# Texas Transparency in Coverage

**INDIVIDUAL ON-EXCHANGE COVERAGE**

At Friday Health Plans, we want to help you better understand your health care coverage. If you purchased your health insurance plan directly from Friday Health Plans, or through the Health Insurance Marketplace, the following information is for you. Choose a topic below to learn more about using your coverage.

Note that the following information is a general overview of information related to health insurance plans and Health Maintenance Organization (HMO) health plans. Your specific plan may have some differences. Please refer to your policy for more information, including benefits, limits and exclusions.

## Other Types of Coverage

**Coverage through your job:** If you have questions about your plan, please contact your employer's HR department or call Friday Health Plans at the number on the back of your member ID card. You can also log in to your fridayhealthplans.com account to access your plan information.

## What is a Provider Network?

The provider network that is available to you under the terms of your plan is made up of doctors, hospitals and other health care providers. The contracted providers in your network have agreements with us, Friday Health Plans, that may help save you money for covered services.

Your costs will vary depending on whether your provider is participating in the network. Please refer to the Provider Directory to find in-network providers. You should check if your plan has out-of-network benefit coverage before scheduling a visit.

## Your Network and Your Plan Type

The way you use the provider network available under your health plan may vary by your plan type. The following is a brief description of how each plan type works.

### Health Maintenance Organization (HMO)

If you have an HMO, you must work with a contracted (in-network) primary care physician (PCP) to help coordinate any care you receive within your provider network. When you first sign up for an HMO, you choose, or are assigned, a PCP.

Your PCP is your partner to help guide you with your health care needs. When using your HMO plan, keep in mind the following:

- **You must work with your PCP whenever you need care.** When you first choose or are assigned a PCP, schedule a visit as soon as possible. Going right away will help avoid delays later when you are sick or need a referral.
- **You will need a referral to see a specialist.** If you need to see a specialist, you must obtain a referral from your PCP. Your PCP will usually refer you to a specialist that is in your network, but you should always check to make sure. Women don't need a referral to see an in-network OB-GYN, which is an obstetrician/gynecologist or a family practice doctor. Friday Health Plans does not require a prior-authorization for you to see an in-network specialist. If you are referred to an out-of-network specialist you will need to obtain a prior authorization from us.

**You are encouraged to see in-network providers.**

If you receive care from an out-of-network provider you are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out- of-network".
Out-of-network hospitals, facilities or providers often bill you the difference between what Friday Health Plans decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called 'surprise' or 'balance' billing.

***If you intentionally receive non-emergency services from an out-of-network provider or facility, Friday Health Plans may exercise its right to impose a 50% penalty which means Friday Health Plans will pay 50% of the claim/s and you will be responsible for the other 50%.***
To make sure a provider is in your plan's network, search Provider Directory before visiting a new doctor or health care facility.

**When Do I Need a Benefit Approval for a Medical Service?**

Sometimes, to receive benefits for certain services or prescription drugs, you or your provider must call Friday Health Plans before you receive treatment. This is known as a prior authorization. It is also sometimes called pre-certification or preapproval. Note that this is different than getting a referral to see a specialist. Sometimes, you may need to get a referral to see a specialist and prior authorization to receive benefits for a service from that specialist. You can work with your doctor on determining when you need each.

When you or your provider contact Friday Health Plans with a prior authorization request, we will ask for the following:

- Information about your medical condition
- The proposed treatment plan
- The estimated length of stay (if you are being admitted)

During the prior authorization process, Friday Health Plans reviews the requested service or medication to see if the service or medication is medically necessary.

"Medically Necessary" is defined in your policy and generally refers to health care services or supplies that:

1. are essential to the diagnosis, prevention or direct treatment of a condition or injury;
2. follow generally accepted standards of medical practice, based on credible scientific evidence;
3. are not primarily for the convenience of you or your doctor; and
4. are the most economical services or supplies that are appropriate for your safe and effective treatment.

The service or treatment must meet your plan's definition of medical necessity in order to be eligible for benefits under your plan. The prior authorization process is not a substitute for the medical advice of your health care provider. The final decision to receive any medical service or treatment is between you and your health care provider.

