




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](http://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 <a href="#">deductible</a> ?                                | For <a href="#">network providers</a> \$2,300 individual / \$4,600 family.   | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | No.  | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> \$8,250 individual / \$16,500 family.  | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="#">network providers</a> or call 1-844-451-4444 for a list of <a href="#">network providers</a> .          | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.  | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |

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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<br>(You will pay the least)                     | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic  | Primary care visit to treat an injury or illness        | No charge; <a href="#">deductible</a> does not apply             | Not covered  | Friday designated Telemedicine <a href="#">providers</a> are not subject to <a href="#">deductible</a> and covered in full.   |
|   | <a href="#">Specialist</a> visit                        | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  | None  |
|   | <a href="#">Preventive care/screening/</a> immunization | No charge; <a href="#">deductible</a> does not apply             | Not covered  | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.   |
| If you have a test  | <a href="#">Diagnostic test</a> (x-ray, blood work)     | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  | For some diagnostic and imaging services, <a href="#">preauthorization</a> may be required. If You obtain services without a <a href="#">preauthorization</a> 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)                            | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  |   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://caprx.adaptiverx.com/webSearch/index?key=8F02B26A288102C27BAC82D14C006C6FC54D480F80409B68E5FAE0FB47E8C029">https://caprx.adaptiverx.com/webSearch/index?key=8F02B26A288102C27BAC82D14C006C6FC54D480F80409B68E5FAE0FB47E8C029</a> | Generic drugs (Tier 1)                                  | No charge; <a href="#">deductible</a> does not apply             | Not covered  | Applies to <a href="#">formulary</a> 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)                          | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  | Applies to <a href="#">formulary</a> preferred brand only. Up to 30-day supply Retail and up to 90-day supply Retail & Mail Order, except narcotics and Specialty drugs. *See Section 7   |
|   | Non-preferred drugs (Tier 2 & 4)                        | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  | Applies to <a href="#">formulary</a> non-preferred brand, non-preferred generic and non-preferred specialty. Up to 30-day supply Retail and up to 90-day supply Retail & Mail Order, except narcotics and Specialty drugs. *See   |

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

| Common Medical Event                    | Services You May Need                            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|--|--|--|--|
|   |  | Network Provider<br>(You will pay the least)                                 | Out-of-Network Provider<br>(You will pay the most)                           |  |
|   |  |  |  | Section 7  |
|   | <a href="#">Specialty drugs</a> (Tier 5)         | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | Not covered  | Applies to <a href="#">formulary</a> specialty only. Some specialty medications are available in other tiers. Not all <a href="#">Specialty drugs</a> are covered and <a href="#">Preauthorization</a> may be required. If You obtain services without a <a href="#">preauthorization</a> 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%. Specialty tier medications are always subject to one copay/coinsurance payment per thirty (30)-day supply. *See Section 7 |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | Not covered  | <a href="#">Preauthorization</a> may be required. If You obtain services without a <a href="#">preauthorization</a> 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                           | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | Not covered  |  |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | You pay the same as In-network if it is an emergency as defined in your <a href="#">plan</a> .   |
|   | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | You pay the same as In-network if it is an emergency as defined in your <a href="#">plan</a> .   |
|   | <a href="#">Urgent care</a>                      | \$75 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply | \$75 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply | None.  |
| If you have a hospital stay             | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | Not covered  | <a href="#">Preauthorization</a> is required. If You obtain services without a <a href="#">preauthorization</a> 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  |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | Not covered  |  |

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

| Common Medical Event  | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|---|--|--|--|
|   |   | Network Provider<br>(You will pay the least)                     | Out-of-Network Provider<br>(You will pay the most) |  |
|   |   |  |  | the other 50%. *See Section 7  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | No charge  | 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 <a href="#">preauthorization</a> 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 |
|   | Inpatient services                        | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  |  |
| If you are pregnant   | Office visits                             | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Will cover 48-hour hospital stay for uncomplicated vaginal delivery and 96-hour hospital stay for uncomplicated caesarean section. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                      |
|   | Childbirth/delivery professional services | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  |  |
|   | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  |  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  | 60 days/year. <a href="#">Preauthorization</a> is required after the first 30 days. If You obtain services without a <a href="#">preauthorization</a> 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%.   |
|   | <a href="#">Rehabilitation services</a>   | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 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. <a href="#">Referral</a> required.  |

