# LARGE GROUP SELECT HMO PLAN OVERVIEW

MEMORIAL® HERMANN Health Plan

# HEALTH INSURANCE ROOTED IN HOUSTON

Memorial Hermann Health Plan, Inc. 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 Plan is transforming health insurance and advancing health care in our community, visit our website: healthplan.memorialhermann.org. Or call (713) 338-6556 today.

LARGE GROUP

## LARGE GROUP SELECT HMO PLAN

### from Memorial Hermann Health Plan

Memorial Hermann Health Plan offers a range of solutions created specifically for large group employers interested in providing high quality care options at an affordable price. With our Large Group Select HMO Plan, your employees get the quality, affordability and access they need, as well as something no other insurance provider can bring to the table: a unique relationship with Memorial Hermann, one of the largest and most trusted nonprofit health systems in the nation.

| | Select 001 HMO | Select 2000-100 HMO | Select 3000-80 HMO | Select 5000-80 HMO | Select 5000-100 HMO | Select 6600-100 Premier HMO | Select 6600-100 Standard HMO | Select Premier Copay HMO | Select Standard Copay HMO | Select 3000-80 HSA HMO | Select 3000-100 HSA HMO | Select 5000-80 HSA HMO | Select 6450-100 HSA HMO |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Deductible – INN | $0 | $2,000 | $3,000 | $5,000 | $5,000 | $6,600 | $6,600 | $0 | $0 | $3,000 | $3,000 | $5,000 | $6,450 |
| Out of Pocket Maximum | $6,600 | $3,500 | $6,000 | $6,350 | $6,350 | $6,600 | $6,600 | $6,600 | $6,600 | $6,350 | $4,500 | $6,350 | $6,450 |
| Member Coinsurance | 0% | 0% | 20% | 20% | 0% | 0% | 0% | 0% | 0% | 20% | 0% | 20% | 0% |
| PCP OV | $30 copay[a] | $30 copay[a] | $30 copay[a] | $35 copay[a] | $30 copay[a] | $30 copay[a] | $35 copay[a] | $30 copay[a] | $50 copay[a] | 20% | 0%[c] | 20% | 0%[c] |
| Specialist | $55 copay[a] | $60 copay[a] | $60 copay[a] | $70 copay[a] | $60 copay[a] | $60 copay[a] | $70 copay[a] | $55 copay[a] | $100 copay[a] | 20% | 0%[c] | 20% | 0%[c] |
| Preventive Care | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] |
| Telemedicine/Telehealth | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | Not Covered | Not Covered | Not Covered | Not Covered |
| Urgent Care | $55 copay[a] | $50 copay[a] | $50 copay[a] | $50 copay[a] | $50 copay[c] | $50 copay[a] | $50 copay[a] | $55 copay[a] | $100 copay[a] | 20% | 0%[c] | 20% | 0%[c] |
| Emergency Room | $250 copay[a] | $250 copay[a] | $300 copay[b] + 20% coinsurance | $350 copay[b] + 20% coinsurance | $350 copay[a] | $400 copay[a] | $500 copay[a] | $250 copay[a] | $700 copay[a] | 20% | 0%[c] | 20% | 0%[c] |
| Vision – Routine Exams for Children Only (Ages 0–18) | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] | 0%[a] |
| Hearing & Speech Exams | $55 copay[a] | $20 copay[a] | $20 copay[a] | $20 copay[a] | $20 copay[a] | $20 copay[a] | $20 copay[a] | $55 copay[a] | $100 copay[a] | 20% | 0%[c] | 20% | 0%[c] |
| Mental Health & Substance Use Disorder – Professional Services in Office | $30 copay[a] | $30 copay[a] | $30 copay[a] | $35 copay[a] | $30 copay[a] | $30 copay[a] | $35 copay[a] | $30 copay[a] | $50 copay[a] | 20% | 0%[c] | 20% | 0%[c] |
| Lab/Pathology | $30 copay[a] | $30 copay[a] | $30 copay[a] | $35 copay[a] | $30 copay[a] | $35 copay[a] | $35 copay[a] | $30 copay[a] | $50 copay[a] | 20% | 0%[c] | 20% | 0%[c] |
| Radiology/X-rays | $55 copay[a] | $60 copay[a] | $60 copay[a] | $70 copay[a] | $60 copay[a] | $70 copay[a] | $35 copay[a] | $55 copay[a] | $100 copay[a] | 20% | 0%[c] | 20% | 0%[c] |
| Complex Imaging (CT/PET, MRI, MRA) | $250 copay[a] | 0%[c] | 20% | 20% | 0%[c] | 0%[c] | $35 copay[b] | $250 copay[a] | $700 copay[a] | 20% | 0%[c] | 20% | 0%[c] |
| Office Administered Drugs (Excluding Allergy Injections) | 0%[a] | 0%[c] | 0% | 20% | 0%[c] | 0%[c] | $35 copay[a] | 0%[a] | 0%[a] | 20% | 0%[c] | 20% | 0%[c] |
| Allergy Injections in Physician's Office | 0%[a] | $30 copay[a] | $30 copay[a] | $35 copay[a] | $30 copay[a] | $35 copay[a] | $35 copay[a] | 0%[a] | 0%[a] | $30 copay[c] | $30 copay[c] | $30 copay[c] | 0%[c] |
| Inpatient Hospital | $350/day for 1st 3 days of admission[a] | 0%[c] | 20% | 20% | 0%[c] | 0%[c] | $35 copay[c] | $350/day for 1st 3 days of admission[a] | $1,500/day for 1st 3 days of admission[a] | 20% | 0%[c] | 20% | 0%[c] |
| Physical/Occupational Therapy & Chiropractic 20 Visits Maximum Combined Per Year | $55 copay[a] | $60 copay[a] | $60 copay[a] | $70 copay[a] | $60 copay[a] | $70 copay[a] | $35 copay[a] | $55 copay[a] | $100 copay[a] | 20% | 0%[c] | 20% | 0%[c] |
| Retail Generic Rx | $0[a] | $0[a] | $0[a] | $0[a] | $0[a] | $0[a] | $0[a] | $0[a] | $0[a] | $0[c] | $0[c] | $0[c] | 0%[c] |
| Retail Brand Rx | $50 copay[a] | $25 copay[a] | $40 copay[a] | $40 copay[a] | $40 copay[a] | $40 copay[a] | $40 copay[a] | $50 copay[a] | $65 copay[a] | $25 copay[c] | $25 copay[c] | $25 copay[c] | 0%[c] |
| Retail Non-Formulary Brand Rx | $100 copay[a] | $50 copay[a] | $75 copay[a] | $75 copay[a] | $75 copay[a] | $75 copay[a] | $75 copay[a] | $100 copay[a] | $130 copay[a] | $50 copay[c] | $50 copay[c] | $50 copay[c] | 0%[c] |
| Retail Specialty Rx $3,000/Member Maximum Per Year | $200 copay[a] | 25% coinsurance[b] $200/member maximum per month | 30% coinsurance[b] $200/member maximum per month | 30% coinsurance[b] $200/member maximum per month | 30% coinsurance[b] $200/member maximum per month | 30% coinsurance[b] $200/member maximum per month | 30% coinsurance[b] $200/member maximum per month | $200 copay[a] | $300 copay[a] | 30% coinsurance $200/member maximum per month | 25% coinsurance $200/member maximum per month | 30% coinsurance $200/member maximum per month | 0%[c] |

