Summary of Benefits and Coverage (SBC)

Coverage Tiers. 5 tier (4-way)

Frequently Asked Questions	In-Network Benefit	Out-of-Network Benefit	Limitations and Exceptions
What is the overall deductible?	Individual: $500 Family: $1,500	Individual: $1,000 Family: $3,000	The out-of-network deductible accumulates to the in-network deductible; the in-network deductible does NOT accumulate to the out-of-network deductible. Covered expenses incurred during any calendar year and applied toward satisfaction of a covered family member's individual calendar year deductible will be accumulated toward the Family Limit. Once the family deductible has been satisfied, it will not apply for any other family member's charges. Other family member's charges previously applied to the deductible will not be recalculated. For a confinement that continues into a new calendar year, amounts applied toward the prior calendar year deductible will also count toward satisfying the next calendar year deductible for charges during confinement. All other charges are subject to the new calendar year deductible amount.
Are there other deductibles for specific services?	No	No	
Is there a maximum out-of-pocket limit on all my expenses?	Individual: $7,900 Family: $15,800	Individual: $15,000 Family: $30,000	The maximum out-of-pocket limit is the most you could pay in a year for covered services and includes in-network deductibles and coinsurance and medical and prescription copayments. If you have other family members in this plan, they have to meet their own maximum out-of-pocket limits until the overall family maximum out-of-pocket limit has been met.
What is not included in the maximum out-of-pocket limit?	*See Limitations and Exceptions*	*See Limitations and Exceptions*	Premiums, penalties, non-covered services, and out-of-network expenses will not accumulate to your maximum out-of-pocket amount.
Does this plan use a network of providers?	Yes	N/A	Go to tmlhealthbenefits.org or call (800) 282-5385 for a list of participating providers. Your deductible, out-of-pocket expenses, and coinsurance will be different for In-Network and Out-of-Network services.
Do I need a referral to see a specialist?	No	No	This plan does not require referrals. You have the option to choose any provider. *Note: In-Network and Out-of-Network benefits may vary.*
What is my copayment?	Office Visit: $20	N/A	The Office Visit In-Network copay includes: Physician office visits, consultations, labs (excluding Genetic/Genomic testing which are subject to deductible and coinsurance) and x-rays. SpecialtyRx/Biotech drugs obtained in an In-Network physician's office require Pre-Authorization. Refer to your Medical Book for Pre-Authorization requirements. If approved, Specialty/Biotech drugs are subject to a separate $100 copay, deductible waived. **SpecialtyRx/Biotech drugs obtained from an Out-of-Network provider are not covered.**
Is there an overall annual limit on what the plan pays?	No	No	This plan does not have an annual limit for all benefits combined. The plan does have some limits on lifetime and calendar year benefits for specific conditions and/or treatments, as indicated.
Are there services this plan does not cover?	Yes	Yes	Please refer to the exclusion list and unproven/experimental definition in the plan document.

Common Medical Event	Services You May Need	In-Network Benefit	Out-of-Network Benefit	Expanded Benefit Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	100% after $20 copay	60% after deductible up to R&C	The Primary Care office visit In-Network copay includes labs (excluding Genetic/Genomic lab which are subject to deductible and coinsurance) and x-rays. For maternity the copay will only apply to the initial visit. SpecialtyRx/Biotech drugs obtained in an In-Network physician's office require Pre-Authorization. Refer to your Medical Book for Pre-Authorization requirements. If approved, Specialty/Biotech drugs are subject to a separate $100 copay, deductible waived. SpecialtyRx/Biotech drugs obtained from an Out-of-Network provider are not covered.
	Specialist visit	100% after $40 copay	60% after deductible up to R&C	The Specialist office visit In-Network copay includes labs(excluding Genetic/Genomic lab which are subject to deductible and coinsurance) and x-rays. SpecialtyRx/Biotech drugs obtained in an In-Network physician's office require Pre-Authorization. Refer to your Medical Book for Pre-Authorization requirements. If approved, Specialty/Biotech drugs are subject to a separate $100 copay, deductible waived. SpecialtyRx/Biotech drugs obtained from an Out-of-Network provider are not covered.

