The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, <a href="http://healthplan.memorialhermann.org/">http://healthplan.memorialhermann.org/</a>
for-brokers/resource-center or call 855-645-8448. For general definitions of common terms, such as <a href="mailto:allowed-amount">allowed amount</a>, <a href="mailto:blance-billing">blance</a> <a href="mailto:billing">billing</a>, <a href="mailto:coinsurance">coinsurance</a>, <a href="mailto:coinsurance">copayment</a>, <a href="mailto:deductible">deductible</a>, <a href="mailto:provider">provider</a>, or other <a href="mailto:underlined">underlined</a> terms, see the Glossary. You can view the Glossary at <a href="https://www.healthcare.gov/sbc-glossary/">https://www.healthcare.gov/sbc-glossary/</a> or call 855-645-8448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers - \$0 person / \$0 family. Out-of-network Providers - None.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> . Does not apply to Generic, Preferred brand or Non-Preferred brand <u>prescription drugs</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Network Providers - \$6,500 person / \$14,300 family. Out-of-network Providers - None.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> 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 <u>network provider</u> ?	Yes. See <a href="https://healthplan.memorialhermann.org/find-a-doctor?network=Select+HMO">https://healthplan.memorialhermann.org/find-a-doctor?network=Select+HMO</a> or call 855-645-8448 for a list of <a href="https://www.Network.providers">Network Providers</a> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.



All  $\underline{\textbf{copayment}}$  and  $\underline{\textbf{coinsurance}}$  costs shown in this chart are after your  $\underline{\textbf{deductible}}$  has been met, if a  $\underline{\textbf{deductible}}$  applies.

		What You \	Will Pay	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a	Primary care visit to treat an injury or illness	\$50 <u>copay</u> /visit.	Not covered	None.
health care	Specialist visit	\$100 <u>copay</u> /visit.	Not covered	None.
provider's office or clinic	Preventive care/screening/ immunization	No Charge.	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a	<u>Diagnostic test</u> (x-ray, blood work)	Lab - \$50 <u>copay</u> /visit. X-ray - \$100 <u>copay</u> /visit.	Not covered	Preauthorization required for all Genetic Testing and Complex
test	Imaging (CT/PET scans, MRIs)	\$500 <u>copay</u> /visit.	Not covered	Imaging. Non-compliance may result in a penalty.
If you need drugs to treat your illness or condition  More information	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
about prescription drug coverage is available at https://healthpl an.memorialh	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	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.
ermann.org/M embers/Phar macy-Benefit- Information, or by calling 1- 866-333-2757.	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	Preauthorization required for some drugs. Non-compliance may result in a penalty.

	What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	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	Facility fee (e.g., ambulatory surgery center)	\$400 copay/visit	Not covered	Preauthorization required. Non-compliance may result in a penalty.
outpatient surgery	Physician/surgeon fees	No Charge.	Not covered	Preauthorization required. Non-compliance may result in a penalty.
	Emergency room care	\$750 <u>copay</u> /visit	\$750 <u>copay</u> /visit	Copayment waived if admitted.
If you need immediate medical	Emergency medical transportation	\$350 <u>copay</u> /trip	\$350 <u>copay</u> /trip	None.
attention	<u>Urgent care</u>	\$100 copay/visit	\$100 <u>copay</u> /visit	None.
If you have a	Facility fee (e.g., hospital room)	\$750 <u>copay</u> /day for the first 3 days of admission.	Not covered	Preauthorization required. Non-compliance may result in a penalty.
hospital stay	Physician/surgeon fees	No Charge.	Not covered	Cost included in Inpatient stay.
If you need mental health, behavioral health, or	Outpatient services	Professional Office Visits - \$50 <u>copay</u> /visit. Outpatient services - \$400 <u>copay</u> /visit.	Not covered	<u>Preauthorization</u> 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.
substance abuse services	Inpatient services	\$750 <u>copay</u> /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.

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Childbirth/delivery professional services	No Charge.	Not covered	Childbirth/delivery professional services: Cost included in Inpatient stay.	
	Childbirth/delivery facility services	\$400 <u>copay</u> /day for the first 3 days of admission	Not covered	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).	
	Home health care	\$80 <u>copay</u> /visit	Not covered	Limited to 60 visits/year. Preauthorization required. Non-compliance may result in a penalty.	
If you need help recovering or have other special health needs	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	
	Habilitation services	Professional Office Visits: Speech & Hearing Exams - \$80 copay/ visit. PT/OT/ST -\$100 copay/ visit. Outpatient services - No charge	Not covered	Therapy. Non-compliance may result in a penalty.	
	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 <u>plan</u> requirements. <u>Preauthorization</u> required. Non-compliance may result in a penalty.	
	Hospice services	No Charge.	Not covered	Preauthorization required. Non-compliance may result in a penalty.	

		What You	Will Pay	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child	Children's eye exam	Not covered	Not covered	None.
needs dental	Children's glasses	Not covered	Not covered	None.
or eye care	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 <u>plan</u> document.)

- Bariatric Surgery (Preauthorization required)
- Chiropractic care (35 visits per year)
- Cosmetic surgery (<u>Reconstructive surgery</u> 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 <a href="http://healthplan.memorialhermann.org">http://healthplan.memorialhermann.org</a>, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">http://www.dol.gov/ebsa/healthreform</a>. 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 <a href="http://www.cciio.cms.gov">http://www.cciio.cms.gov</a>. 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 <a href="health-Insurance Marketplace">Health Insurance Marketplace</a>. For more information about the <a href="https://www.HealthCare.gov">Marketplace</a>, visit <a href="https://www.HealthCare.gov">www.HealthCare.gov</a> 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 <a href="http://www.dol.gov/ebsa/healthreform">http://www.dol.gov/ebsa/healthreform</a>; or Memorial Hermann Health Solutions Customer Service at 855-645-8448 or <a href="http://healthplan.memorialhermann.org">http://healthplan.memorialhermann.org</a>.

### 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 <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$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
-------------------------

#### In this example, Peg would pay:

Cost Sharing		
<u>Deductibles</u>	\$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:

<u>Primary care physician</u> office visits (*including disease education*)

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
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#### In this example, Joe would pay:

Cost Sharing		
<u>Deductibles</u>	\$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	<b>\$0</b>
■ 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)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
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#### In this example, Mia would pay:

Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$2,000	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$60	
The total Mia would pay is	\$2,060	

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.



# Multi-Language Insert

#### **Multi-language Interpreter Services**

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-645-8448. Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-645-8448. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我 们提供免费的翻译服务,帮助您解答关于健康或药物保险的任何疑 问。如果您需 我 我 我 译服务,请致电 1-855-645-8448。我 们的中文工作人员很乐意帮助您。 这是一项免费服务。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-645-8448. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-645-8448. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-855-645-8448 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-645-8448. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-645-8448번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-645-8448. Вам окажет помощь сотрудник, который говорит порусски. Данная услуга бесплатная.

#### Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة فوري، ليس عليك سوى الاتصال بنا على 1-558-546-8448. سيقوم شخص ما يتحدث العربية مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-645-8448 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-645-8448. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-645-8448. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-645-8448. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-645-8448. Ta usługa jest bezpłatna.

Japanese: 当社の健康 我 我 策と薬品 処方薬プランに関するご質問にお答えするため に、我 我 の獄 サービスがありますございます。通訳をご用命になるには、1-855-645-8448にお我 我 ください。 我 我我 を 我 す我 我 が我 我 いたします。 これは我 我 のサー ビスです。