Deductible and/or Coinsurance apply to benefits unless otherwise noted (a) Deductible and Coinsurance Waived (b) Deductible Waived (c) Coinsurance Waived

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

## Excluded Services

The Participating Provider 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 MHHP.

D. Services or supplies that MHHP considers to be **Experimental or Investigative.**

E. Services received **before the Effective Date of Coverage.**

F. Services received **after coverage ends.**

G. Services for which You have **no legal obligation to pay** or for which no charge would be made if You 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 You do 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;** or (e) services received for any condition caused by a Member's commission of, or attempt to commit, a **felony.**

J. Any intentionally **self-inflicted** Injury or Illness.

K. 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.

L. 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.

M. Inpatient or outpatient services of a **private duty nurse.**

N. 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; or services provided by a rest home, a home for the aged, a nursing home or any similar facility service.

O. 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.

P. **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).

Q. **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.

R. **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.

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

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

U. 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.

V. **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.

W. 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.**

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

Y. 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 Evidence of Coverage.

Z. 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 if the In-Vitro Fertilization Rider is elected.

AA. **Cryopreservation** of sperm or eggs.

AB. 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 Evidence of Coverage.

AC. 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.

AD. **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.

AE. 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.)

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

AG. **Educational services** except as specifically provided [for Diabetes Self-Management Training or as provided] or arranged by MHHP.

AH. **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.

AI. **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.

AJ. **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.

AK. 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.

AL. 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.

AM. 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, symptoms involving the feet, diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

AN. **Charges for which We are unable to determine Our liability** because You or 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.

AO. Charges for the services of a **standby Physician.**

AP. Charges for **animal to human organ transplants.**

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

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

AS. Allergy testing.

AT. Acupuncture/Acupressure.

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