



Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage for: Individual and/or Family | **Plan Type:** POS



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/2026-large-group.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> : \$0 Individual/ \$0 Family – Option 1 \$250 Individual/\$500 Family – Option 2 <u>Out-of-network providers</u> : \$500 Individual / \$1,000 Family – Option 3	Generally, you must pay all of the costs from providers 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> . <u>Deductible</u> amounts cross-accumulate between Option 1 and Option 2.
Are there services covered before you meet your <u>deductible</u> ?	Yes. In-Network <u>preventive care</u> , and services not subject to the 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> : \$3,000 Individual/ \$6,000 Family – Option 1 \$4,000 Individual/\$8,000 Family – Option 2 <u>Out-of-network providers</u> : \$6,000 Individual/ \$12,000 Family – Option 3	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. <u>Out-of-pocket maximum</u> amounts cross-accumulate between Option 1 and Option 2.
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 www.fhcp.com/find-providers/physician or call 1-877-615-4022 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in Option 1. You pay more if you use a <u>provider</u> in Option 2. 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 provider's 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> ?	No.	You can see the <u>Specialist</u> you choose without a referral.



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	Option 1: \$20 Copay /Visit Option 2: \$30 Copay /Visit	Option 3: Deductible + 50% Coinsurance	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	Option 1: \$35 Copay /Visit Option 2: Deductible + 30% Coinsurance	Option 3: Deductible + 50% Coinsurance	Additional cost share may apply for Allergy shots, Injections and Infusions.
	Preventive care/screening /immunization	Option 1: No charge Option 2: No charge	Option 3: Deductible + 50% Coinsurance	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)	Option 1: Lab work: No charge for laboratory & professional services at an independent clinical lab. Option 2: Not Covered. Option 1: X-ray: No charge / Option 2: Deductible + 30% Coinsurance for x-ray & diagnostic imaging at an independent diagnostic testing center. Option 1: \$25 Copay for laboratory & professional services and \$50 Copay for x-ray & diagnostic imaging at an outpatient hospital facility / Option 2: Not Covered at an outpatient hospital facility.	Option 3: Deductible + 50% Coinsurance	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.

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)	
	Imaging (CT/PET scans, MRIs)	Option 1: No charge / Option 2: <u>Deductible</u> + 30% <u>Coinsurance</u> at an independent facility. Option 1: \$100 <u>Copay</u> at an outpatient hospital facility / Option 2: Not Covered at an outpatient hospital facility.	Option 3: <u>Deductible</u> + 50% <u>Coinsurance</u>	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://fm.formularynavi.gator.com/FBO/126/2026_NGF_Formulary.pdf	Generic drugs – preferred / non-preferred	Retail: \$3 <u>Copay</u> per <u>prescription</u> for Preferred at FHCP/ Mail Order: \$6 <u>Copay</u> per <u>prescription</u> for Preferred/ Retail: \$10 <u>Copay</u> per <u>prescription</u> for Non-Preferred at FHCP/ Mail Order: \$27 <u>Copay</u> per <u>prescription</u> for Non-Preferred/ Retail: \$15 <u>Copay</u> per <u>prescription</u> at select Non-Preferred Retail Pharmacies.	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	Retail: \$30 <u>Copay</u> per <u>prescription</u> at FHCP/ Mail Order: \$87 <u>Copay</u> per <u>prescription</u> / Retail: \$35 <u>Copay</u> per <u>prescription</u> at select Non-Preferred Retail Pharmacies.	Not covered	
	Non-preferred brand drugs	Retail: \$55 <u>Copay</u> per <u>prescription</u> at FHCP/ Mail Order: \$162 <u>Copay</u> per <u>prescription</u> / Retail: \$60 <u>Copay</u> per <u>prescription</u> at select Non-Preferred Retail Pharmacies.	Not covered	
	<u>Specialty drugs</u> – preferred / non-preferred	Retail: 15% <u>Coinsurance</u> for Preferred Specialty at FHCP. 25% <u>Coinsurance</u> for Non-Preferred Specialty at select Non-	Not covered	31 Days per Benefit Period. Available at FHCP Pharmacy Only. Mail Order not available.

