



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



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 provider's office or clinic | Primary care visit to treat an injury or illness | \$65 Copay . 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 provider . |
| | Specialist visit | \$120 Copay . Deductible does not apply. | Not Covered | Additional cost share may apply for Allergy Shots, Injections and Infusions. |
| | Preventive care/screening/immunization | No Charge | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | <p>\$50 Copay for laboratory & professional services at an independent clinical lab.</p> <p>\$150 Copay for x-ray & diagnostic imaging at an independent diagnostic testing center.</p> <p>\$100 Copay for laboratory & professional services and \$300 Copay for x-ray & 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) | \$1,000 Copay at an independent facility / \$2,000 Copay at an outpatient hospital facility. | Not Covered | |

* 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>.

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|---|--|---|--|---|
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| 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. |

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| If you are pregnant | Office visits | \$120 <u>Copay</u> . 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 <u>Copay</u> per Day / \$7,500 maximum. Deductible does not apply. | Not Covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 50% <u>Coinsurance</u> . Deductible does not apply. | Not Covered | 20 Days per Benefit Period. Prior authorization is required. |
| | <u>Rehabilitation services</u> | \$80 <u>Copay</u> . Deductible does not apply. | Not Covered | 35 Visit(s) per Benefit Period. Includes physical therapy, speech therapy, and occupational therapy. |
| | <u>Habilitation services</u> | \$80 <u>Copay</u> . Deductible does not apply. | Not Covered | 35 Visit(s) per Benefit Period. Includes physical therapy, speech therapy, and occupational therapy. |
| | <u>Skilled nursing care</u> | \$50 <u>Copay</u> per Day. Deductible does not apply. | Not Covered | 60 Days per Benefit Period. Prior authorization is required. |
| | <u>Durable medical equipment</u> | 50% <u>Coinsurance</u> . Deductible does not apply. | Not Covered | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Prior authorization is required. |
| | <u>Hospice services</u> | 50% <u>Coinsurance</u> . Deductible does not apply. | Not Covered | None |
| If your child needs dental or eye care | Children's eye exam | \$10 <u>Copay</u> . Deductible does not apply. | Not Covered | Coverage limited to one exam/year. |
| | Children's glasses | \$25 <u>Copay</u> . 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](#).)

- | | | |
|---|-------------------------|--|
| • Abortion with the Exception of Limited Services | • Hearing Aids | • Non-emergency care when traveling outside the U.S. |
| • Acupuncture | • Infertility treatment | • Private-duty nursing |
| • Bariatric surgery | • Long-term care | • Routine eye care (Adult) |
| • Cosmetic surgery | | • Routine foot care |
| • Dental care (Adult) | | |

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, 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 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 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------|---------|
| Deductibles | \$0 |
| Copayments | \$5,900 |
| Coinsurance | \$0 |

| <i>What isn't covered</i> | |
|---------------------------|------|
| Limits or exclusions | \$60 |

| | |
|-----------------------------------|----------------|
| The total Peg would pay is | \$5,960 |
|-----------------------------------|----------------|

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 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------|---------|
| Deductibles | \$3,100 |
| Copayments | \$1,200 |
| Coinsurance | \$0 |

| <i>What isn't covered</i> | |
|---------------------------|------|
| Limits or exclusions | \$20 |

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$4,320 |
|-----------------------------------|----------------|

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 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------|---------|
| Deductibles | \$900 |
| Copayments | \$1,200 |
| Coinsurance | \$100 |

| <i>What isn't covered</i> | |
|---------------------------|-----|
| Limits or exclusions | \$0 |

| | |
|-----------------------------------|----------------|
| The total Mia would pay is | \$2,200 |
|-----------------------------------|----------------|

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