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, refer to http://healthplan.memorialhermann.org/brokers/resource-center/ or call 844-644-4777. 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 844-644-4777 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating Providers - $550 person / $1,100 family. Non-Participating Providers - None.	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 - $3,500 person / $7,000 family. Non-Participating Providers – None.	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 https://healthplan.memorialhermann.org/find-a-doctor?network=Select+HMO 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 see a specialist?	No.	You can see the specialist you choose without a referral.

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	$20 copay/visit; Deductible does not apply.	Not covered	Premise Clinic (Onsite) $5 copay/visit.
	Specialist visit	$45 copay/visit; Deductible does not apply.	Not covered	None.
	Preventive care/screening/ immunization	No Charge; Deductible does not apply.	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	Lab – $25 copay/visit; X-Ray - $50 copay/visit; Deductible does not apply.	Not covered	Prior Authorization required for all Genetic Testing; Non-compliance may result in a penalty.
	Imaging (CT/PET scans, MRIs)	20% coinsurance/visit; Deductible applies first.	Not covered	
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	Generic drugs	Retail Preferred: $4 copay/prescription; Mail Order: $10 copay/prescription; Deductible does not apply.	Not covered	Lower cost applies at Preferred Participating Pharmacies Retail covers 30-day supply and mail order covers 90-day supply. Annual Participating Provider Deductible does NOT apply to Generic, Brand, and Non-Formulary brand prescription drugs. Participating Provider prescription drug copayment/coinsurance applies to the annual Participating Provider 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.
	Brand drugs	Retail Preferred: $40 copay/prescription; Mail Order: $100 copay/prescription; Deductible does not apply.	Not covered	
	Non-Formulary Brand drugs	Retail Preferred: $60 copay/prescription; Mail Order: $150 copay/prescription; Deductible does not apply.	Not covered	
	Specialty drugs	50% coinsurance/prescription (30-day Retail)*	Not covered	*30-day supply only; $200 maximum per Specialty Drug per prescription per month; 90-day Mail Order not covered. Annual Participating Provider Deductible applies to **ALL** Specialty drugs. Prior

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)	
1-866-333-2757.		Deductible applies first. 90-day Mail Order – Not Covered.		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)	20% coinsurance; Deductible applies first.	Not covered	Prior Authorization required. Non-compliance may result in a penalty.
	Physician/surgeon fees	20% coinsurance; Deductible applies first.	Not covered	Prior Authorization required. Non-compliance may result in a penalty.
If you need immediate medical attention	Emergency room care	$250 then 20% coinsurance/visit; Deductible does not apply.	$250 then 20% coinsurance/visit Deductible does not apply.	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance/trip; Deductible applies first.	20% coinsurance/trip; Deductible applies first.	None.
	Urgent care	$50 copay/visit; Deductible does not apply.	$50 copay/visit. Deductible does not apply.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance; Deductible applies first.	Not covered	Prior Authorization required. Non-compliance may result in a penalty.
	Physician/surgeon fees	20% coinsurance; Deductible applies first.	Not covered	Cost included in Inpatient stay.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Professional Office Visit - $20 copay/visit; Deductible does not apply. Outpatient services – 20% coinsurance/visit; Deductible applies first.	Not covered	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	20% coinsurance/visit; Deductible applies first.	Not covered	Prior Authorization required. Non-compliance may result in a penalty.
If you are pregnant	Office visits	20% coinsurance/visit; Deductible applies first.	Not covered	Prior Authorization required. Non-compliance may result in a penalty. Cost sharing does not apply for preventive services.

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)	
	Childbirth/delivery professional services	20% coinsurance; Deductible applies first.	Not covered	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 facility services	20% coinsurance; Deductible applies first.	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance/visit; Deductible applies first.	Not covered	Limited to 60 visits/year. Prior Authorization required. Non-compliance may result in a penalty.
	Rehabilitation services	Inpatient Facility Services: 20% coinsurance; Deductible applies first. Outpatient Services: $45 copay/visit; Deductible does not apply. Other Practitioner Office Visit: $45 copay/visit; Deductible does not apply.	Not covered	Physical Therapy/Occupational Therapy/Speech Therapy and Chiropractic: Limited to 20 combined visits/year; and 1 visit per day.. Prior Authorization required for Inpatient & ABA in Cognitive Therapy. Non-compliance may result in a penalty.
	Habilitation services	Inpatient Facility Services: 20% coinsurance; Deductible applies first. Outpatient Services: $45 copay/visit; Deductible does not apply. Other Practitioner Office Visit: $45 copay/visit; Deductible does not apply.	Not covered	
	Skilled nursing care	20% coinsurance;	Not covered	Limited to 100 days/year. Prior Authorization required. Non-

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)	
		Deductible applies first.		compliance may result in a penalty.
	Durable medical equipment	20% coinsurance; Deductible applies first.	Not covered	Limited to Plan Requirements; Prior Authorization required. Non-compliance may result in a penalty.
	Hospice services	20% coinsurance; Deductible applies first.	Not covered	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	Prior Authorization required for benefits other than diagnostic or Preventive Services through age 19. Non-compliance may result in a penalty. Subject to Plan Exclusions.

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.)

- Bariatric surgery
- 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.)

- Acupuncture (20 visits per year)
- Chiropractic care (20 visits per year combined with Physical Therapy/Occupational Therapy)
- Cosmetic surgery (reconstructive surgery for birth defects, injuries, tumor 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 MHCHP Customer Service at 844-644-4777 or http://healthplan.memorialhermann.org or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law at the Texas Department of Insurance, 1-800-252-3439 or http://www.tdi.texas.gov. 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 on how 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 Commercial Health Plan Customer Service at 844-644-4777 or http://healthplan.memorialhermann.org.

Does this plan provide Minimum Essential Coverage? **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

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	$550
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$550
Copayments	$500
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,410**

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

The plan's overall deductible	$550
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$550
Copayments	$1,300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,210**

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

The plan's overall deductible	$550
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$550
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$950**

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

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-645-8448. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-645-8448. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-855-645-8448。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-855-645-8448。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-645-8448. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-645-8448. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-855-645-8448 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-645-8448. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-645-8448번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-645-8448. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة فوري، ليس عليك سوى الاتصال بنا على 1-558-546-8448. سيقوم شخص ما يتحدث العربية مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-645-8448 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-645-8448. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-645-8448. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-645-8448. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-645-8448. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と 薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-855-645-8448にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。