



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 <a href="#">deductible</a> ?	<a href="#">Participating Providers</a> - \$6,550 person / \$13,100 family. <a href="#">Non-Participating Providers</a> - \$13,100 person / \$26,200 family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> . Does not apply to penalties, Generic, Preferred brand or Non-Preferred brand <a href="#">prescription drugs</a> .	This plan covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive</a> services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive</a> services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Participating Providers</a> – \$6,550 person / \$13,100 family. <a href="#">Non-Participating Providers</a> – \$13,100 person / \$26,200 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">prior authorization</a> for services and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://healthplan.memorialhermann.org/brokers/find-a/?searchfor=doctors">http://healthplan.memorialhermann.org/brokers/find-a/?searchfor=doctors</a> or call 855-645-8448 for a list of Participating Providers.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	None.
	<a href="#">Preventive care/screening</a> /immunizations	No Charge. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab - No Charge. X-ray - No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required for Genetic Testing and all Imaging that exceeds \$1,000; Non-compliance may result in a penalty.
	Imaging (CT/PET scans, MRIs)	No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://healthplan.memorialhermann.org/members/resource-center/pharmacy-benefit-information/">http://healthplan.memorialhermann.org/members/resource-center/pharmacy-benefit-information/</a> Or by calling 1-877-633-4461	Generic drugs	Preferred: No Charge <a href="#">copay/prescription</a> ; Non-Preferred: No Charge <a href="#">copay/prescription</a> ; Mail Order: No Charge <a href="#">copay/prescription</a> . <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a> / <a href="#">prescription</a> - (30 day Retail), 90 day Mail Order - Not covered.	Preferred Participating <a href="#">Providers</a> /Pharmacies: Lower cost applies.  Retail covers 30-day supply and mail order covers 90-day supply.
	Preferred brand drugs	Preferred: No Charge <a href="#">copay/prescription</a> ; Non-Preferred: No Charge <a href="#">copay/prescription</a> ; Mail Order: No Charge <a href="#">copay/prescription</a> . <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a> / <a href="#">prescription</a> - (30 day Retail), 90 day Mail Order - Not covered.	<a href="#">Participating Provider prescription drug copayment/coinsurance</a> apply to the <a href="#">Maximum Out-of-Pocket limit</a> .  Member responsible for paying applicable <a href="#">copay</a> , allowable <a href="#">claim</a> amount, or the contracted rate of the <a href="#">prescription</a> if less than the established <a href="#">copay</a> . <a href="#">Prior Authorization</a> required for some Drugs.
	Non-preferred brand drugs	Preferred: No Charge	50% <a href="#">coinsurance</a>	Non-compliance may result in a penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
		<a href="#">copay/prescription</a> ; Non-Preferred: No Charge <a href="#">copay/prescription</a> ; Mail Order: No Charge <a href="#">copay/ prescription</a> . <a href="#">Deductible</a> applies first.	<a href="#">/prescription</a> - (30 day Retail), 90 day Mail Order - Not covered.	
	<a href="#">Specialty drugs</a>	No Charge <a href="#">copay/prescription</a> (30-day Retail), 90-day Mail Order - Not Covered. <a href="#">Deductible</a> applies first.	45% <a href="#">coinsurance</a> <a href="#">/prescription</a> (30-day Retail), 90 day Mail Order - Not covered.	30-day supply only; \$300 maximum per Specialty Drug per prescription per member; 90-day Mail Order not covered. Annual <a href="#">Participating Provider Deductible</a> applies to <b>ALL</b> <a href="#">Specialty drugs</a> . <a href="#">Prior Authorization</a> required for some <a href="#">Specialty drugs</a> . Non-compliance may result in a penalty.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	<a href="#">Prior Authorization</a> required. Non-compliance may result in a penalty.
	Physician/surgeon fees	No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	<a href="#">Prior Authorization</a> required. Non-compliance may result in a penalty.
If you need immediate medical attention	<a href="#">Emergency room care</a>	No Charge/visit. <a href="#">Deductible</a> applies first.	No Charge/visit. <a href="#">Deductible</a> applies first.	None.
	<a href="#">Emergency medical transportation</a>	No Charge/trip. <a href="#">Deductible</a> applies first.	No Charge/trip. <a href="#">Deductible</a> applies first.	None.
	<a href="#">Urgent care</a>	No Charge. <a href="#">Deductible</a> applies first.	No Charge. <a href="#">Deductible</a> applies first.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	<a href="#">Prior Authorization</a> required. Non-compliance may result in a penalty.
	Physician/surgeon fees	No Charge.	50% <a href="#">coinsurance</a>	Cost Included in Inpatient Stay.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Professional Office Visits - No Charge. <a href="#">Deductible</a> applies first. Other Outpatient Services - No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	<a href="#">Prior Authorization</a> required for MH/SA 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	No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	<a href="#">Prior Authorization</a> required. Non-compliance may result in a penalty.
<b>If you are pregnant</b>	Office visits	No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	<a href="#">Prior Authorization</a> 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	No Charge.	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	Childbirth/delivery professional services: Cost included in Inpatient Stay.  <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No Charge/visit. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	Limited to 60 visits/year. <a href="#">Prior Authorization</a> required. Non-compliance may result in a penalty.
	<a href="#">Rehabilitation services</a>	Professional Office Visits: Speech & Hearing Exams - No Charge. <a href="#">Deductible</a> applies first. PT/OT/ST - No Charge. <a href="#">Deductible</a> applies first. Outpatient Services - No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	Physical Therapy/Occupational Therapy/Speech Therapy: Limited to 60 combined visits/year; and 1 visit per day. Plan limitations do not apply to services related to Autism Spectrum Disorder. <a href="#">Prior Authorization</a> required for Inpatient & ABA in Cognitive Therapy. Non-compliance may result in a penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	<a href="#">Habilitation services</a>	Professional Office Visits: Speech & Hearing Exams - No Charge. <a href="#">Deductible</a> applies first. PT/OT/ST - No Charge. <a href="#">Deductible</a> applies first. Outpatient Services - No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	Limited to 25 days/year. <a href="#">Prior Authorization</a> required. Non-compliance may result in a penalty.
	<a href="#">Durable medical equipment</a>	No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	Limited to <a href="#">Plan</a> Requirements. <a href="#">Prior Authorization</a> required. Non-compliance may result in a penalty.
	<a href="#">Hospice services</a>	No Charge. <a href="#">Deductible</a> applies first.	50% <a href="#">coinsurance</a>	<a href="#">Prior Authorization</a> 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 (Prior Authorization 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, 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, 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](http://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>.

