Your Choice for Quality Coverage and Care.

Only Memorial Hermann Health Plan can offer coverage backed by Memorial Hermann, a trusted name in health for more than 100 years. By combining care delivery, physicians and health coverage, Memorial Hermann has built Houston's first and only truly integrated health system designed to deliver care that's safer, smarter and more cost effective.

Designed With Your Business in Mind.
Large Group HMO coverage from Memorial Hermann Health Plan provides businesses in Greater Houston with the highest quality care at the best possible price. Plus, our Large Group HMO plans offer something no other insurance provider can: a unique relationship with Memorial Hermann, one of the largest and most respected health systems in the nation.

To learn more about how Memorial Hermann Health Plan is transforming health coverage and advancing care in our community, visit **healthplan.memorialhermann.org** or call **713.338.6556** today.

Exclusions and Limitations

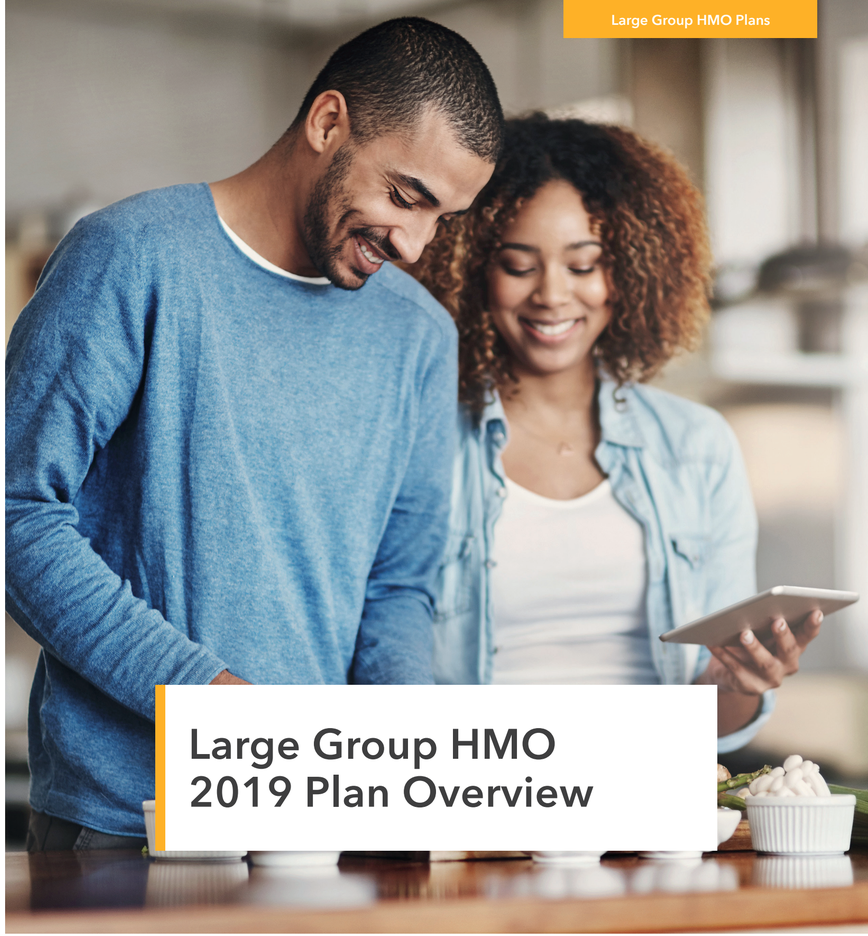
The following are services, supplies and treatment for services that are not covered under this Evidence of Coverage and complications from services, supplies and treatment for services that are not covered under this Evidence of Coverage. MHCHP will not pay for any charges incurred for or in connection with:

