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?	Network Providers - $3,000 person / $6,000 family. Out-of-Network Providers - $6,000 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?	Network Providers – $6,850 person / $13,700 family. Out-of-Network Providers –$13,700 person / $27,400 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?	Premiums, balance-billing charges, penalties for failure to obtain Preauthorization 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+PPO or call 855-645-8448 for a list of Network 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
		Network Provider (You will pay the least)	Out-of-Network 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	$5 copay/visit. Deductible does not apply.	50% coinsurance. Deductible applies first.	None.
	Specialist visit	$10 copay/visit. Deductible does not apply.	50% coinsurance. Deductible applies first.	None.
	Preventive care/screening/ immunization	No Charge. Deductible does not apply.	50% 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 - 50% coinsurance /visit. X-ray - 50% coinsurance /visit. Deductible applies first.	50% coinsurance. Deductible applies first.	Preauthorization required for all Genetic Testing and Complex Imaging. Non-compliance may result in a penalty.
	Imaging (CT/PET scans, MRIs)	50% coinsurance. Deductible applies first.	50% coinsurance. Deductible applies first.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network 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 https://healthplan.memorialhermann.org/members/pharmacy-benefit-information or by calling 1-866-333-2757.	Tier 1 Low cost, high value Generic and select Brand drugs	Preferred: $2 copay/prescription; Non-Preferred: $8 copay/prescription; Mail Order: $4 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. Network 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. Preauthorization required for some Drugs. Non-compliance may result in a penalty.
	Tier 2 Preferred Brand and select Generic drugs	Preferred: $40 copay/prescription; Non-Preferred: $50 copay/prescription; Mail Order: $80 copay/prescription. Deductible does not apply.	50% coinsurance /prescription. Deductible applies first. (30 day Retail) Mail Order - Not covered.	
	Tier 3 Non-Preferred Brand and Generic drugs	Preferred: $70 copay/prescription; Non-Preferred: $80 copay/prescription; Mail Order: $140 copay/prescription. Deductible does not apply.	50% coinsurance /prescription. Deductible applies first. (30 day Retail), Mail Order - Not covered.	
	Tier 4 Specialty drugs	33% coinsurance /prescription. Deductible does not apply. (30-day Retail)	45% coinsurance /prescription. Deductible applies first.(30-day Retail),	30-day supply only; 90-day Mail Order not covered. Preauthorization required for some Specialty drugs. Non-compliance may result in a penalty.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital - 50% coinsurance. Deductible applies first. Freestanding Clinic - $300 copay/visit. Deductible does not apply.	50% coinsurance. Deductible applies first.	Preauthorization required. Non-compliance may result in a penalty.
	Physician/surgeon fees	Included in Outpatient facility stay.	50% coinsurance. Deductible applies first.	Preauthorization required. Non-compliance may result in a penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	50% coinsurance/visit. Deductible applies first.	50% coinsurance/visit. Deductible applies first.	None.
	Emergency medical transportation	50% coinsurance/trip. Deductible applies first.	50% coinsurance/trip. Deductible applies first.	None.
	Urgent care	$10 copay/visit. Deductible does not apply.	$20 copay/visit. Deductible does not apply.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance. Deductible applies first.	50% coinsurance. Deductible applies first.	Preauthorization required. Non-compliance may result in a penalty.
	Physician/surgeon fees	No Charge.	50% coinsurance. Deductible applies first.	In-network: Cost included in Inpatient stay .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Professional Office Visits - $5 copay/visit; Deductible does not apply. Outpatient services –$5 copay/visit; Deductible does not apply.	50% coinsurance. Deductible applies first.	Preauthorization required for Mental Health/Substance Abuse 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	50% coinsurance. Deductible applies first.	50% coinsurance. Deductible applies first.	Preauthorization required. Non-compliance may result in a penalty.
If you are pregnant	Office visits	$5 copay/visit. Deductible does not apply.	50% coinsurance. Deductible applies first.	Preauthorization 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: In-network: 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.	50% coinsurance. Deductible applies first.	
	Childbirth/delivery facility services	50% coinsurance. Deductible applies first.	50% coinsurance. Deductible applies first.	
If you need help recovering or	Home health care	50% coinsurance. Deductible applies first.	50% coinsurance. Deductible applies first.	Limited to 60 visits/year. Preauthorization required. Non-compliance may result in a penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
have other special health needs	Rehabilitation services	Professional Office Visits: Speech & Hearing Exams - $5 copay/visit. Deductible does not apply. PT/OT/ST - $5 copay/visit. Deductible does not apply. Outpatient Services - 50% coinsurance. Deductible applies first.	50% coinsurance. Deductible applies first.	Physical Therapy/Occupational Therapy/Speech Therapy: Limited to 60 combined visits/year; and 1 visit per day. Plan limitations do not apply to medically necessary services or services related to Autism Spectrum Disorder. Preauthorization required for Inpatient & ABA in Cognitive Therapy. Non-compliance may result in a penalty.
	Habilitation services	Professional Office Visits: Speech & Hearing Exams - $5 copay/visit. Deductible does not apply. PT/OT/ST - $5 copay/visit. Deductible does not apply. Outpatient Services - 50% coinsurance. Deductible applies first.	50% coinsurance. Deductible applies first.	
	Skilled nursing care	50% coinsurance. Deductible applies first.	50% coinsurance. Deductible applies first.	Limited to 25 days/year. Preauthorization required. Non-compliance may result in a penalty.
	Durable medical equipment	50% coinsurance. Deductible applies first.	50% coinsurance. Deductible applies first.	Limited to Plan Requirements. Preauthorization required. Non-compliance may result in a penalty.
	Hospice services	50% coinsurance. Deductible applies first.	50% coinsurance. Deductible applies first.	Preauthorization 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.)

- 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)
- Bariatric surgery (Preauthorization required)
- Chiropractic care (10 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 MHHIC 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, 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. Church plans are not covered by the Federal COBRA continuation coverage rules. 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 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 Insurance Company Customer Service at 855-645-8448 or http://healthplan.memorialhermann.org, or the Texas Department of Insurance at 1-800-252-3439 or http://www.tdi.texas.gov, or the Texas Attorney General Consumer Protection Hotline at 1-800-621-0508 or https://www.texasattorneygeneral.gov..

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.

PRA Disclosure Statement: According to the paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland, 21244-1850.

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	$3,000
Specialist copayment	$10
Hospital (facility) coinsurance	50%
Other copayment	$5

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$3,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,960**

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

The plan's overall deductible	$3,000
Specialist copayment	$10
Hospital (facility) coinsurance	50%
Other copayment	$5

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	$3,000
Specialist copayment	$10
Hospital (facility) coinsurance	50%
Other copayment	$5

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,100
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,150**

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.

MEMORIAL HERMANN
Health Plan
Commercial Group Plans

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 لإلجابة عن أي أسئلة تتعلق بالصحة أو جدول ألدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى االتصال بنا على 1-558-546-8448. سيقوم شخص ما يتحدث العربية. مجانية هذه خدمة بمساعدتك.

Hindi: हमारे स्वास्य या दवा की योजना के बारे में आपके ककसी भी प्रश्न के जवाब के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपिब्ध है एक दुभाषिया प्राप्त करने के लिए, बस पर फोन 1-855-645-8448 पर फोन करें कोई व्यक्ति जो हिन्दी बोिता 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.

Português: 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。