



**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](http://www.healthplan.memorialhermann.org) or by calling 1-888-594-0671.

| Important Questions  | Answers   | Why this Matters:  |
|--|---|--|
| <b>What is the overall <u>deductible</u>?</b>                    | Participating Provider- <b>\$5,000</b> Individual / <b>\$10,000</b> Family; Does not apply to penalties or preventive. Non Participating Provider- <b>\$10,000</b> Individual / <b>\$20,000</b> Family. | You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> 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 <b><u>deductible</u></b> .   |
| <b>Are there other <u>deductibles</u> for specific services?</b> | No.   | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.  |
| <b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>    | Yes. Participating Provider- <b>\$6,350</b> Individual / <b>\$12,700</b> Family; Non Participating Provider- <b>\$15,000</b> Individual / <b>\$30,000</b> Family.                                       | The <b><u>out-of-pocket limit</u></b> 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.  |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>   | 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 <b><u>out-of-pocket limit</u></b> .  |
| <b>Is there an overall annual limit on what the plan pays?</b>   | No.   | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.   |
| <b>Does this plan use a <u>network of providers</u>?</b>         | Yes. See <a href="http://www.healthplan.memorialhermann.org">www.healthplan.memorialhermann.org</a> or call 1-888-594-0671 for a list of participating providers.                                       | If you use a participating doctor or other health care <b><u>provider</u></b> , this plan will pay some or all of the costs of covered services. Be aware, your participating doctor or hospital may use a non-participating <b><u>provider</u></b> for some services. Plans use the term in-network, <b><u>preferred</u></b> , or participating for <b><u>providers</u></b> in their <b><u>network</u></b> . See the chart starting on page 2 for how this plan pays different kinds of <b><u>providers</u></b> . |
| <b>Do I need a referral to see a <u>specialist</u>?</b>          | No. You don't need a referral to see a specialist.  | You can see the <b><u>specialist</u></b> you choose without permission from this plan.   |
| <b>Are there services this plan doesn't cover?</b>               | 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 <b><u>excluded services</u></b> .   |

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- **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  |
|---|--|---|---|---|
| <b>If you visit a health care provider’s office or clinic</b> | Primary care visit to treat an injury or illness | \$40/visit, deductible applies, plus 10% coinsurance applies  | 30% coinsurance, after deductible                 | —————none—————  |
|   | Specialist visit                                 | \$80/visit, deductible applies, plus 10% coinsurance applies  | 30% coinsurance, after deductible                 | —————none—————  |
|   | Other practitioner office visit                  | 10% coinsurance, after deductible   | 30% coinsurance, after deductible                 | Physical/Occupational Therapy & Chiropractic limited to 35 visits combined per year   |
|   | Preventive care/ screening/immunizations         | No charge, deductible waived  | 30% coinsurance, after deductible                 | —————none—————  |
| <b>If you have a test</b>                                     | Diagnostic test (x-ray, blood work)              | <b>Lab</b> - \$50/visit deductible applies plus 10% coinsurance<br><b>Xray</b> -10% coinsurance, after deductible | 30% coinsurance, after deductible                 | Prior Authorization required for Genetic Testing<br>50% Reduction in Benefits Penalty; No charge, after deductible, in physician’s office with office visit |
|   | Imaging (CT/PET scans MRIs)                      | 10% coinsurance, after deductible   | 30% coinsurance, after deductible                 | Prior Authorization required<br>50% Reduction in Benefits Penalty   |

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| 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   |
|--|--|--|---|--|
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.Caremark.com">www.Caremark.com</a> Or 1-800-552-8159 | Generic drugs                                  | 10% coinsurance/prescription (Retail) & (Mail Order)             | 30%/prescription-(Retail) Mail Order-not covered              | Participating Provider deductible applies to Network Prescription Drugs; Non-Participating Provider Deductible applies to ALL Non-Network Provider Prescription Drugs<br>All pharmacy coinsurance applies to the Annual Out-of-Pocket Maximum<br>Covers up to a 30-day supply (Retail Prescription)<br>Covers up to a 90-day supply (Mail Order Prescription)<br>Prior Authorization required for some Drugs<br>50% Reduction in Benefits Penalty<br>Self Injectables-Network- 20% coinsurance |
|  | Preferred brand drugs                          | 10% coinsurance/prescription (Retail) & (Mail Order)             | 30%/prescription-(Retail) Mail Order-not covered              |  |
|  | Non-preferred brand drugs                      | 10% coinsurance/prescription (Retail) & (Mail Order)             | 30%/prescription-(Retail) Mail Order-not covered              |  |
|  | Specialty drugs*                               | 10% coinsurance/prescription (Retail) * (Mail Order-)Not Covered | 30%/prescription-(Retail) * Mail Order-not covered            |  |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance, after deductible                                | 30% coinsurance, after deductible                             | Prior Authorization required<br>50% Reduction in Benefits Penalty  |
|  | Physician/surgeon fees                         | 10% coinsurance, after deductible                                | 30% coinsurance, after deductible                             | —————none—————   |
| <b>If you need immediate medical attention</b>   | Emergency room services                        | \$500/visit, deductible applies plus 10% coinsurance applies     | \$500/visit, deductible applies, plus 10% coinsurance applies | Copayment waived if admitted   |
|  | Emergency medical transportation               | 10% coinsurance, after deductible                                | 30% coinsurance, after deductible                             | —————none—————   |
|  | Urgent care                                    | \$75/visit, deductible applies, then 10% coinsurance applies     | 30% coinsurance, after deductible                             | —————none—————   |