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

| Common Medical Event | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|----------------------|---|--|--|---|
|                      |   | Network Provider<br>(You will pay the least)                     | Out-of-Network Provider<br>(You will pay the most) |   |
|                      |   |  |  | <a href="#">Preauthorization</a> may be required. If You obtain services without a <a href="#">preauthorization</a> 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   |
|                      | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  | 35 visits/year. The 35-visit limit does not apply to mental health and substance use disorder or autism. <a href="#">Referral</a> required. <a href="#">Preauthorization</a> may be required. If You obtain services without a <a href="#">preauthorization</a> 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 |
|                      | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  | 25 days/year. <a href="#">Preauthorization</a> may be required. If You obtain services without a <a href="#">preauthorization</a> 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   |
|                      | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  | Only <a href="#">Durable medical equipment</a> considered standard and/or basic as defined by nationally recognized guidelines are covered. <a href="#">Preauthorization</a> may be required. If You obtain services without a <a href="#">preauthorization</a> when one is required and the Plan agrees to pay the claim; the Plan may exercise its rights to impose a penalty   |

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

| Common Medical Event                   | Services You May Need            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|--|----------------------------------|--|--|---|
|  |                                  | Network Provider<br>(You will pay the least)                     | Out-of-Network Provider<br>(You will pay the most) |   |
|  | <a href="#">Hospice services</a> | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not covered  | of 50% of the allowed amount in which You will be responsible for the other 50%. *See Section 7<br><br>Benefits for Inpatient and in-home <a href="#">Hospice services</a> are Covered if you are terminally ill. <a href="#">Preauthorization</a> is required. If You obtain services without a <a href="#">preauthorization</a> 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                            |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (Adult &amp; Children)</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside U.S.</li> </ul>                      | <ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss program</li> </ul>   |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)   |   |  |
| <ul style="list-style-type: none"> <li>• Chiropractic care (35 visits/year)</li> </ul>   | <ul style="list-style-type: none"> <li>• Hearing aids (Once every 3 years)</li> <li>• Infertility treatment (limited to diagnosis and up to 6 cycles of IVF treatment, per lifetime)</li> </ul> | <ul style="list-style-type: none"> <li>• Private duty nurse (limited to Inpatient only)</li> <li>• Routine eye care (Adult) (1 exam per year)</li> </ul> |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.fridayhealthplans.com/members/resources/tx](http://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. For group health coverage subject to ERISA contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) 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](http://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: For group health coverage subject to ERISA contact Friday Health Plans at 1-844-451-4444, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or 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? 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 1-844-451-4444.

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, kwijjigo holne' 1-844-451-4444.

*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](#) \$2,300
- [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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,300        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$2,100        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,460</b> |

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$2,300
- [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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,300        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$400          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,720</b> |

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$2,300
- [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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,300        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$100          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,400</b> |

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:** تفكّكنا اية دون من بلغتك الضرورية والمعلومات المساعدة إلى الحصول في 1-844-451-4444 بخصوص أسئلة تساعد شخص لدى أو لديك كان إن Friday Health Plans الحق فلديك. ب اتصل مترجم عم للتحديث

**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 आफैं आवेदनको काम गर्नु, वा कसैलाई मद्दत गर्नु हानुहान्छु Friday Health Plans बारे प्रश्न छन् भने आफ्नो मातृभाषामा निःशुल्क सहायता वा जानकारी पाउने अधिकार छ । दोभाषे (इन्टरप्रेटर) सँग कु रा गनर्ुपरे 1-844-451-4444 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 Products and services are provided by or through Friday Health Insurance Company, Inc., an operating subsidiary of Friday Health Plans, Inc.

