

# 2019 Medical plan comparison

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