

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 Benefits as described in the Evidence of Coverage or Certificate of Coverage are not available for any services, complications from services, treatment or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a Sickness, Injury, condition, disease, or bodily malfunction. MHCHP and MHHIC will not pay for charges incurred for or in connection with:

- The amount of any charge which is greater than the Allowed Charge, except as otherwise provided for in this Evidence or Certificate of Coverage.
- 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. This exclusion does not apply to the required coverage of whole blood and blood including the cost of blood, blood plasma, and blood plasma expanders.
- 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 or Certificate of Coverage ; complications of Cosmetic 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 Evidence or Certificate 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 or Certificate of Coverage.
- Experimental or Investigational treatments, procedures, Hospitalizations, Drugs, biological products, or medical devices, except as otherwise stated in this Evidence or Certificate of Coverage . Extraction of teeth, except as otherwise stated in this Evidence or Certificate of Coverage.
- Services or supplies for or in connection with:
 - o Except as otherwise stated in this Evidence or Certificate 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.
 - o Except as otherwise stated in this Evidence or Certificate 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
 - o 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 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 Drug Benefits" section of the Certificate of Coverage; and c) ovulation predictor kits. See also the separate exclusion addressing sterilization reversal.
- Except as stated in the Newborn hearing screening and hearing aids provisions, services or supplies related to hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them.
- 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 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 Evidence or Certificate of Coverage.
- Charges for missed appointments.
- Charges for nicotine dependence treatments and management Drugs unless otherwise stated in the "Preventive and Wellness Care" section of this Evidence or Certificate of Coverage .
- Any charge identified as a non-Covered Charge or which are specifically limited or excluded elsewhere in this Evidence or Certificate of Coverage, or which are not Medically Necessary and appropriate, except as otherwise stated in this Evidence or Certificate of Coverage.
- Non-Prescription Drugs or supplies, except
 - o insulin needles and syringes and glucose test strips and lancets.
 - o colostomy bags, belts, and irrigators; and
 - o as stated in this Evidence or Certificate 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 TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.
- The following Exclusions apply specifically to Outpatient coverage of Prescription Drugs:
 - o Charges to administer an orally administered Drug.
 - o Charges for Immunization agents related to travel or not approved by the ACIP.
 - o Charges for a Prescription Drug which is: labeled "Caution — limited by Federal Law to Investigational use"; or Experimental.
 - o Charges for refills in excess of that specified by the prescribing Practitioner, or refilled too soon, or in excess of therapeutic limits.
 - o Charges for refills dispensed after one year from the original date of the Prescription.
 - o Charges for controlled substances as a replacement for a previously dispensed controlled substance that was lost, misused, stolen, broken, or destroyed.
 - o Charges for Drugs, except insulin, which can be obtained legally without a practitioner's Prescription.
 - o Charges for a self-administered Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
 - an Inpatient 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
 - o Charges for:
 - therapeutic devices or appliances without a Preauthorization.
 - hypodermic needles or syringes, except insulin syringes; and
 - other non-medical substances, regardless of their intended use.
 - o Charges for over-the-counter vitamins and dietary supplements.
 - o Charges for any Drug used to treat baldness.
 - o Charges for Drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder.
 - o Covered Person taking part in the commission of a felony.
 - o Charges for Drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
 - o Charges for Drugs dispensed to a Covered Person while on active duty in any armed forces.
 - o 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.
 - o Charges for Drugs covered under the Home Health Care or Hospice Care subsections of the Evidence or Certificate 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 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.
 - o Compounded Drugs that are available as a similar commercially available Prescription Drug product.
 - o 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.
 - o Drugs used solely for the purpose for weight loss.
 - o Life enhancement Drugs for the treatment of sexual dysfunction, (e.g., Viagra).
 - o Prescription Drugs dispensed outside of the United States, except as required for Emergency treatment.

All HMO Products are underwritten by Memorial Hermann Commercial Health Plan, Inc. 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. Memorial Hermann Commercial Health Plan has determined that the prescription drug coverage offered by Select 6550 H.S.A. is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered non-creditable coverage. You will most likely get more help with your drug costs if you join a Medicare drug plan than if you only have prescription drug coverage from the large group plans listed above. 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 large 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). Copyright © 2024 Memorial Hermann. All rights reserved.



