MEMORIAL HERMANN Health Plan
Commercial Group Plans

Schedule of Benefits

Notes:

- Copayments (Copay) – The specific dollar amount a Member must pay when specified Covered Services are rendered, as shown on the Schedule of Benefits. The Copayment may be collected directly from a Member by a Network Provider. The Copayment amount does not count toward the Deductible.
- The Evidence of Coverage does not provide coverage when you use an Out-of-Network Provider, except for an Emergency.
- Some Benefits may require Preauthorization. Please check your Evidence of Coverage for details.
- Please read the entire Evidence of Coverage for other Covered Services, Benefits, Exclusions, & Limitations.
- Benefits are applied per Calendar Year.
- This Evidence of Coverage does not cover Cosmetic Surgery, Dental Care (Pediatric & Adult), Long Term Care, Pediatric Vision or Non-Emergency care when traveling outside the United States.
- In-Network Benefits are paid based on the Negotiated Rate.
- The Emergency Room Service Copayment does not count toward satisfying the Deductible.

2025 Schedule of Benefits – Select 5000-100 HSA HMO	
Annual	**Participating Provider (In-Network)**
Individual Deductible:	$5,000
Family Deductible:	$10,000
Individual Out-of-Pocket Maximum:	$6,350
Family Out-of-Pocket Maximum:	$12,700
Coinsurance:	0%
Payment Order:	Copayment applies first (if applicable), then Deductible then Coinsurance (if applicable). These cost shares apply toward the Maximum Out-of-Pocket amount.

Schedule of Benefits				
Medical Event & Professional Services	**Services You May Need**	**Participating Provider (In-Network)**	**Non- Participating Provider (Out-of-Network)**	**Exclusions & Limitations**
Primary Care Office Visits *Also Applies to Walk-in Clinics	Primary (PCP) Care Visit to Treat an Illness or Injury	No Charge Deductible applies first	Not Covered	

Primary Care Office Visits *Also Applies to Walk-in Clinics	Specialist Visit	No Charge Deductible applies first	Not Covered	
	Other practitioner office visit (e.g., Nurse, Physician Assistant)	No Charge Deductible applies first	Not Covered	
	Preventive Care/Screening/ Immunizations	No Charge	Not Covered	For Children under the age of 6: Required immunizations are not subject to Copayment requirements for Participating Providers. 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 tests – Outpatient Lab and Professional Services	No Charge Deductible applies first	Not Covered	Preauthorization required for all genetic testing and complex imaging.
	Diagnostic tests – X-Rays and Diagnostic Imaging	No Charge Deductible applies first	Not Covered	
	Imaging (CT/PET Scans, MRIs)	No Charge Deductible applies first	Not Covered	
If you need immediate medical attention	Emergency Medical Transportation	No Charge Deductible applies first	No Charge Deductible applies first	
	Emergency Room Services	No Charge Deductible applies first	No Charge Deductible applies first	
	Urgent Care	No Charge Deductible applies first	No Charge Deductible applies first	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge Deductible applies first	Not Covered	Preauthorization required.
	Physician/surgeon fees	No Charge Deductible applies first	Not Covered	Cost included in Inpatient stay.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital – No Charge Deductible applies first Freestanding Clinic - No Charge Deductible applies first.	Not Covered	Preauthorization required.
	Physician/surgeon fees	Included in Outpatient facility stay.	Not Covered	
If you have mental health, behavioral health, or substance abuse services	Professional Office Visits	No Charge Deductible applies first	Not Covered	Preauthorization required for MH/SA intensive (extended) or residential services, Applied Behavioral Analysis (ABA) therapy and non-behavioral health providers neuropsychiatric testing.
	Outpatient Services	No Charge Deductible applies first	Not Covered	
	Inpatient Services	No Charge Deductible applies first	Not Covered	Preauthorization required.
If you are pregnant	Office Visits	No Charge Deductible applies first	Not Covered	Preauthorization required only for the period outside the 48/96-hour timeframe listed in the Evidence of Coverage. Childbirth/delivery professional services: Cost included in Inpatient stay.
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge Deductible applies first	Not Covered	
Oral Contraceptives and Contraceptive services and devices	All FDA approved devices - Educational services & counseling	No Charge	Not Covered	Not subject to Copayment for Generic or Brand Name Formulary Drugs, if Generic Drug not available.
If you need help recovering or have special health needs	Home Health Care	No Charge Deductible applies first	Not Covered	Limited to 60 visits per year. Preauthorization required.

