# SMALL GROUP SELECT PPO PLAN OVERVIEW

MEMORIAL® HERMANN
Health Insurance Co

# HEALTH INSURANCE ROOTED IN HOUSTON

Memorial Hermann Insurance Co is backed by Memorial Hermann Health System, the health system Houston has counted on for more than 100 years. By aligning care delivery, physicians and health insurance, Memorial Hermann has built Houston's first and only truly integrated health system. And together, we're committed to delivering health care that's safer, smarter and more cost-effective.

To learn about how Memorial Hermann Health Insurance Co is transforming health insurance and advancing health care in our community, visit healthplan.memorialhermann.org. Or call (713) 338-6556 today.

## SMALL GROUP SELECT PPO PLANS

A Small Group Select PPO Plan from Memorial Hermann Health Insurance Co provides small businesses in Greater Houston with the highest quality care at the best possible price. Plus, with our Small Group Select PPO Plan, small businesses get something no other insurance provider can offer: a unique relationship with Memorial Hermann, one of the largest and most trusted nonprofit health systems in the nation.

# SMALL GROUP SELECT PPO PLAN

from Memorial Hermann Insurance Co

| | PLATINUM | GOLD | | | | | SILVER | | | | | | | | | BRONZE | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Select Platinum 500 PPO | Select Gold 1000 PPO | Select Gold 1500 PPO | Select Gold 2000-2500 PPO | Select Gold 2000-3500 PPO | Select Gold Copay PPO | Select Silver 2000 PPO | Select Silver 2500-5500 PPO | Select Silver 3000 PPO | Select Silver 4500-100 PPO | Select Silver 4500 PPO | Select Silver Copay PPO | Select Silver 2600 HSA PPO | Select Silver 3000 HSA PPO | Select Silver 3500 HSA PPO | Select Bronze 4000 HSA PPO | Select Bronze 5000 PPO | Select Bronze 5500 HSA PPO | Select Bronze 6850 PPO |
| Deductible | $500 | $1,000 | $1,500 | $2,000 | $2,000 | $0 | $2,000 | $2,500 | $3,000 | $4,500 | $4,500 | $0 | $2,600 | $3,000 | $3,500 | $4,000 | $5,000 | $5,500 | $6,850 |
| Family Deductible (For Display Only) | $1,500 | $2,500 | $3,000 | $6,000 | $6,000 | $0 | $4,000 | $5,000 | $6,000 | $9,000 | $9,000 | $0 | $5,200 | $6,000 | $10,500 | $8,000 | $10,000 | $11,000 | $13,700 |
| Out-of-Pocket Maximum (Individual) | $1,500 | $4,500 | $4,500 | $2,500 | $3,500 | $6,850 | $6,350 | $5,500 | $6,350 | $4,500 | $6,450 | $6,850 | $5,900 | $6,400 | $3,500 | $6,500 | $6,500 | $6,150 | $6,850 |
| Out-of-Pocket Maximum (Family) | $4,500 | $11,250 | $9,000 | $7,500 | $10,500 | $13,700 | $12,700 | $11,000 | $12,700 | $9,000 | $12,900 | $13,700 | $11,800 | $12,800 | $10,500 | $13,000 | $13,000 | $12,300 | $13,700 |
| Member Coinsurance | 10% | 10% | 20% | 0% | 0% | 0% | 30% | 0% | 30% | 0% | 10% | 0% | 20% | 15% | 0% | 40% | 10% | 10% | 0% |
| PCP | $15 | $25 | $25 | $25 | $25 | $30 | 30% coinsurance after deductible | $35 | $35 | $35 | $40 | $100 | 20% coinsurance after deductible | 15% coinsurance after deductible | 0% after deductible | 40% coinsurance after deductible | $25 | 10% coinsurance after deductible | $40 |
| Specialist | $30 | $50 | $50 | $50 | $50 | $45 | 30% coinsurance after deductible | $70 | $70 | $70 | $50 | $200 | 20% coinsurance after deductible | 15% coinsurance after deductible | 0% after deductible | 40% coinsurance after deductible | $45 | 10% coinsurance after deductible | $100 |
| Telemedicine/Telehealth | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $40 applies to deductible | $40 applies to deductible | $40 applies to deductible | $40 applies to deductible | $0 | $40 applies to deductible | $0 |
| Urgent Care | $50 | $50 | $50 | $50 | $50 | $100 | 30% coinsurance after deductible | $70 | $50 | $100 | $50 | $200 | 20% coinsurance after deductible | 15% coinsurance after deductible | 0% after deductible | 40% coinsurance after deductible | 10% coinsurance after deductible | 10% coinsurance after deductible | $50 |
| Emergency Room | $400 then 10% coinsurance | $400 then 10% coinsurance | $400 then 20% coinsurance | $0 after deductible | $0 after deductible | $500 | 30% coinsurance after deductible | $0 after deductible | $400 then 30% coinsurance | $0 after deductible | $350 then 10% coinsurance | $1,000 | 20% coinsurance after deductible | 15% coinsurance after deductible | 0% after deductible | 40% coinsurance after deductible | 10% coinsurance after deductible | 10% coinsurance after deductible | $750 |
| Hearing & Speech Exams | $15 | $25 | $25 | $25 | $25 | $100 | 30% coinsurance after deductible | $35 | $35 | $35 | $40 | $200 | 20% coinsurance after deductible | 15% coinsurance after deductible | 0% after deductible | 40% coinsurance after deductible | 10% coinsurance after deductible | 10% coinsurance after deductible | $40 |
