2020 Medical Plan Comparison

	Consumer Basic Limited	Consumer Basic Choice		Consumer Plus Limited	Consumer Plus Choice	
	Memorial Hermann network only	Tier I	Tier II	Memorial Hermann network only	Tier I	Tier II
RATES						
Based on 24 Pay Periods						
Employee Only	$32	$43		$46	$67	
Employee + Spouse	$235	$250		$262	$325	
Employee + Child(ren)	$145	$165		$168	$213	
Employee + Family	$303	$344		$348	$433	
PLAN LIMITS						
Annual deductible						
Individual	$2,250	$2,250	$2,750	$1,750	$1,750	$2,250
Family	$4,500	$4,500	$5,000	$3,500	$3,500	$4,000
Annual out-of-pocket max (includes all medical and pharmacy deductibles, copays and coinsurance)						
Individual	$5,500	$5,500	$6,850	$4,500	$4,500	$6,000
Family	$11,000	$11,000	$12,500	$9,000	$9,000	$10,500
YOUR COST FOR COVERED SERVICES						
Preventive	Free	Free		Free	Free	
Office Visit						
PCP	25%	25% (all PCPs are Tier I)		20%	20% (all PCPs are Tier I)	
Non-designated specialists (NDS)[1]	25%	25% all (NDS' are Tier I)		20%	20% all (NDS' are Tier I)	
Designated specialists	25%	25%	45%	20%	20%	35%
Inpatient – hospital (pre-certification required)	25%	25%	45% + $500 copay per admission[2]	20%	20%	35% + $500 copay per admission[2]
Outpatient- hospital (pre-certification required)	25%	25%	45%	20%	20%	35%
Outpatient – freestanding and surgical center (pre-certification required)	25%	25%		20%	20%	
Emergency Care	35% + $250 copay (waived if admitted)	35% + $250 copay (waived if admitted)		30% + $250 copay (waived if admitted)	30% + $250 copay (waived if admitted)	
Urgent Care Facility	25%	25%		20%	20%	
Lab, X-Ray, diagnostic mammogram, diagnostic scans (MRI, MRA, CAT, PET) Outpatient hospital	25%	25%	45%	20%	20%	35%
Lab, X-Ray, diagnostic mammogram, diagnostic scans (MRI, MRA, CAT, PET) Freestanding facility, independent lab	25%	25%		20%	20%	
Maternity – delivery	25%	25%	45%	20%	20%	35%
Mental health and substance abuse (inpatient and outpatient)	25%	25%		20%	20%	
PRESCRIPTION						
Annual prescription deductibles [3]	$0 Generic / $200 Brand					
Prescription drug 30-day retail	$20 Generic / $40 Preferred brand / $80 Nonpreferred brand					
Prescription drug 90-day mail or retail	$40 Generic / $100 Preferred brand / $200 Nonpreferred brand					

1 These are in-network specialists who are not in the designated specialty areas.

2 Limited to two $500 copays per plan year.

3 The deductible applies once per year per person and a copay may also be requested.