




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 www.fridayhealthplans.com/members/resources/nm or call 1-844-805-5000. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers \$2,300 individual / \$4,600 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 ?	Yes. Preventive care and primary care services are covered before you meet your 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 ?	For network providers \$8,250 individual / \$16,500 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 Click here to see network providers or call 1-844-805-5000 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 a specialist for covered services 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	No charge; deductible does not apply	Not covered	Friday designated Telemedicine providers are not subject to deductible and covered in full.
	Specialist visit	20% coinsurance after deductible	Not covered	None
	Preventive care/screening/immunization	No charge; deductible does not apply	Not covered	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. Preventive care now also includes artery calcification testing for diagnosis of heart disease.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	Not covered	There is no charge for testing and delivery of healthcare services related to COVID-19. Preauthorization is not required for gynecological or obstetrical diagnostic ultrasounds
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://caprx.adaptiverx.com/webSearch/index?key=8F02B26A288102C27BAC82D14C006C6FC54D480F80409B68E5FAE0FB47E8C029	Generic drugs (Tier 1)	No charge; deductible does not apply	Not covered	Applies to formulary preferred generic only, deductible waived. Certain prescription drugs for preventive care, the treatment of mental illness, behavioral health, or substance abuse disorders will be covered at No Charge to you. See your plan's covered drug list for details.
	Preferred brand drugs (Tier 3)	20% coinsurance after deductible	Not covered	Applies to formulary preferred brand only. Insulin will not exceed \$25 per prescription for a 30-day supply
	Non-preferred drugs (Tier 2 & 4)	43% coinsurance after deductible	Not covered	Applies to formulary non-preferred brand, non-preferred generic and non-preferred specialty.
	Specialty drugs (Tier 5)	50% coinsurance after deductible	Not covered	Applies to formulary specialty only. Some specialty medications are available in other

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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)	
				tiers. Not all Specialty drugs are covered, and preauthorization may be required. See your policy documents for more details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not covered	Preauthorization may be required. If you don't get preauthorization , it may result in denial of coverage. See your policy documents* for details.
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	
If you need immediate medical attention	Emergency room care	45% coinsurance after deductible	45% coinsurance after deductible	You pay the same as In-network if it is an emergency as defined in your plan . Balance billing is not allowed for out-of-network care. Deductible waived.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	
	Urgent care	\$75 copay /visit; deductible does not apply	\$75 copay /visit; deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not covered	Failure to obtain preauthorization for any service that requires preauthorization may result in denial of benefits. See your policy documents for more details.
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; deductible does not apply	Not covered	Failure to obtain preauthorization for any service that requires preauthorization may result in denial of benefits. See your policy documents for more details.
	Inpatient services	No charge; deductible does not apply	Not covered	
If you are pregnant	Office visits	20% coinsurance after deductible	Not covered	Cost sharing does not apply for preventive services . For non-preventative services a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	20% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not covered	100 days/year. Failure to obtain preauthorization for any service that requires preauthorization may result in denial of benefits. See your policy documents for more details.

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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)	
	Rehabilitation services	No charge; deductible does not apply	Not covered	Failure to obtain preauthorization for any service that requires preauthorization may result in denial of benefits. See your policy documents for more details.
	Habilitation services	No charge; deductible does not apply	Not covered	Provider must determine in advance that rehabilitation services can be expected to result in significant improvement in your condition. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
	Skilled nursing care	20% coinsurance after deductible	Not covered	60 days/year. Failure to obtain preauthorization for any service that requires preauthorization may result in denial of benefits. See your policy documents for more details.
	Durable medical equipment	20% coinsurance after deductible	Not covered	Preauthorization may be required. See your policy documents for more details.
	Hospice services	20% coinsurance after deductible	Not covered	Benefits for Inpatient and in-home Hospice services are covered if you are terminally ill.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage limited to one exam/year and one refraction exam/year.
	Children's glasses	No charge	Not covered	Covers one (1) pair of lenses/year when a prescription change is determined Medically Necessary; One (1) pair of frames.
	Children's dental check-up	Not covered	Not covered	Pediatric dental coverage can be purchased separately as a stand-alone policy.

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](#).)