For more information on medical necessity, see your policy.
If you are unsure which health care services or medications need prior authorization, you can call the Customer Service number on the back of your Friday Health Plans member ID card.

**Remember, even if a service or medication is authorized, if the provider is out of network you will likely pay more out of pocket. Check Provider Directory to ensure the provider is in your plan's network. Also, a determination that a service is authorized or medically necessary is not a guarantee of coverage. The applicable terms of your plan will control the benefits that you will receive.**
**For HMO members:** Contact your primary care physician (PCP) to coordinate your care. If you are seeking care from a specialist, ask your PCP to ensure that you have received any needed prior benefit authorization.
**For all members:** If your or your doctor's request for prior authorization is denied, you have the right to appeal the decision. However, you may be responsible for the cost of that service or drug. You can learn more about the appeals process in the **Why Was Payment for the Service I Received Denied?** section. You can also refer to your benefits documents or call the Customer Service number on the back of your member ID card.

**How Quickly Does Friday Health Plans Respond to a Prior Authorization Request?**

The time it usually takes Friday Health Plans to respond to your prior benefit authorization request depends on a number of factors, including when we receive your

information, the type of service or medication being requested, if additional information is needed and certain regulatory requirements.

**For HMO members:** Your primary care physician (PCP) helps coordinate your in-network care. If you are seeking care from a specialist, ask your PCP to ensure that you have received any needed prior authorization.
***NOTE: This table is not intended as medical advice or a substitute for medical advice. The final decision about any care or treatment you receive is between you and your health care provider. Check your plan details for more information.***

| Type of Care | Usual Response Time |
|---|---|
| **Non-Urgent Care** requested before you receive services or for services you are currently receiving that have extended past the initial approval | After we receive your request, we will issue a notification within three calendar days<br><br>For requests related to Acquired Brain Injuries, we will respond within three business days. |
| **Urgent Care*** requested before you receive services | After we receive your request, we will make a decision within two business days or 72 hours, whichever is sooner. |
| **Urgent Care*** for inpatient services you are currently receiving and/or if you are hospitalized | We will respond within 24 hours of receiving your request. |
| Stabilization Care after an emergency or life-threatening situation | We will respond as soon as possible and no later than one hour after we receive the request. |

* Urgent care is treatment that, when delayed, could seriously jeopardize your life and health or your ability to regain maximum function.

If you and your doctor are requesting authorization after you have already received services, Friday Health Plans will notify you or your doctor with a coverage decision within 30–45 days.

In addition to the above, the following applies to all required prior benefit authorizations:

- **Prior authorization does not guarantee payment by your plan.** Even if a service or medication has been authorized, coverage or payment can still be affected for a variety of reasons. For example, you may have become ineligible or have different coverage as of the date of service.
- **We may request additional information.** Friday Health Plans may require more information from your doctor or pharmacist during the prior benefit authorization process. This could include a written explanation of the requested services, reasons for treatment, projected outcome, cost statements or other documents that could be helpful to decide on the medical necessity of the treatment.
- **You are responsible for making sure your prior authorization requirements are met.** All health insurance and HMO health plans require prior authorization for certain services. When you stay in network, your provider may take care of this step for you, but you should always ask your doctor to make sure. If you decide to see an out-of-network provider, you are responsible for this step as well as additional amounts the out-of-network charges as mentioned in the balance billing section. For more information, please refer to your policy.
  If you don't get prior authorization for a service that requires it, you may be responsible for a charge in addition to any other applicable deductibles, copayments or coinsurance. In addition, we may review the service to determine if it is medically necessary as defined in your policy. If we determine that the treatment(s) does not meet the definition of medically necessary, you may be responsible for paying for the services you received.

**What Happens if a Drug I Need is Not Covered?**

Whether you take medication to manage an ongoing health condition or you need a prescription for an illness, you will want to become familiar with your health care plan's drug list. This is a list of covered drugs that are available to Friday Health Plans' members.

Both brand and generic medications are included on the drug list. The drug list has different levels of coverage, which are called "tiers." Generally, if you choose a drug that is a lower tier, your out-of-pocket costs for a prescription drug will be less.

