2020 Medical plan comparison

		Open Access Select	KelseyCare ACO	Memorial Hermann ACO
RATES				
Based on 24 pay periods	Employee only	$48.00	$77.18	$93.26
	Employee + spouse	$312.07	$355.70	$429.82
	Employee + child	$205.08	$254.52	$307.56
	Employee + children	$266.24	$331.62	$400.72
	Employee + family	$484.30	$629.12	$760.21
WHEN YOU GET IN-NETWORK CARE, YOU PAY[1]				
Annual deductible	Individual	$4,500	$2,500	$2,500
	Family	$9,000	$5,000	$5,000
Annual out-of-pocket max (includes all medical and pharmacy deductibles, copays and coinsurance)	Individual	$7,100	$6,500	$6,500
	Family	$14,200	$13,100	$13,000
COST FOR COVERED SERVICES AFTER YOUR DEDUCTIBLE HAS BEEN MET[2]				
Preventive care exams		Free	Free	Free
Office visits	Primary care (PCP)	0% for the first $225, then 30%	$50	$50
	Specialists		$100	$100
Teladoc (RediMD)		$35	$35	$35
Inpatient—hospital (pre-certification required)		30%	20%	20%
Outpatient—hospital (pre-certification required)				
Outpatient—freestanding and surgical center (pre-certification required)				
Emergency care		30% + $250 copay (copay waived if admitted to the hospital)	$20% + $250 copay (copay waived if admitted to the hospital)	20% + $250 copay (copay waived if admitted to the hospital)
Non-emergency care in an emergency room		50%	40%	40%
Urgent care facility		30%	$75	$75
Lab, X-Ray, diagnostic testing		30%	Included in physician copay at Kelsey-Seybold	20%
Advanced imaging, diagnostic scans (MRI, MRA, CAT, PET) freestanding facility, independent lab, outpatient hospital		30%	20% + $100 copay	20%
Lab, X-ray, diagnostic mammogram, diagnostic scans (MRI, MRA, CAT, PET) freestanding facility, independent lab, outpatient hospital		See office visits or 30% if in facility	20% + $100 copay	20%
Maternity—delivery		30%	20%	20%
Mental health and substance abuse—inpatient		30%	20%	20%
Mental health and substance abuse—outpatient		30%	$100	$100
PRESCRIPTION DRUG				
Annual deductible	Generic	$250	$75	$75
	Brand	$500	See individual rate per person	See individual rate per person
30-DAY RETAIL				
Generic		30%	$15	$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		30%	$37.50	$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 deductible. **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 (Smart 90) program is the same as mail order copay

BENEFITS OUTLOOK

ALDINE Independent School District