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.
Small Group Hybrid HMO and PPO coverage from Memorial Hermann Health Plan provides small businesses in Greater Houston with the highest quality care at the best possible price. Plus, our Small Group Hybrid HMO and PPO 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

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan section above. The following are services, supplies and treatments that are not covered under this Plan. The Plan will not cover 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 Covered 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.
- 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 and Reconstructive Surgery except as otherwise stated in this Member Handbook; complications of Cosmetic and Reconstructive Surgery; 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 Member Handbook.
- Services or supplies, the primary purpose of which is educational in 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 Member Handbook.
- Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this Member Handbook.
- Extraction of teeth, except as otherwise stated in this Member Handbook.
- Services or supplies for or in connection with:
    - Refraction exams to determine the need for (or changes of) eyeglasses or lenses of any type;
    - 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 Covered Persons 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 this Member Handbook; 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, 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 Member Handbook.
- Charges for missed appointments.
- Charges for nicotine dependence treatments and management drugs unless otherwise stated in the Preventive and Wellness Care Services section of this Member Handbook.
- Any charge identified as a non-Covered Charge or which are specifically limited or excluded elsewhere in this Member Handbook, or which are not Medically Necessary, except as otherwise stated in this Member Handbook.
- Services or supplies that are not furnished by an eligible provider.
- Services related to Outpatient Private Duty Nursing care, except as provided under the Home Health Care section of this Member Handbook.
- Services or supplies related to rest or convalescent cares.
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 and Wellness 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 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 another practitioner 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 Medical Condition; 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 Plan 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 a Medical Emergency and except as provided below with respect to a full-time student.
Exception: Subject to MHHSI's 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 MHHSI are not covered under the Plan.
- Travel to obtain medical treatment, drugs or supplies is not covered. In addition, the Plan 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. 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 a 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.
- 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 Member Handbook.
- Transportation, travel except as otherwise listed in this Member Handbook
- Vision therapy except as otherwise listed in this Member Handbook.
- Vitamins and dietary supplements.
- 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 a 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 Member Handbook.
- 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/radio-therapy or for Syphilitic alopecia up to 1 per lifetime or a maximum dollar amount of $350.
- Complications from services, supplies and treatment for services that are not covered under this Plan.

The intent of this information is for marketing purposes only. This information is meant for health insurance brokers and agents only, not intended for public distribution. The benefits listed are purely illustrative; please contact Memorial Hermann Health Plan for more information. Benefit exclusions and limitations may apply. All applicants must complete and submit an application to obtain coverage from Memorial Hermann Health Plan. Please do not send money in any form to Memorial Hermann Health Plan in response to this ad.
All Hybrid Plans are administrated by Memorial Hermann Health Solutions.
Memorial Hermann Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.
Please note, you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible. While you can keep your current coverage from the list of small group plans above, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855.645.8448 (TTY 711).
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Small Group Hybrid HMO & PPO 2021 Plan Overview

MEMORIAL HERMANN Health Plan

Memorial Hermann Health Plan, Inc.
Memorial Hermann Health Solutions, Inc.
Memorial Hermann Health Insurance Company
Memorial Hermann Commercial Health Plan, Inc.

