




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/nv or call 1-844-535-2000. 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 \$8,550 individual / \$17,100 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 \$8,550 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 www.fridayhealthplans.com/members-resources-nv or call 1-844-535-2000 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 .

FHPNV-0006-0920

82461NV0010002-00

 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 after deductible	Not covered	Friday designated Telemedicine providers are not subject to deductible and covered in full.
	Specialist visit	No charge 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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	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.
	Imaging (CT/PET scans, MRIs)	No charge 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=8F02B26A288102C27BAC82D14C006C6FC54D480F80409B6897145FB47DE4F581	Generic drugs (Tier 1)	No charge after deductible	Not covered	Applies to formulary preferred generic only, deductible waived.
	Preferred brand drugs (Tier 2)	No charge after deductible	Not covered	Applies to formulary preferred brand only. Insulin will not exceed \$25 per prescription for a 30-day supply.
	Non-preferred brand drugs (Tier 3)	No charge after deductible	Not covered	Applies to formulary non-preferred brand, non-preferred generic and non-preferred specialty.
	Specialty drugs (Tier 4)	No charge after deductible	Not covered	Applies to formulary specialty only. Some specialty medications are available in other tiers. Not all specialty drugs are covered, and pre-authorization may be required. See your policy documents for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge 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	No charge after deductible	Not covered	

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

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	No charge after deductible	No charge after deductible	You pay the same as In-network if it is an emergency as defined in your plan.
	Emergency medical transportation	No charge after deductible	No charge after deductible	
	Urgent care	No charge after deductible	No charge after deductible	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not covered	Preauthorization is required. If you don't get preauthorization , it may result in denial of coverage, unless for emergency.
	Physician/surgeon fees	No charge after deductible	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	Not covered	All inpatient and non-routine Outpatient non-emergency Mental Health, Severe Mental Illness or Substance Abuse require preauthorization .
	Inpatient services	No charge after deductible	Not covered	
If you are pregnant	Office visits	No charge after deductible	Not covered	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge after deductible	Not covered	
	Childbirth/delivery facility services	No charge after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Unlimited benefit except for One (1) medical social service consultation per course of treatment; One (1) nutrition consultation by a certified registered dietitian; and health aide services are furnished only when receiving nursing services or therapy.
	Rehabilitation services	No charge after deductible	Not covered	120 combined days/visits per Plan Year. Includes inpatient/outpatient and physical therapy, speech therapy, and occupational therapy.
	Habilitation services	No charge after deductible	Not covered	120 days/visits per Plan Year. Includes physical therapy, speech therapy, and occupational therapy.
	Skilled nursing care	No charge after deductible	Not covered	100 days/year

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

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)	
	Durable medical equipment	No charge after deductible	Not covered	Purchases are limited to a single purchase of a type of DME, including repair and replacement, every three (3) years.
	Hospice services	No charge after deductible	Not covered	5 days per episode. Limits apply to respite services (combined maximum benefit of five (5) Inpatient days or five (5) Outpatient visits per Member per ninety (90) days of Home Hospice Care) and to bereavement services (maximum benefit of five (5) group therapy sessions).
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage limited to one 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 .)		
<ul style="list-style-type: none"> • Acupuncture • Basic or Routine dental care (Adult) • Cosmetic surgery 	<ul style="list-style-type: none"> • Long-term care • Major dental care (Adult) • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Orthodontia (Adult) • Routine eye care (Adult) • Routine foot care • Weight loss program

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"> • Accidental dental • Bariatric surgery (1 procedure/lifetime) • Chiropractic care (20 visits/year) 	<ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Nutritional Counseling 	<ul style="list-style-type: none"> • Private duty nursing • Prosthetic devices

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

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: Nevada Division of Insurance, 1818 E. College Pkwy., Suite 103, Carson City, NV 89706, (775) 687-0700, (888) 872-3234. 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 Nevada Division of Insurance, 3300 W. Sahara Ave., Suite 275, Las Vegas, Nevada 89102, 1-888-872-3234 or Nevada Health Link, Attn: Appeals, 2310 S. Carson St., Suite 2, Carson City, NV 89701, 1-800-547-2927 or TTY 711.

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 1-844-535-2000.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-535-2000.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-535-2000.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-535-2000.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review 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	\$8,550
■ Specialist copayment	100%
■ Hospital (facility) coinsurance	100%
■ Other coinsurance	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*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$8,550
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$8,550

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$8,550
■ Specialist copayment	100%
■ Hospital (facility) coinsurance	100%
■ Other coinsurance	100%

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:

<i>Cost Sharing</i>	
Deductibles *	\$5,600
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$5,600

Mia's Simple Fracture

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

■ The plan's overall deductible	\$8,550
■ Specialist copayment	100%
■ Hospital (facility) coinsurance	100%
■ Other coinsurance	100%

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:

<i>Cost Sharing</i>	
Deductibles *	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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 1-744-535-2000.

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 1-744-535-2000.

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 1-744-535-2000.

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 1-744-535-2000 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 1-744-535-2000.

Amharic: እርስዎ፣ ወይም እርስዎ የሚያገዙት ግለሰብ፣ ስለ Friday Health Plans ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-744-535-2000 ይደውሉ።

Arabic: إن كان لديك أو لدى شخص تساعد أسئلة بخصوص 1-744-535-2000 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 1-744-535-2000 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 1-744-535-2000.

Nepali: यदि तपाईं ंआफ्ना लागि आफैं आवेदनको काम गर्नु, वा कसैलाई मद्दत गर्नु हानुहन्छ Friday Health Plans बारे प्रश्न छन् भने आफ्नो मातृभाषामा िनःशुल्क सहायता वा जानकारी पाउने अधिकार छ । दोभाषे (इन्टरप्रेटर) सँग कु रा गनर्ुपरे 1-744-535-2000 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 1-744-535-2000.

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、1-744-535-2000 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 1-744-535-2000 tiin bilbilaa.

Persian: گر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد 1-744-535-2000 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 nsaawogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-744-535-2000.

Ibo: O bụrụ gị, ma o bụ onye I na eyere-aka, nwere ajujụ gbasara Friday Health Plans, I nwere ohere iwenta nye maka na omuma na asusụ gị na akwu gị ugwo. I choro I kwuru onye-ntapia okwu, kpọ 1-744-535-2000.

Yoruba: Bí iwọ, tàbí ẹnìkẹ̀ni tí o n ranlọwọ, bá ní ibeere nipa Friday Health Plans, o ní ẹ̀tọ̀ lati rí iranwọ àti ifitónilétí gbà ní èdè rẹ̀ láìsanwó. Látí bá ongbufo kan sọrọ, pè sórí 1-744-535-2000.