Compare Your FY26 Plans

Medical Plan Comparison

	MH Care Plan			MH Care Broad Access Plan	
	MH Preferred Tier	Basic Tier	Outside Specialty Tier	MH Preferred Tier	Broad Network Tier
Employee Health Credit Available	Yes	Yes	Yes	Yes	Yes
Covered Services					
Annual Deductible	$750/individual $1,875/family	$1,000/individual $2,500/family	$6,000 Individual/ $12,000 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	$9,200 Individual / $18,400 Family	$5,500/individual $11,000/family	$5,500/individual $11,000/family
Physician Office Visit	$25 copay per visit	$50 copay per visit	$100 copay per visit	$25 copay per visit	30% after deductible
Procedure in Physician Office	10% after deductible	25% after deductible	40% after deductible	10% after deductible	30% after deductible
Specialist Office Visit	$40 copay per visit	$75 copay per visit	$150 copay per visit	$40 copay per visit	30% after deductible
Physical Therapy, Occupational Therapy, Speech Therapy	$15 copay per visit	$30 copay per visit	$150 copay per visit	$15 copay per visit	30% after deductible
Allergy Testing	$25 copay per visit	$45 copay per visit	$100 copay per visit	$25 copay per visit	30% after deductible
Allergy Injections	$15 copay per visit	$25 copay per visit	$100 copay per visit	$25 copay per visit	$25 copay per visit
Preventive Services					
Adult Wellness	$0	$0	$0	$0	$0
Routine Adult Physical Exams and Immunizations	$0	$0	$0	$0	$0
Mammogram	$0	$0	$0	$0	$0
Well Child Care	$0	$0	$0	$0	$0
Colonoscopy	$0	$0	$0	$0	$0
Nutrition and/or Tobacco Counseling	$0	$0	$0	$0	$0
Depression Screening	$0	$0	$0	$0	$0
Type 2 Diabetes Mellitus Adult Screening	$0	$0	$0	$0	$0
High Blood Pressure Screening	$0	$0	$0	$0	$0

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MEMORIAL HERMANN

Compare Your FY26 Plans

Medical Plan Comparison (cont.)

	MH Care Plan			MH Care Broad Access Plan	
	MH Preferred Tier	Basic Tier	Outside Specialty Tier	MH Preferred Tier	Broad Network Tier
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	$300 copay after deductible	$300 copay after deductible	$300 copay after deductible
Ambulance*	25% after deductible	25% after deductible	25% after deductible	25% after deductible	25% after deductible
Memorial Hermann Employee Medical Clinics (acute visits only)	$0 copay per visit	Not covered	Not covered	$0 copay per visit	Not covered
Urgent Care Visit	Memorial Hermann – GoHealth Urgent Care Centers only: $25 copay per visit	$50 copay per visit	$100 copay per visit	Memorial Hermann – GoHealth Urgent Care Centers only: $25 copay per visit	30% after deductible
Walk-In Clinic	$25 copay per visit	$50 copay per visit	$100 copay per visit	$25 copay per visit	30% after deductible
Memorial Hermann E-Visit	$15 copay per consultation	Not covered	Not covered	$15 copay per consultation	Not covered
Memorial Hermann Video Visit	$25 copay per consultation	Not covered	Not covered	$25 copay per consultation	Not covered
Teladoc	$15 copay per consultation	$15 copay per consultation	$15 copay per consultation	$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	40% after deductible	$100 copay per visit after deductible	30% after deductible
Lab*	10% after deductible	25% after deductible	40% after deductible	10% after deductible	30% after deductible

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MEMORIAL HERMANN

Compare Your FY26 Plans

Medical Plan Comparison (cont.)

	MH Care Plan			MH Care Broad Access Plan	
	MH Preferred Tier	Basic Tier	Outside Specialty Tier	MH Preferred Tier	Broad Network Tier
Maternity Services					
Prenatal Office Visit	$40 copay, initial visit only	$75 copay, initial visit only	$150 copay, initial visit only	$40 copay, initial visit only	30% after deductible, initial visit only
Professional Fees	$500 copay	$500 copay	$500 copay	$500 copay	30% after deductible
Inpatient Hospitalization*	Included in copay above	Included in copay above	Included in copay above	Included in copay above	$1,000 per admission + 30% after deductible
Ultrasound	0%, deductible waived	$75 copay per visit	$150 copay per visit	0%, deductible waived	30% after deductible
Lab*	0%, deductible waived	$75 copay, initial visit only	$150 copay per visit	0%, deductible waived	30% after deductible
Anesthesiology Services	Included in copay above	Included in copay above	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	40% 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	40% 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
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	40% 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	40% 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

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MEMORIAL HERMANN

Compare Your FY26 Plans

Medical Plan Comparison (cont.)

