



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-2026.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 or call 1-877-615-4022 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network providers</u> : \$6,000 individual / \$12,000 family. <u>Out-of-network providers</u> : Not Covered	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and services not subject to deductible	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>Network providers</u> : \$10,150 individual / \$20,300 family; <u>Out-of-network providers</u> : Not Covered	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://www.fhcp.com/our-provider-network/ or call 1 (877) 615-4022 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$65 <u>Copay</u> . Deductible does not apply.	Not Covered	Additional cost share may apply for Allergy Shots, Injections and Infusions. See schedule of benefits for telehealth benefit specific cost sharing through designated <u>provider</u> .
	<u>Specialist</u> visit	\$120 <u>Copay</u> . Deductible does not apply.	Not Covered	Additional cost share may apply for Allergy Shots, Injections and Infusions.
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$50 <u>Copay</u> for laboratory & professional services at an independent clinical lab. \$150 <u>Copay</u> for x- ray & diagnostic imaging at an independent diagnostic testing center. \$100 <u>Copay</u> for laboratory & professional services and \$300 <u>Copay</u> for x-ray & diagnostic imaging at an outpatient hospital facility.	Not Covered	Prior authorization is required. Tests in hospitals, or facilities owned or operated by hospitals are subject to the outpatient hospital facility cost share. 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
	Imaging (CT/PET scans, MRIs)	\$1,000 <u>Copay</u> at an independent facility / \$2,000 <u>Copay</u> 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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://fm.formularynavigator.com/FBO/126/2026_QHP_Formulary.pdf	Generic drugs – preferred / non-preferred	\$4 Copay / \$35 Copay Deductible does not apply.	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	Deductible + 35% Coinsurance	Not Covered	
	Non-preferred brand drugs	Deductible + 40% Coinsurance	Not Covered	
	Specialty drugs – preferred / non-preferred	Deductible + 45% Coinsurance / Deductible + 45% Coinsurance	Not Covered	31 Days per Benefit Period. Available at FHCP Pharmacy Only. Mail Order not available.
If you have outpatient surgery	Facility fee (ambulatory surgery center (ASC) / outpatient hospital facility OHF	\$2,000 Copay – ASC. Deductible does not apply. / \$2,500 Copay – OHF. Deductible does not apply.	Not Covered	Pre-certification/pre-authorization of coverage required for non-emergency outpatient surgical care. Your benefits/services may be denied.
	Physician/surgeon fees	\$120 Copay .	Not Covered	Prior approval required. Your benefits/services may be denied.
If you need immediate medical attention	Emergency room care	\$1,000 Copay . Deductible does not apply.	\$1,000 Copay . Deductible does not apply.	Waived if admitted.
	Emergency medical transportation	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	None
	Urgent care	\$100 Copay . Deductible does not apply.	\$100 Copay . Deductible does not apply.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$2,500 Copay per Day / \$7,500 maximum. Deductible does not apply.	Not Covered	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$120 Copay . Deductible does not apply.	Not Covered	The cost share displayed applies to outpatient office visits only, other outpatient services may be subject to additional cost share.
	Inpatient services	\$2,500 Copay per Day / \$7,500 maximum. Deductible does not apply.	Not Covered	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.

* For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/qhp-small-group-2026.pdf>.

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 are pregnant	Office visits	\$120 Copay . Deductible does not apply.	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.
	Childbirth/delivery facility services	\$2,500 Copay per Day / \$7,500 maximum. Deductible does not apply.	Not Covered	
If you need help recovering or have other special health needs	Home health care	50% Coinsurance . Deductible does not apply.	Not Covered	20 Days per Benefit Period. Prior authorization is required.
	Rehabilitation services	\$80 Copay . Deductible does not apply.	Not Covered	35 Visit(s) per Benefit Period. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	\$80 Copay . Deductible does not apply.	Not Covered	35 Visit(s) per Benefit Period. Includes physical therapy, speech therapy, and occupational therapy.
	Skilled nursing care	\$50 Copay per Day. Deductible does not apply.	Not Covered	60 Days per Benefit Period. Prior authorization is required.
	Durable medical equipment	50% Coinsurance . Deductible does not apply.	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Prior authorization is required.
	Hospice services	50% Coinsurance . Deductible does not apply.	Not Covered	None
If your child needs dental or eye care	Children's eye exam	\$10 Copay . Deductible does not apply.	Not Covered	Coverage limited to one exam/year.
	Children's glasses	\$25 Copay . Deductible does not apply.	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none">• Abortion with the Exception of Limited Services• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care (Adult)	<ul style="list-style-type: none">• Hearing Aids• Infertility treatment• Long-term care	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Private-duty nursing• Routine eye care (Adult)• Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care
- Weight loss programs

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. 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 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, kwiijigo holne' 1-877-615-4022

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

* For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/ghp-small-group-2026.pdf>.

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 plan's overall deductible	\$6000
■ Specialist copayment	\$120
■ Hospital (facility) copayment	\$2500
■ Other copayment	\$150

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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing

Deductibles	\$0
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Copayments	\$5,900
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Coinsurance	\$0
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What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$5,960
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Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$6000
■ Specialist copayment	\$120
■ Hospital (facility) copayment	\$2500
■ Other coinsurance	50%

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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing

Deductibles	\$3,100
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Copayments	\$1,200
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Coinsurance	\$0
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What isn't covered

Limits or exclusions	\$20
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The total Joe would pay is	\$4,320
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Mia's Simple Fracture

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

■ The plan's overall deductible	\$6000
■ Specialist copayment	\$120
■ Hospital (facility) copayment	\$2500
■ Other copayment	\$1000

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing

Deductibles	\$900
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Copayments	\$1,200
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Coinsurance	\$100
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What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$2,200
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.