The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, http://healthplan.memorialhermann.org/brokers/resource-center/ or call 855-645-8448. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 855-645-8448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating Providers - $2,000 person / $6,000 family. Non-Participating Providers - $4,000 person / $12,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible. Does not apply to Generic, Preferred brand or Non-Preferred brand prescription drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Participating Providers – $4,000 person / $12,000 family. Non-Participating Providers –$15,000 person / $45,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, penalties for failure to obtain prior authorization for services and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See http://healthplan.memorialhermann.org/brokers/find-a/?searchfor=doctors or call 855-645-8448 for a list of Participating Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to	No.	You can see the specialist you choose without a referral.

see a specialist?		

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit. Deductible does not apply.	30% coinsurance. Deductible applies first.	None.
	Specialist visit	$50 copay/visit. Deductible does not apply.	30% coinsurance. Deductible applies first.	None.
	Preventive care/screening/ immunizations	No Charge. Deductible does not apply.	30% coinsurance. Deductible applies first.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. For Children under the age of 6: Required immunizations are not subject to deductible, copayment or coinsurance requirements for Participating or Non-Participating Providers.
If you have a test	Diagnostic test (x-ray, blood work)	Lab - $25 copay/visit, X-ray - $50 copay/visit. Deductible does not apply.	30% coinsurance. Deductible applies first.	Prior Authorization required for all Genetic Testing and Complex Imaging $1,000 or above. Non-compliance may result in a penalty.
	Imaging (CT/PET scans, MRIs)	No Charge. Deductible applies first.	30% coinsurance. Deductible applies first.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://healthplan.memorialhermann.org/members/resource-center/pharmacy-benefit-information/ Or by calling 1-877-633-4461	Generic drugs	Preferred: $4 copay/prescription; Non-Preferred: $10 copay/prescription; Mail Order: $10 copay/prescription. Deductible does not apply.	50% coinsurance /prescription. Deductible applies first. (30 day Retail), Mail Order - Not covered.	Preferred Participating Providers/Pharmacies: Lower cost applies. Retail covers 30-day supply and mail order covers 90-day supply. Participating Provider prescription drug copayment/coinsurance apply to the Maximum Out-of-Pocket limit. Member responsible for paying applicable copay, allowable claim amount, or the contracted rate of the prescription if less than the established copay. Prior Authorization required for some Drugs. Non-compliance may result in a penalty.
	Preferred brand drugs	Preferred: $50 copay/prescription; Non-Preferred: $60 copay/prescription; Mail Order: $125 copay/prescription. Deductible does not apply.	50% coinsurance /prescription. Deductible applies first. (30 day Retail), Mail Order - Not covered.	
	Non-preferred brand drugs	Preferred: $100 copay/prescription; Non-Preferred: $110 copay/prescription; Mail Order: $250 copay/prescription. Deductible does not apply.	50% coinsurance /prescription. Deductible applies first. (30 day Retail), Mail Order - Not covered.	
	Specialty drugs	45% coinsurance /prescription. Deductible applies first. (30-day Retail), Mail Order - Not covered.	45% coinsurance /prescription. Deductible applies first. (30-day Retail), Mail Order - Not covered.	30-day supply only. Annual Participating Provider Deductible applies to **ALL** Specialty drugs. Prior Authorization required for some Specialty drugs. Non-compliance may result in a penalty.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge. Deductible applies first.	30% coinsurance. Deductible applies first.	Prior Authorization required. Non-compliance may result in a penalty.
	Physician/surgeon fees	No Charge. Deductible applies first.	30% coinsurance. Deductible applies first.	Prior Authorization required. Non-compliance may result in a penalty.
If you need immediate medical attention	Emergency room care	$400 copay/visit. Deductible does not apply.	$400 copay/visit. Deductible does not apply.	Copayment waived if admitted.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Emergency medical transportation	25% coinsurance/trip. Deductible applies first.	25% coinsurance/trip. Deductible applies first.	None.
	Urgent care	$50 copay/visit. Deductible does not apply.	$100 copay/visit. Deductible does not apply.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge. Deductible applies first.	30% coinsurance. Deductible applies first.	Prior Authorization required. Non-compliance may result in a penalty.
	Physician/surgeon fees	No Charge. Deductible applies first.	30% coinsurance. Deductible applies first.	Cost included in Inpatient stay.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Professional Office Visits - $25 copay/visit. Deductible does not apply; Outpatient services - No Charge. Deductible applies first.	30% coinsurance. Deductible applies first.	Prior Authorization required for MH/SA intensive (extended) or residential services, Applied Behavioral Analysis (ABA) therapy and non-behavioral health providers neuropsychiatric testing; Non-compliance may result in a penalty.
	Inpatient services	No Charge. Deductible applies first.	30% coinsurance. Deductible applies first.	Prior Authorization required. Non-compliance may result in a penalty.
If you are pregnant	Office visits	25% coinsurance. Deductible applies first.	30% coinsurance. Deductible applies first.	Prior Authorization required only for period outside the 48/96-hour timeframe listed in the Certificate of Coverage. Non-compliance may result in a penalty. Childbirth/delivery professional services: Cost included in Inpatient stay. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge. Deductible applies first.	30% coinsurance. Deductible applies first.	
	Childbirth/delivery facility services	No Charge. Deductible applies first.	30% coinsurance. Deductible applies first.	
If you need help recovering or have	Home health care	25% coinsurance. Deductible applies first.	30% coinsurance. Deductible applies first.	Limited to 60 visits/year. Prior Authorization required. Non-compliance may result in a penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
other special health needs	Rehabilitation services	Professional Office Visits: Speech & Hearing Exams - $30 copay/visit. Deductible does not apply. PT/OT/ST - 25% coinsurance. Deductible applies first. Outpatient Services - No Charge. Deductible applies first.	30% coinsurance. Deductible applies first.	Physical Therapy/Occupational Therapy/Speech Therapy and Chiropractic: Limited to 35 visits/year/service; and 1 visit per day. Plan limitations do not apply to medically necessary services or services related to Autism Spectrum Disorder. Prior Authorization required for Inpatient & ABA in Cognitive Therapy. Non-compliance may result in a penalty.
	Habilitation services	Professional Office Visits: Speech & Hearing Exams - $30 copay/visit. Deductible does not apply. PT/OT/ST - 25% coinsurance. Deductible applies first. Outpatient Services - No Charge. Deductible applies first.	30% coinsurance. Deductible applies first.	
	Skilled nursing care	No Charge. Deductible applies first.	30% coinsurance. Deductible applies first.	Limited to 25 days/year. Prior Authorization required. Non-compliance may result in a penalty.
	Durable medical equipment	25% coinsurance. Deductible applies first.	30% coinsurance. Deductible applies first.	Limited to Plan Requirements. Prior Authorization required. Non-compliance may result in a penalty.
	Hospice services	25% coinsurance. Deductible applies first.	30% coinsurance. Deductible applies first.	Prior Authorization required. Non-compliance may result in a penalty.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None.
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	None.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Dental care	• Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Routine eye care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (Prior authorization required) • Chiropractic care (35 visits per year)	• Cosmetic surgery (Reconstructive surgery for birth defects, injuries, tumors or infection) • Hearing aids (1 pair every 36 months)	• Private-duty nursing (Outpatient Home Health aide services & Inpatient services only - covered when medically necessary) • Routine foot care (For an illness such as diabetes or a circulatory disorder of the lower extremities)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage subject to ERISA, call MHHSI Customer Service at 855-645-8448 or http://healthplan.memorialhermann.org; also Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform; for non-federal governmental group health plans, 1-877-267-2323 x61565 or http://www.cciio.cms.gov; Church plans are not covered by the Federal COBRA continuation coverage rules. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA, U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform; or Memorial Hermann Health Solutions Customer Service at 855-645-8448 or http://healthplan.memorialhermann.org.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$600
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,260**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$1,800
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,560**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	25%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact Customer Service at: 855-645-8448.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Multi-Language Insert
Multi-Language Interpreter Services