	Telehealth Medical Consult for General Medical Consults (minor medical condition)	$10 copay	N/A	Telehealth services provided by RediMD. Website: www.redimd.com After Hours Phone = 281-633-0148
	Telehealth for Behavioral Health/Psychiatrist Interview and Evaluation	$25 copay	NA	
	Telehealth for Behavioral Health/Psychiatrist Follow-up	$10 copay	NA	
	Telehealth for Dermatology Consults/Treatment	$10 copay	N/A	
	Telehealth for Lab Result Consultation and Follow-up	$10 copay	N/A	
	Telehealth for Wellness Exam and Follow-up	$0 copay	N/A	
	All other Physician services	80% after deductible	60% after deductible up to R&C	Provider of Service must be licensed to perform services rendered to Covered Individual.
	Preventive care/ screening/ immunization	100% deductible waived	60% after deductible up to R&C	**Preventive Care Benefit** The following will be processed for both in-network and out-of-network reimbursement at 100% of allowable as mandated by the USPSTF. To be considered as an eligible preventive/routine care benefit, the provider's bill must designate or outline a routine diagnosis code. The following preventive/routine care benefits include but are not limited to: • Immunizations • Physical Exam • Well Baby and Well Child Visits • Vision Exam (including refractions) • PAP Test and Office Visit • Hearing Exams • Routine Venipuncture • General Health Panel • Mammograms • Prostate Specific Antigen test (PSA) • Coronary Risk Profile (lipid panel) • Urinalysis • (TB) Tuberculosis test • Autism Screenings (eighteen (18) & twenty-four (24) months of age) • Handling of specimen to/from physician's office to a laboratory • Occult Stool Test • Examination for the detection of skin cancer • Chest X-Ray (front & lateral) • EKG (electrocardiogram) • Digital Rectal Exam **Detection and Prevention of Osteoporosis** – limit one routine bone density screening per lifetime if the covered individual meets one or more of these requirements. There is not a limit for screenings submitted with a diagnosis. **Colorectal Exam** – coverage for the medically recognized screening exam for the detection of the colorectal cancer for covered individuals at any age who have a personal or family history of polyps (or colon cancer), or who are at normal risk for developing colon cancer. Includes expenses incurred while conducting a medically-recognized screening exam for the detection of colorectal cancer. Benefit also applies for the first non-routine colorectal exam claim received during the five (5) year time period as noted below. This includes annual fecal occult blood tests and a flexible sigmoidoscopy recommended to be performed every five (5) years with a family or personal history of polyps (or colon cancer) or a colonoscopy recommended to be performed every ten (10) years. **Virtual colonoscopies are excluded**. Plan also covers more frequent colonoscopies, sigmoidoscopies and fecal occult blood tests for all covered individuals at any age with no limits at regular plan benefits, including when they are billed with a non-routine diagnosis and/or when they are billed with a diagnosis of personal or family history of polyps (or colon cancer).
If you visit an urgent care clinic	Urgent care visit to treat an injury or illness	100% after $60 copay	60% after deductible up to R&C	• **Urgent Care Services billed on a HCFA** will be processed under the Urgent Care benefit. The Urgent Care Copay includes office visits, consultations, labs (excluding Genetic/Genomic testing which are subject to deductible and coinsurance), and x-rays. SpecialtyRx/Biotech drugs obtained in an In-Network Urgent Care Clinic billed on a HCFA require Pre-Authorization. Refer to the Pre-Authorization section of your Medical Book. If Specialty/Biotech drugs are approved, they will be subject to a separate $100 copay, deductible waived. • **Urgent Care Services billed on a UB** will be processed under the Hospital Benefit.

