Friday Silver Copay

Coverage for: Individual/Family | Plan Type: HMO

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 or call 1-800-475-8466. 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 1-800-475-8466 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $5,500 Individual/$11,000 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 $8,700 Individual/$17,400 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. Click here to see network providers or call 1-800-475-8466 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	No Charge	Not covered	Deductible waived.
	Specialist visit	$80 copay/visit	Not covered	Deductible waived.
	Preventive care/screening/ immunization	No Charge	Not covered	You may have to pay for services that are not 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)	$100 copay/visit; Deductible waived.	Not covered	For some diagnostic and imaging services, preauthorization may be required.
	Diagnostic test (blood work)	30% coinsurance	Not covered	
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	For some diagnostic and imaging services, preauthorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.fridayhealthplans.com.	Generic drugs (Tier 1)	Up to $30 copay/prescription	Not covered	Applies to formulary preferred generic only. Up to 30-day supply Retail and up to 90-day supply Retail & Mail Order, except narcotics and Specialty drugs. ACA Preventive Care medications are provided with no cost sharing, regardless of tier. Deductible waived.
	Preferred brand drugs (Tier 3)	Up to $80 copay/prescription	Not covered	Applies to formulary preferred brand only. Deductible waived.
	Non-preferred drugs (Tier 2 & 4)	Up to $150 copay/prescription	Not covered	Applies to formulary non-preferred brand, non-preferred generic and non-preferred specialty. Deductible waived.
	Specialty drugs (Tier 5)	Up to $425 copay/prescription	Not covered	Applies to formulary specialty only. Some specialty medications are available in other tiers. Not all specialty drugs are covered, and preauthorization may be required. See your policy documents for details. Deductible waived.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Preauthorization may be required
	Physician/surgeon fees	30% coinsurance	Not covered	Preauthorization may be required

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 immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	You pay the same as In-network if it is an emergency as defined in your plan.
	Emergency medical transportation	30% coinsurance	30% coinsurance	You pay the same as In-network if it is an emergency as defined in your plan.
	Urgent care	$100 copay/visit	$100 copay/visit	Deductible waived
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Preauthorization is required, unless for emergency.
	Physician/surgeon fees	30% coinsurance	Not covered	Preauthorization is required, unless for emergency.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copay/visit	Not covered	All inpatient for Severe Mental Illness or Substance Abuse require preauthorization. Deductible waived
	Inpatient services	30% coinsurance	Not covered	All inpatient for Severe Mental Illness or Substance Abuse require preauthorization.
If you are pregnant	Office visits	$80 copay/visit	Not covered	Cost sharing does not apply for preventive services. Deductible waived
	Childbirth/delivery professional services	30% coinsurance	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	30% coinsurance	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Preauthorization is required.
	Rehabilitation services	$80 copay/visit	Not covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year. Deductible waived
	Habilitation services	$80 copay/visit	Not covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year. Deductible waived
	Skilled nursing care	30% coinsurance	Not covered	Limited to 100 days per Plan Year. Preauthorization may be required.
	Durable medical equipment	30% coinsurance	Not covered	Only Durable medical equipment considered standard and/or basic as defined by nationally recognized guidelines are covered. Preauthorization may be required.

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)	
	Hospice services	30% coinsurance	Not covered	Cost sharing waived at non-IHCP In Network Provider with IHCP referral. Benefits for Hospice services for care of a terminally ill Member with a life expectancy of six months or less. No authorization for first 6 months, prior authorization required for subsequent 6 months.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Deductible waived. Limited to 1 exam per Plan Year
	Children's glasses	No Charge	Not covered	Limited to 1 pair every 24 months
	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.)

- Abortion
- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids (Adult)
- Long Term Care
- Non-Emergency Care (outside US)
- Routine Eye Care (Adult)
- 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.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids (children)
- Infertility Treatment
- Private-duty Nursing

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: Colorado Department of Insurance at 1-800-930-3745. 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, 1-800-475-8466.

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.

* For more information about limitations and exceptions, see the plan or policy document at www.fridayhealthplans.com

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 1-888-338-5514.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-338-5514.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-338-5514.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-338-5514.

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 www.fridayhealthplans.com

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	$5,500
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	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	$5,500
Copayments	$200
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$7,760

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5,500
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other *coinsurance*	30%

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	$900
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,320

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

The plan's overall deductible	$5,500
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$2,000
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,700

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 1-800-475-8466.

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 1-800-475-8466.

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 1-800-475-8466.

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 1-800-475-8466 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 1-800-475-8466.

Amharic: እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Friday Health Plans ጥያቄ ካላቸው፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸው። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-800-475-8466 ይደውሉ።

Arabic: الحق فلديك Friday Health Plans إن كان لديك أو لدى شخص تساعده أسئلة بخصوص 1-800-475-8466 يف الحصول ىلع المساعدة والمعلومات الضرورية بلغتك دون من أية تكلفة. مترجم عم للتحدث بـ اتصل

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 1-800-475-8466 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 1-800-475-8466.

Napali: यिद तपाई ंआफ्ना लाि ग आफैं आवेदनको काम गद, वा कसैलाई मद्दत गद ह नुह न्छ Friday Health Plans बारे प्र ह छन् भने आफ्नो मातृभाषामा ि न:शुल्क सहायता वा जानकार पाउने अिधकार छ । दोभाषे (इन्टरप्रेटर) सँग कु रा गनर् ुपरे 1-800-475-8466 मा फोन गनर् ुहोस् ।

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Friday Health Plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-475-8466.

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、1-800-475-8466 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 1-800-475-8466 tiin bilbilaa.

Persian: ، Friday Health Plans گر ،شما به امشه که سکه ایی او کمک میکنید ، مورد در سوال 1-800-475-8466 این قحد داهتشد یشابد را به طور رالگین به اطاعلات و که کمک دارید را خود زابن به را به صاحل امتس بیامند درفایت بیامند.

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 1-800-475-8466.

Ibo: Ọbụụgị, ma o bụonye I na eyere-aka, nwere ajụjụgbasara Friday Health Plans, I nwere ohere iwenta nye maka na ọnụma na asụsụgị na akwu gị ụgwọ I chọọl kwụụonye-ntapịa okwu, kpọ1-800-475-8466.

Yoruba: Bí ìwọ tàbí ẹnikẹni tí o n ranlọwọ bá ní ibeere nipa Friday Health Plans, o ní ẹtọlati rí iranwọàti ìfitónilétí gbà ní èdè rẹláìsanwó. Láti bá ongbufọkan sọrọ pè sórí 1-800-475-8466.