The drug list is not a substitute for the independent medical judgment of your health care provider. The final decision on what prescription drug is appropriate for you is between your health care provider and you.
You can view the formulary at www.fridayhealthplans.com. Be sure to choose the section that describes your plan.

**When You Can Request a Coverage Exception**

If your medication is not on (or has been removed) from your drug list, you or your prescribing doctor may want to request a coverage exception.

To request this exception, your prescribing doctor will need to send us documentation. To begin this process, you or your doctor should call the Customer Service number on the back of your ID card for more information.

Friday Health Plans will usually let you or your doctor know of the benefit coverage decision within the lesser of two business days or 72 hours of receiving your request. If the coverage request is denied, Friday Health Plans will let you know why it was denied and may advise you of a covered alternative drug (if applicable). You can also appeal the benefit determination (see below for more information).

You or your doctor may be able to ask for an expedited review if:

- You take medication for a health condition and failure to get that medication may either pose a risk to your life or health or could keep you from regaining maximum function
- Your current drug therapy uses a non-covered drug
- If your review is expedited, Friday Health Plans will usually let you or your doctor know of the coverage decision within 24 hours of receiving your request. If the coverage request is denied, Friday Health Plans will let you know why it was denied and may advise you of a covered alternative drug (if applicable). You can also appeal the benefit determination.

**How to Request a Reconsideration of a Drug Coverage Exception Determination**

If your coverage request is denied, you may request a reconsideration through Friday Health Plans verbally by calling the telephone number on the back of your ID card or by written request to:

Friday Health Plans
700 Main Street
Alamosa, CO 81101

If your request is Urgent or Expedited, an external review with an Independent Review Organization (IRO) may be requested. If your case qualifies for external review, an IRO will review your case, at no cost to you, and make a final decision.

If your standard coverage exception reconsideration is denied, you may be able to request an independent, external review by an Independent Review Organization (IRO). To request an independent review, contact Friday Health Plans at the number on the back of your member ID card.

For questions about your rights, you may visit the Texas Department of Insurance website or contact:
Texas Department of Insurance Consumer Protection
Mail Code 111-1A, 333 Guadalupe
PO Box 149091
Austin, Texas 78714

Phone: **1-800-252-3439**
Email: ConsumerProtection@tdi.texas.gov
If you have any questions about requesting a coverage exception, call the Customer Service number on the back of your member ID card.

**What Happens if I Go Out of Network?**

Before you seek care, it is always best to confirm that your provider is in network in order to receive the highest level of your benefits. However, there are some times when care you receive from an out-of-network provider may be covered, such as:

- **Emergency care.** If you experience a medical emergency and visit an out-of-network emergency room, you do not need approval from your plan first. Afterwards, your claim may be reviewed to ensure it meets the criteria for an emergency medical condition. Once approved, your services will be paid in accordance with the terms of your plan.
- **Medically necessary services that are unavailable inside your network.** If you need services or treatments not covered by the doctors or facilities in your plan's network, you can seek approval to go out of network for these services. To learn more, see **When Do I Need Benefit Approval for Medical Services?**

When you see a provider who is part of your network, he or she has agreed to accept a set amount as full payment for covered services and will only bill you for any copays, coinsurance or deductibles under your health benefit plan.

When you see an out-of-network provider, if he or she charges more than this amount, the provider may try to bill you the difference. This is known as balance or "surprise" billing.

If you receive medical care on or after Jan. 1, 2020, you are protected from surprise bills in many situations where you don't have a choice in where to get care. Instead, the responsibility for agreeing on the price for services is on the health care provider and the insurance company. The provider and insurer use an independent reviewer, called an arbitrator or mediator, to help them decide how much can be charged for the services provided.

