100 Copay	$85 Copay
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 40%	Deductible + 30%
Prescription Drugs	Drug Deductible (per person / family aggregate)	Integrated with Medical	$1,100 / $2,200	$3,000 / $3,000	Integrated with Medical
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0	$0
	Preferred Generic / Non Preferred Generic	$3 / $10	$3 / $15	$3 / $10	$3 / $15
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	DED + $30 / DED + $55 / DED + 40% / DED + 50%	DED + 20% / DED + 30% / DED + 40% / DED + 50%	DED + $30 / DED + $55 / DED + 40% / DED + 50%	DED + $50 / DED + $100 / DED + 40% / DED + 50%
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$6 / $27 / DED + $87 / DED + $162	$6 / $42 / DED + 20% / DED + 30%	$6 / $27 / DED + $87 / DED + $162	$6 / $42 / DED + $147 / DED + $297
	Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

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Cost Sharing		Gym Access IND Bronze POS 1042	Gym Access IND Bronze POS H.S.A 5000/6550	Gym Access IND Bronze POS H.S.A 6000/6000
Medical Deductible (Per Person / Family Aggregate)	In-Network	$5,000 / $10,000	$5,000 / $10,000	$6,000 / $12,000
	Out-of-Network	$10,000 / $20,000	$8,000 / $16,000	$8,000 / $16,000
Coinsurance (Amount member pays)	In-Network	50%	30%	100%
	Out-of-Network	50%	40%	30%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$8,150 / $16,300	$6,550 / $13,100	$6,000 / $12,000
	Out-of-Network	$20,000 / $40,000	$12,000 / $24,000	$16,000 / $32,000
Physician Office Services	Primary Care Office	$40 Copay	Deductible + 30%	Deductible
	Specialist	$65 Copay	Deductible + 30%	Deductible
	Allergy Injections	50% Coinsurance	Deductible + 30%	Deductible
Medical Pharmacy preferred/non-preferred (Does not include immunizations)		DED + 45%/DED + 45%	DED + 40%/DED + 50%	Deductible/Deductible
	Out of Network	Deductible + 50%	Deductible + 40%	Deductible + 30%
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	INN Deductible + 50%[1]	INN Deductible + 30%[1]	INN Deductible[1]
Urgent Care Centers	In-Network and Out-of-Network	$100 Copay	INN Deductible + 30%[1]	INN Deductible[1]
Independent Diagnostic Testing Facility/ Provider's Office				
	Allergy Testing	Deductible + 50%	Deductible + 30%	Deductible
X-Rays / Ultrasounds / Diagnostic Services (other than AIS)		Deductible + 50%	Deductible + 30%	Deductible
Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)		Deductible + 50%	Deductible + 30%	Deductible
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 30%
Independent Clinical Lab	In-Network	Deductible + 50%	Deductible + 30%	Deductible
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 30%
Provider Services at ER	In-Network and Out-of-Network	INN Deductible + 50%[1]	INN Deductible + 30%[1]	INN Deductible[1]
Provider Services at Hospital	Inpatient	Deductible + 50%	Deductible + 30%	Deductible
	Outpatient	Deductible + 50%	Deductible + 30%	Deductible
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 30%
Ambulatory Surgical Center Facility (ASC)	In-Network	Deductible + 50%	Deductible + 30%	Deductible
Provider Services at ASC	In-Network	Deductible + 50%	Deductible + 30%	Deductible
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 30%
Inpatient Hospital Facility Services (per admission)	In-Network	Deductible + 50%	Deductible + 30%	Deductible
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 30%
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	Deductible + 50%	Deductible + 30%	Deductible
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 30%
Chiropractic Care (per visit)	In-Network	$40 Copay	Deductible + 30%	Deductible
	Out-of-Network	Deductible + 50%	Deductible + 40%	Deductible + 30%
Prescription Drugs*	Drug Deductible (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Out of Pocket Maximum (per person / family aggregate)	Integrated with Medical	Integrated with Medical	Integrated with Medical
	Preventive Medications	$0	$0	$0
	Preferred Generic / Non Preferred Generic	$4 / $35	DED + $3 / DED + $10	DED / DED
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	DED + 35% / DED + 40% / DED + 45% / DED + 45%	DED + $30 / DED + $55 / DED + 40% / DED + 50%	DED / DED / DED / DED
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$9 / $102 / DED + 35% / DED + 40%	DED + $6 / DED + $27 / DED + $87 / DED + $162	DED / DED / DED / DED
	Out-of-Network	Not Covered	Not Covered	Not Covered

