

2027 RATES PER PAYCHECK

RATES ARE PER PAY PERIOD, BASED ON 24 PAYCHECKS PER YEAR.



MEDICAL PLANS

	HDHP (High Deductible Health Plan)	Memorial Herman ACO	Kelsey-Seybold	PPO (Choice POS II)
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



VISION PLANS

	Low Plan	High Plan
Employee Only	\$4.06	\$6.74
Employee + 1	\$6.82	\$11.32
Employee + Family	\$10.26	\$17.03



DENTAL PLANS

	DHMO Low Plan	Mid Plan	High Plan
Employee Only	\$7.30	\$15.14	\$25.77
Employee + Spouse	\$13.68	\$28.36	\$52.30
Employee + Child(ren)	\$10.39	\$21.54	\$46.91
Employee + Family	\$17.87	\$37.04	\$66.10



DISABILITY PLANS

Elimination Period	Rate
STD (14 day waiting period)	\$0.263 per \$10 covered benefit
LTD (90 day waiting period)	\$0.212 per \$100 frozen salary



SUPPLEMENTAL LIFE AND AD&D

Age January 1 of plan year	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Employee Rate per \$10,000	\$0.30	\$0.35	\$0.40	\$0.45	\$0.65	\$0.90	\$1.30	\$2.00	\$2.95	\$4.65
Spouse Rate per \$10,000	\$0.20	\$0.25	\$0.30	\$0.35	\$0.55	\$0.80	\$1.20	\$1.90	\$2.85	\$4.55
Spouse Rate per \$20,000	\$0.40	\$0.50	\$0.60	\$0.70	\$1.10	\$1.60	\$2.40	\$3.80	\$5.70	\$9.10
Spouse Rate per \$35,000	\$0.70	\$0.88	\$1.05	\$1.23	\$1.93	\$2.80	\$4.20	\$6.65	\$9.98	\$15.93
Child Life										
\$5,000	\$0.20									
\$10,000	\$0.40									



SAFETYNETS PLANS

Identity Theft Protection	\$7.97 for all 3 benefits
Family Legal Plan	
Roadside Assistance	



ACCIDENT PLAN

Employee Only	\$4.55
Employee + Spouse	\$7.75
Employee + Child(ren)	\$8.13
Employee + Family	\$11.33



PERMANENT LIFE (NON-TOBACCO USERS)

Ages	18-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70
Employee - \$25,000 Benefit	\$5.85	\$6.79	\$8.03	\$10.06	\$12.99	\$16.94	\$23.43	\$34.48	\$44.51	\$68.25
Spouse - \$12,500 Benefit	\$3.26	\$3.79	\$4.48	\$5.61	\$7.20	\$9.23	\$12.38	\$17.41	\$25.63	\$38.94
Child Rate for \$25,000	\$5.21									



HOSPITAL INDEMNITY

Employee Only	\$9.26
Employee + Spouse	\$16.26
Employee + Child(ren)	\$14.51
Employee + Family	\$21.51



CRITICAL ILLNESS

Age Band*	<30	30-39	40-49	50-59	60-69	70-79	80+
Employee Rate per \$1,000	\$0.18	\$0.28	\$0.46	\$0.90	\$1.99	\$2.67	\$2.67
Spouse Rate per \$1,000	\$0.18	\$0.28	\$0.46	\$0.90	\$1.99	\$2.67	\$2.67

*Your age January 1 of plan year



EMERGENCY TRANSPORT

	Complete Plus	Global Plus
Employee + Family	\$7.00	\$10.00



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)	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.