



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, <http://healthplan.memorialhermann.org/for-brokers/resource-center> or call 855-645-8448. 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 855-645-8448 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | <a href="#">Network Providers</a> - \$0 person / \$0 family.<br><a href="#">Out-of-network Providers</a> - None.                                                                                                                              | 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> services are covered before you meet your <a href="#">deductible</a> . Does not apply to Generic, Preferred brand or Non-Preferred brand <a href="#">prescription drugs</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> ? | <a href="#">Network Providers</a> - \$6,500 person / \$13,000 family. <a href="#">Out-of-network Providers</a> – None.                                                                                                                        | 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, penalties for failure to obtain <a href="#">Preauthorization</a> for services 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="https://healthplan.memorialhermann.org/find-a-doctor?network=Select+HMO">https://healthplan.memorialhermann.org/find-a-doctor?network=Select+HMO</a> or call 855-645-8448 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



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) |                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                                                                                                            | Primary care visit to treat an injury or illness       | \$50 <a href="#">copay</a> /visit.                                                                                                              | Not covered.                                       | None.                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                          | <a href="#">Specialist</a> visit                       | \$100 <a href="#">copay</a> /visit.                                                                                                             | Not covered.                                       | None.                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                          | <a href="#">Preventive care/screening/immunization</a> | No charge.                                                                                                                                      | Not covered.                                       | For children under the age of 6: required immunizations are not subject to <a href="#">copay</a> requirements for <a href="#">network providers</a> . 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.                                                                                                      |
| <b>If you have a test</b>                                                                                                                                                                                                                                                                                                | <a href="#">Diagnostic test</a> (blood work, x-ray)    | Blood work – \$50 <a href="#">copay</a> /visit<br>X-ray - \$100 <a href="#">copay</a> /visit                                                    | Not covered.                                       | Professional/interpretation service is included in diagnostic blood work and x-ray cost shares.                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                          | Imaging (CT/PET scans, MRIs)                           | \$500 <a href="#">copay</a> /visit.                                                                                                             | Not covered.                                       | <a href="#">Preauthorization</a> required for all genetic testing and complex imaging.                                                                                                                                                                                                                                                                                                                               |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://healthplan.memorialhermann.org/Members/Pharmacy-Benefit-Information">https://healthplan.memorialhermann.org/Members/Pharmacy-Benefit-Information</a> , | Generic Drugs                                          | Retail: \$4 <a href="#">copay</a> / <a href="#">prescription</a> .<br>Mail order: \$8 <a href="#">copay</a> / <a href="#">prescription</a> .    | Not covered.                                       | Retail covers 30-day supply and mail order covers up to 90-day supply unless stated by the <a href="#">formulary</a> or <a href="#">plan</a> benefits.                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                          | Preferred Brands Drugs                                 | Retail: \$45 <a href="#">copay</a> / <a href="#">prescription</a> .<br>Mail order: \$90 <a href="#">copay</a> / <a href="#">prescription</a> .  | Not covered.                                       | <a href="#">Network provider prescription drug copayment</a> applies to the <a href="#">maximum out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                          | Non-Preferred Brands / Drugs                           | Retail: \$95 <a href="#">copay</a> / <a href="#">prescription</a> .<br>Mail order: \$190 <a href="#">copay</a> / <a href="#">prescription</a> . | Not covered.                                       | Member responsible for paying applicable <a href="#">copay</a> , allowable <a href="#">claim</a> amount, or the contracted rate of the <a href="#">prescription</a> , if less than the established <a href="#">copay</a> .<br><br><a href="#">Preauthorization</a> required for some <a href="#">drugs</a> .<br><br>Some <a href="#">prescription drugs</a> and/or medications are not available through mail order. |