				SpecialtyRx/Biotech drugs obtained in an In-Network Urgent Care Clinic billed on a UB are subject to deductible and coinsurance. Pre-Authorization requirements must be met for Specialty/Biotech drugs billed on a UB. • **SpecialtyRx/Biotech drugs obtained from an Out-of-Network provider are not covered.**
If you have a test	Diagnostic test (x-ray, blood work)	80% after deductible	60% after deductible up to R&C	Preferred Lab will pay at 100% In-Network. The Preferred Lab benefit does not apply to Genetic/Genomic testing. Genetic/Genomic lab tests are subject to deductible and coinsurance. Refer to the Pre-Authorization section in the Medical Plan Book for Genetic/Genomic testing pre-authorization requirements.
	Imaging (CT/PET scans, MRIs)	80% after deductible	60% after deductible up to R&C	Review Pre-authorization Requirements' section in SPD.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at tmlhealthbenefits.org.**	Generic drugs	$5 for 1-30 day supply at Retail $10 for thirty-one (31)-ninety (90) day supply at Retail$10 up to a ninety (90)-day supply through Mail Order		Refer to your Prescription Schedule of Benefits for information regarding your Prescription Drug Plan and any applicable Prior Authorization requirements.
	Brand	$50 up to thirty (30)-day supply at Retail $100 for thirty-one (31)-ninety (90) day at Retail $100 up to a ninety (90)-day supply - Mail Order		
	Specialty drugs	$100 copay per thirty (30)-day supply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	80% after deductible	60% after deductible up to R&C	In addition to the plan's deductible, there is a hospital admission deductible. A $250 per admission deductible will apply to all Out-of-Network hospital admissions. This deductible does not apply when the admission is related to emergent/immediate care.
	Physician/surgeon fees	80% after deductible	60% after deductible up to R&C	
If you need immediate medical attention	Emergency room Facility services (Emergent/ Urgent)	80% deductible waived	80% deductible waived	All Emergency Room Facility charges are subject to a $200 facility fee. The Emergency Room Access fee is waived if admitted. The access fee also applies to emergent/immediate care. The ER fee applies to the OOP. Please refer to the definitions in the plan document for what is considered emergent/immediate care.
	Emergency room Physician services (Emergent/ Urgent)	80% after deductible	80% after deductible	
	Emergency room Facility services (Non-Emergent/Non-Urgent)	80% deductible waived	60% after deductible up to R&C	
	Emergency room Physician services (Non-Emergent/Non-Urgent	80% after deductible	60% after deductible up to R&C	
	Emergency medical transportation	80% after deductible	80% after deductible	• Ground ambulance maximum benefit: None • Air ambulance maximum benefit (all providers): $12,000 per occurrence (Eff 10/1/19) • In-Network and Out-of-Network charges are subject to the In-Network Deductible and In-Network out-of-pocket. This plan does not include benefits for transportation for non-emergency medical Services.
If you have a hospital stay	Facility fee (e.g., hospital room)	80% deductible waived	60% after deductible up to R&C	In addition to the plan's deductible, there is a hospital admission deductible. A $250 per admission deductible will apply to all Out-of-Network hospital admissions. This deductible does not apply when the admission is related to emergent/immediate care
	Physician/surgeon fees	80% after deductible	60% after deductible up to R&C	
If you have mental health, behavioral health, or substance use needs	Mental/Behavioral health outpatient facility and physician services	80% after deductible	60% after deductible up to R&C	In addition to the plan's deductible, there is a hospital admission deductible. A $250 per admission deductible will apply to all Out-of-Network hospital admissions. This deductible does not apply when the admission is related to emergent/immediate care.
	Mental/Behavioral health inpatient facility and physician services	80% deductible waived	60% after deductible up to R&C	
	Substance use disorder outpatient facility and physician services	80% after deductible	60% after deductible up to R&C	In addition to the plan's deductible, there is a hospital admission deductible. A $250 per admission deductible will apply to all Out-of-Network hospital admissions. This deductible does not apply when the admission is related to emergent/immediate care. Substance use treatment is submitted to a lifetime maximum of one (1) treatment series.
	Substance use disorder inpatient facility and physician services	80% deductible waived	60% after deductible up to R&C	