| Independent & Outpatient Lab/ Pathology | $15 | $25 | $25 | $15 | $25 | $50 | 30% coinsurance after deductible | $40 | $40 | $40 | $40 | $100 | 20% coinsurance after deductible | 15% coinsurance after deductible | 0% after deductible | 40% coinsurance after deductible | 10% coinsurance after deductible | 10% coinsurance after deductible | $100 |
| Radiology/X-rays | $50 | $50 | $50 | $50 | $50 | $100 | 30% coinsurance after deductible | $0 after deductible | $50 | $0 after deductible | $50 | $200 | 20% coinsurance after deductible | 15% coinsurance after deductible | 0% after deductible | 40% coinsurance after deductible | 10% coinsurance after deductible | 10% coinsurance after deductible | $0 after deductible |
| MRI/Scans/Nuclear Medicine | 10% coinsurance after deductible | 10% coinsurance after deductible | 20% coinsurance after deductible | $0 after deductible | $0 after deductible | $350 | 30% coinsurance after deductible | $0 after deductible | 30% coinsurance after deductible | $0 after deductible | 10% coinsurance after deductible | $1,000 | 20% coinsurance after deductible | 15% coinsurance after deductible | 0% after deductible | 40% coinsurance after deductible | 10% coinsurance after deductible | 10% coinsurance after deductible | $0 after deductible |
| Inpatient Hospital | 10% coinsurance after deductible | 10% coinsurance after deductible | 20% coinsurance after deductible | $0 after deductible | $0 after deductible | $500/day for first 3 days of admission | 30% coinsurance after deductible | $0 after deductible | 30% coinsurance after deductible | $0 after deductible | 10% coinsurance after deductible | $2500/day for first 3 days of admission | 20% coinsurance after deductible | 15% coinsurance after deductible | 0% after deductible | 40% coinsurance after deductible | 10% coinsurance after deductible | 10% coinsurance after deductible | $0 after deductible |
| PT/OT/Chiro | 10% coinsurance after deductible | 10% coinsurance after deductible | 20% coinsurance after deductible | $0 after deductible | $0 after deductible | $100 | 30% coinsurance after deductible | $0 after deductible | 30% coinsurance after deductible | $0 after deductible | 10% coinsurance after deductible | $200 | 20% coinsurance after deductible | 15% coinsurance after deductible | 0% after deductible | 40% coinsurance after deductible | 10% coinsurance after deductible | 10% coinsurance after deductible | $0 after deductible |
| Retail Generic Rx | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | 20% coinsurance after deductible | $0 after deductible | $0 after deductible | 40% coinsurance after deductible | $0 | 10% coinsurance after deductible | $0 |
| Retail Brand Rx | $25 | $30 | $30 | $45 | $20 | $50 | $50 | $50 | $50 | 0% after deductible | $40 | $125 | 20% coinsurance after deductible | $10 after deductible | 0% after deductible | 40% coinsurance after deductible | $25 | 10% coinsurance after deductible | 0% after deductible |
| Retail Non-Formulary Brand Rx | $50 | $60 | $60 | $80 | $35 | $100 | $100 | $100 | $100 | 0% after deductible | $100 | $250 | 20% coinsurance after deductible | $20 after deductible | 0% after deductible | 40% coinsurance after deductible | $60 | 10% coinsurance after deductible | 0% after deductible |
| Retail Specialty Rx | $100 | $100 | $100 | $200 | 50% coinsurance, deductible waived | $200 | $200 | $200 | $200 | 0% after deductible | $200 | $500 | 20% coinsurance after deductible | 50% coinsurance after deductible | 0% after deductible | 40% coinsurance after deductible | $100 | 10% coinsurance after deductible. $500 maximum per specialty drug. | 0% after deductible |

# EXCLUSIONS AND LIMITATIONS:
# WHAT THE PLAN DOES NOT PAY FOR

## Excluded Services

The Plan does not provide benefits for:

A. Any amounts in excess of maximum amounts of Covered Expenses stated in this Plan.

B. Services not specifically listed in this Plan as Covered Services.

C. Services or supplies that are not Medically Necessary as defined by MHHIC.

D. Services or supplies that MHHIC considers to be Experimental or Investigative.

E. Services received before the Effective Date of Coverage.

F. Services received after coverage ends.

G. Services which Members have no legal obligation to pay or for which no charge would be made if a Member did not have a health plan or insurance coverage, except to the extent that the availability of insurance or health plan coverage may be considered by a tax supported institution of the State of Texas providing treatment of Mental Illness or mental retardation to determine if a patient is non-indigent, as provided in Article 3196a of Vernon's Texas Civil Statutes.

H. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Member does not claim those benefits.

