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?	**$525 Individual/$1,050 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, 3 PCP visits 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?	**No.**	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$7,000 Individual/$14,000 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	20% coinsurance	Not covered	3 $0 copay visits before deductible
	Specialist visit	20% coinsurance	Not covered	
	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)	20% coinsurance	Not covered	
	Imaging (CT/PET scans, MRIs)	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	$0 copay/prescription	Not covered	Deductible waived. Applies to formulary preferred generic only.
	Preferred brand drugs	$250 copay/prescription	Not covered	Deductible waived. Applies to formulary preferred brand only.
	Non-preferred brand drugs	$580 copay/prescription	Not covered	Deductible waived. Applies to formulary non-preferred brand, non-preferred generic and non-preferred specialty.
	Specialty drugs	$575 copay/prescription	Not covered	Deductible waived. Applies to formulary preferred 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)	20% coinsurance	Not covered	
	Physician/surgeon fees	20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$75 copay/visit	$75 copay/visit	Deductible waived
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	
	Physician/surgeon fees	20% 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	20% coinsurance	Not covered	
	Inpatient services	20% coinsurance	Not covered	
If you are pregnant	Office visits	20% coinsurance	Not covered	
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	
	Rehabilitation services	20% coinsurance	Not covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year.
	Habilitation services	20% coinsurance	Not covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year.
	Skilled nursing care	20% coinsurance	Not covered	Limited to 100 days per Plan Year.
	Durable medical equipment	20% coinsurance	Not covered	
	Hospice services	20% 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.)

- Abortion
- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids (Adult)
- Long Term Care
- Non-Emergency Care (outside US)
- 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.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids (children)
- Infertility Treatment
- 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	$525
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$525
Copayments	$0
Coinsurance	$2,455
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,040**

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

The plan's overall deductible	$525
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$525
Copayments	$5,100
Coinsurance	$1,375
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$7,060**

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

The plan's overall deductible	$525
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$525
Copayments	$0
Coinsurance	$275
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

The plan would be responsible for the other costs of these EXAMPLE covered services.