The law outlaws surprise medical bills from various Texas health care providers, including:

- Out-of-network providers at in-network hospitals, birthing centers, ambulatory surgical centers and free-standing emergency medical care facilities
- Out-of-network providers and facilities, including hospitals and free-standing emergency medical care facilities, that provide emergency services and supplies
- Certain out-of-network diagnostic imaging services and laboratories

If you visit a health care provider outside of your plan's network, they may ask you to sign a form that would allow them to balance bill you before they provide any care. **It is very important that you read any paperwork that a doctor asks you to sign.** They cannot ask you to sign this form if you received emergency services.
If you have any additional questions regarding surprise medical bills, please contact us at the number on the back of your ID Card.

To avoid balance billing charges, use the Provider Directory to make sure that the provider is in network.
Learn more about surprise medical bills and your protections against them.
**All covered services are subject to contract benefits, limitations and exclusions. For more information regarding your benefits, please refer to your policy.**

**How Can I See My Plan's Coverage Information?**

To help you better understand your health care coverage, we are providing Summary of Benefits and Coverage (SBC) documents for each of our plans. These SBCs describe key features such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.
Information in these SBCs represents an overview of coverage. It is not a complete list of what is covered or excluded. Information is subject to change. The full terms of coverage are in the insurance policy. The full terms of the policy will govern your benefits, so it is important that you read and understand them.

**Enrollee claims submission**

A claim is a request to an insurance company for payment of health care services. Usually, providers file claims with us on your behalf. If you received services from an out-of-network provider, and if that provider does not submit a claim to us, you can file

the claim directly. Please contact customer service at 844-521-7999 to determine the specific time limit for submitting your claim.

To file a claim, follow these steps:

1. Submit a written request filing a claim
2. Attach an itemized bill from the provider for the covered service.
3. Make a copy for your records.
4. Mail your claim to the address below.
5. Alternatively, you can send the information by fax to (719) 589-4901.

Friday Health Plans
700 Main Street
Alamosa, CO  81101

**When and How Do I Submit a Claim?**

When you visit a doctor or other health care provider, your provider will usually submit a claim to us on your behalf. However, if the provider fails to do so, you can submit the claim yourself. You are more likely to have to file your own claim if you get care from an out-of-network provider.

**How to File a Claim**

If you need to file a claim, you will find instructions in you plan policy to help guide you.

If you have any questions, you can also contact us at the number on the back of your member ID card.

You can submit a claim up to 12 months from the date of service.

When submitting a claim, it's important to include a copy of the original bill issued by your health care provider. Be sure to make copies for your records as documents sent in with your claim cannot be returned to you. Basic information to have handy when preparing a claim form includes:

- Your provider’s name and address
- Date of service;
- Type of service;
- Dollar amounts charged by doctor or other health care provider for each service;
- Patient name;
- Member name; and
- Member identification number (found on ID card)

Follow these steps to avoid any delays in processing your claim:

- File your claim right away after receiving medical care. Waiting to file a claim may result in a denial of medical benefits.
- Give as much detail as you can. Including the original bill from your doctor or other health care provider helps. Be sure to make a copy for your records as any documents attached to your claim cannot be returned to you.
- If FRIDAY HEALTH PLANS asks you for more information, please get back to us quickly.
- If signatures are needed, be sure to get the proper signatures before sending in your claim.

**Check the Status of a Claim**

You can check the status of a claim in one of the following ways:

- Visit the “My Claims” section in your Friday Health Plans Member portal
- Call the Customer Service number on the back of your ID card.

If your claim has been denied, you can file an appeal to have it reviewed again. The appeals information is located with your Explanation of Benefits (EOB) and your insurance policy. For more information about EOBs, see below.

What is an Explanation of Benefits (EOB)?

An Explanation of Benefits (EOB) is a document that is usually sent to you when a medical benefits claim is processed by your health care plan. It explains the actions taken on the claim and provides information to help understand the following:

- The fees billed by your doctor or other health care provider;
- The date of service which applies to the EOB;
- The services and procedures that were covered;
- The amount that your plan will pay;
- The amount that you may still owe (if you haven't already paid); and
- Any reasons for denying payment along with the claims appeal process.

**Your EOB Details**

Your Friday Health Plans EOB is normally divided into 3 major sections:

1. **Total of Claim(s)**features the main financial information about your claims. It includes the total amount billed, benefits approved and what you may owe to the provider. Sometimes one EOB may contain more than one claim.