| 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) |                                                                                                                                                                        |
| or by calling 1-833-502-3346.                                             | <a href="#">Specialty Drugs</a>                  | 33% <a href="#">coinsurance</a> .                                                                   | Not covered.                                       | 30-day supply only; 90-day mail order not covered.<br><br>Some <a href="#">Specialty drugs</a> are subject to utilization review or <a href="#">preauthorization</a> . |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | \$400 <a href="#">copay</a> /visit.                                                                 | Not covered.                                       | <a href="#">Preauthorization</a> required.                                                                                                                             |
|                                                                           | Physician/surgeon fees                           | No charge.                                                                                          | Not covered.                                       | Cost included in outpatient facility fee.                                                                                                                              |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$750 <a href="#">copay</a> /visit.                                                                 | \$750 <a href="#">copay</a> /visit.                | <a href="#">Copayment</a> waived if admitted.                                                                                                                          |
|                                                                           | <a href="#">Emergency medical transportation</a> | \$350 <a href="#">copay</a> /trip.                                                                  | \$350 <a href="#">copay</a> /trip.                 | None.                                                                                                                                                                  |
|                                                                           | <a href="#">Urgent care</a>                      | \$100 <a href="#">copay</a> /visit.                                                                 | \$100 <a href="#">copay</a> /visit.                | None.                                                                                                                                                                  |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | \$750 <a href="#">copay</a> /day for the first 3 days of admission.                                 | Not covered.                                       | <a href="#">Preauthorization</a> required.                                                                                                                             |
|                                                                           | Physician/surgeon fees                           | No charge.                                                                                          | Not covered.                                       | Cost included in inpatient stay.                                                                                                                                       |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Professional office visits - \$50 <a href="#">copay</a> /visit.<br>Outpatient services – No charge. | Not covered.                                       | <a href="#">Preauthorization</a> required for MH/SA intensive (extended) or residential services and Applied Behavioral Analysis (ABA) therapy.                        |
|                                                                           | Inpatient services                               | \$750 <a href="#">copay</a> /day for the first 3 days of admission.                                 | Not covered                                        | <a href="#">Preauthorization</a> required.                                                                                                                             |

| 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 are pregnant                                            | Office visits                             | No charge.                                                                                                                                                                            | Not covered.                                       | <a href="#">Preauthorization</a> required for the period outside the 48/96-hour time frame listed in the Evidence of Coverage (EOC).<br><br><a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                | Childbirth/delivery professional services | No charge.                                                                                                                                                                            | Not covered.                                       |                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                | Childbirth/delivery facility services     | \$400 <a href="#">copay</a> /day for the first 3 days of admission.                                                                                                                   | Not covered.                                       |                                                                                                                                                                                                                                                                                                                                                                                                              |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | \$80 <a href="#">copay</a> /visit.                                                                                                                                                    | Not covered.                                       | Limited to 60 visits/year. <a href="#">Preauthorization</a> required.                                                                                                                                                                                                                                                                                                                                        |
|                                                                | <a href="#">Rehabilitation services</a>   | Professional office visits:<br>Speech & hearing exams - \$80 <a href="#">copay</a> /visit.<br>PT/OT/ST/chiro –\$100 <a href="#">copay</a> /visit.<br>Outpatient services – No charge. | Not covered.                                       | <a href="#">Preauthorization</a> required for Inpatient & ABA in Cognitive Therapy.                                                                                                                                                                                                                                                                                                                          |
|                                                                | <a href="#">Habilitation services</a>     | Professional office visits:<br>Speech & hearing exams - \$80 <a href="#">copay</a> /visit.<br>PT/OT/ST/chiro –\$100 <a href="#">copay</a> /visit.<br>Outpatient services – No charge. | Not covered.                                       |                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                | <a href="#">Skilled nursing care</a>      | \$750 <a href="#">copay</a> /day for the first 3 days of admission.                                                                                                                   | Not covered.                                       | Limited to 25 days/year. <a href="#">Preauthorization</a> required.                                                                                                                                                                                                                                                                                                                                          |
|                                                                | <a href="#">Durable medical equipment</a> | 25% <a href="#">coinsurance</a> .                                                                                                                                                     | Not covered.                                       | Limited to <a href="#">plan</a> requirements. <a href="#">Preauthorization</a> required for items exceeding \$500.                                                                                                                                                                                                                                                                                           |
|                                                                | <a href="#">Hospice services</a>          | No charge.                                                                                                                                                                            | Not covered.                                       | <a href="#">Preauthorization</a> required.                                                                                                                                                                                                                                                                                                                                                                   |

| 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 your child needs dental or eye care | Children's eye exam        | Not covered.                                 | Not covered.                                       | None.                                                  |
|                                        | Children's glasses         | Not covered.                                 | Not covered.                                       | None.                                                  |
|                                        | Children's dental check-up | Not covered.                                 | Not covered.                                       | None.                                                  |

