




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/members/resources/tx or call 1-844-451-4444. 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 1-800-756-4448 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible ? | For network providers \$8,700 individual / \$17,400 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 \$8,700 individual / \$17,400 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. See network providers or call 1-844-451-4444 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 the specialist you choose without a referral . |

FHPTX-0176-091621

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 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 | No charge; deductible does not apply | Not covered | Friday designated Telemedicine providers are not subject to deductible and covered in full. |
| | Specialist visit | \$150 copay /visit; deductible does not apply | Not covered | None |
| | Preventive care/screening/immunization | No charge; deductible does not apply | 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) | No charge after deductible | Not covered | For some diagnostic and imaging services, preauthorization may be required. If You obtain services without a preauthorization when one is required and the plan agrees to pay the claim ; the plan may exercise its rights to impose a penalty of 50% of the allowed amount in which You will be responsible for the other 50%. *See Section 7 |
| | Imaging (CT/PET scans, MRIs) | No charge after deductible | Not covered | |
| 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) | \$30 copay /per 30 day supply; Deductible waived. | 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. |
| | Preferred brand drugs (Tier 3) | \$160 copay /per 30 day supply; Deductible waived. | Not covered | Applies to formulary preferred brand only. *See Section 7 |
| | Non-preferred drugs (Tier 2 & 4) | No charge after deductible | Not covered | Applies to formulary non-preferred brand, non-preferred generic and non-preferred specialty. *See Section 7 |
| | Specialty drugs (Tier 5) | No charge after deductible | Not covered | Applies to formulary specialty only. Some specialty medications are available in other tiers. Not all Specialty drugs are covered, and Preauthorization may be required. If You obtain services without a |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.fridayhealthplans.com/members/resources/tx.

| 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) | |
| | | | | preauthorization when one is required and the plan agrees to pay the claim ; the plan may exercise its rights to impose a penalty of 50% of the allowed amount in which You will be responsible for the other 50%. *See Section 7 |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge after deductible | Not covered | Preauthorization may be required. If You obtain services without a preauthorization when one is required and the plan agrees to pay the claim ; the plan may exercise its rights to impose a penalty of 50% of the allowed amount in which You will be responsible for the other 50%. *See Section 7 |
| | Physician/surgeon fees | No charge after deductible | Not covered | |
| If you need immediate medical attention | Emergency room care | No charge after deductible | No charge after deductible | You pay the same as In-network if it is an emergency as defined in your plan . |
| | Emergency medical transportation | No charge after deductible | No charge after deductible | You pay the same as In-network if it is an emergency as defined in your plan . |
| | Urgent care | \$175 copay /visit; Deductible waived. | \$175 copay /visit; Deductible waived. | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge after deductible | Not covered | Preauthorization is required, unless for emergency. If You obtain services without a preauthorization when one is required and the plan agrees to pay the claim ; the plan may exercise its rights to impose a penalty of 50% of the allowed amount in which You will be responsible for the other 50%. *See Section 7 |
| | Physician/surgeon fees | No charge after deductible | Not covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge; deductible does not apply | Not covered | All inpatient and non-routine Outpatient non-emergency Mental Health, Severe Mental Illness or Substance Abuse require preauthorization . If You obtain services without a preauthorization when one is required and the plan agrees to pay the claim ; the plan may exercise its |
| | Inpatient services | No charge after deductible | Not covered | |

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| 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) | |
| | | | | rights to impose a penalty of 50% of the allowed amount in which You will be responsible for the other 50%. *See Section 7 |
| If you are pregnant | Office visits | \$150 copay /visit; deductible does not apply | 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). Will cover 48-hour hospital stay for uncomplicated vaginal delivery and 96-hour hospital stay for uncomplicated caesarean section |
| | Childbirth/delivery professional services | No charge after deductible | Not covered | |
| | Childbirth/delivery facility services | No charge after deductible | Not covered | |
| If you need help recovering or have other special health needs | Home health care | No charge after deductible | Not covered | 60 days/year. Preauthorization is required after the first 30 visits. If You obtain services without a preauthorization when one is required and the plan agrees to pay the claim ; the plan may exercise its rights to impose a penalty of 50% of the allowed amount in which You will be responsible for the other 50%. |
| | Rehabilitation services | \$150 copay /visit; Deductible waived. | Not covered | Limited to combined 35 visits per year, including Chiropractic. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Referral required. Preauthorization may be required. If You obtain services without a preauthorization when one is required and the plan agrees to pay the claim ; the plan may exercise its rights to impose a penalty of 50% of the allowed amount in |

