



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:
<p>What is the overall deductible?</p>	<p>Network Providers - \$0 person / \$0 family. Out-of-network Providers - None.</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care services are covered before you meet your deductible. Does not apply to Generic, Preferred brand or Non-Preferred brand prescription drugs.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Network Providers - \$6,500 person / \$14,300 family. Out-of-network Providers – None.</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, penalties for failure to obtain Preauthorization for services and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See https://healthplan.memorialhermann.org/find-a-doctor?network=Select+HMO or call 855-645-8448 for a list of Network Providers.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>



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	\$50 copay /visit.	Not covered	None.
	Specialist visit	\$100 copay /visit.	Not covered	None.
	Preventive care/screening/immunization	No Charge.	Not covered	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 (x-ray, blood work)	Lab - \$50 copay /visit. X-ray - \$100 copay /visit.	Not covered	Preauthorization required for all Genetic Testing and Complex Imaging. Non-compliance may result in a penalty.
	Imaging (CT/PET scans, MRIs)	\$500 copay /visit.	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 , or by calling 1-866-333-2757.	Tier 1 (Low cost, high value Generics and select Brands)	Retail Preferred: \$2 copay/ prescription ; Retail Non-Preferred: \$8 copay/ prescription Mail Order: \$4 copay/ prescription .	Not covered	Preferred Network Providers /Pharmacies: Lower cost applies. Retail covers 30-day supply and mail order covers 90-daysupply. Network Provider prescription drug copayment/ coinsurance apply 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 . Non-compliance may result in a penalty.
	Tier 2 (Preferred Brands and select Generics)	Retail Preferred: \$40 copay/ prescription ; Retail Non-Preferred: \$50 copay/ prescription Mail Order: \$80 copay/ prescription	Not covered	
	Tier 3 (Non-Preferred Brands and Generics)	Retail Preferred: \$90 copay/ prescription ; Retail Non-Preferred: \$100 copay/ prescription Mail Order: \$180 copay/ prescription	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)	
	Tier 4 (Specialty drugs)	33% coinsurance / prescription	Not covered	30-day supply only. Annual Network Provider Deductible applies to all Specialty drugs . Preauthorization required for some Specialty drugs . Specialty drugs are subject to utilization review.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$400 copay /visit	Not covered	Preauthorization required. Non-compliance may result in a penalty.
	Physician/surgeon fees	No Charge.	Not covered	Preauthorization required. Non-compliance may result in a penalty.
If you need immediate medical attention	Emergency room care	\$750 copay /visit	\$750 copay /visit	Copayment waived if admitted.
	Emergency medical transportation	\$350 copay /trip	\$350 copay /trip	None.
	Urgent care	\$100 copay /visit	\$100 copay /visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 copay /day for the first 3 days of admission.	Not covered	Preauthorization required. Non-compliance may result in a penalty.
	Physician/surgeon fees	No Charge.	Not covered	Cost included in Inpatient stay.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Professional Office Visits - \$50 copay /visit. Outpatient services - \$400 copay /visit.	Not covered	Preauthorization 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	\$750 copay /day for the first 3 days of admission	Not covered	Preauthorization required. Non-compliance may result in a penalty.
If you are pregnant	Office visits	No Charge.	Not covered	Preauthorization required for the period outside the 48/96-hour time frame listed in the Evidence of Coverage (EOC). Non-compliance may result in a penalty.

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)	
	Childbirth/delivery professional services	No Charge.	Not covered	Childbirth/delivery professional services: Cost included in Inpatient stay. 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 facility services	\$400 copay /day for the first 3 days of admission	Not covered	
If you need help recovering or have other special health needs	Home health care	\$80 copay /visit	Not covered	Limited to 60 visits/year. Preauthorization required. Non-compliance may result in a penalty.
	Rehabilitation services	Professional Office Visits: Speech & Hearing Exams - \$80 copay / visit. PT/OT/ST –\$100 copay / visit. Outpatient services – No charge	Not covered	Preauthorization required for Inpatient & ABA in Cognitive Therapy. Non-compliance may result in a penalty.
	Habilitation services	Professional Office Visits: Speech & Hearing Exams - \$80 copay / visit. PT/OT/ST –\$100 copay / visit. Outpatient services – No charge	Not covered	
	Skilled nursing care	\$750 copay /day for the first 3 days of admission	Not covered	Limited to 25 days/year. Preauthorization required. Non-compliance may result in a penalty.
	Durable medical equipment	25% coinsurance /visit.	Not covered	Limited to plan requirements. Preauthorization required. Non-compliance may result in a penalty.
	Hospice services	No Charge.	Not covered	Preauthorization required. Non-compliance may result in a penalty.

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 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](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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](#) \$0
- [Specialist copayment](#) \$100
- Hospital (facility) [copayment](#) \$750
- Other [copayment](#) \$100

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	\$0
Copayments	\$1,900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,960

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$100
- Hospital (facility) [copayment](#) \$750
- Other [copayment](#) \$100

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	\$0
Copayments	\$2,100
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,320

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$100
- Hospital (facility) [copayment](#) \$750
- Other [copayment](#) \$100

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	\$0
Copayments	\$2,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Mia would pay is	\$2,060

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

