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/for-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 - $1,500 person / $3,000 family. Out-of-network Providers - None.	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 - $4,500 person / $9,000 family. Out-of-network Providers – None.	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+HMO 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	$25 copay/visit. Deductible does not apply.	Not covered.	None.
	Specialist visit	$50 copay/visit. Deductible does not apply.	Not covered.	None.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered.	For children under the age of 6: required immunizations are not subject to copay requirements for network 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 test (blood work, x-ray)	Blood work - 25% coinsurance. X-ray - 25% coinsurance/ visit. Deductible applies first.	Not covered.	Professional/interpretation service is included in diagnostic blood work and x-ray cost shares. Preauthorization required for all genetic testing and complex imaging.
	Imaging (CT/PET scans, MRIs)	25% coinsurance. Deductible applies first.	Not covered.	
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,	Generic Drugs	Retail: $4 copay/ prescription. Mail order: $8 copay/ prescription;. Deductible does not apply.	Not covered.	Retail covers 30-day supply and mail order covers up to 90-day supply unless stated by the formulary or plan benefits. Network provider prescription drug copayment applies 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. Some prescription drugs and/or medications are not available through mail order.
	Preferred Brand Drugs	Retail: $25 copay/ prescription. Mail order: $50 copay/ prescription; Deductible does not apply.	Not covered.	
	Non-Preferred Brands / Drugs	Retail: $55 copay/ prescription. Mail order: $110 copay/ prescription. Deductible does not apply.	Not covered.	

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)	
or by calling 1-833-502-3346.	Specialty Drugs	33% coinsurance. Deductible applies first.	Not covered.	30-day supply only; 90-day mail order not covered. Some Specialty drugs are subject to utilization review or preauthorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance. Deductible applies first.	Not covered.	Preauthorization required.
	Physician/surgeon fees	25% coinsurance. Deductible applies first.	Not covered.	Preauthorization required.
If you need immediate medical attention	Emergency room care	$500 copay/visit. Deductible does not apply.	$500 copay/visit. Deductible does not apply.	Copayment waived if admitted.
	Emergency medical transportation	25% coinsurance. Deductible applies first.	25% coinsurance. Deductible applies first.	None.
	Urgent care	$50 copay/visit. Deductible does not apply.	$50 copay/visit. Deductible does not apply.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance. Deductible applies first.	Not covered.	Preauthorization required.
	Physician/surgeon fees	25% coinsurance. Deductible applies first.	Not covered.	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Professional office visits - $25 copay/visit. Deductible does not apply. Outpatient services - 25% coinsurance. Deductible applies first.	Not covered.	Preauthorization required for MH/SA intensive (extended) or residential services and Applied Behavioral Analysis (ABA) therapy.
	Inpatient services	25% coinsurance. Deductible applies first.	Not covered.	Preauthorization required.

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 are pregnant	Office visits	25% coinsurance. Deductible applies first.	Not covered.	Preauthorization required for the period outside the 48/96-hour timeframe listed in the Evidence of Coverage (EOC). 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	25% coinsurance. Deductible applies first.	Not covered.	
	Childbirth/delivery facility services	25% coinsurance. Deductible applies first.	Not covered.	
If you need help recovering or have other special health needs	Home health care	25% coinsurance. Deductible applies first.	Not covered.	Limited to 60 visits/year. Preauthorization required.
	Rehabilitation services	Professional office visits: Speech & hearing exams - $25 copay/visit. Deductible does not apply. PT/OT/ST/chiro – 25% coinsurance. Deductible applies first. Outpatient services - 25% coinsurance. Deductible applies first.	Not covered.	Physical therapy (PT)/occupational therapy (OT)/speech therapy (ST) and chiropractic: Limited to 35 combined visits for rehabilitation services and 35 combined visits for habilitation services across physical medical services per plan year. Plan limitations do not apply to medically necessary services or services related to autism spectrum disorder. Cardio/pulmonary rehabilitation limited to 36 visits for cardiac rehabilitation and 36 visits for pulmonary rehabilitation per plan year. Preauthorization required for inpatient & ABA in cognitive therapy.
	Habilitation services	Professional office visits: Speech & hearing exams - $25 copay/visit. Deductible does not apply. PT/OT/ST/chiro – 25% coinsurance. Deductible applies first. Outpatient services - 25% coinsurance. Deductible applies first.	Not covered.	