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| 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  |
|---|--|--|---|---|
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)           | 10% coinsurance, after deductible  | 30% coinsurance, after deductible                 | Prior Authorization required<br>50% Reduction in Benefits Penalty                       |
|   | Physician/surgeon fee                        | 10% coinsurance, after deductible  | 30% coinsurance, after deductible                 | —————none—————  |
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | \$40/visit, deductible applies, then 10% coinsurance for professional office visit;; 10% coinsurance, after deductible for outpatient srvs | 30% coinsurance, after deductible                 | Prior Authorization required for Outpatient Services; 50% Reduction in Benefits Penalty |
|   | Mental/Behavioral health inpatient services  | 10% coinsurance, after deductible  | 30% coinsurance, after deductible                 | Prior Authorization required<br>50% Reduction in Benefits Penalty                       |
|   | Substance use disorder outpatient services   | \$40/visit, deductible applies, then 10% coinsurance for professional office visit; 10% coinsurance, after deductible for outpatient srvs  | 30% coinsurance, after deductible                 | Prior Authorization required for Outpatient Services; 50% Reduction in Benefits Penalty |
|   | Substance use disorder inpatient services    | 10% coinsurance, after deductible  | 30% coinsurance, after deductible                 | Prior Authorization required<br>50% Reduction in Benefits Penalty                       |
| <b>If you are pregnant</b>  | Prenatal and postnatal care                  | 10% coinsurance, after deductible  | 30% coinsurance, after deductible                 | Prior Authorization required<br>50% Reduction in Benefits Penalty                       |
|   | Delivery and all inpatient services          | 10% coinsurance, after deductible  | 30% coinsurance, after deductible                 | Prior Authorization required<br>50% Reduction in Benefits Penalty                       |

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| 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  |
|---|---------------------------|--|--|---|
| <b>If you need help recovering or have other special health needs</b> | Home health care          | 10% coinsurance, after deductible  | 30% coinsurance, after deductible  | Limited to 60 visits per year<br>Prior Authorization required<br>50% Reduction in Benefits Penalty  |
|   | Rehabilitation services   | 10% coinsurance, after deductible  | 30% coinsurance, after deductible  | Prior Authorization required<br>Inpatient: 50% Reduction in Benefits Penalty  |
|   | Habilitation services     | 10% coinsurance, after deductible  | 30% coinsurance, after deductible  | Prior Authorization required<br>Inpatient: 50% Reduction in Benefits Penalty  |
|   | Skilled nursing care      | 10% coinsurance, after deductible  | 30% coinsurance, after deductible  | Limited to 100 days per year; Prior Authorization required; 50% Reduction in Benefits Penalty   |
|   | Durable medical equipment | 10% coinsurance, after deductible  | 30% coinsurance, after deductible  | Limited to Plan Requirements; Prior Authorization Required; 50% Reduction in Benefits Penalty   |
|   | Hospice service           | 10% coinsurance, after deductible  | 30% coinsurance, after deductible  | Prior Authorization Required<br>50% Reduction in Benefits Penalty   |
| <b>If your child needs dental or eye care</b>                         | Eye exam                  | \$40-PCP \$80 Specialist/visit, deductible applies then 10% coinsurance                          | 30% coinsurance, after deductible  | 1 exam per year for all ages  |
|   | Glasses                   | 10% coinsurance, after deductible  | 30% coinsurance, after deductible  | 1 pair of eyeglasses or contact lenses per year through age 18, subject to plan limitations   |
|   | Dental check-up           | Class A-No charge, deductible waived, Class B, C & D & General Pedi Dental-50%, after deductible | Class A-No charge, deductible waived, Class B, C & D & General Pedi Dental-50%, after deductible | Network deductible applies; through age 18, Prior Authorization Required for Class C & D, 50% Reduction in Benefits Penalty, Subject to Plan Exclusions |

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## 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
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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)
- Hearing aids (1 pair per 36 months)
- Routine eye care (Adult) (1 exam per year)

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**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](http://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](http://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 Plan 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](mailto: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.*

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## 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** \$1,240
- **Patient pays** \$6,300

#### 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           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$5,900        |
| Copays               | \$200          |
| Coinsurance          | \$50           |
| Limits or exclusions | \$150          |
| <b>Total</b>         | <b>\$6,300</b> |

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** \$4,020
- **Patient pays** \$1,380

#### 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          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$1,000        |
| Copays               | \$200          |
| Coinsurance          | \$100          |
| Limits or exclusions | \$80           |
| <b>Total</b>         | <b>\$1,380</b> |

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## 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.

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