

 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, 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 [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-475-8466 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$3,000 Individual/\$6,000 Family</b>	If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of deductible expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes. Preventive care and 1 eye exam.</b>	This plan covers some items and services even if you haven't met the annual deductible amount. But a copayment or coinsurance may apply. For example, this <a href="#">plan</a> covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	<b>No.</b>	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$6,550 Individual/\$13,100 Family</b>	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 <a href="#">out-of-pocket limit</a> ?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.fridayhealthplans.com">www.fridayhealthplans.com</a> 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 (a balance bill). 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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	<b>No.</b>	You can see the <a href="#">specialist</a> you choose without permission from this plan for consults. Procedures or other services may need 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	30% coinsurance	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.
	<a href="#">Specialist</a> visit	30% coinsurance	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No Copay - 100% covered	Not covered	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% coinsurance	Not covered	
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	
<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="http://www.fridayhealthplans.com">www.fridayhealthplans.com</a>	Generic drugs	\$15 copay / prescription	Not covered	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.
	Preferred brand drugs	30% coinsurance	Not covered	
	Non-preferred brand drugs	30% coinsurance	Not covered	
	<a href="#">Specialty drugs</a>	50% coinsurance	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	
	Physician/surgeon fees	30% coinsurance	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	30% coinsurance	30% coinsurance	
	<a href="#">Emergency medical transportation</a>	30% coinsurance	30% coinsurance	
	<a href="#">Urgent care</a>	\$75 copay /visit	\$75 copay /visit	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	
	Physician/surgeon fees	30% coinsurance	Not covered	

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

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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	30% coinsurance	Not covered	
	Inpatient services	30% coinsurance	Not covered	
<b>If you are pregnant</b>	Office visits	30% coinsurance	Not covered	
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% coinsurance	Not covered	
	<a href="#">Rehabilitation services</a>	30% coinsurance	Not covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year.
	<a href="#">Habilitation services</a>	30% coinsurance	Not covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year.
	<a href="#">Skilled nursing care</a>	30% coinsurance	Not covered	Limited to 100 days per Plan Year.
	<a href="#">Durable medical equipment</a>	30% coinsurance	Not covered	
	<a href="#">Hospice services</a>	30% coinsurance	Not covered	
<b>If your child needs dental or eye care</b>	Children's eye exam	\$0 Copay/visit	Not covered	Limited to 1 exam per Plan Year.
	Children's glasses	\$0 Copay/visit	Not covered	Limited to 1 pair every 24 months.
	Children's dental check-up	Not covered	Not covered)	

### Excluded Services & Other Covered Services:

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>Abortion</li> <li>Acupuncture</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids (Adult)</li> <li>Long Term Care</li> <li>Non-Emergency Care (outside US)</li> </ul>	<ul style="list-style-type: none"> <li>Routine Eye Care (Adult)</li> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>Bariatric Surgery</li> <li>Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids (children)</li> <li>Infertility Treatment</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty Nursing</li> </ul>

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and

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Human Services 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 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 at 1-800-475-8466. Additionally, a consumer assistance program can help you file your appeal. Contact:

**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](mailto:insurance@dora.state.co.us)

For group health coverage subject to ERISA, you can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Colorado Department of Insurance at 303-894-7490 or [www.dora.state.co.us/insurance](http://www.dora.state.co.us/insurance).

**Does this plan provide Minimum Essential Coverage? YES**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 1-800-475-8466.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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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](#) **\$3,000**
- [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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$3,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,560</b>

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

- The [plan's](#) overall [deductible](#) **\$3,000**
- [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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$500
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$5,560</b>

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

- The [plan's](#) overall [deductible](#) **\$3,000**
- [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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>