
 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/2023-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.fhcp.com 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> : \$750 Individual/ \$1,500 Family <u>Out-of-network providers</u> : Not covered	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> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <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</u> services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> services at 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> : \$5,000 Individual/ \$10,000 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 www.fhcp.com/find-providers/physician or call 1-877-615-4022 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 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> ?	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 provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>Copay</u> /Visit	Not covered	Additional <u>cost share</u> may apply for Allergy shots, Injections and Infusions.
	<u>Specialist</u> visit	\$50 <u>Copay</u> /Visit	Not covered	Additional <u>cost share</u> 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 <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab work: No Charge / X-ray: \$50 <u>Copay</u> /Test	Not covered	Cost sharing varies based on type of diagnostic test performed. Tests in hospitals, or facilities owned and operated by hospitals, may have higher cost share.
	Imaging (CT/PET scans, MRIs)	\$250 <u>Copay</u> /Test	Not covered	Prior approval required. Your benefits / services may be denied. Tests in hospitals, or facilities owned and operated by hospitals, may have higher cost share.

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/2023-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 need drugs to treat your illness or condition More information about prescription drug coverage is available at https://fm.formularynavigator.com/FBO/126/2023_NGF_Formulary.pdf	Generic drugs	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 Walgreen's.	Not covered	Covers up to 31 day supply at retail pharmacy, and up to 93 day supply for mail order.
	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 Walgreen's.	Not covered	Covers up to 31 day supply at retail pharmacy, and up to 93 day supply for mail order.
	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 Walgreen's.	Not covered	Covers up to 31 day supply at retail pharmacy, and up to 93 day supply for mail order.
	Specialty drugs	Retail: \$250 <u>Copay</u> for Preferred Specialty at FHCP. \$250 <u>Copay</u> for Non-Preferred Specialty at FHCP.	Not covered	Available at FHCP pharmacies only.
If you have outpatient surgery	Facility fee (ambulatory surgery center (ASC) / outpatient hospital facility (OHF))	\$300 <u>Copay</u> – ASC \$500 <u>Copay</u> – OHF	Not covered	Pre-certification/pre-authorization of coverage required for non-emergency outpatient surgical care. Your benefits / services may be denied.
	Physician/surgeon fees	No charge	Not covered	Prior approval required. Your benefits / services may be denied.
If you need immediate medical attention	Emergency room care	\$250 <u>Copay</u>	\$250 <u>Copay</u>	Waived if admitted.
	Emergency medical transportation	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	—————none—————

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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)	
	Urgent care	\$65 <u>Copay</u>	\$65 <u>Copay</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 <u>Copay/Day</u> (\$1,500 Maximum, Days 1-5)	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	\$50 <u>Copay/Visit</u>	Not covered	—————none—————
	Inpatient services	\$300 <u>Copay/Day</u> (\$1,500 Maximum, Days 1-5)	Not covered	Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
If you are pregnant	Office visits	\$50 <u>Copay/Visit</u>	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	\$300 <u>Copay/Day</u> (\$1,500 Maximum, Days 1-5)	Not covered	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	<u>Deductible</u> + 20% <u>Coinsurance</u>	Not covered	Prior approval required. Your benefits / services may be denied. Prior approval required. Coverage limited to 60 visits.
	Rehabilitation services	\$50 <u>Copay/Visit</u>	Not covered	Coverage limited to 20 visits. Includes Physical, Speech, Occupational Therapy
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	<u>Deductible</u> + 20% <u>Coinsurance</u>	Not covered	Pre-certification/pre-authorization of coverage required. Your benefits /

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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)	
				services may be denied. Coverage limited to 20 days.
	Durable medical equipment	<u>Deductible</u> + 20% <u>Coinsurance</u>	Not covered	Prior approval required. Your benefits / services may be denied. Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	<u>Deductible</u> + 20% <u>Coinsurance</u>	Not covered	—————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 .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (Adult) • Dental care (Child) 	<ul style="list-style-type: none"> • Habilitation services • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Chiropractic care 	<ul style="list-style-type: none"> • 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/consumer_info_health.html.

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): 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.

For more information about limitations and exceptions, see the plan or policy document at <http://www.fhcp.com/documents/coc/2023-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** \$750
- **Specialist copayment** \$50
- **Hospital (facility) copayment** \$300
- **Other copayment** \$50

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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** \$750
- **Specialist copayment** \$50
- **Hospital (facility) copayment** \$300
- **Other coinsurance** 20%

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

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

- The **plan's overall deductible** \$750
- **Specialist copayment** \$50
- **Hospital (facility) copayment** \$300
- **Other copayment** \$250

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,540

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