2018 Medical plan comparison

		Memorial Hermann ACO	Open Access Select	KelseyCare HMO
RATES				
Based on 24 pay periods	Employee only	$93.26	$48.00	$152.67
	Employee + spouse	$429.82	$312.07	$566.86
	Employee + child	$307.56	$205.08	$416.43
	Employee + children	$400.72	$266.24	$531.06
	Employee + family	$760.21	$484.30	$973.37
WHEN YOU GET IN-NETWORK CARE, YOU PAY[1]				
Annual deductible	Individual	$2,500	$4,500	$2,000
	Family	$5,000	$9,000	$5,500
Annual out-of-pocket max	Individual	$6,500	$7,100	$6,400
	Family	$13,000	$14,200	$12,800
Preventive care exams		Free	Free	Free
COST FOR COVERED SERVICES AFTER YOUR DEDUCTIBLE HAS BEEN MET[2]				
Office visits	Primary care (PCP)	$50	0% for the first $225, then 30%	$30
	Specialists	$100		$60
Inpatient—hospital (pre-certification required)		20%	30%	20% after $150 copay per day for first 5 days
Outpatient—hospital				20%
Outpatient—freestanding and surgical center				20% after $150 copay
Emergency care		20% + $250 copay (copay waived if admitted)	30%	20% after $200 copay
Non-emergency care in an emergency room		40%	50%	20% after $200
Urgent care facility		$75	30%	$50
Lab, X-ray, diagnostic mammogram, diagnostic scans (MRI, MRA, CAT, PET)—outpatient hospital		20%	30%	20%
Lab, X-ray, diagnostic mammogram, diagnostic scans (MRI, MRA, CAT, PET)—freestanding facility, independent lab		20%	See Office Visits or 30% if in facility	20%
Maternity—delivery		20%	30%	20% after $150 copay per day for first 5 days
Mental health and substance abuse—inpatient		20%	30%	20% after $150 copay per day for first 5 days
Mental health and substance abuse—outpatient		$50	30%	$30
PRESCRIPTION DRUG				
Annual deductible	Individual	$75	$250	$75
	Family	See Individual rate per person	$500	See Individual rate per person
Annual out-of-pocket max	Individual	Included with medical	Included with medical	$750
	Family			$1,500
30-DAY RETAIL				
Generic		$15	30%	$15
Preferred brand		$35		$35
Non-preferred brand		$55		$55
Specialty Tier II (generic/preferred)[3]		$75		$75
Specialty Tier III (non-preferred)[3]		$150		$150
90-DAY MAIL OR RETAIL[4]				
Generic		$37.50	30%	$37.50
Preferred brand		$87.50		$87.50
Non-preferred brand		$137.50		$137.50
Specialty Tier II (generic/preferred)		$75		$75
Specialty Tier III (non-preferred)		$150		$150

1. Medical copays and prescription drug deductible and copays, plus limited fee schedule or reasonable and customary cutback penalties, do not apply to the annual deduct
2. Out-of-network facility charges exceeding the limited fee schedule amount are not covered and will not be applied to the deductible or coinsurance maximum. Employee is responsible for paying the difference between the covered amount and the amount the facility charges.
3. Specialty drugs limited to a 30-day supply and distribution amount
4. 90-day retail through ESI (Smart90) program is the same as mail order copay

BENEFITS OUTLOOK ALDINEISD