



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit: <http://www.fhcp.com/documents/coc/qhp-small-group-2024.pdf>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-877-615-4022 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network providers</a> : \$0. <a href="#">Out-of-network providers</a> : Not Covered	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not Applicable	
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network providers</a> : \$7,300 individual / \$14,600 family; <a href="#">Out-of-network providers</a> : Not Covered	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://www.fhcp.com/our-provider-network/">https://www.fhcp.com/our-provider-network/</a> or call 1 (877) 615-4022 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">Copay</a>	Not Covered	Additional cost share may apply for Allergy Shots, Injections and Infusions.
	<a href="#">Specialist</a> visit	\$50 <a href="#">Copay</a>	Not Covered	Additional cost share may apply for Allergy Shots, Injections and Infusions.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<p>\$25 <a href="#">Copay</a> for laboratory &amp; professional services.</p> <p>\$50 <a href="#">Copay</a> for x-ray &amp; diagnostic imaging.</p> <p>\$50 <a href="#">Copay</a> for laboratory &amp; professional services and \$100 <a href="#">Copay</a> for x-ray &amp; diagnostic imaging at an outpatient hospital facility.</p>	Not Covered	<p>Prior authorization is required.</p> <p>Tests in hospitals, or facilities owned or operated by hospitals are subject to the outpatient hospital facility cost share.</p> <p>Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details.</p>
	Imaging (CT/PET scans, MRIs)	\$250 <a href="#">Copay</a> at an independent facility / \$500 <a href="#">Copay</a> at an outpatient hospital facility.	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://fm.formularynavigator.com/FBO/126/2024_QHP_Formulary.pdf">prescription drug coverage</a> is available at <a href="https://fm.formularynavigator.com/FBO/126/2024_QHP_Formulary.pdf">https://fm.formularynavigator.com/FBO/126/2024_QHP_Formulary.pdf</a>	Generic drugs – preferred / non-preferred	\$3 <a href="#">Copay</a> / \$10 <a href="#">Copay</a>	Not Covered	31 Days per Benefit Period. Available at Preferred-FHCP and select Non-Preferred Retail Pharmacies Only. Up to 93-day Mail Order available through FHCP Only. Refer to the schedule of benefits for cost sharing at Non-Preferred Pharmacies.
	Preferred brand drugs	\$30 <a href="#">Copay</a>	Not Covered	
	Non-preferred brand drugs	\$55 <a href="#">Copay</a>	Not Covered	
	<a href="#">Specialty drugs</a> – preferred / non-preferred	40% <a href="#">Coinsurance</a> / 50% <a href="#">Coinsurance</a>	Not Covered	31 Days per Benefit Period. Available at FHCP Pharmacy Only. Mail Order not available.
<b>If you have outpatient surgery</b>	Facility fee (ambulatory surgery center (ASC) / outpatient hospital facility (OHF))	\$300 <a href="#">Copay</a> – ASC / \$500 <a href="#">Copay</a> – OHF	Not Covered	Pre-certification/pre-authorization of coverage required for non-emergency outpatient surgical care. Your benefits/services may be denied.
	Physician/surgeon fees	\$50 <a href="#">Copay</a>	Not Covered	Prior approval required. Your benefits/services may be denied.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$350 <a href="#">Copay</a>	\$350 <a href="#">Copay</a>	Waived if admitted.
	<a href="#">Emergency medical transportation</a>	\$350 <a href="#">Copay</a>	\$350 <a href="#">Copay</a>	None
	<a href="#">Urgent care</a>	\$50 <a href="#">Copay</a>	\$50 <a href="#">Copay</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$350 <a href="#">Copay</a> per Day (\$1,750 Maximum, Days 1-5)	Not Covered	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.
	Physician/surgeon fees	\$50 <a href="#">Copay</a>	Not Covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$50 <a href="#">Copay</a>	Not Covered	None
	Inpatient services	\$350 <a href="#">Copay</a> per Day (\$1,750 Maximum, Days 1-5)	Not Covered	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.
<b>If you are pregnant</b>	Office visits	\$50 <a href="#">Copay</a>	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	\$50 <a href="#">Copay</a>	Not Covered	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.
	Childbirth/delivery facility services	\$350 <a href="#">Copay</a> per Day (\$1,750 Maximum, Days 1-5)	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$30 <a href="#">Copay</a>	Not Covered	20 Days per Benefit Period. Prior authorization is required.
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">Copay</a>	Not Covered	35 Visit(s) per Benefit Period. Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Habilitation services</a>	\$50 <a href="#">Copay</a>	Not Covered	35 Visit(s) per Benefit Period. Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Skilled nursing care</a>	\$15 <a href="#">Copay</a> per Day	Not Covered	60 Days per Benefit Period. Prior authorization is required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">Coinsurance</a>	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Prior authorization is required.
	<a href="#">Hospice services</a>	\$30 <a href="#">Copay</a>	Not Covered	None
If your child needs dental or eye care	Children's eye exam	\$10 <a href="#">Copay</a>	Not Covered	Coverage limited to one exam/year.
	Children's glasses	\$25 <a href="#">Copay</a>	Not Covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	No Charge	Not Covered	Coverage limited to two visits/year.

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Abortion with the Exception of Limited Services</li> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)
<ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Weight loss programs</li> </ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa> or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the insurer at 1-877-615-4022. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>.

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

#### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-615-4022

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-615-4022

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-615-4022

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-615-4022

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$350
■ Other <a href="#">copayment</a>	\$50

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,360</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$350
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$350
■ Other <a href="#">copayment</a>	\$350

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,450</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.