

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

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$3,500 Individual/\$7,000 Family	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 1 eye exam.	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 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?	Yes. \$500 RX.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$7,350 Individual/\$14,700 Family	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 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 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 referral to see a specialist ?	No.	You can see the specialist 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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay / visit	Not covered	Deductible does not apply
	Specialist visit	\$75 copay / visit	Not covered	Deductible does not apply
	Preventive care/screening/immunization	No Copay - 100% covered	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)	30% coinsurance	Not covered	
	Imaging (CT/PET scans, MRIs)	30% 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	\$15 copay / prescription	Not covered	Deductible does not apply
	Preferred brand drugs	\$75 copay / prescription	Not covered	
	Non-preferred brand drugs	\$120 copay / prescription	Not covered	
	Specialty drugs	50% coinsurance	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	
	Physician/surgeon fees	30% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	
	Emergency medical transportation	30% coinsurance	30% coinsurance	
	Urgent care	\$75 copay /visit	\$75 copay /visit	Deductible does not apply
If you have a hospital stay	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.

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay / visit	Not covered	Deductible does not apply
	Inpatient services	30% coinsurance	Not covered	
If you are pregnant	Office visits	\$30 copay / visit	Not covered	Deductible does not apply
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	
	Rehabilitation services	30% coinsurance	Not covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year.
	Habilitation services	30% coinsurance	Not covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year.
	Skilled nursing care	30% coinsurance	Not covered	Limited to 100 days per Plan Year.
	Durable medical equipment	30% coinsurance	Not covered	
	Hospice services	30% coinsurance	Not covered	
If your child needs dental or eye care	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:

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 (outside US) 	<ul style="list-style-type: none"> 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.)		
<ul style="list-style-type: none"> Bariatric Surgery Chiropractic Care 	<ul style="list-style-type: none"> Hearing Aids (children) Infertility Treatment 	<ul style="list-style-type: none"> 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and

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

Human Services at 1-877-267-2323 x61565 or 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 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

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 or the Colorado Department of Insurance at 303-894-7490 or 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.

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](#) \$3,500
- [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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$100
Coinsurance	\$3,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$7,360

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

- The [plan's](#) overall [deductible](#) \$3,500
- [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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,800
Copayments	\$1,800
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$4,260

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

- The [plan's](#) overall [deductible](#) \$3,500
- [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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1000
Copayments	\$500
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900