

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/2027-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 deductible ?	Network providers : \$500 Individual/\$1,000 Family – Option 1 \$1,000 Individual/\$2,000 Family – Option 2 Out-of-network providers : \$2,000 Individual/\$4,000 Family – Option 3	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 . Deductible amounts cross-accumulate between Option 1 and Option 2.
Are there services covered before you meet your deductible ?	Yes. In-Network preventive care , and services not subject to the 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 : \$4,000 Individual/ \$8,000 Family – Option 1 \$4,000 Individual/\$8,000 Family – Option 2 Out-of-network providers : \$6,000 Individual/\$12,000 Family – Option 3	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. Out-of-pocket maximum amounts cross-accumulate between Option 1 and Option 2.
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 www.fhcp.com/find-providers/physician or call 1-877-615-4022 for a list of network providers .	You pay the least if you use a provider in Option 1. You pay more if you use a provider in Option 2. 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 ?	No.	You can see the Specialist 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 Deductible does not apply. Option 2: \$35 Copay /Visit Deductible does not apply.	Option 3: Deductible + 30% Coinsurance	Additional cost sharing 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 Deductible does not apply. Option 2: \$60 Copay /Visit Deductible does not apply.	Option 3: Deductible + 30% Coinsurance	Additional cost sharing may apply for Allergy shots, Injections and Infusions.
	Preventive care/screening /immunization	Option 1: No charge Option 2: No charge	Option 3: Deductible + 30% 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 + 20% Coinsurance for x-ray & diagnostic imaging at an independent diagnostic testing center. Option 1: Deductible + 10% Coinsurance for laboratory & professional services and Deductible + 10% Coinsurance for x-ray & diagnostic imaging at an outpatient hospital facility / Option 2: Not Covered at an outpatient	Option 3: Deductible + 30% Coinsurance	Prior authorization is required. Tests in hospitals, or facilities owned or operated by hospitals are subject to the outpatient hospital facility cost shar cost sharing . 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.

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcop.com/documents/coc/2027-large-group.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)	
		hospital facility.		
	Imaging (CT/PET scans, MRIs)	Option 1: \$150 Copay . Deductible does not apply. / Option 2: Deductible + 20% Coinsurance at an independent facility. Option 1: Deductible + 10% Coinsurance at an outpatient hospital facility / Option 2: Not Covered at an outpatient hospital facility.	Option 3: Deductible + 30% Coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://fm.formularynavigator.com/FBO/126/2027_NGF_Formulary.pdf	Generic drugs – preferred / non-preferred	Preferred Generic: \$3 Copay at Preferred Retail Pharmacy / Mail Order: \$9 Copay . Non-Preferred Generic: \$10 Copay at Preferred Retail Pharmacy / Mail Order: \$30 Copay . Non-Preferred Retail Pharmacy: \$15 Copay .	Not covered	31 Days per Benefit Period. Available at Preferred and Non-Preferred Retail Pharmacies only. Up to 93-day Mail Order is only available through a Preferred Pharmacy.
	Preferred brand drugs	\$30 Copay at Preferred Retail Pharmacy / Mail Order: \$90 Copay . \$35 Copay at Non-Preferred Retail Pharmacies.	Not covered	Copay is per prescription order up to the day supply limit listed above.
	Non-preferred brand drugs	\$55 Copay at Preferred Retail Pharmacy / Mail Order: \$165 Copay . \$60 Copay at Non-Preferred Retail Pharmacies.	Not covered	Go to www.fhcp.com and click find a pharmacy to locate Preferred and Non-Preferred pharmacy locations.
	Specialty drugs – preferred / non-preferred	Preferred Specialty: 15% Coinsurance at Preferred Retail Pharmacy. Non-Preferred Specialty: 25% Coinsurance at Preferred Retail Pharmacy.	Not covered	31 Days per Benefit Period. Available at a Preferred Pharmacy only. Mail Order not available.