If you are pregnant	Prenatal and postnatal care	80% deductible waived	60% after deductible up to R&C	A copay will apply to the initial office visit charge for in-network services. The remainder of the physician charges will be subject to the deductible and covered at the appropriate coinsurance. In addition to the plan's deductible, there is a hospital admission deductible. A $250 per admission deductible will apply to all Out-of-Network hospital admissions.
	Delivery and all inpatient services	80% deductible waived	60% after deductible up to R&C	
If you need help recovering or have other special health needs	Home Health Care	80% deductible waived	60% after deductible up to R&C	Limited to one-hundred (100) days per calendar year. The maximum calendar year benefit is for In-Network and Out-of-Network is combined.
	Rehabilitation/Habilitation services	80% deductible waived	60% after deductible up to R&C	• Outpatient Physical Therapy, Occupational Therapy, and Aquatic Therapy services are limited to thirty-six (36) visits per calendar year combined. • Speech Therapy services limited to twenty-four (24) visits per calendar year. • Applied Behavior Analysis Therapy (ABAT) for eligible dependent children with an Autism Spectrum Disorder diagnosis. This benefit is limited to $36,000 per calendar year. Refer to the Pre-Authorization section in your Medical Book for Pre-Authorization requirements.
	Chiropractic Care	80% after deductible	60% after deductible up to R&C	
	Skilled nursing care	80% after deductible	60% after deductible up to R&C	Limited to one-hundred (100) days per calendar year. The maximum calendar year benefit is for In-Network and Out-of-Network is combined.
	Durable medical equipment	80% after deductible	60% after deductible up to R&C	Pre-authorization is required for charges in excess of $1,500 per durable medical equipment prior to purchase, in excess of $500 for lease or rental, and in excess of $1,000 for prosthetics, non-standard orthotics, and ocular prosthetic lens; limited to the R&C charges of standard models as determined by Medical Management.
	Hospice services	100% deductible waived	60%after deductible up to R&C	Bereavement Counseling ***is*** covered under this benefit with no maximum. Respite Care ***is not*** covered under this benefit.
If your child needs dental or eye care *(attained age of nineteen (19))*	Eye exam			Vision Acuity Screenings and Refractions-paid as Preventive under Medical Plan-100% allowed Reasonable and Customary (R&C). Vision screening services [for the detection of eye disease and refractive disorders and well-child visits that include visual acuity testing stereoacuity, cover-uncover tests, Hirschberg light reflect test, Hirschberg light reflex test, autorefraction and photoscreening may be done starting age three (3) to attained age of nineteen (19) years] as required by law.
	Glasses	Ineligible under Medical Plan		
	Dental check-up			Dental Screenings-paid as Preventive under Medical Plan-100% allowed Reasonable and Customary (R&C). Pediatric oral [application of fluoride varnish to the primary teeth of all infants starting at the age of primary tooth eruption; recommended at six (6), nine (9), twelve (12), eighteen (18), twenty-four (24), thirty (30) months, three (3) and six (6) years].

Excluded Services and Other Covered Services (This is not a complete list. Check your policy or plan document for other excluded services.)

Unproven Medical Procedures/Treatment. Experimental/Investigational/Unproven Services: medical, surgical, diagnostic, mental health, substance use disorder, or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time TML Health makes a determination regarding coverage in a particular case, are determined to be any of the following: • Any drug not approved by the U.S. Food and Drug Administration (FDA) for marketing; any drug that is classified as IND (Investigational New Drug) by the FDA; • Determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials; • Not consistent with the standards of good medical practice in the United States as evidenced by endorsement by national guidelines; • Exceeds (in scope, duration, or intensity) that level of care which is needed • Given primarily for the personal comfort or convenience of the patient, family member(s) or the provider; • Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered Experimental or Investigational.); or • The subject of an ongoing clinical trial that meets the definition of a Phase 1 or 2 clinical trial, or is the experimental arm of a Phase 3 or 4 clinical trial as set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Medically Justified. A service that falls under the Plan definition of UNPROVEN MEDICAL PROCEDURES/THERAPY, but that can be justified for an individual patient due to: • A rare/orphan disease (a rare/orphan disease is one that affects fewer than 200,000 people, according to the U.S. Rare Disease Act of 2002). • A unique co-morbidity, or complication that precludes treatment with a proven medical procedure or therapy. > No other treatment available due to co-morbidities > Co-morbid Disease State Risk • Continuation and/or repeat of a previously approved successful treatment plan. • Concern for Complications due to treatment area. • Repeat of prior successful treatment intervention and disease state; disease state put in remission. • Treatment dose should be in compliance for best outcome. • Severity of illness defined as ongoing intensity and complication of disease state with lab value concerns.

Evidence-Based Medicine (EBM). Aims to apply the best available evidence gained from the scientific method to medical decision making. It seeks to assess the quality of evidence of the risks and benefits of treatments (including lack of treatment). EBM recognizes that many aspects of medical care depend on individual factors such as quality and value of life judgments, which are only partially subject to scientific methods. EBM, however, seeks to clarify those parts of medical practice that are in principle subject to scientific methods and to apply these methods to ensure the best prediction of outcomes in medical treatment, even as debate continues about which outcomes are desirable.