- Care or treatment by means of acupuncture except when used as a substitute for other forms of anesthesia. Preauthorization required when used as a substitute.
- The amount of any charge which is greater than the Allowed Charge, except as provided under the hospital-based providers provision.
- Services for ambulance for transportation from a hospital or other health care Facility, unless the Covered Person is being transferred to another inpatient health care facility.
- Blood or blood plasma which is replaced by or for a Covered Person.
- Services or supplies for which the Provider has not obtained a Certificate of Need or such other approvals as required by law.
- Care and/or treatment by a Christian Science Practitioner.
- Completion of claim forms.
- Services or supplies related to Cosmetic Surgery except as otherwise stated in this Evidence of Coverage; complications of Cosmetic Surgery; or Drugs prescribed for Cosmetic purposes.
- Services related to custodial or domiciliary care.
- Dental care or treatment, including appliances and dental implants, except as otherwise stated in this Evidence of Coverage.
- Care or treatment by means of dose-intensive chemotherapy, except as otherwise stated in this Evidence of Coverage.
- Services or supplies, the primary purpose of which is educational providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for behavior problems or learning disabilities except as otherwise stated in this Evidence of Coverage.
- Experimental or investigational treatments, procedures, hospitalizations, drugs, biological products, or medical devices, except as otherwise stated in this Evidence of Coverage. Denials based on experimental or investigational treatments are adverse determinations subject to the Utilization Review Process including reviews by an Independent Review Organization.
- Extraction of teeth, except as otherwise stated in this Evidence of Coverage.
- Services or supplies for or in connection with:
  - Except as otherwise stated in this Evidence of Coverage for Covered Persons through the end of the month in which he or she turns age 19, exams to determine the need for (or changes of) eyeglasses or lenses of any type;
  - Except as otherwise stated in this Evidence of Coverage for Covered Persons through the end of the month in which he or she turns age 19, eyeglasses or lenses of any type; this exclusion does not apply to initial replacements for loss of the natural lens; or
  - Eye surgery such as radial keratotomy or Lasik Surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- Services or supplies, with the exception of dental coverage, provided by one of the following members of Your family: spouse, child, parent, in-law, brother, sister or grandparent.
- Services or supplies furnished in connection with any procedures to enhance fertility which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to, the following: (a) procedures: embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); donor sperm, surrogate motherhood; (b) prescription drugs not eligible under the Prescription Drugs section of the Evidence of Coverage; and (c) ovulation predictor kits. See also the separate exclusion addressing sterilization reversal.
- Services or supplies related to herbal medicine.
- Services or supplies related to hypnotism.
- Services or supplies related to Medicinal Marijuana.
- Elective abortions when prohibited by law.
- Services or supplies necessary because the Covered Person engaged, or tried to engage, in an illegal occupation or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony.
- Services or supplies necessary while the Covered Person is in the custody of Law Enforcement.
- Illness or injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under Workers' Compensation, employer's liability, occupational disease or similar law. This does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for Workers' Compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, the limited liability company or the partnership.
- Local anesthesia charges billed separately if such charges are included in the fee for the surgery.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Services and supplies related to marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling, and related services, except as otherwise stated in this Evidence of Coverage.
- Charges for missed appointments.
- Charges for nicotine dependence treatments and management drugs unless otherwise stated in the Preventive Care section of this Evidence of Coverage.
- Any charge identified as a Non-Covered Charge or which is specifically limited or Excluded elsewhere in this Evidence of Coverage, or which are not medically necessary and appropriate, except as otherwise stated in this Evidence of Coverage.
- Non-prescription drugs or supplies, except:
  - Insulin needles and syringes and glucose test strips and lancets;
  - Colostomy bags, belts and irrigators; and
  - As stated in this Evidence of Coverage for food and food products for inherited metabolic diseases.
- Services provided by a pastoral counselor in the course of his or her normal duties as a religious person.
- Personal convenience or comfort items including but not limited to such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs, etc.
- The following exclusions apply specifically to outpatient coverage of prescription drugs:
  - Charges to administer an orally administered Drug.
    - Charges for Immunization agents related to travel or not approved by the ACIP.
  - Charges for a prescription drug which is: labeled "Caution – limited by Federal Law to Investigational use"; or experimental.
  - Charges for refills in excess of that specified by the prescribing practitioner, or refilled too soon, or in excess of therapeutic limits.
  - Charges for refills dispensed after one year from the original date of the prescription.
  - Charges for Controlled Substances as a replacement for a previously dispensed Controlled Substance that was lost, misused, stolen, broken or destroyed.
  - Drugs or medications not requiring a prescription, except insulin.
  - Charges for a prescription drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
    - A hospital
    - A rest home
    - A sanitarium
