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 towards the Deductible.
- If an Out-of-Network Provider charges more than the Allowed Amount, You may have to pay the difference.
- Some Benefits may require Preauthorization. Please check your Certificate of Coverage for details.
- Please read the entire Certificate of Coverage for other Covered Services, Benefits, Exclusions & Limitations. Inpatient private duty nursing care is covered, but only when Medically Necessary.
- Benefits are applied per Calendar Year.
- This Certificate of Coverage does not cover Cosmetic Surgery, Dental Care, Long Term Care, or Non-Emergency care when traveling outside the United States.
- In-Network Benefits are paid based on the Negotiated Rate; Out-of-Network Benefits are paid based on maximum Allowable Amounts.
- The Emergency Room service Copayment does not count toward satisfying the Deductible.

2025 Schedule of Benefits - Select 6600-100 Standard PPO		
Annual	**Participating Provider (In-Network)**	**Non-Participating Provider (Out-of-Network)**
Individual Deductible:	$6,600	$13,200
Family Deductible:	$13,200	$26,400
Individual Out-of-Pocket Maximum:	$6,600	$13,200
Family Out-of-Pocket Maximum:	$13,200	$26,400
Coinsurance:	0%	50%
Payment Order:	Copayment applies first, 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	$35 Copay Deductible does not apply	50% Coinsurance Deductible applies first.	
	Specialist Visit	$70 Copay Deductible does not apply	50% Coinsurance Deductible applies first.	
	Other practitioner office visit (e.g., Nurse, Physician Assistant)	$35 Copay Deductible does not apply	50% Coinsurance Deductible applies first.	

Primary Care Office Visits *Also Applies to Walk-in Clinics	Preventive Care/ Screening/Immunizations	No Charge	50% Coinsurance Deductible applies first.	For Children under the age of 6: Required immunizations are not subject to Deductible, Copayment, or Coinsurance requirements for Participating or Non-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	$25 Copay Deductible does not apply	50% Coinsurance Deductible applies first.	Preauthorization required for all Genetic Testing and Complex Imaging.
	Diagnostic tests - X-Rays and Diagnostic Imaging	$50 Copay Deductible does not apply	50% Coinsurance Deductible applies first.	
	Imaging (CT/PET scans, MRIs)	$150 Copay Deductible does not apply	50% Coinsurance Deductible applies first.	
If you need immediate medical attention	Emergency Medical Transportation	No Charge Deductible applies first	No Copay Deductible applies first	
	Emergency Room Services	$400 Copay per visit Deductible does not apply	$400 Copay per visit Deductible does not apply	Copayment waived if admitted.
	Urgent Care	$50 Copay Deductible does not apply	$100 Copay Deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	Preauthorization required.
	Physician/surgeon fees	No Charge Deductible does not apply	50% Coinsurance Deductible applies first.	In-network: Cost included in Inpatient stay.
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	Hospital – No Copay Deductible applies first Freestanding Clinic - $300 Copay Deductible does not apply.	50% Coinsurance Deductible applies first.	Preauthorization required.
	Physician/surgeon fees	Included in Outpatient facility stay.	50% Coinsurance Deductible applies first.	In-network: Cost included in Outpatient facility stay.

If you have mental health, behavioral health, or substance abuse services	Professional Office Visits	$35 Copay Deductible does not apply	50% Coinsurance Deductible applies first.	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 does not apply	50% Coinsurance Deductible applies first.	
	Inpatient Services	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	Preauthorization required.
If you are pregnant	Office Visits	$35 Copay Deductible does not apply	50% Coinsurance Deductible applies first.	Preauthorization required for the period outside the 48/96-hour timeframe listed in the Certificate of Coverage. Childbirth/delivery professional services: Cost included in Inpatient stay.
	Childbirth/delivery professional services	No Charge	50% Coinsurance Deductible applies first.	
	Childbirth/delivery facility services	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	Preauthorization required.
Oral Contraceptives and Contraceptive services and devices	All FDA approved devices – Educational services & counseling	No Charge	50% Coinsurance Deductible applies first.	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	50% Coinsurance Deductible applies first.	Limited to 60 visits per year, and 1 visit per day. Preauthorization required.
	Skilled Nursing Care	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	Limited to 25 days per year. Preauthorization required.
	Prosthetic & Orthotic devices (Appliances)	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	Medically necessary prosthetic devices and orthotic devices are not subject to calendar year maximum. Preauthorization required.
	Durable Medical Equipment	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	Preauthorization required for items exceeding $500.
	Hospice Services	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	Preauthorization required.

Rehabilitative & Habilitative Services and Devices	Hearing Aids & Cochlear Implants	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	Hearing Aids & Cochlear implants limited to 1 pair OR one implant every 36 months. Preauthorization required.
	Outpatient Rehabilitation Services	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	PT/OT/ST – Limited to 60 combined visits for Rehabilitation Services and 60 combined visits for Habilitation Services across physical medical services 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	50% Coinsurance Deductible applies first.	
	Physical Therapy & Occupational Therapy & Speech Therapy	$35 Copay Deductible does not apply	50% Coinsurance Deductible applies first.	
	Chiropractic Care (Manipulative Therapy)	$35 Copay Deductible does not apply	50% Coinsurance Deductible applies first.	Limited to 10 visits per plan year.
	Speech & Hearing Exams	$35 Copay Deductible does not apply	50% Coinsurance Deductible applies first.	
	Acupuncture	$35 Copay Deductible does not apply	50% Coinsurance Deductible applies first.	Limited to 20 visits per plan year; 1 visit per day.
Other Professional Services	Radiation & Chemotherapy	$25 Copay per visit Deductible does not apply	50% Coinsurance Deductible applies first.	
	Transplant	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	Preauthorization required.
	Routine Foot Care	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	

Other Professional Services	Infusion Therapy	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	
	Allergy Testing	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	
	Dialysis	No Charge Deductible applies first	50% Coinsurance Deductible applies first.	
	Telehealth or Telemedicine Services	No Charge	50% Coinsurance Deductible applies first.	Copayment, Coinsurance, and Deductible 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 does not apply.	50% Coinsurance Deductible applies first.	Cost-sharing for insulin on the formulary will not exceed $25 per prescription for a 30-day supply.
	Preferred Brand Drugs	$40 Copay Deductible does not apply.	50% Coinsurance Deductible applies first.	
	Non-Preferred Brands / Drugs	$75 Copay Deductible does not apply.	50% Coinsurance Deductible applies first.	
	Specialty Drugs	33% Coinsurance Deductible does not apply.	50% Coinsurance Deductible applies first.	Prior Authorization required for some Specialty Drugs. Specialty Drugs are subject to Utilization Review.
90-Day Mail Order Service	Generic Drugs	$8 Copay Deductible does not apply.	Not Covered	Some prescription drugs and/or medications are not available through the Mail Order Service.
	Preferred Brand Drugs	$80 Copay Deductible does not apply.	Not Covered	
	Non-Preferred Brands / Drugs	$150 Copay Deductible does not apply.	Not Covered	
	Specialty Drugs	Not Covered	Not Covered	