Friday Silver Copay 94%

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

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/ok or call 1-844-817-1600. 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 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $0 individual / $0 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 1-844-817-1600 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.

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	$20 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. All Preventive care that is not state mandated is not covered Out-of-network.
If you have a test	Diagnostic test x-ray	$25 copay/visit; deductible does not apply	Not covered	For some diagnostic and imaging services, preauthorization may be required. *See Section 6
	Diagnostic test blood work	10% coinsurance after deductible	Not covered	For some diagnostic and imaging services, preauthorization may be required. *See Section 6
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	Not covered	For some diagnostic and imaging services, preauthorization may be required. *See Section 6
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)	$0 copay; deductible does not apply	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)	Up to $20 copay; deductible does not apply	Not covered	Applies to formulary preferred brand only,. Insulin will not exceed $30 for a 30 day supply and $90 for a 90 day supply. Up to 30-day supply Retail and up to 90-day supply Retail & Mail Order, except narcotics and Specialty drugs. * See Section 7

* For more information about limitations and exceptions, see the plan or policy document at www.fridayhealthplans.com/members/resources/ok.

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)	
	Non-preferred drugs (Tier 2 & 4)	Up to $75 copay; deductible does not apply	Not covered	Applies to formulary 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 Section 7
	Specialty drugs (Tier 5)	Up to $240 copay; deductible does not apply	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, Specialty tier medications are always subject to one copay/coinsurance payment per thirty (30)-day supply. * See Section 6
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	Not covered	Preauthorization may be required. *See Section 6
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	Preauthorization may be required. *See Section 6
If you need immediate medical attention	Emergency room care	10% coinsurance after deductible	10% coinsurance after deductible	You pay the same as In-network if it is an emergency as defined in your plan .
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	You pay the same as In-network if it is an emergency as defined in your plan .
	Urgent care	$25 copay/visit; deductible does not apply	$25 copay/visit; deductible does not apply	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not covered	Preauthorization is required, unless for emergency. *See Section 6
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	Preauthorization is required, unless for emergency. *See Section 6
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; deductible does not apply	Not covered	Preauthorization is required for procedures. *See Section 6
	Inpatient services	10% coinsurance after deductible	Not covered	All inpatient for Severe Mental Illness or Substance Abuse require preauthorization. *See Section 6
If you are pregnant	Office visits	$20 copay/visit; deductible	Not covered	Cost sharing does not apply for

* For more information about limitations and exceptions, see the plan or policy document at www.fridayhealthplans.com/members/resources/ok.

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)	
		does not apply		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).
	Childbirth/delivery professional services	10% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	10% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	Not covered	Limited to 30 visits/year.
	Rehabilitation services	$20 copay/visit; deductible does not apply	Not covered	Combined 30 visit limit for occupational, speech and physical therapies. *See Section 6
	Habilitation services	No charge; deductible does not apply	Not covered	30 visit limit per therapy for occupational, speech and physical. *See Section 6
	Skilled nursing care	10% coinsurance after deductible	Not covered	Limited to 30 days per plan year. Preauthorization may be required. *See Section 6
	Durable medical equipment	10% coinsurance after deductible	Not covered	Only Durable medical equipment considered standard and/or basic as defined by nationally recognized guidelines are covered. Preauthorization required per item over $500. *See Section 6
	Hospice services	10% coinsurance after deductible	Not covered	Benefits for Hospice services for care of a terminally ill Member with a life expectancy of six months or less. No authorization for first 6 months, prior authorization required for subsequent 6 months. *See Section 6
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

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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)	
				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 (Prior Authorization required after 30 visits)	• Hearing aids (1 per ear/48 months) • Infertility treatment (up to diagnosis)	• Private duty nursing (85 visits/year) • Routine eye care (Adult) (1 exam/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 1-844-817-1600. You may also contact your state insurance department at 1-800-522-0071. 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: Oklahoma Insurance Department Five Corporate Plaza 3625 NW 56th, STE 100 Oklahoma City, OK 73112-4511 Local: (918) 295-3700 (405) 521-2991 (800) 522-0071 (in state only) Fax: (918) 994-7916 or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov, or Friday Health Plans, 1-844-817-1600.

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 1-844-817-1600.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-817-1600.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-817-1600.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-817-1600.

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 $0
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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	$0
Copayments	$50
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,310

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

- The plan's overall deductible $0
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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	$0
Copayments	$300
Coinsurance	$90
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$410

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

- The plan's overall deductible $0
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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	$0
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$400

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 1-844-817-1600.

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 1-844-817-1600.

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 1-844-817-1600.

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 1-844-817-1600 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 1-844-817-1600.

Amharic: እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Friday Health Plans ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-844-817-1600 ይደውሉ።

Arabic: الحق فلديك Friday Health Plans إن كان لديك أو لدى شخص تساعده أسئلة بخصوص 1-844-817-1600 في الحصول على المساعدة والمعلومات الضرورية دون من بلغتك الخاصة. للتحدث مترجم عم 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 1-844-817-1600 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 1-844-817-1600.

Napali: यिद तपाई ंआफ्ना लाि ंग आफैं आवेदनको काम गद, वा कसैलाई मद्दत गद ह ुनुह ुन्छ Friday Health Plans बारे प्र ह छन् भने आफ्नो मातृभाषामा िन:शुल्क सहायता वा जानकार पाउने अिधकार छ । दोभाषे (इन्टरप्रेटर) सँग कु रा गनर्ुपरे 1-844-817-1600 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 1-844-817-1600.

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、1-844-817-1600 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 1-844-817-1600 tiin bilbilaa.

Persian: رایگان طور به را خود زبان به اطاعلات و که کمک دارید را این قحد داهتشد یشابد 1-844-817-1600 مورد در سوال ، میکنید کمک او ایی سک که امشد به ،شما گر ، Friday Health Plans بیامند صاحل امتس بیامند درفایت.

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 1-844-817-1600.

Ibo: Ọbụrụgị, ma o bụonye I na eyere-aka, nwere ajụjụgbasara Friday Health Plans, I nwere ohere iwenta nye maka na ọnụma na asụsụgị na akwu gị ụgwọ I chọọl kwụụonye-ntapịa okwu, kpọ1-844-817-1600.

Yoruba: Bí ìwọ tàbí ẹnikẹni tí o n ranlọwọ bá ní ibeere nipa Friday Health Plans, o ní ẹtọlati rí iranwọàti ìfitónilétí gbà ní èdè rẹláìsanwó. Láti bá ongbufọkan sọrọ pè sórí 1-844-817-1600.