General Exclusions or Limitations:

No Benefits shall be payable under any part of this Plan with respect to any charges:

1. for which a covered individual is not financially responsible or are submitted only because medical coverage exists or for discounts for which the covered individual is not responsible, including but not limited to independent and preferred provider discounts;
2. for services not eligible for diagnosis or treatment of an illness or injury unless covered as part of the Preventive Care Benefit or listed as an Eligible Expense;
3. for treatment of any injury or illness for which the covered individual is not under the regular care of a Physician or does not follow the attending Physician's treatment plan;
4. for expenses applied under this Plan toward satisfaction of any deductibles, copayments, coinsurance or access charge;
5. in excess of reasonable and customary for services and supplies;
6. for treatment of any injury, illness or disability, resulting from or sustained as a result of being engaged in a felonious act as defined by Texas law regardless of whether arrested, indicted or convicted;
7. for treatment of any injury, illness or disability resulting from or sustained as a result of war or act of war, declared or undeclared;
8. for treatment of injuries resulting from covered individual's participation in a riot or insurrection;
9. for treatment of any illness, injury or disability reimbursement, which could have been available if pursued under benefits for Workers' Compensation whether or not the employer is a subscriber or non-subscriber in a Workers' Compensation Program and whether or not the injured person could have been lawfully covered by workers' compensation as a volunteer. In applying this exclusion, work on the covered individual's family farm or ranch is not considered an employment arrangement;
10. for eye glasses or contact lenses, orthoptics or vision therapy. The plan does however provide benefits for Refractive Surgery;
11. incurred in connection with remedying a condition by means of cosmetic surgery unless otherwise specifically covered under this plan;
12. for vocational evaluation, rehabilitation or retraining;
13. for custodial care or maintenance care;
14. for private duty nursing charges, except when covered for extended care;
15. for any services furnished by any institution providing primarily convalescent or custodial care;
16. for repair and maintenance or replacement of lost, missing or stolen (without documentation of a police report) Durable Medical Equipment, when previously purchased by the Plan, except when necessitated by physiological changes or accidental destruction, subject to approval by the Group Benefits Administrator;
17. for home health care expenses that are for:
    a. custodial care;
    b. transportation services; or
    c. any period during which the covered individual is not under the continuing care of Physician;
18. for sex therapy, outpatient group family therapy, marriage counseling or any other social services unless otherwise specified;
19. connected with the treatment of infertility and assisted reproductive technology including but not limited to artificial, in-vitro, embryo transfer and insemination or any surgical procedure for the inducement of pregnancy;
20. for elective abortions for covered individuals except in the case of incest, rape or situations which are life threatening to the mother;

This is not a complete list. Refer to the Medical Plan Book for a complete list of Exclusions and Limitations: Login: tmlhealthbenefits.org • Select: My Tools • Select: MyBenefits on Demand • Select: Benefits • Select: Medical • Medical Plan Book

Other Covered Services. This is not a complete list. Check your plan document for other covered services and your costs for these services.

The Plan Document covers eligible medical expenses that include: Ambulatory Surgical Center (ASC); Anesthesia; Artificial Limbs or Prosthetic Appliances; Autism Screenings; Blood Storage; Breast Oncology; Breast Reduction; Cardiac Rehabilitation; Cataract Surgery.

Federal and State laws may provide protections that allow you to continue health coverage after it would otherwise end. For more information about your rights and obligations under the plan and under Federal law, you should review the Medical Plan booklet or contact TML Health, PO Box 149190, Austin, Texas 78714-9190 or by telephone (800) 282-5385. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the Marketplace, visit www.healthcare.gov or call (800) 318-2596.

Your Grievance and Appeals Rights

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your Medical Plan booklet also provides complete information to submit a claim appeal or a grievance for any reason. For assistance, contact TML Health, PO Box 149190, Austin, Texas 78714-9190 or by telephone (800) 282-5385. You may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at (877) 267-2323 x61565 or www.cciio.cms.gov.

Does this plan provide Minimum Essential Coverage? Yes. The Affordable Care Act requires most people to have health coverage that qualifies as "minimum essential coverage". This plan does provide minimum essential coverage.

Does this plan Meet Minimum Value Standard? The Affordable Care Act establishes a minimum-value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum-value standard for the benefits it provides.

About these Coverage Examples. These examples show how this plan might cover medical care in a few situations and show how deductibles, copayments, and coinsurance can add up. Use these examples to see, in general, how much financial protection a sample patient might get from coverage under this plan compared to other plans by comparing the "Covered Individual Pays" section for the same example under each plan's Summary of Benefits and Coverage. **This is not a cost estimator.** Do not use these examples to estimate your actual costs under this plan. Treatments show are just examples and your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Also, costs do not include premiums you pay to buy coverage under a plan.

