Compare Your FY25 Plans

Medical Plan Comparison

	MH Care Plan		MH Care Broad Access Plan	
	Preferred (MH ACO Network)	Basic	Preferred (MH ACO Network)	Aetna Broad Network
Employee Health Credit Available	Yes			
Covered Services				
Annual Deductible	$750/individual $1,875/family	$1,000/individual $2,500/family	$750/individual $1,875/family	$2,000/individual $5,000/family
Annual Medical and Pharmacy Out-of-Pocket Maximum	$5,500/individual $11,000/family		$5,500/individual $11,000/family	
Physician Office Visit	$25 copay per visit	$50 copay per visit	$25 copay per visit	30% after deductible
Procedure in Physician Office	10% after deductible	25% after deductible	10% after deductible	30% after deductible
Specialist Office Visit	$40 copay per visit	$75 copay per visit	$40 copay per visit	30% after deductible
Physical Therapy, Occupational Therapy, Speech Therapy	$15 copay per visit	$30 copay per visit	$15 copay per visit	30% after deductible
Allergy Testing	$25 copay per visit	$45 copay per visit	$25 copay per visit	30% after deductible
Allergy Injections	$15 copay per visit	$25 copay per visit	$25 copay per visit	$25 copay per visit
Preventive Services				
Adult Wellness	$0		$0	
Routine Adult Physical Exams and Immunizations	$0		$0	
Mammogram	$0		$0	
Well Child Care	$0		$0	
Colonoscopy	$0		$0	
Nutrition and/or Tobacco Counseling	$0		$0	
Depression Screening	$0		$0	
Type 2 Diabetes Mellitus Adult Screening	$0		$0	
High Blood Pressure Screening	$0		$0	

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MEMORIAL HERMANN

Compare Your FY25 Plans

Medical Plan Comparison *(cont.)*

	MH Care Plan		MH Care Broad Access Plan	
	Preferred (MH ACO Network)	Basic	Preferred (MH ACO Network)	Aetna Broad Network
Emergency Care, Urgent Care, Walk-In Services and Telemedicine				
Emergency Department (Emergency care copay is waived, if admitted.)	$300 copay after deductible		$300 copay after deductible	
Ambulance*	25% after deductible	25% after deductible	25% after deductible	25% after deductible
Memorial Hermann Employee Medical Clinics (acute visits only)	$0 copay per visit		$0 copay per visit	
Urgent Care Visit	Memorial Hermann – GoHealth urgent care centers: $25 copay per visit All other urgent care centers: $50	$50 copay per visit	Memorial Hermann – GoHealth urgent care centers: $25 copay per visit All other urgent care centers: 30% after deductible	30% after deductible
Walk-In Clinic	$25 copay per visit	$50 copay per visit	$25 copay per visit	30% after deductible
Memorial Hermann eVisit	$15 copay per consultation		$15 copay per consultation	
Memorial Hermann Virtual Clinic	$25 copay per consultation		$25 copay per consultation	
Teladoc	$15 copay per consultation		$15 copay per consultation	
Lab, Diagnostic and Imaging Services				
X-Ray/Imaging*	$100 copay per visit after deductible	25% after deductible	$100 copay per visit after deductible	30% after deductible
Lab*	10% after deductible	25% after deductible	10% after deductible	30% after deductible
Maternity Services				
Prenatal Office Visit	$40 copay, initial visit only	$75 copay, initial visit only	$40 copay, initial visit only	30% after deductible, initial visit only
Professional Fees	$500 copay		$500 copay	30% after deductible
Inpatient Hospitalization*	Included in copay above		Included in copay above	$1,000 per admission + 30% after deductible
Ultrasound	0%, deductible waived	$75 copay per visit	0%, deductible waived	30% after deductible
Lab*	0%, deductible waived	$75 copay, initial visit only	0%, deductible waived	30% after deductible
Anesthesiology Services	Included in copay above		Included in copay above	30% after deductible
Other Services	0% after deductible or applicable copay	25% after deductible or applicable copay	0% after deductible or applicable copay	30% after deductible or applicable copay
Infertility (for testing and treatment)*	0% after deductible, up to a $15,000 lifetime maximum	25% after deductible, up to a $15,000 lifetime maximum	0% after deductible, up to a $15,000 lifetime maximum	30% after deductible, up to a $15,000 lifetime maximum