    - An extended care facility
    - A hospice
    - A substance abuse center
    - An alcohol abuse or mental health center
    - A convalescent home
    - A nursing home or similar institution
    - A provider's office
  - Charges for:
    - Therapeutic devices or appliances without a prior authorization.
    - Hypodermic needles or syringes, except insulin syringes.
    - Other non-medical substances, regardless of their intended use.
  - Charges for over-the-counter vitamins and dietary supplements.
  - Charges for any drug used in connection with baldness.
  - Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder.
  - Covered Person taking part in the commission of a felony.
  - Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
  - Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
  - Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and we are legally required to pay it, we will.
  - Charges for drugs covered under Home Health Care or Hospice Care section of the Evidence of Coverage.
  - Charges for drugs needed due to an on-the-job or job-related injury or illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws. Exception: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for Workers' Compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, the limited liability company or the partnership.
  - Compounded drugs that do not contain at least one ingredient that requires a prescription order.
  - Prescription drugs or new dosage forms that are used in conjunction with a treatment or procedure that is determined to not be a covered service.
  - Drugs used solely for the purpose for weight loss.
  - Life enhancement drugs for the treatment of sexual dysfunction, (e.g., Viagra).
  - Prescription drugs dispensed outside of the United States, except as required for emergency treatment.
- Services or supplies that are not furnished by an eligible provider.
- Services related to private duty nursing care, except as provided under the Home Health Care section of this Evidence of Coverage.
- Services or supplies related to rest or convalescent cures.
- Room and board charges for a Covered Person in any facility for any period of time during which he or she was not physically present overnight in the facility.
- Except as stated in the Preventive Care section, routine examinations or preventive care, including related X-rays and laboratory tests, except where a specific illness or injury is revealed or where definite symptomatic condition is present; premarital or similar examinations or tests not required to diagnose or treat illness or injury.
- Services or supplies related to routine foot care except:
  - An open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia, or bunions;
  - The removal of nail roots; and
  - Treatment or removal of corns, calluses, or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.
- Self-administered services such as: biofeedback, patient-controlled analgesia on an outpatient basis, related diagnostic testing, self-care and self-help training.
- Services provided by a social worker, except as otherwise stated in this Evidence of Coverage.
- Services or supplies:
  - Eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
  - For which a charge is not usually made, such as a practitioner treating a professional or business associate, or services at a public health fair;
  - For which a Covered Person would not have been charged if he or she did not have health care coverage;
  - For which the Covered Person has no legal obligation to reimburse the provider;
  - Provided by or in a government hospital except as stated below, or unless the services are for treatment:
    - Of a non-service emergency; or
    - By a Veterans' Administration hospital of a non-service-related illness or injury. Exception: This exclusion does not apply to military retirees, their dependents and the dependents of active duty military personnel who are covered under both this Evidence of Coverage and under military health coverage and who receive care in facilities of the Uniformed Services.
- Provided outside the United States other than in the case of Emergency and except as provided below with respect to a full-time student. Subject to our pre-approval, eligibility for full-time student status, provided the Covered Person is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country for which the institution of higher learning at which the student matriculates in the United States grants academic credit. Charges in connection with full-time students in a foreign country for which eligibility as a full-time student has not been pre-approved by us are non-covered charges.
- Travel to obtain medical treatment, drugs or supplies is not covered. In addition, We will not cover treatment, drugs or supplies that are unavailable or illegal in the United States.
- Stand-by services required by a provider.
- Sterilization reversal and services and supplies rendered for reversal of sterilization.
- Charges for third-party requests for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining a license issued by a municipality, state or federal government; obtaining benefits coverage; foreign travel; school admissions; or attendance including examinations required for participation in athletic activities.
- Transplants, except as otherwise listed in this Evidence of Coverage.
- Transportation, travel.
- Vision therapy.
- Services or supplies received as a result of a war, or an act of war, if the illness or injury occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization and illness or injury suffered as a result of special hazards incident to such service if the illness or injury occurs while the Covered Person is serving in such forces and is outside the home area.
- Weight reduction or control including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, except as otherwise provided in the Surgical Treatment of Morbid Obesity section of this Evidence of Coverage.
- Wigs, toupees, hair transplants, hair weaving or any drug, if such drug is used in connection with baldness; with the exception of hair loss following chemotherapy/radiotherapy or for Syphilitic Alopecia up to one per lifetime or maximum dollar amount of $350.

