



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, [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or by calling 1-800-334-9778. 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 1-800-334-9778 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	For each Plan Year, MH Preferred Tier: Individual \$750 / Family \$1,875. Basic Tier: Individual \$1,000 / Family \$2,500.	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.
<b>Are there services covered before you meet your deductible?</b>	Yes, In-network office visits, preventive care and generic drugs are covered before you meet your deductible.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	Yes. \$50 for prescription drugs. Doesn't apply to generic drugs in-network. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	MH Preferred Tier: Individual \$5,500 / Family \$11,000. Basic Tier: Individual \$5,500 / Family \$11,000.	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.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="https://www.aetna.com/dsepublic/#/memorialhermann">https://www.aetna.com/dsepublic/#/memorialhermann</a> or call 1-800-334-9778 for a list of MH Preferred Tier Provider providers.	You pay the least if you use a provider in MH Preferred Tier Provider. You pay more if you use a provider in Basic Tier Provider. 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. Enrollment in the Memorial Hermann Out of Area (OOA) plan depends on the member's zip code. Contact Memorial Hermann Shared Services to confirm eligibility.
<b>Do you need a referral to see a specialist?</b>	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
		MH Preferred Tier Provider (You will pay the least)	Basic Tier Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply, except 10% <u>coinsurance</u> for office surgery	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply, except 25% <u>coinsurance</u> for office surgery	Not covered	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply, except 10% <u>coinsurance</u> for office surgery	\$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply, except 25% <u>coinsurance</u> for office surgery	Not covered	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> for laboratory; \$100 <u>copay</u> /visit for x-ray	25% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> /visit	25% <u>coinsurance</u>	Not covered	None
If you need drugs to treat your illness or condition	Generic drugs	<u>Copay</u> /prescription (RX), <u>deductible</u> doesn't apply: \$10 (retail), \$25 (mail order)	<u>Copay</u> /prescription (RX), <u>deductible</u> doesn't apply: \$10 (retail), \$25 (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		MH Preferred Tier Provider (You will pay the least)	Basic Tier Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<p><b>Prescription drug coverage is administered by Caremark</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a></p>	Preferred brand drugs	30% <u>coinsurance</u> with minimum (MIN) & maximum (MAX)/RX, after specific <u>deductible</u> : \$35 MIN & \$75 MAX (retail), \$90 MIN & \$190 MAX (mail order)	30% <u>coinsurance</u> with minimum (MIN) & maximum (MAX)/RX, after specific <u>deductible</u> : \$35 MIN & \$75 MAX (retail), \$90 MIN & \$190 MAX (mail order)	Not covered	generic FDA-approved women's contraceptives <u>in-network</u> . \$50 per covered individual pharmacy <u>deductible</u> .
	Non-preferred brand drugs	50% <u>coinsurance</u> with MIN & MAX/RX, after specific <u>deductible</u> : \$50 MIN & \$125 MAX (retail), \$125 MIN & \$315 MAX (mail order)	50% <u>coinsurance</u> with MIN & MAX/RX, after specific <u>deductible</u> : \$50 MIN & \$125 MAX (retail), \$125 MIN & \$315 MAX (mail order)	Not covered	
	<u>Specialty drugs</u>	\$0 <u>copay</u> /RX (30% co-share if not enrolled in PrudentRx for program eligible drugs) <u>Specialty drugs</u> not eligible for PrudentRx: <u>Formulary</u> : \$150 <u>copay</u> /RX <u>Non-Formulary</u> : \$200 <u>copay</u> /RX	\$0 <u>copay</u> /RX (30% co-share if not enrolled in PrudentRx for program eligible drugs) <u>Specialty drugs</u> not eligible for PrudentRx: <u>Formulary</u> : \$150 <u>copay</u> /RX <u>Non-Formulary</u> : \$200 <u>copay</u> /RX	Not covered	

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		MH Preferred Tier Provider (You will pay the least)	Basic Tier Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$300 <u>copay/visit</u>	\$300 <u>copay/visit</u>	\$300 <u>copay/visit</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$25 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$25 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: 10% <u>coinsurance</u>	Office: \$25 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: 25% <u>coinsurance</u>	Office & other outpatient services: Not covered	None
	Inpatient services	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	No charge; except \$40 copay for initial visit to confirm pregnancy, <u>deductible</u> doesn't appl	No charge; except \$75 copay for initial visit to confirm pregnancy, <u>deductible</u> doesn't apply	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	\$500 <u>copay/pregnancy</u> , <u>deductible</u> doesn't apply	\$500 <u>copay/pregnancy</u> , <u>deductible</u> doesn't apply	Not covered	
	Childbirth/delivery facility services	No charge	No charge	Not covered	
	<u>Home health care</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	60 visits/ <u>plan year</u> .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		MH Preferred Tier Provider (You will pay the least)	Basic Tier Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	\$15 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$30 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not covered	75 visits/ <u>plan</u> year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services.  120 visits/ <u>plan</u> year.  Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.  None
	<u>Habilitation services</u>	<u>Deductible</u> doesn't apply: \$25 <u>copay/visit</u> , except \$15 <u>copay/visit</u> for Autism	\$30 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not covered	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	
	<u>Hospice services</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered.

### 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.)**

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture - 20 visits/plan year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care - 10 visits/plan year.
- Hearing aids - 2 hearing aids per ear/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. Artificial insemination & ovulation induction & advanced reproductive technology: \$15,000 maximum/lifetime combined.
- Weight loss programs - Except for required preventive services.

**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 more information on your rights to continue coverage, contact the plan at 1-800-334-9778.
- If your group health coverage is subject to ERISA, you may also contact 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, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-334-9778. You may also contact 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, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

**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*

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 \$750
- Specialist copayment \$40
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$0
<u>Copayments</u>	\$540
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$600</b>

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

- The plan's overall deductible \$750
- Specialist copayment \$40
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

- Primary care provider office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Diabetic supplies (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$200
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,320</b>

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

- The plan's overall deductible \$750
- Specialist copayment \$40
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$800
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,250</b>

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

### [Assistive Technology](#)

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-334-9778.

### [Smartphone or Tablet](#)

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

TTY: 711

- English -** To access language services at no cost to you, call 1-800-334-9778.
- Amharic -** የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-334-9778 ይደውሉ።.
- Arabic -** للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-334-9778.
- Armenian -** Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-334-9778 հեռախոսահամարով:
- Carolinian (Kapasal Falawasch) -** ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-334-9778.
- Chamorro -** Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-334-9778.
- Chinese Traditional -** 如欲使用免費語言服務，請致電 1-800-334-9778.
- Cushitic-Oromo** Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-334-9778.
- French -** Afin d'accéder aux services langagiers sans frais, composez le 1-800-334-9778.
- French Creole (Haitian)-** Pou jwenn sèvis lang gratis, rele 1-800-334-9778.
- German -** Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-334-9778 an.
- Greek -** Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-334-9778.
- Gujarati -** તમારેકોઇ જાતના બર્થવિના ભાષાની સે વિના ઓની પછોર માટે, કોલ કરો 1-800-334-9778.
- Hindi -** आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-334-9778 पर कॉल करें।.
- Hmong -** Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-334-9778.
- Italian -** Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-334-9778.
- Japanese -** 言語サービスを無料でご利用いただくには、1-800-334-9778 までお電話ください。
- Karen -** လာတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-800-334-9778 တက့ၢ်.
- Korean -** 무료 언어 서비스를 이용하려면 1-800-334-9778 번으로 전화해 주십시오.
- Laotian -** ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-334-9778.
- Mon-Khmer, Cambodian -** ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-334-9778 ។

