This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthplan.memorialhermann.org or by calling 1-888-594-0671.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Participating Provider – **$2,850** Individual / **$5,700** Family; Does not apply to penalties or preventive Non-Participating Provider – **$5,000** Individual / **$10,000** Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page two for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Participating Provider – **$6,550** Individual / **$13,100** Family; Non-Participating Provider - **$15,000** Individual / **$30,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, utilization review penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See http://healthplan.memorialhermann.org/brokers/resource-center/ **or call 1-888-594-0671** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance, after deductible	50% coinsurance, after deductible	————————none————————
	Specialist visit	15% coinsurance, after deductible	50% coinsurance, after deductible	————————none————————
	Other practitioner office visit	15% coinsurance, after deductible	50% coinsurance, after deductible	Physical/Occupational Therapy & Chiropractic limited to 35 visits combined per year; 1 visit per day
	Preventive care/ screening/immunizations	No charge	50% coinsurance, after deductible	Participating Provider deductible waived
If you have a test	Diagnostic test (x-ray, blood work)	Lab - 15% coinsurance, after deductible X-Ray - 15% coinsurance, after deductible	50% coinsurance, after deductible	Prior authorization required for Genetic Testing; Non-compliance may result in a service not being covered.
	Imaging (CT/PET scans MRIs)	15% coinsurance, after deductible	50% coinsurance, after deductible	Prior authorization required; Non-compliance may result in a service not being covered

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://ctr.benefits.catamaranrx.com/rxpublic/portal/memberMain?customer=CTRHX Or 1-877-633-4461	Generic drugs	$4/prescription (30 day Retail); $10/prescription (90 day Mail Order)	50%/prescription - (30 day Retail) 90 day Mail Order - Not covered	Annual Participating Provider Deductible applies to Generic, Preferred brand and Non-preferred brand prescription drugs. Participating Provider Prescription Drug copayments/coinsurance apply to the Annual Participating Provider Out-of-Pocket Maximum. Annual Non-Participating Provider Deductible applies to **ALL** Non-Participating Provider Prescription Drugs; Non-Participating Provider Prescription Drug Coinsurance applies to the Non-Participating Provider Annual Out-of-Pocket. Maximum. Prior authorization required for some Drugs; Non-compliance may result in a service not being covered.
	Preferred brand drugs	$50/prescription (30 day Retail); $125/prescription (90 day Mail Order)	50%/prescription - (30 day Retail) 90 day Mail Order - Not covered	
	Non-preferred brand drugs	$100/prescription (30 day Retail); $250/prescription (90 day Mail Order)	50%/prescription - (30 day Retail) 90 day Mail Order - Not covered	
	Specialty drugs*	50%/prescription (30 day Retail)* 90 day Mail Order - Not Covered	50%/prescription - (30 day Retail) 90 day Mail Order - Not covered	Annual Participating Provider Deductible applies to all Specialty Drugs. Prior authorization required for some Specialty Drugs; Non-compliance may result in a service not being covered * 30 day supply only
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance, after deductible	50% coinsurance, after deductible	Prior authorization required; Non-compliance may result in a service not being covered
	Physician/surgeon fees	15% coinsurance, after deductible	50% coinsurance, after deductible	————————none————————
If you need immediate medical attention	Emergency room services	15% coinsurance, after deductible per visit	15% coinsurance, after deductible per visit	————————none————————
	Emergency medical transportation	15% coinsurance, after deductible per trip	15% coinsurance, after deductible per trip	————————none————————
	Urgent care	15% coinsurance, after deductible	50% coinsurance, after deductible	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance, after deductible	50% coinsurance, after deductible	Prior authorization required; Non-compliance may result in a service not being covered
	Physician/surgeon fee	15% coinsurance, after deductible	50% coinsurance, after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% coinsurance, after deductible - Professional Office Visit; 15% coinsurance, after deductible - Outpatient Services	50% coinsurance, after deductible	Prior authorization required for Outpatient Services; Non-compliance may result in a service not being covered
	Mental/Behavioral health inpatient services	15% coinsurance, after deductible	50% coinsurance, after deductible	Prior authorization required Non-compliance may result in a service not being covered
	Substance use disorder outpatient services	15% coinsurance, after deductible - Professional Office Visit; 15% coinsurance, after deductible - Outpatient Services	50% coinsurance, after deductible	Prior authorization required for Outpatient Services; Non-compliance may result in a service not being covered
	Substance use disorder inpatient services	15% coinsurance, after deductible	50% coinsurance, after deductible	Prior authorization required; Non-compliance may result in a service not being covered
If you are pregnant	Prenatal and postnatal care	15% coinsurance, after deductible	50% coinsurance, after deductible	Prior authorization required; Non-compliance may result in a service not being covered
	Delivery and all inpatient services	15% coinsurance, after deductible for Physician's Delivery services & 15% coinsurance, after deductible for Inpatient Facility services	50% coinsurance, after deductible	Prior authorization required; Non-compliance may result in a service not being covered