Small Group Hybrid HMO & PPO Plans

from Memorial Hermann Health Plan

	Select 001 HMO	Select 002 HMO	Select 500 HMO	Select 1000 HMO	Select 1500 HMO	Select 2350 HMO	Select 3000 HMO	Select 3000 HSA HMO	Select 4000 HSA HMO	Select 5000 HMO	Select 5000 HSA HMO	Select 6350 HSA HMO	Select 6850 HMO	Select 7500 HMO	Select 2350 PPO		Select 3000 PPO	
															In Network	Out of Network	In Network	Out of Network
In-Network Deductible	$0	$3,000	$500	$1,000	$1,500	$2,350	$3,000	$3,000	$4,000	$5,000	$5,000	$6,350	$6,850	$7,500	$2,350	$4,700	$3,000	$6,000
Family Deductible (for display only)	$0	$6,000	$1,500	$2,500	$3,000	$7,050	$6,000	$9,000	$8,000	$10,000	$10,000	$12,700	$13,700	$15,000	$7,050	$14,100	$6,000	$12,000
Out-of-Pocket Maximum (individual)	$6,500	$6,200	$1,500	$4,500	$4,500	$3,700	$6,850	$3,500	$6,300	$6,850	$6,300	$6,350	$7,350	$7,900	$4,000	$15,000	$6850	$15,000
Out-of-Pocket Maximum (Family)	$14,300	$12,400	$4,500	$11,250	$9,000	$9,750	$13,700	$12,000	$12,600	$13,700	$12,600	$12,700	$14,700	$15,800	$12,000	$45,000	$13700	$30,000
Member Responsibility	0%	50%	10%	30%	25%	0%	30%	0%	20%	30%	0%	0%	0%	0%	25%	30%	0%	30%
PCP	$50	$5	$15	$25	$25	$25	$35	No Charge After Deductible	20% Coinsurance after Deductible	$35	No Charge After Deductible	No Charge After Deductible	$40	$40	$25 Copay, No Deductible	30% Coinsurance, Deductible applies first	$35 Copay, No Deductible	30% Coinsurance, Deductible applies first
Specialist	$100	$10	$30	$50	$50	$50	$70	No Charge After Deductible	20% Coinsurance after Deductible	$70	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	$70	$50 Copay, No Deductible	30% Coinsurance, Deductible applies first	$70 Copay, No Deductible	30% Coinsurance, Deductible applies first
Telemedicine/ Telehealth	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	$45	$45	No Charge	$45	$45	No Charge	No Charge	No Charge	30% Coinsurance, Deductible applies first	No charge	30% Coinsurance, Deductible applies first
Urgent Care	$100	$10	$50	$50	$50	$50	$50	No Charge After Deductible	20% Coinsurance after Deductible	$50	No Charge After Deductible	No Charge After Deductible	$70	$70	$50	$100	$50	$100
Emergency Room	$750	50% Coinsurance After Deductible	$400 then 10% Coinsurance	$400 then 30% Coinsurance	$400 then 25% Coinsurance	$400	$400 then 30% Coinsurance	No Charge After Deductible	20% Coinsurance after Deductible	$400 then 30% Coinsurance	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	$400 Copay, No Deductible	$400 Copay, No Deductible	$400 Copay, No Deductible	$400 Copay, No Deductible
Independent & Outpatient Lab/ Pathology	$50	50% Coinsurance After Deductible	10% Coinsurance After Deductible	30% Coinsurance After Deductible	25% Coinsurance After Deductible	No Charge After Deductible	30% Coinsurance After Deductible	No Charge After Deductible	20% Coinsurance after Deductible	30% Coinsurance After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	$25 Copay, No Deductible	30% Coinsurance, Deductible applies first	$35 Copay, No Deductible	30% Coinsurance, Deductible applies first
Radiology/X-rays	$100	50% Coinsurance After Deductible	10% Coinsurance After Deductible	30% Coinsurance After Deductible	25% Coinsurance After Deductible	No Charge After Deductible	30% Coinsurance After Deductible	No Charge After Deductible	20% Coinsurance after Deductible	30% Coinsurance After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	$50 Copay, No Deductible	30% Coinsurance, Deductible applies first	$70 Copay, No Deductible	30% Coinsurance, Deductible applies first
MRI/Scans/Nuclear Medicine	$500	50% Coinsurance After Deductible	10% Coinsurance After Deductible	30% Coinsurance After Deductible	25% Coinsurance After Deductible	No Charge After Deductible	30% Coinsurance After Deductible	No Charge After Deductible	20% Coinsurance after Deductible	30% Coinsurance After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	30% Coinsurance, Deductible applies first	No Charge After Deductible	30% Coinsurance, Deductible applies first
