Friday Silver Copay 87%

Coverage for: Individual, Individual + Spouse, Family | Plan Type: EPO

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 $1,000 individual / $2,000 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 $2,900 individual / $5,800 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. 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.

(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		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	$40 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	$50 copay/visit; deductible does not apply	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
	Diagnostic test blood work	15% coinsurance after deductible	Not covered	
	Imaging (CT/PET scans, MRIs)	15% coinsurance 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)	$10 copay/per 30 day supply; Deductible waived	Not covered	Applies to formulary preferred generic only, deductible.waived. 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)	$40 copay/per 30 day supply; Deductible waived	Not covered	Applies to formulary preferred brand only. *See Section 7
	Non-preferred drugs (Tier 2 & 4)	$75 copay/per 30 day supply; Deductible waived	Not covered	Applies to formulary non-preferred brand, non-preferred generic and non-preferred specialty. *See Section 7
	Specialty drugs (Tier 5)	$240 copay/per 30 day supply; Deductible waived	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

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)	
				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 you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance 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	15% coinsurance after deductible	Not covered	
If you need immediate medical attention	Emergency room care	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 .
	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	$50 copay/visit; deductible does not apply	$50 copay/visit; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance 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	15% coinsurance 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
	Inpatient services	15% coinsurance after deductible	Not covered	

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)	
				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 are pregnant	Office visits	$40 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	15% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	15% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	15% coinsurance 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	$40 copay/visit; deductible does not apply	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

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)	
				penalty of 50% of the allowed amount in which You will be responsible for the other 50%. *See Section 7
	Habilitation services	$40 copay/visit; deductible does not apply	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	15% coinsurance 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	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. 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

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	15% coinsurance after deductible	Not covered	Benefits for Inpatient and in-home 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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Children)
- Long-term care
- Non-emergency care when traveling outside U.S.
- 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.)

- Chiropractic care (35 visits/year)
- Hearing aids (Once every 3 years)
- Infertility treatment (up to diagnosis)
- Private duty nursing (limited to Inpatient only)
- Routine eye care (Adult) (1 exam per year)

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, kwiijigo 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	$1,000
Specialist copayment	$40
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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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 የሚያግዙት ግለሰብ፣ ስለ Friday Health Plans ጥያቄ ካላቸው፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸው። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-844-451-4444 ይደውሉ።

Arabic: الحق فلديك Friday Health Plans إن كان لديك أو لدى شخص بخصوص أسئلة تساعده 1-844-451-4444 في الحصول على المعلومات المساعدة والمعلومات الضرورية بلغتك دون من أي تكلفة. مترجم عم للتحدث 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 1-844-451-4444 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.

Napali: यिद तपाई ंआफ्ना लाि ग आफैं आवेदनको काम गद, वा कसैलाई मद्दत गद हनुह न्छ Friday Health Plans बारे प्रह छन् भने आफ्नो मातृभाषामा िन:शुल्क सहायता वा जानकार पाउने अिधकार 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 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、1-844-451-4444 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: گر شما، به امشد کہ سکی یا او کمک میکنید ، سوال در مورد 1-844-451-4444 یشابد داهتشد قح این را دارید کمک کہ و اطاعلات به زابن خود را به طور رااگین ، Friday Health Plans دریافت بیامند امتس صاحل بیامند.

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 1-844-451-4444.

Ibo: Ọbụrụ ụgị, 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 1-844-451-4444.

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 ongbufọkan sọrọ pè sórí 1-844-451-4444.