MEMORIAL HERMANN Health Plan

Spanish	Vietnamese
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.855.645.8448 (TTY 711).	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.855.645.8448 (TTY 711).
Arabic	**Japanese**
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 8448.546.558.1 (رقم هاتف الصم والبكم: 117).	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1. 855. 645. 8448（TTY 711）まで、お電話にてご連絡ください。
Cantonese Chinese	**Korean**
注意：如果您說廣東話，您可以免費獲得語言援助服務。請致電 1.855.645.8448（TTY 711）。	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.855.645.8448 (TTY 711) 번으로 전화해 주십시오.
Mandarin Chinese	**Laotian**
注意：如果您说普通话，您可以免费获得语言援助服务。请致电 1.855.645.8448（TTY 711）。	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄາ, ແມນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.855.645.8448 (TTY 711).
French	**Farsi**
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.855.645.8448 (ATS 711).	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1.855.645.8448 (TTY 711) تماس بگیرید.
German	**Russian**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.855.645.8448 (TTY 711).	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.855.645.8448 (телетайп 711).
Gujarati	**Tagalog**
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.855.645.8448 (TTY 711).	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.855.645.8448 (TTY: 711).
Hindi	**Urdu**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.855.645.8448 (TTY 711) पर कॉल करें।	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1.855.645.8448 (TTY 711).

ATTENTION: Texas Relay Services are available for the hearing impaired at (711).	Resources are available for the visually impaired, please call 1.855.645.8448 (711).

Memorial Hermann Health Plan, Inc., Memorial Hermann Health Insurance Company, Memorial Hermann Commercial Health Plan, Inc. and Memorial Hermann Health Solutions, Inc. (collectively "MHHP") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Memorial Hermann Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MHHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (855) 645-8448.
Customer Service Hours of Operations: 8am-5pm (CST) M-F

If you believe that MHHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
Memorial Hermann Health Plan
929 Gessner Road, Suite 1500
Houston, TX 77024

Fax 713-338-6487
Email MHHealthAppeals@memorialhermann.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, (1-800-537-7697 TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.