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	15% coinsurance, after deductible per visit	50% coinsurance, after deductible per visit	Limited to 60 visits per year; Prior authorization required; Non-compliance may result in a service not being covered
	Rehabilitation services	15% coinsurance, after deductible	50% coinsurance, after deductible	Prior authorization required for Inpatient & ABA Cognitive Therapy; Non-compliance may result in a service not being covered
	Habilitation services	15% coinsurance, after deductible	50% coinsurance, after deductible	Prior authorization required for Inpatient & ABA Cognitive Therapy Non-compliance may result in a service not being covered
	Skilled nursing care	15% coinsurance, after deductible	50% coinsurance, after deductible	Limited to 100 days per year; Prior authorization required; Non-compliance may result in a service not being covered
	Durable medical equipment	15% coinsurance, after deductible	50% coinsurance, after deductible	Limited to plan requirements; Prior authorization required; Non-compliance may result in a service not being covered
	Hospice service	15% coinsurance, after deductible	50% coinsurance, after deductible	Prior authorization required; Non-compliance may result in a service not being covered
If your child needs dental or eye care	Eye exam	15% coinsurance, after deductible - Primary Care Physician 15% coinsurance, after deductible - Specialist	50% coinsurance, after deductible	1 exam per year for all ages
	Glasses	15% coinsurance, after deductible	50% coinsurance, after deductible	1 pair of eyeglasses or contact lenses per year through age 19; Subject to plan limitations
	Dental check-up	Class A-No charge, after deductible Class B, C & D & General Pediatric Dental-50%, after deductible	Class A-No charge, after deductible Class B, C & D & General Pediatric Dental-50%, after deductible	Participating Provider deductible waived for Class A; Participating Provider deductible applies to all other charges; through age 19, Prior Authorization Required for Class C & D, 50% Reduction in Benefits Penalty; Subject to Plan Exclusions

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care (35 visits per year combined with PT/OT)
- Routine eye care (Adult) (1 exam per year)
- Cosmetic surgery (reconstructive surgery for birth defects, injuries, tumors or infection)
- Routine foot care (for an illness such as diabetes or a circulatory disorder of the lower extremities)
- Hearing aids (1 pair every 36 months)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-594-0671. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 questions about your rights, this notice, or assistance, you can contact: Memorial Hermann Health Insurance Company Customer Service at 1-888-594-0671.

Texas Department of Insurance
PO Box 149104
Austin, TX 78714-9104
Toll Free Number: 1-800-252-3439
Fax: 1-512-475-1771
Email: ConsumerProtection@tdi.state.tx.us
Website: http://www.tdi.texas.gov

U. S. Department of Labor
Employee Benefits Security Administration
Toll Free Number: 1-866-444-3272
Website: http://www.dol.gov/ebsa/healthreform

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the 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.**

Language Access Services:

Para obtener asistencia en Spanish (Español), llame al 1-888-594-0671.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $380
- **Patient pays:** $7,160

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,750
Copays	$10
Coinsurance	$3,200
Limits or exclusions	$200
Total	**$7,160**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-888-252-7680.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,080
- **Patient pays**: $3,320

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,850
Copays	$20
Coinsurance	$350
Limits or exclusions	$100
Total	**$3,320**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.