




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?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or \$4,300 individual / \$8,600 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 .	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 \$8,550 individual / \$17,100 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://providersearch.fridayhealthplans.com 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 a specialist for covered services without a referral .

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

 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 (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP 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	\$0 copay/visit	Not covered	
	Specialist visit	No charge	20% coinsurance	Not covered	
	Preventive care/screening/immunization	No charge	No Copay - 100% covered	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, blood work)	No charge	20% coinsurance	Not covered	
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.fridayhealthplans.com .	Generic drugs	No charge	\$0 copay/prescription	Not covered	Applies to formulary preferred generic only.
	Preferred brand drugs	No charge	Up to \$250 copay/prescription	Not covered	Deductible waived. Applies to formulary preferred brand only.
	Non-preferred brand drugs	No charge	Up to \$350 copay/prescription	Not covered	Deductible waived. Applies to formulary non-preferred brand, non-preferred generic and non-preferred specialty.
	Specialty drugs	No charge	Up to \$710 copay/prescription	Not covered	Deductible waived. 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Not covered	

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		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge	20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	No charge	50% coinsurance	50% coinsurance	You pay the same as In-network if it is an emergency as defined in your plan.
	Emergency medical transportation	No charge	20% coinsurance	20% coinsurance	
	Urgent care	No charge	\$75 copay/visit	\$75 copay/visit	Deductible waived
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Not covered	
	Physician/surgeon fees	No charge	20% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$0 copay/visit	Not covered	
	Inpatient services	No charge	20% coinsurance	Not covered	
If you are pregnant	Office visits	No charge	20% coinsurance	Not covered	
	Childbirth/delivery professional services	No charge	20% coinsurance	Not covered	
	Childbirth/delivery facility services	No charge	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Not covered	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Rehabilitation services	No charge	20% coinsurance	Not covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year
	Habilitation services	No charge	20% coinsurance	Not covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year
If you need help recovering or have other special health needs	Skilled nursing care	No charge	20% coinsurance	Not covered	Limited to 100 days per Plan Year
	Durable medical equipment	No charge	20% coinsurance	Not covered	
	Hospice services	No charge	20% coinsurance	Not covered	
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	Deductible waived. Limited to 1 exam per Plan Year
	Children's glasses	No charge	No Charge	Not covered	Limited to 1 pair every 24 months
	Children's dental check-up	Not covered	20% coinsurance	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"> • Abortion • Acupuncture • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Hearing Aids (Adult) • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss program

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric Surgery
- Hearing aids (children)
- Private-duty Nursing
- Chiropractic care
- Infertility Treatment

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** or:

Department of Regulatory Agencies

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202
(800) 930-3745
(303) 894-7499

<http://www.dora.state.co.us/insurance>
insurance@dora.state.co.us

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 1-888-338-5514.

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, kwijigo holne' 1-888-338-5514.

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](#) \$4,300
- [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	\$4,300
Copayments	\$0
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,060

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$4,300
- [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	\$5,6000
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In this example, Joe would pay:

Cost Sharing	
Deductibles *	\$1,200
Copayments	\$3,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$4,320

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$4,300
- [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 *	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

*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.

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 1-844-451-4444.

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 1-844-451-4444.

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 1-844-451-4444.

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 1-844-451-4444 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 1-844-451-4444.

Amharic: እርስዎ፣ ወይም እርስዎ የሚያገዙት ግለሰብ፣ ስለ Friday Health Plans ጥያቄ ካላችሁ፣ ያለ ምንም ከፍተኛ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት ካላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-844-451-4444 ይደውሉ።

Arabic: إن كان لديك أو لدى شخص تساعد أسئلة بخصوص 4444-451-844-1 في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع Friday Health Plans فليدك الحق مترجم اتصل بـ

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 1-844-451-4444 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 1-844-451-4444.

Nepali: यिद तपाईं आफ्ना लागि आफैं आवेदनको काम गर्दा, वा कसैलाई मद्दत गर्दा हानुहान्छ Friday Health Plans बारे प्रश्न छन् भने आफ्नो मातृभाषामा निःशुल्क सहायता वा जानकारी पाउने अधिकार छ । दोभाषे (इन्टरप्रेटर) सँग कु रा गनर्ुपरे 1-844-451-4444 मा फोन गनर्ुहोस् ।

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 1-844-451-4444.

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

、情報を入力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、1-844-451-4444 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 1-844-451-4444 tiin bilbilaa.

Persian: ، گر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد 1-844-451-4444 داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان Friday Health Plans دریافت نمایید تماس حاصل نمایید.

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 1-844-451-4444.

Ibo: Ọ bụrụ gị, ma o bụ onye I na eyere-aka, nwere ajujụ gbasara Friday Health Plans, I nwere ohere iwenta nye maka na ọmụma na asụsụ gị na akwu gị ụgwọ. I chọrọ I kwurụ onye-ntapia okwu, kpọ 1-844-451-4444.

Yoruba: Bí iwọ, tàbí ẹnìkẹni tí o n ranlọwọ, bá ní ibeere nipa Friday Health Plans, o ní ẹtọ lati rí iranwọ àti ifitónilétí gbà ní èdè rẹ láìsanwó. Látí bá ongbufo kan sọrọ, pè sórí 1-844-451-4444.