



MEDICAL PLAN COMPARISON CHART



New
Changes!

New
Plan!

	HDHP (High Deductible Health Plan)	Memorial Herman ACO	Kelsey-Seybold	PPO (Choice POS II)
Plan Limits				
Annual In-Network Deductible	Individual: \$5,350 Family: \$10,600	Individual: \$1,950 Family: \$3,775	Individual: \$1,950 Family: \$3,775	Individual: \$5,000 Family: \$8,000
Annual Out-of-Network Deductible	Individual: \$10,600 Family: \$20,000	Individual: No Benefits Family: No Benefits	Individual: No Benefits Family: No Benefits	Individual: \$6,500 Family: \$10,000
Annual In-Network Out-of-Pocket Maximum	Individual: \$5,350 Family: \$10,600	Individual: \$4,900 Family: \$9,400	Individual: \$4,900 Family: \$9,400	Individual: \$8,000 Family: \$14,000
Annual Out-of-Network Out-of-Pocket Maximum ¹	Individual: \$10,600 Family: \$20,000	Individual: No Benefits Family: No Benefits	Individual: No Benefits Family: No Benefits	Individual: \$11,000 Family: \$22,000
Your Cost for In-Network Covered Services				
Preventive	Free	Free	Free	Free
Primary Care Office Visit	0% after deductible	\$10 copay	\$10 copay	30% after deductible
Specialist Office Visit	0% after deductible	\$50 copay	\$50 copay	30% after deductible
Inpatient - Hospital	0% after deductible	20% after deductible	20% after deductible	30% after deductible
Outpatient - Hospital	0% after deductible	20% after deductible	20% after deductible	30% after deductible
Outpatient - Freestanding and Surgical Center	0% after deductible	20% after deductible	20% after deductible	30% after deductible
Emergency Care ²	0% after deductible	\$500 copay; waived if admitted	\$500 copay; waived if admitted	50% after \$750 copay; after deductible; waived if admitted
Urgent Care Facility ²	0% after deductible	\$75 copay	\$75 copay	30% after deductible
Lab, X-Ray	0% after deductible	20% after deductible	0% after deductible	30% after deductible
Diagnostic Complex Imaging	0% after deductible	20% after deductible	\$500 copay	30% after deductible
Maternity - Delivery	0% after deductible	20% after deductible	20% after deductible	30% after deductible
Mental Health and Substance Abuse	0% after deductible	20% after deductible	20% after deductible	30% after deductible
Prescriptions				
Annual Prescription Deductibles	Shared Deductible (Medical and Prescription) \$5,350 Individual \$10,600 Family	Generic: \$0 Brand: \$200	Generic: \$0 Brand: \$200	Generic: \$0 Brand: \$200
Prescription Drug (30-Day Retail)		Generic: \$20 Preferred Brand: \$40 Nonpreferred Brand: \$80	Generic: \$20 Preferred Brand: \$40 Nonpreferred Brand: \$80	Generic: \$20 Preferred Brand: \$40 Nonpreferred Brand: \$80
Prescription Drug (90-Day Retail)		Generic: \$40 Preferred Brand: \$100 ³ Nonpreferred Brand: \$200	Generic: \$40 Preferred Brand: \$100 ³ Nonpreferred Brand: \$200	Generic: \$40 Preferred Brand: \$100 ³ Nonpreferred Brand: \$200
Cost Per Pay Period (based on 24 paychecks a year)				
Employee Only	\$45.50	\$67.50	\$77.50	\$147.50
Employee + Spouse	\$448.50	\$520.00	\$600.00	\$811.50
Employee + Child(ren)	\$210.50	\$251.00	\$264.00	\$458.50
Employee + Family	\$445.00	\$513.50	\$618.00	\$973.50

¹ When using out-of-network (OON) providers, you may be responsible for balance-billed charges in addition to the amounts shown above. Balance-billed charges are not subject to the plan maximums listed above.

² Non-Emergency not covered.

³ \$200 deductible must be met on brand medications before copays apply.