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Cost Sharing		Gym Access IND Bronze POS BC 3841	Gym Access IND Catastrophic Essential Plus POS 37
Medical Deductible (Per Person / Family Aggregate)	In-Network	$6,400 / $12,800	$8,150 / $16,300
	Out-of-Network	$8,000 / $16,000	$13,500 / $27,000
Coinsurance (Amount member pays)	In-Network	50%	100%
	Out-of-Network	50%	100%
Medical Out-of-Pocket Maximum (Per Person / Family Aggregate)	In-Network	$8,000 / $16,000	$8,150 / $16,300
	Out-of-Network	$10,000 / $20,000	$13,500 / $27,000
Physician Office Services	Primary Care Office	$0 visits 1-3 then $35 Copay	$0 visits 1-3 then Deductible
	Specialist	$65 Copay	Deductible
	Allergy Injections	50% Coinsurance	Deductible
	Medical Pharmacy preferred/non-preferred (Does not include immunizations)	DED + 45%/DED + 45%	Deductible/Deductible
	Out of Network	Deductible + 50%	Deductible
Emergency Room Facility Services (per visit; copay waived if admitted)	In-Network and Out-of-Network	INN Deductible + 50%[1]	INN Deductible[1]
Urgent Care Centers	In-Network and Out-of-Network	$125 Copay	INN Deductible[1]
Independent Diagnostic Testing Facility/ Provider's Office			
	Allergy Testing	$10 Copay	Deductible
	X-Rays / Ultrasounds / Diagnostic Services (other than AIS)	Deductible + 50%	Deductible
	Advanced Imaging Services (AIS)(MRI, MRA, PET, CT & Nuclear Medicine)	Deductible + 50%	Deductible
	Out-of-Network	Deductible + 50%	Deductible
Independent Clinical Lab	In-Network	Deductible + 50%	Deductible
	Out-of-Network	Deductible + 50%	Deductible
Provider Services at ER	In-Network and Out-of-Network	INN Deductible[1]	INN Deductible[1]
Provider Services at Hospital	Inpatient	Deductible	Deductible
	Outpatient	Deductible + 50%	Deductible
	Out-of-Network	Deductible + 50%	Deductible
Ambulatory Surgical Center Facility (ASC)	In-Network	Deductible + 50%	Deductible
Provider Services at ASC	In-Network	Deductible + 50%	Deductible
	Out-of-Network	Deductible + 50%	Deductible
Inpatient Hospital Facility Services (per admission)	In-Network	Deductible + $100 Copay	Deductible
	Out-of-Network	Deductible + 50%	Deductible
Outpatient Hospital Facility Services (surgical) (per visit)	In-Network	Deductible + 50%	Deductible
	Out-of-Network	Deductible + 50%	Deductible
Chiropractic Care (per visit)	In-Network	$65 Copay	Deductible
	Out-of-Network	Deductible + 50%	Deductible
Prescription Drugs	Drug 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	$4 / $35	DED / DED
	Preferred Brand/Non-Preferred Brand/Pref. Specialty/NP Specialty	DED + 35% / DED + 40% / DED + 45% / DED + 45%	DED / DED / DED / DED
	Mail-Order (Pref. Specialty/NP Specialty not Available)	$9 / $102 / DED + 35% / DED + 40%	DED / DED / DED / DED
	Out-of-Network	Not Covered	Not Covered

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

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

Individual 2020 Off-Exchange FHCP Plans – Pediatric Vision (In-Network Services Only)

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