|  |  |  |
| --- | --- | --- |
| **PLAN YEAR** | 2021 | 2021  $ 2300 per Member/ $ 4600 per Family  $ 8250 per Member/ $ 16500 per Family  Unlimited |
| **CALENDAR YEAR DEDUCTIBLE (CYD)** | $2,300 per Member / $4,600 per Family |
| **OUT-OF-POCKET MAXIMUM (OOP Max)** | $8,250 per Member / $16,500 per Family |
| **ANNUAL MAXIMUM** | Unlimited |

|  |  |  |  |
| --- | --- | --- | --- |
| **COVERED MEDICAL SERVICES (If obtained from an in-network plan provider)** | | | |
| **GENERAL SERVICES** | | | |
| * PCP Office Visit*1* * Behavioral Health Office Visit * Specialist Office Visit***1*** | $0 Copay  $0 Copay  CYD+20% Coinsurance to OOP max | * Emergency Room * Urgent Care | CYD+50% Coinsurance to OOP max  $75 Copay |
|  | | | |

|  |  |
| --- | --- |
| **PREVENTIVE CARE SERVICES** (Please refer to your Evidence of Coverage) | |
| * Preventive Care (In addition to PCP Office Visits) | No Charge |

|  |  |  |
| --- | --- | --- |
| **OTHER HEALTH CARE SERVICES*2*** | |  |
| *All other services, including but not limited to those listed below* | | CYD+20% Coinsurance to OOP max |
| * **Ambulance** *(Air/Ground)* | | |
| * **Diagnostic Tests** (Facility/Physician **-** *Cardiac Imaging; Colonoscopy (non-preventive); CT Scan; EKG; Genetic Disease Testing; MRI; PET Scan; Sleep Study; Stress Test; Ultrasound)* | | |
| * **Inpatient Services** *(Facility Charges - Behavioral Health, Rehabilitation, Skilled Nursing; Coronary Care Units; Intensive Care Unit (ICU); Labor & Delivery; Laboratory Tests/X-rays; Mental/Behavioral Health; Operating/Recovery Room; Physician Services; Pre-Admission Testing; Short term Habilitation & Rehabilitation Services; Surgical Procedures)* | | |
| * **Outpatient Services** *(Facility Charges, including Behavioral Health and Ambulatory Surgical Facilities; Laboratory Tests/X-rays; Mental/Behavioral Health; Observation Unit; Physician Services; Prenatal & Postnatal Care; Short term Habilitation & Rehabilitation Services; Surgical Procedures)* | | |
| * **Other Services** *(Allergy Testing/Serum/Injections; Amino Acid-Based Elemental Formulas; Applied Behavioral Analysis; Chiropractic/Spinal Manipulation; Clinical Trials; Diabetic Services; Dialysis Services; Durable Medical Equipment; Home Infusion Medications; Habilitation/Rehabilitation Services; Hearing Aids; Home Health Care; Hospice Care; Diagnosis of Infertility; Internal Implantable Devices; Limited Accidental Dental Care; Mastectomy Reconstructive Surgical Services; Medical Supplies; Oral Physician Surgical Services; Other Diagnostic & Therapeutic Services; Organ Transplant Services; Orthotics; Pain Management; Post-Cataract Surgical Services; Prosthetics; Special Food Products & Enteral Formulas; Surgical Procedures in Physician Office; Temporomandibular Joint Treatment (TMJ); Therapy Services)* | | |
| * **All Other Covered Services *(not specified herein)*** | | |
| ***Covered Service Limitations2*** - (Please refer to your Evidence of Coverage for a complete list of covered service limitations) | | |
| * **Chiropractic/Spinal Manipulation, Short Term Rehabilitation/ Habilitation –** Limit of 35 visits/Plan Year combined * **Hearing Aids –** Limited to $1,000 per every 36 months | * **Infertility Treatment –** Limited to the Diagnosis of Infertility * **Prosthetic and Orthotic Devices –** Limited to one every 3 years * **Skilled Nursing Facility –** Limited to 25 days per Plan Year | |
| **OTHER PEDIATRIC CARE SERVICES** – For members up to age 19 | | |
| * **Annual Eye Glasses** **–** *Limited to one routine eye exam and one pair of eyeglasses per Plan Year* | * **Dental Services –** *See pediatric stand-alone plan designs offered through the Health Insurance Marketplace* | |
| **PRESCRIPTION DRUG SERVICES*2*** – 30-day supply | | |
| * **Preventive RX –** No Cost * **Tier I/Preferred Generic -** $0 Copay | * **Tier III/Non-Preferred Generic and Brand -** CYD+50% Coinsurance to OOP max | |
| * **Tier II/Preferred Brand -** CYD+20% Coinsurance to OOP max | * **Tier IV/Specialty -** CYD+50% Coinsurance to OOP max | |

|  |  |  |
| --- | --- | --- |
| |  | | --- | | ***1PCP or Specialist Office Visits –* Some services provided in a physician’s office are subject to additional deductible & coinsurance**  ***2*Prior Authorization may be required for these Covered Services. Please contact the Plan concerning Prior Authorization questions** | | **For more info go to** <https://www.fridayhealthplans.com/members/resources/tx> **or Friday Health Plan’s customer services at 1-**[**800-475-8466**](tel:800-475-8466) | |

*Products and services are provided by or through Friday Health Insurance Company, Inc., an operating subsidiary of Friday Health Plans, Inc.*