** May require precertification. Contact Aetna Concierge Member Advocate Services at 1.800.334.9778 (TTY: 711).*

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MEMORIAL HERMANN

Compare Your FY25 Plans

Medical Plan Comparison *(cont.)*

	MH Care Plan		MH Care Broad Access Plan	
	Preferred (MH ACO Network)	Basic	Preferred (MH ACO Network)	Aetna Broad Network
Hospital/Surgical Services*				
Inpatient Hospitalization*	10% after deductible, precertification is required or a 35% penalty is applied	25% after deductible, precertification is required or a 35% penalty is applied	10% after deductible, precertification is required or a 35% penalty is applied	$1,000 per admission + 30% after deductible; precertification is required or a 35% penalty is applied
Outpatient Facility Services*	10% after deductible, precertification is required or a 35% penalty is applied	25% after deductible, precertification is required or a 35% penalty is applied	10% after deductible, precertification is required or a 35% penalty is applied	30% after deductible, precertification is required or a 35% penalty is applied
Bariatric Procedures Services*				
Limitations	One procedure per lifetime		One procedure per lifetime	
Mandatory Non-Surgical Weight Loss Program*	Must meet Aetna's medical management criteria		Must meet Aetna's medical management criteria	
Inpatient Hospitalization*	10% after deductible, precertification is required		30% after deductible, precertification is required	
Mental Health and Substance Abuse Services				
Inpatient Hospitalization*	10% after deductible, precertification is required or a 35% penalty is applied	10% after deductible, precertification is required, or a 35% penalty is applied	10% after deductible, precertification is required or a 35% penalty is applied	10% after deductible, precertification is required, or a 35% penalty is applied
Outpatient Facility Services*	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Office Visit and Other Outpatient Services	$25 copay	$25 copay	$25 copay	$25 copay
Other Provider Services				
Home Health Care*	10% after deductible	25% after deductible	10% after deductible	30% after deductible
Skilled Nursing Facility*	10% after deductible	25% after deductible	10% after deductible	30% after deductible
Durable Medical Equipment*	10% after deductible	25% after deductible	10% after deductible	30% after deductible
Prosthetics and Orthotics*	10% after deductible	25% after deductible	10% after deductible	30% after deductible
Chiropractic Services*	10% after deductible	25% after deductible	10% after deductible	30% after deductible

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Compare Your FY25 Plans

Prescription Drug Plan Comparison

	CVS Caremark		
	Deductible	**30-day supply (retail)**	**90-day supply (mail service)**
Generic	N/A	$10	$25
Preferred Brand Name	$50/individual	30% after deductible ($35 minimum, $75 maximum)	30% after deductible ($90 minimum, $190 maximum)
Non-preferred Brand Name	$50/individual	50% after deductible ($50 minimum, $125 maximum)	50% after deductible ($125 minimum, $315 maximum)
Specialty	$50/individual	PrudentRx Program: $0 copay/prescription (30% coinsurance if not enrolled in PrudentRx for program eligible drugs) Specialty drugs not eligible for PrudentRX: $150 copay preferred* $200 copay non-preferred*	N/A

* *Applies for 30-day supply through retail or mail service.*

NOTE: If you choose to purchase a brand-name drug when a generic drug is available, you will be responsible for paying the brand name copay plus the difference in cost between the brand and generic.

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Compare Your FY25 Plans

Dental Plan Plan Comparison

	Delta Dental PPO[1]	DeltaCare USA HMO[2]
	In-Network and Out-of-Network	In-Network Only
Annual Deductible	$50 per individual/$150 per family (deductible is waived for diagnostic and preventive services)	Not applicable
Benefit Maximum	$1,500 per person (diagnostic and preventive services don't count toward maximum)	Not applicable
Orthodontic Deductible	$50 lifetime deductible per person	Not applicable
Diagnostic and Preventive Services: Exams, Cleaning, X-Rays	0%	Per DHMO fee schedule
Basic Services: Fillings and Simple Tooth Extractions	20%	Per DHMO fee schedule
Endodontic (root canals) – Covered Under Basic Services	20%	Per DHMO fee schedule
Periodontics (gum treatment) – Covered Under Basic Services	20%	Per DHMO fee schedule
Oral Surgery – Covered Under Basic Services	20%	Per DHMO fee schedule
Major Services: Crowns, Inlays, Onlays and Cast Restorations, Bridges and Dentures	50%	Per DHMO fee schedule
Orthodontic Benefits	Dependent children to age 19: 50%	Dependent children up to the age of 26 and adults (employee and spouse) Per DHMO fee schedule
Orthodontic Maximums	Plan pays: $1,500 lifetime	Per DHMO fee schedule
Enhanced Cleaning Benefits for Pregnancy	Includes oral evaluation and cleaning	Per DHMO fee schedule

1 Includes Delta Dental PPO dentists and non-Delta Dental dentists.

2 Contract specialists may differ.

NOTE: Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fee. You are responsible for any charges above allowed amounts when using a non-Delta Dental dentist.

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Compare Your FY25 Plans

Vision Plan Comparison

	Superior Vision Plan		
	Frequency	**In-Network Only**	**Out-of-Network**
Exam (with an ophthalmologist or optometrist)	Once per plan year	$10 copay	Up to $50 retail
Materials (lenses and frames)	Once per plan year	$10 copay	See allowances for frames/lenses
Frames	Once per plan year	$150 retail allowance	Up to $81 retail
Contact Lens Fitting (standard)	Once per plan year	Covered in full after $25 copay	Not covered
Contact Lens Fitting (specialty)	Once per plan year	Up to $50 after $25 copay	Not covered
Lenses (standard) Per Pair:			
Single Vision	Once per plan year	Covered in full	Up to $50 retail
Bifocal	Once per plan year	Covered in full	Up to $70 retail
Trifocal	Once per plan year	Covered in full	Up to $90 retail
Standard Progressive	Once per plan year	Covered in full	Up to $90 retail
Contact Lenses (in lieu of eyeglass lenses and frames benefit)	One allowance per plan year	$150 retail allowance	Up to $100 retail

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