Friday Silver + Vision Exam 94% X

Coverage for: Individual, Individual + Spouse, 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/member-hub/resources/co/ 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 $0 individual / $0 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 $1,900 individual / $3,800 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 a network specialist for covered services without a referral.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

⚠ 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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge Deductible does not apply	Not Covered	Friday designated telemedicine providers are not subject to deductible and covered in full.
	Specialist visit	15% coinsurance 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 are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Recommendations by the USPSTF for the breast cancer screens mammography and preventions issued prior to Nov 2009 will be considered current. Immunization covered are those recommended by the advisory committee on immunizations practices of the centers for disease control and prevention (CDC).
If you have a test	Diagnostic test (x-ray, blood work)	15% Coinsurance After Deductible	Not Covered	For some diagnostic and imaging services, preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	15% Coinsurance After Deductible	Not Covered	For some diagnostic and imaging services, preauthorization may be required.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Click Here	Generic drugs (Tier 1)	No Charge; Deductible Does Not Apply	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. Preventive Care medications are provided with no cost sharing, regardless of tier. Deductible waived.
	Preferred brand drugs (Tier 3)	10% Coinsurance After Deductible	Not Covered	Applies to formulary preferred brand only.
	Non-preferred brand drugs (Tier 2 & 4)	20% Coinsurance After Deductible	Not Covered	Applies to formulary non-preferred brand, non-preferred generic and non-preferred specialty.
	Specialty drugs (Tier 5)	20% Coinsurance 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)	15% Coinsurance After Deductible	Not Covered	Preauthorization may be required.
	Physician/surgeon fees	15% Coinsurance After Deductible	Not Covered	Preauthorization may be required.
If you need immediate medical attention	Emergency room care	20% Coinsurance After Deductible	20% Coinsurance After Deductible	You pay the same as In-network if it is an emergency as defined in your plan.
	Emergency medical transportation	15% Coinsurance After Deductible	15% Coinsurance After Deductible	You pay the same as In-network if it is an emergency as defined in your plan.
	Urgent care	$25 Copay Deductible Does Not Apply	$25 Copay Deductible Does Not Apply	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% Coinsurance After Deductible	Not Covered	Preauthorization is required, unless for emergency.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	15% Coinsurance After Deductible	Not Covered	Preauthorization is required, unless for emergency.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit No Charge; Other Services 15% Coinsurance after Deductible	Not Covered	All inpatient for Severe Mental Illness or Substance Abuse require preauthorization.
	Inpatient services	15% Coinsurance After Deductible	Not Covered	All inpatient for Severe Mental Illness or Substance Abuse require preauthorization.
If you are pregnant	Office visits	15% Coinsurance 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	15% Coinsurance 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 facility services	15% Coinsurance 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).
If you need help recovering or have other special health needs	Home health care	15% Coinsurance After Deductible	Not Covered	Preauthorization is required. 28 hours per week.
	Rehabilitation services	15% Coinsurance After Deductible	Not Covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year.
	Habilitation services	15% Coinsurance After Deductible	Not Covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year.
	Skilled nursing care	15% Coinsurance After Deductible	Not Covered	100 days/year. Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Durable medical equipment	15% Coinsurance After Deductible	Not Covered	Only Durable medical equipment considered standard and/or basic as defined by nationally recognized guidelines are covered. Preauthorization may be required.
	Hospice services	15% Coinsurance After Deductible	Not Covered	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 one 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 (except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic Surgery
- Dental Care (Adult & Children)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care (20 Visits/year)
- Hearing aids
- Infertility treatment (up to diagnosis)
- Private-duty nursing
- Routine Eye Care (Adult)

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 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 1-800-475-8466.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-475-8466.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-475-8466.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-475-8466.

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	$0
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	

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	$0
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,960

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

The plan's overall deductible	$0
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	

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	$0
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$620

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

The plan's overall deductible	$0
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	

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	$0
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$400

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: Nẵu quý vẳ, hay ngưải mà quý vẳ đang giúp đẳ, có câu hẳi vẳ Friday Health Plans, quý vẳ sẳ có quyẳn đưởc giúp và có thêm thông tin bẳng ngôn ngẳa mình miẳn phí. Đẳ
nói chuyẳn vẳi mẳt thông dẳch viên, xin gẳi 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 부담 없이 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 ካላቸሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-800-475-8466 ይደውሉ።

Arabic: إذا كان لديك أو لدى شخص تقوم برعايته أسئلة عن خطط Friday Health Plans، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك دون مقابل. اتصل بـ 1-800-475-8466 للتحدث مع مترجم.

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 गदर्ै, वा कसैलाई मद्दत गदर्ै हुनँुहुन्छ Friday Health Plans बारे प्रश्नहरु छन् भने आफ्नो मातृभाषामा ि न:शुल्क सहायता वा जानकार पाउने अिधकार छ । दोभाषे (इन्टरप्रेटर) सँग कु रा गनर्ुपरे 1-800-475-8466 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 1-800-475-8466.

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: رگشما، ایی‌سک‌ه امشه‌ب‌وا ک‌مک‌ دینکیم، لاوس‌رد دروم‌ 1-800-475-8466 ه‌تشاد دیشابق‌ح‌نیا ار دیراد ه‌ک‌ ک‌مک‌ و تاعلاطا ه‌ب‌ن‌ابز دوخ ار ه‌ب‌ روط‌ن‌الگیار Plans Health Friday ،
تفایرد دییامنس‌امت‌ لصاح‌ دییامن.

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: å bărå gå, ma o bå onye I na eyere-aka, nwere ajăjă gbasara Friday Health Plans, I nwere ohere iwenta nye maka na ămămа na asăsă gå na akwu gå ụchărå I kwărå onye-ntapåa
okwu, kpå 1-800-475-8466.

Yoruba: Bí ìwå, tàbí ănikăni tí o n ranlåwå, bá ní ibeere nipa Friday Health Plans, o ní åtå lati rí iranwå àti ìfitónilétí gbà ní èdè rå láìsanwó. Láti bá ongbufå kan sọrọ pè sórí 1-800-475- 8466.