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| 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) | |
| | | | | which You will be responsible for the other 50%. *See Section 7 |
| | Habilitation services | \$150 copay /visit; Deductible waived. | Not covered | 35 visits/year. The 35-visit limit does not apply to mental health and substance use disorder or autism. Mental health services are covered at no charge; deductible does not apply. Referral required. Preauthorization may be required. If You obtain services without a preauthorization when one is required and the plan agrees to pay the claim ; the plan may exercise its rights to impose a penalty of 50% of the allowed amount in which You will be responsible for the other 50%. *See Section 7 |
| | Skilled nursing care | No charge after deductible | Not covered | 25 days/year. Preauthorization may be required. If You obtain services without a preauthorization when one is required and the plan agrees to pay the claim ; the plan may exercise its rights to impose a penalty of 50% of the allowed amount in which You will be responsible for the other 50%. *See Section 7 |
| | Durable medical equipment | No charge 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. If You obtain services without a preauthorization when one is required and the plan agrees to pay the claim ; the plan may exercise its rights to impose a penalty of 50% of the allowed amount in which You will be responsible for the other 50%. *See Section 7 |
| | Hospice services | No charge after deductible | Not covered | Benefits for Inpatient and in-home |

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| 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) | |
| | | | | Hospice services are Covered if you are terminally ill. Preauthorization is required. If You obtain services without a preauthorization when one is required and the plan agrees to pay the claim ; the plan may exercise its rights to impose a penalty of 50% of the allowed amount in which You will be responsible for the other 50%. *See Section 7 |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | Coverage limited to one exam/year. |
| | Children's glasses | No charge | Not covered | Covers one (1) pair of lenses/year when a prescription change is determined Medically Necessary ; One (1) pair of frames. |
| | 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 .) | | |
|--|--|--|
| <ul style="list-style-type: none"> • Abortion (except in cases of rape, incest, or when the life of the mother is endangered) • Acupuncture • Bariatric surgery • Cosmetic surgery | <ul style="list-style-type: none"> • Dental care (Adult & Children) • Long-term care • Non-emergency care when traveling outside U.S. | <ul style="list-style-type: none"> • Routine foot care • Weight loss program |

| 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"> • Chiropractic care (35 visits/year) | <ul style="list-style-type: none"> • Hearing aids (Once every 3 years) • Infertility treatment (up to diagnosis) | <ul style="list-style-type: none"> • Private duty nursing (limited to Inpatient only) • Routine eye care (Adult) (1 exam per year) |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.fridayhealthplans.com/members/resources/tx.

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: Friday Health Plans at 1-844-451-4444. You may also contact your state insurance department at 1-800-252-3439. 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 on how 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: Texas Department of Insurance at 1-800-578-4677 or visit <https://www.tdi.texas.gov>.

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? Not Applicable

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 1-844-451-4444.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-451-4444.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-451-4444.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-451-4444.

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](#) \$8,700
- [Specialist copayment](#) \$150
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$8,700 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$8,760 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$8,700
- [Specialist copayment](#) \$150
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$900 |
| Copayments | \$2,500 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$3,420 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$8,700
- [Specialist copayment](#) \$150
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,100 |
| Copayments | \$700 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |

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 1-844-451-4444.

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 1-844-451-4444.

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 1-844-451-4444.

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 1-844-451-4444 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 1-844-451-4444.

Amharic: እርስዎ፣ ወይም እርስዎ የሚያገዙት ግለሰብ፣ ስለ Friday Health Plans ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-844-451-4444 ይደውሉ።

Arabic: مترجم عم للتحدث. تفكنا اية دون من بلغتك الضرورية والمعلومات المساعدة على الحصول في 1-844-451-4444 بخصوص أسئلة تساعد شخص لدى أو لديك كان إن Friday Health Plans الحق فليديك با اتصل

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 1-844-451-4444 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 1-844-451-4444.

Nepali: यदि तपाईं आफ्ना लागि आफैँ आवेदनको काम गर्नु, वा कसैलाई मद्दत गर्नु, हाम्रो Friday Health Plans बारे प्रश्न छन् भने आफ्नो मातृभाषामा निःशुल्क सहायता वा जानकारी पाउने अधिकार छ । दोभाषे (इन्टरप्रेटर) सँग कु रा गनर्परे 1-844-451-4444 मा फोन गनर्होस् ।

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 1-844-451-4444.

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、情報を入力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、1-844-451-4444 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 1-844-451-4444 tiin bilbilaa.

Persian: ، Friday Health Plans را ماگین طور بهرا خود زابن به اطاعات و به کمک دارید را این قد دامتشد یشاید 1-844-451-4444 مورد در سوال ، میکنید کمک او ای یسکه به امشد به ، شما گر ، پیامند صحاحل امتس پیامند در فایت

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 nsaawogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-844-451-4444.

Ibo: Obugi, ma o buonye I na eyere-aka, nwere ajiugbasara Friday Health Plans, I nwere ohere iwenta nye maka na onuma na asugji na akwu gi uwof I chof kwuonye-ntapia okwu, kpof 1-844-451-4444.

Yoruba: Bí iwọ̀tá bí ní kẹ́ni tí o n ranlọ́wọ́ bá ní ibeere nipa Friday Health Plans, o ní ẹ̀lẹ́lẹ́ rí iranwọ̀tí ifitónilẹ́tí gbà ní èdè rẹ̀láìsanwọ̀. Láti bá ongbufọ́kan sọ́pè sọ́rí 1-844-451-4444.