



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-2025.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](http://www.cciio.cms.gov) or call 1-877-615-4022 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">Network providers</a> : \$0. <a href="#">Out-of-network providers</a> : \$10,000 individual / \$20,000 family.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and cost sharing without a deductible.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes, \$0 at IHCP or with IHCP referral at non-IHCP; \$2,000 individual / \$4,000 family for non-preferred brand and specialty prescription drug coverage.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<a href="#">Network providers</a> : \$9,200 individual / \$18,400 family; <a href="#">Out-of-network providers</a> : \$20,000 individual / \$40,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="https://www.fhcp.com/our-provider-network/">https://www.fhcp.com/our-provider-network/</a> or call 1 (877) 615-4022 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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
		Indian Health Care Provider (You will pay the least)	Non-IHCP Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	No Charge	\$50 <a href="#">Copay</a>	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Additional cost share may apply for Allergy Shots, Injections and Infusions. See <a href="#">plan</a> brochure/schedule of benefits for telehealth benefit specific cost sharing through designated <a href="#">provider</a> .
	<a href="#">Specialist</a> visit	No Charge	\$85 <a href="#">Copay</a>	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Additional cost share may apply for Allergy Shots, Injections and Infusions.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	No Charge	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	<p>\$55 <a href="#">Copay</a> for laboratory &amp; professional services at an independent clinical lab.</p> <p>\$100 <a href="#">Copay</a> for x-ray &amp; diagnostic imaging at an independent diagnostic testing center.</p> <p>\$110 <a href="#">Copay</a> for laboratory &amp; professional services and \$200 <a href="#">Copay</a> for x-ray &amp; diagnostic imaging at an outpatient hospital facility.</p>	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<p><a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a>.</p> <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</p>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (You will pay the least)	Non-IHCP Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	No Charge	\$850 <a href="#">Copay</a> at an independent facility / \$1,700 <a href="#">Copay</a> at an outpatient hospital facility.	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	of benefits. See your policy for more details.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://fm.formularynavigator.com/FBO/12/2025_QHP_Formulary.pdf">https://fm.formularynavigator.com/FBO/12/2025_QHP_Formulary.pdf</a>	Generic drugs – preferred / non-preferred	No Charge	\$4 <a href="#">Copay</a> / \$30 <a href="#">Copay</a>	Not Covered	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . 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	No Charge	\$250 <a href="#">Copay</a>	Not Covered	
	Non-preferred brand drugs	No Charge	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	Not Covered	
	<a href="#">Specialty drugs</a> – preferred / non-preferred	No Charge	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a> / <a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (ambulatory surgery center (ASC) / outpatient hospital facility (OHF))	No Charge	\$1,000 <a href="#">Copay</a> – ASC / \$2,000 <a href="#">Copay</a> – OHF	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Pre-certification/pre-authorization of coverage required for non-emergency outpatient surgical care. Your benefits/services may be denied.
	Physician/surgeon fees	No Charge	\$85 <a href="#">Copay</a>	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Prior approval required. Your benefits/services may be denied.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No Charge	\$1,000 <a href="#">Copay</a>	\$1,000 <a href="#">Copay</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Waived if admitted.
	<a href="#">Emergency medical transportation</a>	No Charge	50% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <http://www.fhpc.com/documents/coc/qhp-ind-2025.pdf>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (You will pay the least)	Non-IHCP Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Urgent care</a>	No Charge	\$85 <a href="#">Copay</a>	\$85 <a href="#">Copay</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No Charge	\$3,000 <a href="#">Copay</a> per Stay	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.
	Physician/surgeon fees	No Charge	No Charge	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No Charge	\$85 <a href="#">Copay</a>	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Inpatient services	No Charge	\$3,000 <a href="#">Copay</a> per Stay	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.
<b>If you are pregnant</b>	Office visits	No Charge	\$85 <a href="#">Copay</a>	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No Charge	No Charge	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.
	Childbirth/delivery facility services	No Charge	\$3,000 <a href="#">Copay</a> per Stay	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (You will pay the least)	Non-IHCP Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No Charge	50% <a href="#">Coinsurance</a>	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . 20 Days per Benefit Period. Prior authorization is required.
	<a href="#">Rehabilitation services</a>	No Charge	\$85 <a href="#">Copay</a>	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . 35 Visit(s) per Benefit Period. Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Habilitation services</a>	No Charge	\$85 <a href="#">Copay</a>	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . 35 Visit(s) per Benefit Period. Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Skilled nursing care</a>	No Charge	\$50 <a href="#">Copay</a> per Day	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . 60 Days per Benefit Period. Prior authorization is required.
	<a href="#">Durable medical equipment</a>	No Charge	50% <a href="#">Coinsurance</a>	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Prior authorization is required.
	<a href="#">Hospice services</a>	No Charge	50% <a href="#">Coinsurance</a>	<a href="#">Deductible</a> + 50% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	\$10 <a href="#">Copay</a>	Not Covered	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Coverage limited to one exam/year.
	Children's glasses	No Charge	\$25 <a href="#">Copay</a>	Not Covered	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Coverage limited to one pair of glasses/year.
	Children's dental check-up	Not Covered	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

**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](http://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](http://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, kwijjigo 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](#) \$85
- Hospital (facility) [copayment](#) \$3000
- Other [copayment](#) \$100

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$0</b>

### 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](#) \$85
- Hospital (facility) [copayment](#) \$3000
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$0</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$85
- Hospital (facility) [copayment](#) \$3000
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$0</b>

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.

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