- Cosmetic surgery
- Dental care (Adult)
- Routine foot care (Unless you are diabetic)
- Long-term care
- Non-emergency care when traveling outside the U.S.
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Abortion (Except in cases of rape, incest or when the life of the mother is endangered)
- Chiropractic care (20 visits/year unless habilitative and rehabilitative)
- Infertility treatment
- Acupuncture (20 visits/year unless habilitative and rehabilitative purposes)
- Hearing Aids
- Private-duty nursing
- Bariatric surgery
- Routine eye care (Adult) (1 exam per year)
- Weight loss program

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: Office of the Superintendent of Insurance (OSI) at 1-855-427-5674. 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 Friday Health Plans, 1-844-805-5000. You may also contact the Office of the Superintendent of Insurance at 1-855-427-5674.

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? 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 1-844-805-5000.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-805-5000.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-805-5000.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-805-5000.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	\$2,300
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$2,300
Copayments	\$0
Coinsurance	\$2,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,460

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$2,300
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ 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:

Cost Sharing	
Deductibles*	\$2,300
Copayments	\$0
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,720

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,300
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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*	\$2,300
Copayments	\$0
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,400

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

Multi-Language Insert
Multi-language Interpreter Services

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Friday Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-805-5000.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ có câu hỏi về Friday Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-805-5000.

Chinese: 如果您，或您正在幫助的人，有關於 Friday Health Plans 方面的問題，您有權利免費以您的母語得到幫助和訊息。想要跟一位翻譯員通話，請致電 1-844-805-5000。

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Friday Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-805-5000 로 전화하십시오.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Friday Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-805-5000.

Amharic: እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Friday Health Plans ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-844-805-5000 ይደውሉ።

Arabic: تفكّكنا اية دون من بلغتك الضرورية والمعلومات المساعدة إلى الحصول في 1-844-805-5000 بخصوص أسئلة تساعد شخص لدى أو لديك كان إن Friday Health Plans الحق فليدك. بـ اتصل مترجم عم للتحدث

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Friday Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-805-5000 an.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Friday Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-805-5000.

Nepali: यिद तपाईं ंआफ्ना लागि आफैं आवेदनको काम गर्नु, वा कसैलाई मद्दत गर्नु हानुहान्छु Friday Health Plans बारे प्रहृ छन् भने आफ्नो मातृभाषामा िनःशुल्क सहायता वा जानकारी पाउने अधिकार छ । दोभाषे (इन्टरप्रेटर) सँग कु रा गर्नरुपरे 1-844-805-5000 मा फोन गर्नरुहोस् ।

Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Friday Health Plans, may karapatan ka na makakuha ng tulong at impormasyon. Products and services are provided by or through Friday Health Plans of Colorado, Inc., an operating subsidiary of Friday Health Plans, Inc.

sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-805-5000.

Japanese: ご本人様、またはお客様の身の回りの方でも、Friday Health Plans についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-805-5000 までお電話ください。

Cushite: Isin yookan namni biraa isin deeggartan Friday Health Plans irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-805-5000 tiin bilbilaa.

Persian: ، Friday Health Plans ، شما گر ، امشد ، سک مک او ای ی سک مک ، می کنید کمک را این قد دامتد یشابد 1-844-805-5000 مورد در سوال ، میامند ساحل امتس بیامند در فایت رالمگین طور

Kru: I bale we, tole mut u ye hola, a gwee mbarga inyu Friday Health Plans, U gwee Kunde I kosna mahola ni biniiguene i hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-844-805-5000.

Ibo: Ọbụgị, ma o bụonye I na eyere-aka, nwere ajiugbasara Friday Health Plans, I nwere ohere iwenta nye maka na ọmuna na asụgị na akwu gị ụgwọ I chọọ kwụnyonye-ntapịa okwu, kpọ1-844-805-5000.

Yoruba: Bí iwọ tàbí ẹnikẹni tí ó n ranlowọ bá ní ibeere nipa Friday Health Plans, o ní ẹlẹlati rí iranwọàti ifitónilétí gbà ní èdè rẹlàìsanwó. Látí bá ongbufọkan sọọ pè sọrí 1-844-805-5000.