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)	
		Preferred Retail Pharmacies.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center (ASC) / outpatient hospital facility (OHF))	Option 1: \$100 <u>Copay</u> – ASC / \$200 <u>Copay</u> – OHF Option 2: Not covered	Option 3: <u>Deductible</u> + 50% <u>Coinsurance</u>	Pre-certification/pre-authorization of coverage required for non-emergency outpatient surgical care. Your benefits / services may be denied.
	Physician/surgeon fees	Option 1: No charge Option 2: <u>Deductible</u> + 30% <u>Coinsurance</u>	Option 3: <u>Deductible</u> + 50% <u>Coinsurance</u>	Prior approval required. Your benefits / services may be denied.
If you need immediate medical attention	<u>Emergency room care</u>	Option 1: \$100 <u>Copay</u> /Visit Option 2: \$100 <u>Copay</u> /Visit	Option 3: \$100 <u>Copay</u> /Visit	Waived if admitted.
	<u>Emergency medical transportation</u>	Option 1: \$100 <u>Copay</u> /Transport Option 2: \$100 <u>Copay</u> /Transport	Option 3: \$100 <u>Copay</u> /Transport	—————none—————
	<u>Urgent care</u>	Option 1: \$60 <u>Copay</u> /Visit Option 2: \$60 <u>Copay</u> /Visit	Option 3: \$60 <u>Copay</u> /Visit	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	Option 1: \$250 per Day / \$1,250 max Option 2: Not covered	Option 3: <u>Deductible</u> + 50% <u>Coinsurance</u>	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.
	Physician/surgeon fees	Option 1: No charge Option 2: <u>Deductible</u> + 30% <u>Coinsurance</u>	Option 3: <u>Deductible</u> + 50% <u>Coinsurance</u>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Option 1: \$35 <u>Copay</u> /Visit Option 2: <u>Deductible</u> + 30% <u>Coinsurance</u>	Option 3: <u>Deductible</u> + 50% <u>Coinsurance</u>	The cost share displayed applies to outpatient office visits only, other outpatient services may be subject to additional cost share.
	Inpatient services	Option 1: \$250 per Day / \$1,250 max Option 2: Not covered	Option 3: <u>Deductible</u> + 50% <u>Coinsurance</u>	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
If you are pregnant	Office visits	Option 1: \$35 <u>Copay</u> /Visit Option 2: <u>Deductible</u> + 30% <u>Coinsurance</u>	Option 3: <u>Deductible</u> + 50% <u>Coinsurance</u>	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	Option 1: No charge Option 2: Deductible + 30% Coinsurance	Option 3: Deductible + 50% Coinsurance	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
	Childbirth/delivery facility services	Option 1: \$250 per Day / \$1,250 max Option 2: Not covered	Option 3: Deductible + 50% Coinsurance	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
If you need help recovering or have other special health needs	Home health care	Option 1: \$15 Copay /Day Option 2: Not covered	Option 3: Deductible + 50% Coinsurance	Prior approval required. Your benefits / services may be denied. Prior approval required. Coverage limited to 60 days.
	Rehabilitation services	Option 1: \$15 Copay /Visit Option 2: Deductible + 30% Coinsurance	Option 3: Deductible + 50% Coinsurance	Coverage limited to 20 visits. Includes Physical, Speech, Occupational Therapy
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Option 1: \$50 Copay /Day Option 2: Not covered	Option 3: Deductible + 50% Coinsurance	Pre-certification/pre-authorization of coverage required. Your benefits / services may be denied. Coverage limited to 20 days.
	Durable medical equipment	Option 1: 15% Coinsurance Option 2: Not covered	Option 3: Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Prior authorization is required.
	Hospice services	Option 1: \$15 Copay /Day Option 2: Not covered	Option 3: Deductible + 50% Coinsurance	—————none—————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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](#).)

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|---|-------------------------|----------------------------|
| • Abortion with the Exception of Limited Services | • Habilitation services | • Private-duty nursing |
| • Acupuncture | • Hearing aids | • Routine eye care (Adult) |

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

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| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Dental care (Child) | <ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine eye care (Child) • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none"> • Chiropractic care | <ul style="list-style-type: none"> • Bariatric surgery |
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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 www.dol.gov/ebsa/healthreform or the 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 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 Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health [plans](#) and church [plans](#) that are group health [plans](#) contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your [appeal](#). Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

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 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): Dinekehgo 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.

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcop.com/documents/coc/2026-large-group.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	\$0
■ Specialist copayment	\$35
■ Hospital (facility) copayment	\$250
■ Other copayment	\$0

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
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$560

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$35
■ Hospital (facility) copayment	\$250
■ Other coinsurance	15%

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	\$0
Copayments	\$1,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$35
■ Hospital (facility) copayment	\$250
■ Other copayment	\$100

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	\$0
Copayments	\$500
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$540

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