2. **Service Detail** for each claim describes each service you or your dependent received, the facility or doctor, the dates and the charges. It shows the savings your Friday Health Plans benefits plan provides for you from discounts and other reductions. And, you can see any costs that may not be covered.
3. **Summary** gives you a clear picture for each claim of your deductible, coinsurance, copays, and health spending accounts, if these apply to you.

The EOB statement is an important record of claims for medical services and benefit coverage. Remember to keep your EOBs for future reference, in case questions come up later about your claim or your bill. Keep your EOBs in a safe place with your other important personal documents, such as your medical records.

**Why Was Payment for the Service I Received Denied?**

Typically, when you receive medical services, your provider will bill your health plan (Friday Health Plans) before sending a bill to you. Friday Health Plans then reviews the services you received and determines which services are covered by your plan. Occasionally, claims may be denied after you've received services. If the claim has already been paid, we may seek a refund from the providers and you may be responsible for the cost. This is also known as a retroactive denial and can happen for a variety of reasons, including:

- Friday Health Plans conducts a medical necessity review and determines that your services did not meet the definition set forth in your benefit plan. For more information, see the **When Do I Need Benefit Approval for a Medical Service?**
- You are no longer covered by your plan or eligible for benefits, or you were not covered at the time that you received medical services.
- You visited an out-of-network provider for non-emergency services and are covered by a plan that does not have out-of-network benefits.
- Another insurer or source should have been billed for your services before or in place of Friday Health Plans.

***Note: This is not a complete list. For more information, please see your policy booklet.***
The following steps may help you to avoid having your claim denied:

- Review your plan's policy before you seek medical services.
- Verify your benefits by calling Customer Service at the phone number on the back of your ID card.
- Talk to your provider about Friday Health Plans’ medical policy. You and your provider can access our medical policies online. These policies offer information about medical services that may have limitations based on published clinical research.

In addition to the above, your claims may be denied if you lose coverage after failing to pay your premium. For more information, see the **What Happens if I Miss a Premium Payment?** section.

- If a claim is denied, you may be responsible for the cost of the services received. However, you also have the right to submit an appeal. An appeal is a way to have that decision reviewed.

To get started, follow the directions listed on your Explanation of Benefits (EOB) under Your Right to Appeal section.

You can also refer to your benefit plan materials by logging in to your Friday Health Plans member portal. Or, call the Customer Service number on the back of your ID card to learn more about the appeal process and plan benefits available to you.

## Grace Periods and Claims Pending

You are required to pay your premium by the scheduled due date. If you do not do so, your coverage could be canceled. For most individual health care plans, if you do not pay your premium on time, you will receive a 30-day grace period. A grace period is a time period when your plan will not terminate even though you did not pay your premium. Any claims submitted for you during that grace period will be pended. When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full. If you do not pay your delinquent premium by the end of the 30-day grace period, your coverage will be terminated. If you pay your full outstanding premium before the end of the grace period, we will pay all claims for covered services you received during the grace period that are submitted properly. If you have an individual HMO plan in Texas, we will pay your claims during the 30-day grace period; however, your benefits will terminate if your delinquent premium is not paid by the end of that grace period.

If you are enrolled in an individual health care plan offered on the Health Insurance Marketplace and you receive an advance premium tax credit, you will get a 3-month grace period and we will pay all claims for covered services that are submitted properly during the first month of the grace period. During the second and third months of that grace period, any claims you incur will be pended. If you pay your full outstanding premium before the end of the 3-month grace period, we will pay all claims for covered services that are submitted properly for the second and third months of the grace period. If you do not pay all of your outstanding premium by the end of the 3-month grace period, your coverage will terminate, and we will not pay for any pended claims submitted for you during the second and third months of the grace period. Your provider may balance bill you for those services.

## I Overpaid for My Premium. How Do I Get a Refund?

In the case of one of the following events, you can recover premium payments you have already made to Friday Health Plans, also known as recoupment of overpayments.

