

2019-2020 Medical plan key features

The chart below shows what you pay for common types of covered services.

Plan Features	Charter Kelsey-Seybold Plan Year	Nexus ACO R Memorial Hermann Plan Year		Choice Plus HDHP Calendar Year	
Note: The plan year is September 1 – August 31. The calendar year is January 1 – December 31.		Tier 1 Maximum Savings	Tier 2 Higher Out-of- Pocket Costs	Network	Out-of-Network
		Deductibles and out-of-pocket maximums cross-apply when using both Tier 1 and Tier 2 providers in the same plan year			
Deductible					
Individual	\$1,000	\$1,250	\$2,500	\$3,000	\$4,000
Family	\$2,000	\$2,500	\$5,000	\$6,000	\$8,000
Out-of-Pocket Maximum (includes deductibles, copays, and coinsurance)					
Individual	\$5,000	\$6,250	\$7,350	\$6,750	Unlimited
Family	\$10,000	\$12,500	\$14,700	\$13,500	Unlimited
Office Visit					
Primary Care Physician	\$30 copay	\$35 copay	\$50 copay	30% after deductible	50% after deductible
Specialist	\$45 copay	\$50 copay	\$80 copay	30% after deductible	50% after deductible
Conroe ISD Employee Health & Wellness Center	\$10	\$10		\$10 (not eligible if you or your spouse contribute to an HSA)	N/A
Convenience Clinic	N/A	\$50 copay		30% after deductible	50% after deductible
Preventive Care (subject to age and frequency limits)					
Routine Physical Exams, Preventive Care Immunizations, Well-Woman Preventive Visits, Routine Cancer Screenings, Prenatal Care	\$0 (plan pays 100%)	\$0 (plan pays 100%)		\$0 (plan pays 100%)	Not covered
Hospital, Surgery, and Specialty Service					
Emergency Room	20% after deductible plus \$200 copay	20% after deductible plus \$200 copay	20% after Tier 1 deductible plus \$200 copay	30% after deductible plus \$150 copay	30% after deductible plus \$150 copay
Urgent Care Center	\$75 copay	\$75 copay		30% after deductible	50% after deductible
Diagnostic Lab and X-Ray	\$0 (plan pays 100%)	\$0 (plan pays 100%)		30% after deductible	50% after deductible
Complex Imaging	\$100 copay	\$100 copay		30% after deductible	50% after deductible
Inpatient Hospital and Physician Care	10% after deductible	20% after deductible	35% after deductible	30% after deductible	50% after deductible plus \$500 admission copay
Virtual Visit	\$15 copay	\$15 copay		30% after deductible	N/A
Virtual Visit - Mental Health	\$45 copay	\$50 copay		30% after deductible	N/A
Kelsey-Seybold Video Visit	\$30 copay	N/A	N/A	N/A	N/A
Pharmacy Benefits (Flex Base 3-Tier)					
Prescription Drug Deductible (waived for Tier 1 medications)	\$200 per individual, per plan year	\$200 per individual, per plan year		N/A	N/A
Prescriptions (Retail)					
Tier 1 (mostly generic)	\$15 copay	\$15 copay		30% after deductible	Not covered
Tier 2 (mainly preferred brand-name)	\$60 copay	\$60 copay		30% after deductible	Not covered
Tier 3 (highest cost)	\$120 copay	\$120 copay		30% after deductible	Not covered
Prescriptions (Specialty)					
Must use BrivoRx® specialty pharmacy for specialty medications (limit 30-day supply)	\$250 copay	\$250 copay		30% after deductible	Not covered
Prescriptions (Mail-order)					
Tier 1 (mostly generic)	\$30 copay	\$30 copay		30% after deductible	Not covered
Tier 2 (mainly preferred brand-name)	\$120 copay	\$120 copay		30% after deductible	Not covered
Tier 3 (highest cost)	\$240 copay	\$240 copay		30% after deductible	Not covered