### 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>Acupuncture</li> <li>Dental care (Adult)</li> <li>Infertility treatment</li> </ul>                                                                                                                                                           | <ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>                                                                                                                  | <ul style="list-style-type: none"> <li>Routine eye care</li> <li>Weight loss programs</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>Bariatric surgery (<a href="#">preauthorization</a> required)</li> <li>Chiropractic care (35 visits per year)</li> <li>Cosmetic surgery (<a href="#">reconstructive surgery</a> for birth defects, injuries, tumors or infection)</li> </ul> | <ul style="list-style-type: none"> <li>Hearing aids (1 pair every 36 months)</li> <li>Private-duty nursing (outpatient home health aide services &amp; inpatient services only – covered when <a href="#">medically necessary</a>)</li> </ul> | <ul style="list-style-type: none"> <li>Routine foot care (for an illness such as diabetes or a circulatory disorder of the lower extremities)</li> </ul> |  |

**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: For group health coverage subject to ERISA, call MHHSI Customer Service at 855-645-8448 or <http://healthplan.memorialhermann.org>, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>. For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <http://www.cciio.cms.gov>. Church plans are not covered by the Federal COBRA continuation coverage rules. 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, U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>; or Memorial Hermann Health Solutions Customer Service at 855-645-8448 or <http://healthplan.memorialhermann.org>.

**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 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](#).

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0   |
| ■ <a href="#">Specialist copayment</a>                          | \$100 |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$750 |
| ■ Other <a href="#">copayment</a>                               | \$100 |

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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$1,900        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,960</b> |

### Managing Joe's Type 2 Diabetes

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0   |
| ■ <a href="#">Specialist copayment</a>                          | \$100 |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$750 |
| ■ Other <a href="#">copayment</a>                               | \$100 |

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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$2,100        |
| <a href="#">Coinsurance</a>       | \$200          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,320</b> |

### Mia's Simple Fracture

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0   |
| ■ <a href="#">Specialist copayment</a>                          | \$100 |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$750 |
| ■ Other <a href="#">copayment</a>                               | \$100 |

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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$2,000        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Mia would pay is</b> | <b>\$2,060</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Notice of Availability

### English

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-645-8448 (TTY: 711) or speak to your provider.

### Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-645-8448 (TTY: 711) o hable con su proveedor.

### Việt (Vietnamese)

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-645-8448 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

### 台語 (Traditional Chinese)

注意：如果您說台語，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-855-645-8448 (TTY: 711) 或與您的提供者討論。

### 中文 (Simplified Chinese)

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-855-645-8448 (文本电话: 711) 或咨询您的服务提供商。

### العربية (Arabic)

تنبيه: إذا كنت تتحدث العربية، ستتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضاً صيغ معلومات قابلة للوصول مجاناً. اتصل بالرقم 1-855-645-8448 أو تحدث إلى مزود الخدمة الخاص بك (711).

### हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-855-645-8448 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

### Français (French)

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-645-8448 (TTY : 711) ou parlez à votre fournisseur. »

### فارسی (Persian, Farsi)

شما می‌توانید به خدمات رایگان حمایت زبانی دسترسی داشته باشید. علاوه بر این، خدمات مناسب و پشتیبانی برای ارائه اطلاعات در قالب‌های قابل دسترسی به تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید (TTY: 711) صورت رایگان در دسترس است. لطفاً با شماره 1-855-645-8448

### Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-645-8448 (TTY: 711) o makipag-usap sa iyong provider.

## اردو (Urdu)

توجہ: اگر آپ اردو بولتے ہیں تو آپ کے لئے مفت زبان کی معاونت خدمات دستیاب ہیں۔ معلومات کو قابل رسائی فارمیٹس میں فراہم کرنے کے لئے مناسب یا اپنے فراہم کنندہ سے بات کریں۔ (TTY: 711) معاونت اور خدمات بھی مفت میں دستیاب ہیں۔ کال کریں 1-855-645-8448

## తెలుగు (Telugu)

సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-855-645-8448 (TTY: 711)కి కాల్ చేయండి లేదా మీ ప్రావైడర్‌తో మాట్లాడండి.

## বাংলা (Bengali)

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-855-645-8448 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।”

## ગુજરાતી (Gujarati)

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓક્ટિલરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-645-8448 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.”

## Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-645-8448 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

## РУССКИЙ (Russian)

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-645-8448 (TTY: 711) или обратитесь к своему поставщику услуг.

## 한국어 (Korean)

주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-855-645-8448 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

## ລາວ (Laotian, Laos)

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-855-645-8448 (TTY: 711) ຫຼື ນິມັກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.”