- **Through your right to examine the policy**. You have 10 days after your policy is issued to review it. If, for any reason, you are not satisfied with your health care benefits, you may return your policy and your member ID card(s) to Friday Health Plans. This will void your coverage. Friday Health Plans will refund any premium you have paid, as long as you haven't had a claim paid under this policy before the end of the 10 days.
- **If the policyholder passes away**. Friday Health Plans will refund any premiums paid in advance, following the death of a plan's primary policyholder. You can request that the refund is issued to a different payee, including the deceased's estate.
- **If you overpaid for your active policy.** Friday Health Plans will refund additional premium payments up until the end of the current month. For example, if you paid your premium in advance for the month of June, you can receive a refund up until the last day in May.
- **If you ask to cancel your policy.** After you cancel your policy, Friday Health Plans will automatically refund any payments you have made for billing periods after your termination date. You do not need to request this refund.
- **If you do not pay your premium and your policy is terminated.** After your policy is terminated, Friday Health Plans will automatically refund any payments you have made for billing periods after your termination date. This would apply if you do not pay your premium on time and do not pay your outstanding notices by the end of grace period. (For more information on grace periods, please see the **What Happens if I Miss a Premium Payment?** ) You do not need to request this refund.

For more information and to begin the process to recover premium payments, please call us at the number on the back of your member ID card.

**What Happens if I Miss a Premium Payment?**

If you miss the due date for a premium payment, you have extra time to make that payment. This is known as the "grace period." During this time, your health care coverage will not be cancelled, although you may see some changes in your coverage, as outlined below.
The length of the additional time and the changes depend on whether you have a Marketplace plan with an Advanced Premium Tax Credit (tax credit).

**For members with a tax credit**: If your premium payment is past due, you have up to 3 months to pay your premium and to keep from losing your coverage. While you may get health care during those 3 months, it does not mean all your claims will be covered by your plan.
During the grace period, Friday Health Plans will:

- Process claims for services received during the grace period;
- Notify the Department of Health and Human Services of your non-payment of premium; and,
- Notify providers that your claims may be denied for services provided during the 2nd and 3rd months of your grace period.

If you get behind on paying your premium, you must pay all past-due premiums before the end of the 3rd month that your payment is late. If the premiums are past due for more than 3 months, your plan coverage will be terminated. If your coverage is terminated, you will not be able to enroll in a new plan until the next open enrollment period unless you qualify for a Special Enrollment Period.

**For members without a tax credit**: After your premium payments are late, you must get your account current within 31 days of the payment due date. After 31 days, your policy will be cancelled. If you receive health care during this 31-day period, you may be responsible for paying the entire amount of your medical bills. You must pay all of your outstanding premiums to keep your coverage. If your coverage is cancelled, you will not be able to enroll in a new plan until the next open enrollment period unless you qualify for a Special Enrollment Period.

**Prescription Drug Benefits and the Grace Period**

Missing your premium payment also affects your prescription drug coverage.

**For members with a tax credit:** During the grace period, you may not see changes to your prescription drug coverage. However, if you do not pay your premium in full by the end of the 3 month grace period, your coverage will be cancelled. In addition, we will bill you for prescriptions we covered in the 2nd and 3rd month.

**For members without a tax credit**: During the grace period, you may not see changes to your prescription drug coverage. However, if you do not pay your premium in full by the end of the 31-day grace period, your coverage will be cancelled. In addition, we will bill you for prescriptions we covered during the grace period.

**Which of My Health Insurance Plans is Primary?**

If you have more than one insurance or HMO health plan, the section of your policy titled "Coordination of Benefits (COB)" will help explain how your claims are paid by each plan. For example, you and your spouse may be covered under each other's health care benefits plans. In this case, your plan is usually the primary plan for your claims. Your spouse's plan is usually primary for his or her claims.

In both cases, the primary plan will pay first. Afterward, the secondary plan may then pay an additional amount toward the claim, depending on its rules.

If you have dependent children covered under both your and your spouse's health care benefits plan, their primary plan will often be determined by your and your spouse's birthdays. The plan of the parent whose birthday (month and day) occurs first in the calendar year will be considered primary.

For more information about COB, refer to your benefit materials or call the Customer Service number on the back of your member ID card.