MEDICAL PLAN COMPARISON CHART

		Memorial Hermann ACO	HDHP (High Deductible Health Plan)	Choice POS II
RATES ARE PER PAY PERIOD, based on 24 paychecks per year.				
Employee Only		$49.50	$34.50	$77.00
Employee + Spouse		$327.50	$294.00	$406.50
Employee + Child(ren)		$181.50	$156.50	$239.00
Employee + Family		$376.00	$327.00	$498.00
PLAN LIMITS				
Annual in-network deductible	Individual	$1,750	$5,000	$2,250
	Family	$3,500	$10,000	$4,500
Annual out-of-pocket max (includes all medical and pharmacy deductibles, copays and coinsurance)	Individual	$4,500	$5,000	$5,500
	Family	$9,000	$10,000	$11,000
YOUR COST FOR IN-NETWORK COVERED SERVICES				
Preventive		Free	Free	Free
Office Visit	PCP	20% after deductible	0% after deductible	25% after deductible
	Specialists	25% after deductible	0% after deductible	25% after deductible
Inpatient – hospital (pre-certification required)		20% after deductible	0% after deductible	25% after deductible
Outpatient – hospital (pre-certification required)		20% after deductible	0% after deductible	25% after deductible
Outpatient – freestanding and surgical center (pre-certification required)		20% after deductible	0% after deductible	25% after deductible
Emergency Care		50% after $250 copay; after deductible; waived if admitted	0% after deductible	50% after $250 copay; after deductible; waived if admitted
Urgent Care Facility		20% after deductible	0% after deductible	25% after deductible
Lab, X-Ray, diagnostic mammogram, diagnostic scans (MRI, MRA, CAT, PET)	Outpatient hospital	20% after deductible	0% after deductible	25% after deductible
	Freestanding facility, independent lab	20% after deductible	0% after deductible	25% after deductible
Maternity – delivery		20% after deductible	0% after deductible	25% after deductible
Mental health and substance abuse (inpatient and outpatient)		20% after deductible	0% after deductible	25% after deductible
PRESCRIPTION				
Annual prescription deductibles[1]	Generic	$0	Shared deductible (medical and prescription) $5,000 Individual / $10,000 Family	$0
	Brand	$200		$200
Prescription drug (30-day retail)	Generic	$20		$20
	Preferred brand	$40		$40
	Nonpreferred brand	$80		$80
Prescription drug (90-day mail or retail)	Generic	$40		$40
	Preferred brand	$100		$100
	Nonpreferred brand	$200		$200

[1] The deductible applies once per year per person and a copay may also be requested.

BENEFITS OUTLOOK

KATY Katy Independent School District