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 help recovering or have other special health needs	Skilled nursing care	25% coinsurance. Deductible applies first.	Not covered.	Limited to 25 days/year. Preauthorization required.
	Durable medical equipment	25% coinsurance. Deductible applies first.	Not covered.	Limited to plan requirements. Preauthorization required for items exceeding $500.
	Hospice services	25% coinsurance. Deductible applies first.	Not covered.	Preauthorization required.
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.)

- Acupuncture
- Dental care (Adult)
- 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.)

- Bariatric surgery (preauthorization required)
- Chiropractic care (35 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 MHHSI Customer Service at 855-645-8448 or http://healthplan.memorialhermann.org, or the Department of Labor's 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. 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 on how 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 Solutions Customer Service at 855-645-8448 or http://healthplan.memorialhermann.org.

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.

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*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

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	$1500
Specialist copayment	$50
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$1,500
Copayments	$10
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,370**

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

The plan's overall deductible	$1500
Specialist copayment	$50
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

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

The plan's overall deductible	$1500
Specialist copayment	$50
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$1,500
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Notice of Availability

English
ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-645-8448 (TTY: 711) or speak to your provider.

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-645-8448 (TTY: 711) o hable con su proveedor.

Việt (Vietnamese)
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-645-8448 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

台語 (Traditional Chinese)
注意：如果您說台語，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-855-645-8448（TTY：711）或與您的提供者討論。

中文 (Simplified Chinese)
注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-855-645-8448（文本电话：711）或咨询您的服务提供商。

العربية (Arabic)
تنبيه :إذا كنت تتحدث العربية، ستتوفر لك خدمات المساعدة اللغوية المجانية .تتوفر أيضًا صيغ معلومات قابلة للوصول مجانًا .اتصل بالرقم 1-855-645-8448 (711) أو تحدث إلى مزود الخدمة الخاص بك.

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-645-8448 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Français (French)
ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-645-8448 (TTY : 711) ou parlez à votre fournisseur. »

فارسي (Persian, Farsi)
شما می‌توانید به خدمات رایگان حمایت زبانی دسترسی داشته باشید .علاوه بر این، خدمات مناسب و پشتیبانی برای ارائه اطلاعات در قالب‌های قابل دسترسی به صورت رایگان در دسترس است .لطفاً با شماره 1-855-645-8448 (TTY: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

Tagalog
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-645-8448 (TTY: 711) o makipag-usap sa iyong provider.

اردو (Urdu)
توجہ :اگر آپ اردو بولتے ہیں تو آپ کے لئے مفت زبان کی معاونت خدمات دستیاب ہیں۔ معلومات کو قابل رسائی فارمیٹس میں فراہم کرنے کے لئے مناسب معاونت اور خدمات بھی مفت میں دستیاب ہیں۔ کال کریں 1-855-645-8448 (TTY: 711) یا اپنے فراہم کنندہ سے بات کریں۔

తెలుగు (Telugu)
సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-855-645-8448 (TTY: 711)కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

বাংলা (Bengali)
মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-855-645-8448 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।"

ગુજરાતી (Gujarati)
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-645-8448 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો."

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-645-8448 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

РУССКИЙ (Russian)
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-645-8448 (TTY: 711) или обратитесь к своему поставщику услуг.

한국어 (Korean)
주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-855-645-8448 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

ລາວ (Laotian, Laos)
ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-855-645-8448 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ."