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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $0. Out-of-network providers: $250 individual / $500 family.	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?	Not Applicable	
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: $3,200 individual / $6,400 family; Out-of-network providers: $6,000 individual / $12,000 family.	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?	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	$10 Copay	Deductible + 50% Coinsurance	Additional cost share may apply for Allergy Shots, Injections and Infusions.
	Specialist visit	$20 Copay	Deductible + 50% Coinsurance	Additional cost share may apply for Allergy Shots, Injections and Infusions.
	Preventive care/screening/ immunization	No Charge	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)	$30 Copay for laboratory & professional services. $30 Copay for x-ray & diagnostic imaging. $30 Copay for laboratory & professional services and $30 Copay for x-ray & diagnostic imaging at an outpatient hospital facility.	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.
	Imaging (CT/PET scans, MRIs)	$100 Copay at an independent facility / $100 Copay at an outpatient hospital facility.	Deductible + 50% 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/126/2024_QHP_Standard_Formulary.	Generic drugs – preferred / non-preferred	$5 Copay / $5 Copay	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	$10 Copay	Not Covered	
	Non-preferred brand drugs	$50 Copay	Not Covered	
	Specialty drugs – preferred / non-preferred	$150 Copay / $150 Copay	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)	
pdf				
If you have outpatient surgery	Facility fee (ambulatory surgery center (ASC) / outpatient hospital facility (OHF))	$150 Copay – ASC / $300 Copay – OHF	Deductible + 50% Coinsurance	Pre-certification/pre-authorization of coverage required for non-emergency outpatient surgical care. Your benefits/services may be denied.
	Physician/surgeon fees	$150 Copay	Deductible + 50% Coinsurance	Prior approval required. Your benefits/services may be denied.
If you need immediate medical attention	Emergency room care	$100 Copay	$100 Copay. Deductible does not apply.	Waived if admitted.
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	None
	Urgent care	$15 Copay	$15 Copay. Deductible does not apply.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 Copay per Stay	Deductible + 50% Coinsurance	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.
	Physician/surgeon fees	No Charge	Deductible + 50% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 Copay	Deductible + 50% Coinsurance	None
	Inpatient services	$350 Copay per Stay	Deductible + 50% Coinsurance	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.
If you are pregnant	Office visits	$20 Copay	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No Charge	Deductible + 50% Coinsurance	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.
	Childbirth/delivery facility services	$350 Copay per Stay	Deductible + 50% Coinsurance	

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 help recovering or have other special health needs	Home health care	10% Coinsurance	Deductible + 50% Coinsurance	20 Days per Benefit Period. Prior authorization is required.
	Rehabilitation services	$10 Copay	Deductible + 50% Coinsurance	35 Visit(s) per Benefit Period. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	$10 Copay	Deductible + 50% Coinsurance	35 Visit(s) per Benefit Period. Includes physical therapy, speech therapy, and occupational therapy.
	Skilled nursing care	$150 Copay	Deductible + 50% Coinsurance	60 Days per Benefit Period. Prior authorization is required.
	Durable medical equipment	10% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Prior authorization is required.
	Hospice services	10% Coinsurance	Deductible + 50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	$10 Copay	Not Covered	Coverage limited to one exam/year.
	Children's glasses	$25 Copay	Not Covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	Not Covered	Not Covered	None

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Hearing Aids
- Infertility treatment
- Long-term care
- 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

* For more information about limitations and exceptions, see the plan or policy document at http://www.fhcp.com/documents/coc/qhp-ind-2024.pdf

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? Not Applicable
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.

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	$20
Hospital (facility) copayment	$350
Other copayment	$30

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:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

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	$20
Hospital (facility) copayment	$350
Other coinsurance	10%

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:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$350
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	$0
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

The plan would be responsible for the other costs of these EXAMPLE covered services.