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/2027-large-group.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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Option 1: Deductible + 10% Coinsurance Option 2: Not covered	Option 3: Deductible + 30% Coinsurance	Pre-certification/Pre-authorization of coverage required for non-emergency outpatient surgical care. Your benefits / services may be denied.
	Physician/surgeon fees	Option 1: Deductible + 10% Coinsurance Option 2: Deductible + 20% Coinsurance	Option 3: Deductible + 30% Coinsurance	Prior approval required. Your benefits / services may be denied.
If you need immediate medical attention	Emergency room care	Option 1: \$100 Copay /Visit Deductible does not apply. Option 2: \$100 Copay /Visit Deductible does not apply.	Option 3: \$100 Copay /Visit. Deductible does not apply.	Waived if admitted.
	Emergency medical transportation	Option 1: Deductible + 10% Coinsurance Option 2: Deductible + 10% Coinsurance	Option 3: In-Network Deductible + 10% Coinsurance	None
	Urgent care	Option 1: \$75 Copay /Visit Deductible does not apply. Option 2: \$75 Copay /Visit Deductible does not apply.	Option 3: \$75 Copay /Visit. Deductible does not apply.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Option 1: Deductible + 10% Coinsurance Option 2: Not covered	Option 3: Deductible + 30% Coinsurance	Pre-certification/Pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
	Physician/surgeon fees	Option 1: Deductible + 10% Coinsurance Option 2: Deductible + 20% Coinsurance	Option 3: Deductible + 30% Coinsurance	None

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 mental health, behavioral health, or substance abuse services	Outpatient services	Option 1: \$35 Copay /Visit Deductible does not apply. Option 2: \$60 Copay /Visit Deductible does not apply.	Option 3: Deductible + 30% Coinsurance	The cost sharing displayed applies to outpatient office visits only, other outpatient services may be subject to additional cost sharing .
	Inpatient services	Option 1: Deductible + 10% Coinsurance Option 2: Not covered	Option 3: Deductible + 30% Coinsurance	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 Copay /Visit Deductible does not apply. Option 2: \$60 Copay /Visit Deductible does not apply.	Option 3: Deductible + 30% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Option 1: Deductible + 10% Coinsurance Option 2: Deductible + 20% Coinsurance	Option 3: Deductible + 30% Coinsurance	Pre-certification/Pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
	Childbirth/delivery facility services	Option 1: Deductible + 10% Coinsurance Option 2: Not covered	Option 3: Deductible + 30% 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: Deductible + 10% Coinsurance Option 2: Not covered	Option 3: Deductible + 30% Coinsurance	Prior approval required. Your benefits / services may be denied. Coverage limited to 60 days.
	Rehabilitation services	Option 1: Deductible + 10% Coinsurance Option 2: Deductible + 20% Coinsurance	Option 3: Deductible + 30% Coinsurance	Coverage limited to 20 visits. Includes Physical, Speech, Occupational Therapy.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Option 1: Deductible + 10% Coinsurance Option 2: Not covered	Option 3: Deductible + 30% Coinsurance	Pre-certification/Pre-authorization of coverage required. Your benefits / services may be denied. Coverage limited to 20 days.

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/2027-large-group.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)	
	Durable medical equipment	Option 1: Deductible + 10% Coinsurance Option 2: Not covered	Option 3: Deductible + 30% Coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Prior authorization is required.
	Hospice services	Option 1: Deductible + 10% Coinsurance Option 2: Not covered	Option 3: Deductible + 30% 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 .)		
- Abortion with the Exception of Limited Services - Acupuncture - Cosmetic surgery - Dental care (Adult) - Dental care (Child)	Habilitation services - Hearing aids - Infertility treatment - Long-term care - Non-emergency care when traveling outside the U.S.	- Private-duty nursing - Routine eye care (Adult) - Routine eye care (Child) - Routine foot care - Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
Chiropractic care	Bariatric surgery	

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.

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	\$500
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	10%
■ Other copayment	\$0

This EXAMPLE event includes services like:

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

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayment	\$50
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,410

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

[Primary Care physician](#) office visits (*including disease education*)
[Diagnostic test](#) (*blood work*)
[Prescription Drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayment	\$1,000
Coinsurance	\$0
What isn't covered	
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	\$500
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	10%
■ 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
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayment	\$200
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$800

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