If you need help recovering or have special health needs	Skilled Nursing Care	No Charge Deductible applies first	Not Covered	Limited to 25 days per year. Preauthorization required.
	Prosthetic & Orthotic Devices (Appliances)	No Charge Deductible applies first	Not Covered	Medically necessary prosthetic devices and orthotic devices are not subject to calendar year maximum. Preauthorization required.
	Durable Medical Equipment	No Charge Deductible applies first	Not Covered	Preauthorization required for items exceeding $500.
	Hospice Services	No Charge Deductible applies first	Not Covered	Preauthorization required.
Rehabilitative & Habilitative Services and Devices	Hearing Aids & Cochlear Implants	No Charge Deductible applies first	Not Covered	Hearing Aids & Cochlear Implants limited to 1 pair OR one implant every 36 months. Preauthorization required.
	Outpatient Rehabilitation Services	No Charge Deductible applies first	Not Covered	PT/OT/ST – Limited to 60 combined visits per plan 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.
	Outpatient Habilitation Services	No Charge Deductible applies first	Not Covered	
	Physical Therapy & Occupational Therapy & Speech Therapy	No Charge Deductible applies first	Not Covered	
	Chiropractic Care (Manipulative Therapy)	No Charge Deductible applies first	Not Covered	Limited to 10 visits per plan year.
	Speech & Hearing Exams	No Charge Deductible applies first	Not Covered	
	Acupuncture	No Charge Deductible applies first	Not Covered	Limited to 20 visits per plan year; 1 visit per day.

Other Professional Services	Radiation & Chemotherapy	No Charge Deductible applies first	Not Covered	
	Transplant	No Charge Deductible applies first	Not Covered	Preauthorization required.
	Routine Foot Care	No Charge Deductible applies first	Not Covered	
	Infusion Therapy	No Charge Deductible applies first	Not Covered	
	Allergy Testing	No Charge Deductible applies first	Not Covered	
	Dialysis	No Charge Deductible applies first	Not Covered	
	Telehealth or Telemedicine Services	$45 Copay Deductible does not apply	Not Covered	Copayment, and percentage Copayment amounts will not exceed amount for comparable medical services provided through a face-to- face consultation.

Pharmacy Schedule of Benefits				
		Participating Provider (In- Network)	**Non-Participating Provider (Out-of- Network)**	**Exclusions & Limitations**
30 Day Retail Pharmacy Service	Generic Drugs	$4 Copay Deductible applies first.	Not Covered	Cost-sharing for insulin on the formulary will not exceed $25 per prescription for a 30-day supply.
	Preferred Brand Drugs	$25 Copay Deductible applies first.	Not Covered	
	Non-Preferred Brands / Drugs	$50 Copay Deductible applies first.	Not Covered	
	Specialty Drugs	33% Coinsurance Deductible applies first.	Not Covered	Prior Authorization required for some Specialty Drugs Specialty Drugs are subject to Utilization Review.
90-Day Mail Order Service	Generic Drugs	$8 Copay Deductible applies first.	Not Covered	Some prescription drugs and/or medications are not available through the Mail Order Service.
	Preferred Brand Drugs	$50 Copay Deductible applies first	Not Covered	
	Non-Preferred Brands / Drugs	$100 Copay Deductible applies first	Not Covered	
	Specialty Drugs	Not Covered	Not Covered	