	MH Care Plan			MH Care Broad Access Plan	
	MH Preferred Tier	Basic Tier	Outside Specialty Tier	MH Preferred Tier	Broad Network Tier
Bariatric Procedures Services*					
Mandatory Non-Surgical Weight Loss Program*	Must meet Aetna's medical management criteria	Must meet Aetna's medical management criteria	Must meet Aetna's medical management criteria	Must meet Aetna's medical management criteria	Must meet Aetna's medical management criteria
Inpatient Hospitalization*	10% after deductible, precertification is required	25% after deductible, precertification is required	40% 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	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	10% after deductible
Office Visit and Other Outpatient Services	$25 copay	$25 copay	$25 copay	$25 copay	$25 copay
Other Provider Services					
Home Health Care*	10% after deductible	25% after deductible	40% after deductible	10% after deductible	30% after deductible
Skilled Nursing Facility*	10% after deductible	25% after deductible	40% after deductible	10% after deductible	30% after deductible
Durable Medical Equipment*	10% after deductible	25% after deductible	40% after deductible	10% after deductible	30% after deductible
Prosthetics and Orthotics*	10% after deductible	25% after deductible	40% after deductible	10% after deductible	30% after deductible
Chiropractic Services*	10% after deductible	25% after deductible	40% after deductible	10% after deductible	30% after deductible

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MEMORIAL HERMANN

Review Your FY26 Plans

Prescription Drug Plan Comparison

	CVS Caremark		
	Deductible	**30-day supply (retail)**	**90-day supply (mail service)**
Generic (always ask your doctor if a generic is available – it could save you money!)	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 (if a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list)	$50/individual	50% after deductible ($50 minimum, $125 maximum)	50% after deductible ($125 minimum, $315 maximum)
Specialty (available through Memorial Hermann Specialty Pharmacy)	$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
GLP-1 Weight Loss (e.g., Wegovy, Saxenda, Zepbound)**	$50/individual	$150 copay	N/A

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

** *You must meet certain requirements to receive approval. Refer to the **Weight Management** page for details.*

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 name and generic.*

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MEMORIAL HERMANN

Compare Your FY26 Plans

Dental Plan Comparison

	Essentials DPPO *(available 7/1/25)*[1]	In-network Smiles DHMO *(currently DeltaCareUSA HMO)*[2]	Full Coverage DPPO *(currently Delta Dental DPPO)*[1]
	In-Network and Out-of-Network	In-Network Only	In-Network and Out-of-Network
Annual Deductible	$50 per individual/$150 per family (deductible is waived for diagnostic and preventive services)	Not applicable	$50 per individual/$150 per family (deductible is waived for diagnostic and preventive services)
Benefit Maximum	$750 per person (diagnostic and preventive services don't count toward maximum)	Not applicable	$1,500 per person (diagnostic and preventive services don't count toward maximum)
Orthodontic Deductible	Not applicable	Not applicable	$50 lifetime deductible per person
Diagnostic and Preventive Services: Exams, Cleaning, X-Rays	0%	Per DHMO fee schedule	0%
Basic Services: Fillings and Simple Tooth Extractions	20%	Per DHMO fee schedule	20%
Endodontic (root canals)	Not covered	Per DHMO fee schedule	20%
Periodontics (gum treatment)	Not covered	Per DHMO fee schedule	20%
Oral Surgery	Not covered	Per DHMO fee schedule	20%
Major Services: Crowns, Inlays, Onlays and Cast Restorations, Bridges and Dentures	Not covered	Per DHMO fee schedule	50%
Orthodontic Benefits	Not covered	Dependent children up to the age of 26 and adults (employee and spouse): per DHMO fee schedule	Dependent children to age 19: 50%
Orthodontic Maximums	Not covered	Per DHMO fee schedule	Plan pays: $1,500 lifetime
Enhanced Cleaning Benefits for Pregnancy	Not covered	Per DHMO fee schedule	Includes oral evaluation and cleaning

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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MEMORIAL HERMANN

Review Your FY26 Plans

Vision Plan Comparison

	Superior Vision Plan		
	Frequency	**In-Network Only**	**Out-of-Network**
Exam (with an ophthalmologist or optometrist)	Once per Fiscal Year	$10 copay	Up to $50 retail
Materials (lenses and frames)	Once per Fiscal Year	$10 copay	See allowances for frames/lenses
Frames	Once per Fiscal Year	$175 retail allowance and 20% discount on amounts over $175	Up to $81 retail
Contact Lens Fitting (standard)	Once per Fiscal Year	Covered in full after $25 copay	Not covered
Contact Lens Fitting (specialty)	Once per Fiscal Year	Up to $50 after $25 copay	Not covered
Lenses (standard) Per Pair:			
Single Vision	Once per Fiscal Year	Covered in full	Up to $50 retail
Bifocal	Once per Fiscal Year	Covered in full	Up to $70 retail
Trifocal	Once per Fiscal Year	Covered in full	Up to $90 retail
Standard Progressive	Once per Fiscal Year	Covered in full	Up to $90 retail
Contact Lenses (in lieu of eyeglass lenses and frames benefit)	One allowance per Fiscal Year	$150 retail allowance	Up to $100 retail

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