Form # C0110_S_HMOLargePB18

MEMORIAL HERMANN Health Plan

Large Group HMO Plans



Large Group HMO 2019 Plan Overview

MEMORIAL HERMANN Health Plan

Large Group HMO Plans

from Memorial Hermann Health Plan

	Select 001 HMO	Select 002 HMO	Select 003 HMO	Select 500-80 HMO	Select 1000-80 HMO	Select 1000-100 HMO	Select 1500-80 HMO	Select 2000-80 HMO
In-Network Deductible	$0	$3,000	$6,000	$500	$1,000	$1,000	$1,500	$2,000
Family Deductible	$0	$6,000	$12,000	$1,000	$2,000	$2,000	$3,000	$4,000
Out-of-Pocket Maximum (Individual)	$6,600	$6,850	$7,000	$3,500	$4,000	$4,000	$5,000	$5,000
Out-of-Pocket Maximum (Family)	$13,200	$13,700	$14,000	$7,000	$8,000	$8,000	$10,000	$10,000
Member Coinsurance	0%	50%	50%	20%	20%	0%	20%	20%
PCP	$30	$5	$5	$25	$25	$25	$25	$30
Specialist	$55	$10	$10	$50	$50	$50	$50	$60
Telemedicine/Telehealth	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Urgent Care	$55	$10	$10	$50	$50	$50	$50	$50
Emergency Room	$250	50% Coinsurance After Deductible	50% Coinsurance After Deductible	$250 then 20% Coinsurance	$300 then 20% Coinsurance	$300	$300 then 20% Coinsurance	$300 then 20% Coinsurance
Independent and Outpatient Lab/Pathology	No Charge	50% Coinsurance After Deductible	50% Coinsurance After Deductible	$25 Copay	$25 Copay	$25 Copay	$25 Copay	$25 Copay
Radiology/X-rays	No Charge	50% Coinsurance After Deductible	50% Coinsurance After Deductible	$50 Copay	$50 Copay	$50 Copay	$50 Copay	$50 Copay
MRI/Scans/Nuclear Medicine	$250	50% Coinsurance After Deductible	50% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible	No Charge After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible
Inpatient Hospital	$350 / day for the First 3 Days of Admission	50% Coinsurance After Deductible	50% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible	No Charge After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible
PT/OT/ST/Chiro	$30 Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	$5 Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	$5 Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	$25 Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	$25 Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	$25 Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	$25 Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	$30 Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits
Retail Generic Rx	$2 – Preferred Pharmacy / $10 – Non-Preferred Pharmacy	$2 – Preferred Pharmacy / $10 – Non-Preferred Pharmacy	$2 – Preferred Pharmacy / $10 – Non-Preferred Pharmacy	$2 – Preferred Pharmacy / $10 – Non-Preferred Pharmacy	$2 – Preferred Pharmacy / $10 – Non-Preferred Pharmacy	$2 – Preferred Pharmacy / $10 – Non-Preferred Pharmacy	$2 – Preferred Pharmacy / $10 – Non-Preferred Pharmacy	$2 – Preferred Pharmacy / $10 – Non-Preferred Pharmacy
Retail Brand Rx	$50 – Preferred Pharmacy / $60 – Non-Preferred Pharmacy	$45 – Preferred Pharmacy / $55 – Non-Preferred Pharmacy	$45 – Preferred Pharmacy / $55 – Non-Preferred Pharmacy	$25 – Preferred Pharmacy / $35 – Non-Preferred Pharmacy	$25 – Preferred Pharmacy / $35 – Non-Preferred Pharmacy	$25 – Preferred Pharmacy / $35 – Non-Preferred Pharmacy	$40 – Preferred Pharmacy / $50 – Non-Preferred Pharmacy	$40 – Preferred Pharmacy / $50 – Non-Preferred Pharmacy
Retail Non-Formulary Brand Rx	$100 – Preferred Pharmacy / $110 – Non-Preferred Pharmacy	$75 – Preferred Pharmacy / $85 – Non-Preferred Pharmacy	$75 – Preferred Pharmacy / $85 – Non-Preferred Pharmacy	$50 – Preferred Pharmacy / $60 – Non-Preferred Pharmacy	$50 – Preferred Pharmacy / $60 – Non-Preferred Pharmacy	$50 – Preferred Pharmacy / $60 – Non-Preferred Pharmacy	$75 – Preferred Pharmacy / $85 – Non-Preferred Pharmacy	$75 – Preferred Pharmacy / $85 – Non-Preferred Pharmacy
Retail Specialty Rx	25% Coinsurance $300 Maximum per Prescription per Member	25% Coinsurance After Deductible $300 Maximum per Prescription per Member	25% Coinsurance After Deductible $300 Maximum per Prescription per Member	25% Coinsurance $300 Maximum per Prescription per Member	25% Coinsurance $300 Maximum per Prescription per Member	25% Coinsurance $300 Maximum per Prescription per Member	25% Coinsurance $300 Maximum per Prescription per Member	25% Coinsurance $300 Maximum per Prescription per Member