Large Group HMO 2025 Plan Overview

MEMORIAL
HERMANN
Health Plan
Commercial Group Plans

Large Group HMO Plans

from Memorial Hermann Health Plan

	Select 001 HMO	Select 002 HMO	Select 003 HMO	Select 500-80 HMO	Select 1000-60 HMO	Select 1000-80 HMO	Select 1000-100 HMO	Select 1500-80 HMO	Select 2000-80 HMO	Select 2000-100 HMO	Select 2500-80 HMO	Select 3000-80 HMO	Select 3000-100 HMO	Select 5000-80 HMO	Select 5000-100 HMO	Select 6600-100 Standard HMO	Select 3300-100 HSA HMO	Select 5000-100 HSA HMO	Select 6550-100 HSA HMO		
In-Network Deductible	\$0	\$3,000	\$6,000	\$500	\$1,000	\$1,000	\$1,000	\$1,500	\$2,000	\$2,000	\$2,500	\$3,000	\$3,000	\$5,000	\$5,000	\$6,600	\$3,300	\$5,000	\$6,550		
Family Deductible (for display only)	\$0	\$6,000	\$12,000	\$1,000	\$2,000	\$2,000	\$2,000	\$3,000	\$4,000	\$4,000	\$5,000	\$6,000	\$6,000	\$10,000	\$10,000	\$13,200	\$6,600	\$10,000	\$13,100		
Out-of-Pocket Maximum (individual)	\$6,600	\$6,850	\$7,000	\$3,500	\$3,500	\$4,000	\$4,000	\$5,000	\$5,000	\$3,500	\$5,500	\$5,500	\$5,500	\$6,350	\$6,350	\$6,600	\$4,500	\$6,350	\$6,550		
Out-of-Pocket Maximum (Family)	\$13,200	\$13,700	\$14,000	\$7,000	\$7,000	\$8,000	\$8,000	\$10,000	\$10,000	\$7,000	\$11,000	\$11,000	\$11,000	\$12,700	\$12,700	\$13,200	\$9,000	\$12,700	\$13,100		
Member Responsibility	0%	50%	50%	20%	40%	20%	0%	20%	20%	0%	20%	20%	0%	20%	0%	0%	0%	0%	0%		
PCP	\$30	\$5	\$5	\$25	\$15	\$25	\$25	\$25	\$30	\$30	\$30	\$30	\$30	\$35	\$35	\$35	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible		
Specialist	\$55	\$10	\$10	\$50	\$30	\$50	\$50	\$50	\$60	\$60	\$60	\$60	\$60	\$70	\$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	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	\$45	\$45	\$45		
Urgent Care	\$55	\$10	\$10	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible		
Emergency Room	\$400	50% Coinsurance After Deductible	50% Coinsurance After Deductible	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	\$400	No Charge After Deductible	\$400	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible	
Independent & Outpatient Lab/ Pathology	No Charge	50% Coinsurance After Deductible	50% Coinsurance After Deductible	\$25	\$25 Copay	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible		
Radiology/X-rays	No Charge	50% Coinsurance After Deductible	50% Coinsurance After Deductible	\$50	\$50 Copay	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	No Charge After Deductible	No Charge After Deductible	No Charge After Deductible		
MRI/Scans/Nuclear Medicine	\$250	50% Coinsurance After Deductible	50% Coinsurance After Deductible	20% Coinsurance After Deductible	40% Coinsurance After Deductible	20% Coinsurance After Deductible	No Charge After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible	No Charge After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible	No Charge After Deductible	20% Coinsurance After Deductible	No Charge After Deductible	\$150	No Charge After Deductible	No Charge After Deductible	No Charge 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	40% Coinsurance After Deductible	20% Coinsurance After Deductible	No Charge After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible	No Charge After Deductible	20% Coinsurance After Deductible	20% Coinsurance After Deductible	No Charge After Deductible	20% Coinsurance After Deductible	No Charge 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	\$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	\$15 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	\$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	\$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	\$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	\$4 Plan has no deductible	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 Deductible does not apply	\$4 After Deductible	\$4 After Deductible	No Charge After Deductible	
Retail Preferred Brand	\$45 Plan has no deductible	\$45 Deductible does not apply	\$45 Deductible does not apply	\$25 Deductible does not apply	\$25 Deductible does not apply	\$25 Deductible does not apply	\$25 Deductible does not apply	\$40 Deductible does not apply	\$40 Deductible does not apply	\$25 Deductible does not apply	\$40 Deductible does not apply	\$40 Deductible does not apply	\$40 Deductible does not apply	\$40 Deductible does not apply	\$40 Deductible does not apply	\$40 Deductible does not apply	\$40 Deductible does not apply	\$40 Deductible does not apply	\$25 After Deductible	\$25 After Deductible	No Charge After Deductible
Retail Non-Preferred Brand	\$75 Plan has no deductible	\$75 Deductible does not apply	\$75 Deductible does not apply	\$50 Deductible does not apply	\$50 Deductible does not apply	\$50 Deductible does not apply	\$50 Deductible does not apply	\$75 Deductible does not apply	\$75 Deductible does not apply	\$50 Deductible does not apply	\$75 Deductible does not apply	\$75 Deductible does not apply	\$75 Deductible does not apply	\$75 Deductible does not apply	\$75 Deductible does not apply	\$75 Deductible does not apply	\$75 Deductible does not apply	\$75 Deductible does not apply	\$50 After Deductible	\$50 After Deductible	No Charge After Deductible
Retail Specialty Rx	33% Coinsurance Plan has no deductible	33% Coinsurance After deductible	33% Coinsurance After deductible	33% Coinsurance Deductible does not apply	33% Coinsurance Deductible does not apply	33% Coinsurance Deductible does not apply	33% Coinsurance Deductible does not apply	33% Coinsurance Deductible does not apply	33% Coinsurance Deductible does not apply	33% Coinsurance Deductible does not apply	33% Coinsurance Deductible does not apply	33% Coinsurance Deductible does not apply	33% Coinsurance Deductible does not apply	33% Coinsurance Deductible does not apply	33% Coinsurance Deductible does not apply	33% Coinsurance Deductible does not apply	33% Coinsurance Deductible does not apply	33% Coinsurance After Deductible	33% Coinsurance After Deductible	No Charge After Deductible	