Having a Baby (normal delivery)	
•Amount owed to Providers: $13,170.65 • Plan pays: $10,635.65 • Covered Individual/Patient pays: $2,535.00	
Sample Care Costs	
Hospital charges (mother)	$6,252.00
Routine obstetric care	$2,619.52
Hospital charges (baby)	$1,464.09
Anesthesia	$1,706.72
Laboratory tests	$184.03
Prescriptions	$464.80
Radiology	$479.49
Total	**$13,170.65**
Covered Individual/Patient Pays	
Deductible	$500.00
Copayments: Medical/Rx	$35.00/$0.00
Plan/Max Plan OOP	$2,000.00/$2,500.00
Federal Maximum OOP	$2,535.00
Limits or Exclusions	$0.00
Total	**$2,535.00**

Managing Type 2 Diabetes (routine maintenance of a well-controlled condition)	
•Amount owed to Providers: $6,942.43 • Plan pays: $5,770.80 • Covered Individual/Patient pays: $1,171.63	
Sample Care Costs	
Prescriptions	$5,693.70
Medical Equipment and Supplies	$208.32
Office Visits and Procedures	$642.53
Education	$200.89
Laboratory tests	$58.42
Vaccines, other preventive	$138.57
Total	**$6,942.43**
Covered Individual/Patient Pays	
Deductible	$467.63
Copayments: Medical/Rx	$210.00/$494.00
Plan/Max Plan OOP	$0.00/$467.63
Federal Maximum OOP	$1,171.63
Limits or Exclusions	$0.00
Total	**$1,171.63**

Simple Fracture (with emergency room visit)	
•Amount owed to Providers: $2,053.50 • Plan pays: $1,146.81 • Covered Individual/Patient pays: $906.69	
Sample Care Costs	
Emergency Services	$1,459.00
Medical Equipment and Supplies	$122.00
Office Visits and Procedures	$350.05
Physical Therapy	$92.40
Laboratory tests	$0.00
Prescriptions	$30.05
Total	**$2,053.50**
Covered Individual/Patient Pays	
Deductible	$500.00
Copayments: Medical/Rx	$175.00/$0.00
Plan/Max Plan OOP	$231.69/$731.69
Federal Maximum OOP	$906.69
Limits or Exclusions	$0.00
Total	**$906.69**

Guidance document appears at 77Fed Reg. 8668 and 8706 respectively (2-14-12). Culturally Linguistic documents are available by calling (800) 282-5385 or emailing Customer Care.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other hyperlinked terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call (800) 282-5385 to request a copy.

Non-Discrimination

TML Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. TML Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

TML Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters

- Information written in other languages

If you need these services, contact our Civil Rights Coordinator. If you believe that TML Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, TML Health, PO Box 149190, Austin, TX 78754-9190, (800) 282-5385, TTY 711, Fax (512) 719-6539, CRCoordinator@tmlhb.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at www.hhs.gov/ocr/office/file/index.html. TTY: 711.

Language Assistance:

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call (800) 282-5385.

Spanish ---------------------------- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 282-5385.

Vietnamese ---------------------- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 282-5385.

Chinese ------ 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 282-5385.

Korean ----------------------------- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 282-5385 번으로 전화해 주십시오。

Arabic ----------------------------- رقم) (800) 282-5385- ملحوظة: إذا كنت تتحدث اذكر اللغة فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم . - هاتف الصم والبكم

Urdu ---------------------------------- خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال (800) 282-5385 کریں

Tagalog ---------------------------- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 282-5385.

French ------------------------------ ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 282-5385.

Hindi ---------------------------------- ध्यान द□: य□द आप □हदी बोलते ह □तो आपके ि लए मुफ्त म□ भाषा सहायता सेवाएं उपलब्ध ह।□ (800) 282-5385 पर कॉल कर□।

Persian (Farsi) ------------------- **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما (800) 282-5385 فراهم می باشد. با تماس بگیرید.

German ---------------------------- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 282-5385.

Gujarati --------------------------- **ચુના: જો તમે □જરાતી બોલતા હો, તો િન:□લ્ક ભાષા સહાય સેવાઓ તમારા માટ□ ઉપલબ્ધ છ. ફોન કરો** (800) 282-5385.

Russian --------------------------- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 282-5385.

Japanese ------------------------ 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(800) 282-5385まで、お電話にてご連絡ください。

Laotian ---------------------------- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (800) 282-5385.