	Select 2000-100 HMO	Select 2500-80 HMO	Select 3000-80 HMO	Select 5000-80 HMO	Select 6600-100 Standard HMO	Select 3000-100 HSA HMO	Select 5000-100 HSA HMO	Select 6550-100 HSA HMO
In-Network Deductible	$2,000	$2,500	$3,000	$5,000	$6,600	$3,000	$5,000	$6,550
Family Deductible	$4,000	$5,000	$6,000	$10,000	$13,200	$6,000	$10,000	$13,100
Out-of-Pocket Maximum (Individual)	$3,500	$5,500	$5,500	$6,350	$6,600	$4,500	$6,350	$6,550
Out-of-Pocket Maximum (Family)	$7,000	$11,000	$11,000	$12,700	$13,200	$9,000	$12,700	$13,100
Member Coinsurance	0%	20%	20%	20%	0%	0%	0%	0%
PCP	$30	$30	$30	$35	$35	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible
Specialist	$60	$60	$60	$70	$70	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible
Telemedicine/Telehealth	No Charge	No Charge	No Charge	No Charge	No Charge	$40	$40	$40
Urgent Care	$50	$50	$50	$50	$50	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible
Emergency Room	$250	$300 then 20% Coinsurance	$300 then 20% Coinsurance	$350 then 20% Coinsurance	$350	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible
Independent and Outpatient Lab/Pathology	$25 Copay	$25 Copay	$25 Copay	$25 Copay	$25 Copay	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible
Radiology/X-rays	$50 Copay	$50 Copay	$50 Copay	$50 Copay	$50 Copay	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible
MRI/Scans/Nuclear Medicine	No Charge After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible	$150	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible
Inpatient Hospital	No Charge After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible
PT/OT/ST/Chiro	$30 Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	$30 Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	$30 Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	$35 Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	$35 Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	No Charge After Deductible Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	No Charge After Deductible Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits	No Charge After Deductible Limited to 60 Combined PT/OT/ST Visits; Limited to 10 Chiro Visits
Retail Generic Rx	$2 – Preferred Pharmacy / $10 – Non-Preferred Pharmacy	$2 – Preferred Pharmacy / $10 – Non-Preferred Pharmacy	$2 – Preferred Pharmacy / $10 – Non-Preferred Pharmacy	$2 – Preferred Pharmacy / $10 – Non-Preferred Pharmacy	$2 – Preferred Pharmacy / $10 – Non-Preferred Pharmacy	After Deductible: $2 – Preferred / $10 – Non-Preferred	After Deductible: $2 – Preferred / $10 – Non-Preferred	No Charge After Deductible
Retail Brand Rx	$25 – Preferred Pharmacy / $35 – Non-Preferred Pharmacy	$40 – Preferred Pharmacy / $50 – Non-Preferred Pharmacy	$40 – Preferred Pharmacy / $50 – Non-Preferred Pharmacy	$40 – Preferred Pharmacy / $50 – Non-Preferred Pharmacy	$40 – Preferred Pharmacy / $50 – Non-Preferred Pharmacy	After Deductible: $25 – Preferred / $35 – Non-Preferred	After Deductible: $25 – Preferred / $35 – Non-Preferred	No Charge After Deductible
Retail Non-Formulary Brand Rx	$50 – Preferred Pharmacy / $60 – Non-Preferred Pharmacy	$75 – Preferred Pharmacy / $85 – Non-Preferred Pharmacy	$75 – Preferred Pharmacy / $85 – Non-Preferred Pharmacy	$75 – Preferred Pharmacy / $85 – Non-Preferred Pharmacy	$75 – Preferred Pharmacy / $85 – Non-Preferred Pharmacy	After Deductible: $50 – Preferred / $60 – Non-Preferred	After Deductible: $50 – Preferred / $60 – Non-Preferred	No Charge After Deductible
Retail Specialty Rx	25% Coinsurance $300 Maximum per Prescription per Member	25% Coinsurance $300 Maximum per Prescription per Member	25% Coinsurance $300 Maximum per Prescription per Member	25% Coinsurance $300 Maximum per Prescription per Member	25% Coinsurance $300 Maximum per Prescription per Member	25% Coinsurance After Deductible $300 Maximum per Prescription per Member	25% Coinsurance After Deductible $300 Maximum per Prescription per Member	No Charge After Deductible