I. Conditions caused by or contributed by (a) an act of war; (b) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) A Member participating in the military service of any country; (d) A Member participating in an insurrection, rebellion, or riot; (e) Services received for any condition caused by a Member's commission of, or attempt to commit a felony; (f) A Member, age 19 or older, under the influence of alcohol, illegal narcotics or non-prescribed controlled substances unless administered on the advice of a Physician.

J. Any services provided by a local, state or federal government agency except (a) when payment under this Plan is expressly required by federal or state law; or (b) services provided for the treatment of Mental or Nervous Disorders by a tax supported institution of the State of Texas.

K. Professional services received or supplies purchased from Yourself, a person who lives in the Member's home or who is related to the Member by blood, marriage or adoption, or the Member's employer, unless the employer is a Hospital or a Doctor of Medicine. This exclusion does not apply to professional dental services as long as the dentist is licensed in Texas.

L. Inpatient or outpatient services of a private duty nurse.

M. Inpatient room and board charges in connection with a Hospital stay primarily for environmental change, Physical Therapy or treatment of chronic pain; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.

N. Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

O. Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically stated under Dental Care and Pediatric Dental Benefits in the Comprehensive Benefits section of this Plan, including dental services for Temporomandibular Joint Dysfunction (TMJ), and except as specifically stated under Services and Supplies Provided by a Hospital or Ambulatory Surgical Center.

P. Orthodontic Services, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction, except as specifically stated under Pediatric Dental Benefits in the Comprehensive Benefits section of this Plan.

Q. Dental Implants: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants, except as specifically stated under Pediatric Dental Benefits in the Comprehensive Benefits section of this Plan.

R. Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Plan.

S. An eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).

T. Any Drugs, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Plan. This includes, but is not limited to, items dispensed by a Physician.

U. Cosmetic surgery or other services for beautification, including any medical complications that are generally predictable and associated with such services by the organized medical community. This exclusion does not apply to Medically Necessary Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or to breast reconstruction performed to restore or achieve breast symmetry incident to a mastectomy, or abnormal craniofacial structure caused by congenital defects.

V. Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to sex change.

W. Treatment of sexual dysfunction, impotence and/or inadequacy.

X. Charges for pregnancy and maternity care including but not limited to normal delivery, cesarean sections, and elective abortions, except as specifically stated in the Plan under Comprehensive Benefits, pregnancy and maternity care or Complications of Pregnancy as defined in this certificate.

Y. All services related to the evaluation or treatment of fertility and/or Infertility, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, except as specifically stated under Comprehensive Benefits, What the Plan Pays For, Sterilization, or under the In-Vitro Rider, if elected.

Z. Cryopreservation of sperm or eggs.

AA. All non-prescription contraceptive devices and supplies including but not limited to all consultations, examinations, evaluations, medications, medical, laboratory, devices, Prescription Drugs or surgical procedures except as specifically stated in this Plan. Oral contraceptives and Prescription contraceptive devices available through a pharmacy are covered under the Prescription Drug benefit of this Plan. Over-the-counter contraceptive methods are covered under the Plan if the method is both FDA approved and prescribed by the female Member's health care provider.

AB. Services primarily for weight reduction or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method for treatment, except as provided under the Child and Adult Preventive Care Services provision.

AC. Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority except as specifically stated under the Professional and Other Services, Child and Adult Preventive Care Services and Routine Care Services sections of this Plan.

AD. Charges by a provider for telephone consultations and for Telemedicine or Telehealth Services. (Note: a Telemedicine Medical Service or Telehealth Service will not be excluded solely because the service is not provided through a face to face consultation).

AE. Items which are furnished primarily for personal comfort or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification including wigs, etc.).

AF. Educational services except as specifically provided for Diabetes Self-Management Training or as provided or arranged by MHHIC.

AG. Nutritional counseling or food supplements, except for formulas necessary for the treatment of phenylketonuria and as provided under the Child and Adult Preventive Care Services provision.

AH. Durable medical equipment except as specifically stated in this Plan. Excluded durable medical equipment includes, but is not limited to: air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; and supplies for comfort, hygiene or beautification.

AI. Physical and/or Occupational Therapy/ Medicine, except when provided during an inpatient Hospital confinement or as specifically provided under the benefits for Physical and/or Occupational Therapy/Medicine.

AJ. All Infusion Therapy together with any associated supplies, Drugs or professional services are excluded except as specifically provided under the benefit for Infusion Therapy described in this Plan.

AK. All Foreign Country Provider charges are excluded under this Plan except as specifically stated under Treatment received from Foreign Country Providers under the Benefits section of this Plan.

AL. Routine foot care including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet, diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

AM. Charges for which We are unable to determine Our liability because a Member failed, within 60 days, or as soon as reasonably possible to (a) authorize Us to receive all the medical records and information We requested or, (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.

AN. Charges for the services of a standby Physician.

AO. Charges for animal to human organ transplants.

AP. Self-administered injectable Drugs and syringes, except as stated in the Prescription Drug Benefits section of this Plan.

AQ. Claims received more than 12 months after the date service was rendered.

AR. Acupuncture/Acupressure.

MEMORIAL® HERMANN
Health Insurance Co

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