Inpatient Hospital	$750 / Day for first 3 Days of Admission	50% Coinsurance After Deductible	10% Coinsurance After Deductible	30% Coinsurance After Deductible	25% Coinsurance After Deductible	No Charge After Deductible	30% Coinsurance After Deductible	No Charge After Deductible	20% Coinsurance after Deductible	30% Coinsurance After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	30% Coinsurance, Deductible applies first	No Charge After Deductible	30% Coinsurance, Deductible applies first
PT/OT/Chiro	$100	50% Coinsurance After Deductible	10% Coinsurance After Deductible	30% Coinsurance After Deductible	25% Coinsurance After Deductible	No Charge After Deductible	30% Coinsurance After Deductible	No Charge After Deductible	20% Coinsurance after Deductible	30% Coinsurance After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	25% Coinsurance After Deductible	30% Coinsurance, Deductible applies first	No Charge After Deductible	30% Coinsurance, Deductible applies first
Retail Generic Rx	$4 - preferred $10 - Non preferred	$4 - preferred $10 - Non preferred	$4 - preferred $10 - Non preferred	$4 - preferred $10 - Non preferred	$4 - preferred $10 - Non preferred	$4 - preferred $10 - Non preferred	$4 - preferred $10 - Non preferred	After Deductible $4 - preferred $10 - Non preferred	After Deductible $4 - preferred $10 - Non preferred	$4 - preferred $10 - Non preferred	After Deductible $4 - preferred $10 - Non preferred	No Charge After Deductible	$4 - preferred $10 - Non preferred	$4 - preferred $10 - Non preferred	$4 - preferred $10 - Non preferred	50% coinsurance. Deductible applies first	$4 - preferred $10 - Non preferred	50% coinsurance. Deductible applies first
Retail Brand Rx	$50 - preferred $60 - Non preferred	$50 - preferred $60 - Non preferred	$25 - preferred $35 - Non preferred	$30 - preferred $40 - Non preferred	$30 - preferred $40 - Non preferred	$50 - preferred $60 - Non preferred	$50 - preferred $60 - Non preferred	After Deductible $50 - preferred $60 - Non preferred	After Deductible $50 - preferred $60 - Non preferred	$50 - preferred $60 - Non preferred	After Deductible $50 - preferred $60 - Non preferred	After Deductible No Charge	After Deductible $160 - preferred $170 - Non preferred	After Deductible $160 - preferred $170 - Non preferred	$50 - preferred $60 - Non preferred	50% coinsurance. Deductible applies first	$50 - preferred $60 - Non preferred	50% coinsurance. Deductible applies first
Retail Non-Formulary Brand Rx	$100 - preferred $110 - Non preferred	$100 - preferred $110 - Non preferred	$50 - preferred $60 - Non preferred	$60 - preferred $70 - Non preferred	$60 - preferred $70 - Non preferred	$100 - preferred $110 - Non preferred	$100 - preferred $110 - Non preferred	$100 - preferred $110 - Non preferred	$100 - preferred $110 - Non preferred	$100 - preferred $110 - Non preferred	$100 - preferred $110 - Non preferred	No Charge After Deductible	After Deductible $250 - preferred $260 - Non preferred	After Deductible $250 - preferred $260 - Non preferred	$100 - preferred $110 - Non preferred	50% coinsurance. Deductible applies first	$100 - preferred $110 - Non preferred	50% coinsurance. Deductible applies first
Retail Specialty Rx	45% Coinsurance	45% Coinsurance After Deductible	45% Coinsurance After Deductible	45% Coinsurance After Deductible	45% Coinsurance After Deductible	45% Coinsurance After Deductible	45% Coinsurance After Deductible	45% Coinsurance After Deductible	45% Coinsurance After Deductible	45% Coinsurance After Deductible	45% Coinsurance After Deductible	No Charge After Deductible	45% Coinsurance After Deductible	45% Coinsurance After Deductible	45% Coinsurance After Deductible	45% coinsurance. Deductible applies first	45% Coinsurance After Deductible	45% coinsurance. Deductible applies first