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?	**$950 Individual/$1,900 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 3 PCP visits.**	This plan covers some items and services even if you have not 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 do not have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$2,700 Individual/$5,400 Family**	If you have other family members in this plan, they must 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 do not 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	15% coinsurance	Not covered	3 $0 copay visits before deductible
	Specialist visit	15% coinsurance	Not covered	
	Preventive care/screening/ immunization	No Copay - 100% covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	Not covered	
	Imaging (CT/PET scans, MRIs)	15% 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	Not covered	Applies to formulary preferred generic only
	Preferred brand drugs	15% coinsurance	Not covered	Applies to formulary preferred brand only
	Non-preferred brand drugs	30% coinsurance	Not covered	Applies to formulary non-preferred brand and non-preferred generic
	Specialty drugs	28% coinsurance	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	Not covered	
	Physician/surgeon fees	15% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	You pay the same as In-network if it is an emergency as defined in your plan
	Emergency medical transportation	15% coinsurance	15% coinsurance	
	Urgent care	$50 copay	$50 copay	Deductible waived
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	Not covered	
	Physician/surgeon fees	15% 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	15% coinsurance	Not covered	
	Inpatient services	15% coinsurance	Not covered	
If you are pregnant	Office visits	15% coinsurance	Not covered	
	Childbirth/delivery professional services	15% coinsurance	Not covered	
	Childbirth/delivery facility services	15% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	Not covered	
	Rehabilitation services	15% coinsurance	Not covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year
	Habilitation services	15% coinsurance	Not covered	Limited to 2 months of inpatient services and 20 outpatient visits per therapy per Plan Year
	Skilled nursing care	15% coinsurance	Not covered	Limited to 100 days per Plan Year
	Durable medical equipment	15% coinsurance	Not covered	
	Hospice services	15% coinsurance	Not covered	
If your child needs dental or eye care	Children's eye exam	$0 Copay/visit	Not covered	Deductible waived. Limited to 1 exam per Plan Year
	Children's glasses	0% coinsurance	Not covered	Deductible waived. 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

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

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-EBSA or www.dol.gov/ebsa/contactEBSA/consumerassistance.html , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ or Office of Personnel Management Multi State Plan Program at www.opm.gov/healthcare-insurance/multi-state-plan-program/externalreview/ . 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 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**
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.

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

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	$950
Specialist *coinsurance*	15%
Hospital (facility) *coinsurance*	15%
Other *coinsurance*	15%

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	$950
Copayments	$0
Coinsurance	$1,750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,760**

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

The plan's overall deductible	$950
Specialist *coinsurance*	15%
Hospital (facility) *coinsurance*	15%
Other *coinsurance*	15%

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	$950
Copayments	$0
Coinsurance	$970
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,980**

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

The plan's overall deductible	$950
Specialist *coinsurance*	15%
Hospital (facility) *coinsurance*	15%
Other *coinsurance*	15%

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	$950
Copayments	$0
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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: 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 1-800-475-8466.

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 부담없이 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 ካላቸው፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸው። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-800-475-8466 ይደውሉ።

Arabic: فلديك الحق Friday Health Plans مع للتحدث. في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة 8466-475-800-1 إن كان لديك أو لدى شخص تساعده أسئلة بخصوص 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 1-800-475-8466 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 गद, वा कसैलाई मद्दत गद ह नुह न्छ Friday Health Plans बारे प्र ह छन् भने आफ्नो मातृभाषामा ि नःशुल्क 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: ، Friday Health Plans گر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد 1-800-475-8466 داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان 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 nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-800-475-8466.

Ibo: Ọ bụrụ gị, ma o bụ onye I na eyere-aka, nwere ajụjụ gbasara Friday Health Plans, I nwere ohere iwenta nye maka na ọmụma na asụsụ gị na akwu gị ụgwọ. I chọrọ I kwụrụ onye-ntapịa okwu, kpọ 1-800-475-8466.

Yoruba: Bí ìwọ, tàbí ẹnikẹni tí o n ranlọwọ, bá ní ibeere nipa Friday Health Plans, o ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ongbufọ kan sọrọ, pè sórí 1-800-475-8466.