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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](#).

### Language Access Services:

—————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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,550
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$0

#### 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$6,550
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,610</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,550
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$0

#### 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$6,550
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$6,610</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,550
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$0

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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.

# Multi-Language Insert

## Multi-Language Interpreter Services

<p><b>Spanish</b></p> <p>ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.855.645.8448 (TTY 711).</p>	<p><b>Vietnamese</b></p> <p>CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.855.645.8448 (TTY 711).</p>
<p><b>Arabic</b></p> <p>ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 8448.546.558.1 (رقم هاتف الصم والبكم: 117).</p>	<p><b>Japanese</b></p> <p>注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1. 855. 645. 8448 (TTY 711) まで、お電話にてご連絡ください。</p>
<p><b>Cantonese Chinese</b></p> <p>注意：如果您說廣東話，您可以免費獲得語言援助服務。請致電 1.855.645.8448 (TTY 711)。</p>	<p><b>Korean</b></p> <p>주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.855.645.8448 (TTY 711) 번으로 전화해 주십시오.</p>
<p><b>Mandarin Chinese</b></p> <p>注意：如果您说普通话，您可以免费获得语言援助服务。请致电 1.855.645.8448 (TTY 711)。</p>	<p><b>Laotian</b></p> <p>ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.855.645.8448 (TTY 711).</p>
<p><b>French</b></p> <p>ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.855.645.8448 (ATS 711).</p>	<p><b>Farsi</b></p> <p>توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرد 1.855.645.8448 (TTY 711)</p>
<p><b>German</b></p> <p>ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.855.645.8448 (TTY 711).</p>	<p><b>Russian</b></p> <p>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.855.645.8448 (телетайп 711).</p>
<p><b>Gujarati</b></p> <p>સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.855.645.8448 (TTY 711).</p>	<p><b>Tagalog</b></p> <p>PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.855.645.8448 (TTY: 711).</p>
<p><b>Hindi</b></p> <p>ध्यान दें: यदि आप हृदि बोलते हैं तो आपके लिए सुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.855.645.8448 (TTY 711) पर कॉल करें।</p>	<p><b>Urdu</b></p> <p>خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1.855.645.8448 (TTY 711).</p>

<p><b>ATTENTION:</b> Texas Relay Services are available for the hearing impaired at (711).</p>	<p>Resources are available for the visually impaired, please call 1.855.645.8448 (711).</p>
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MHHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (855) 645-8448.

Customer Service Hours of Operations: 8am-5pm (CST) M-F

If you believe that MHHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator  
Memorial Hermann Health Plan  
929 Gessner Road, Suite 1500  
Houston, TX 77024

Fax 713-338-6487

Email [MHHealthAppeals@memorialhermann.org](mailto:MHHealthAppeals@memorialhermann.org)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, (1-800-537-7697 TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.