Laredo Independent School District
Health Benefit Plan Summary
Blue Cross Blue Shield of Texas, Group #116531
February 1, 2018 through December 31, 2018

approved: 01/08/2018

DESCRIPTION	BASIC	LOW	HIGH	STATE
Deductible (per plan year)	$2,700 employee-only $2,700 employee & spouse, child(ren) & family	$3,000 per individual $6,000 per family	$1,500 per individual $3,000 per family	$500 per individual $1,000 per family
Out-of-Pocket Maximum including deductibles, co-insurance, co-pays & Rx co-pays	$6,350 employee-only $12,700 employee & spouse, child(ren)&family	$7,000 per individual $14,000 per family	$4,000 per individual $8,000 per family	$2,000 per individual $4,000 per family
Coinsurance Plan pays (up to allowable amount) Participant pays (after deductible)	80% 20%	70% 30%	80% 20%	90% 10%
Primary Care Provider Copay Participant pays	**20% after deductible**	**$35 office visit copay**	**$30 office visit copay**	**$20 office visit copay**
Specialist Copay Participant pays	**20% after deductible**	**$45 office visit copay**	**$50 office visit copay**	**$30 office visit copay**
Preventive Care As required under the PPACA	Plan Pays 100% of Allowable Amount	Plan Pays 100% of Allowable Amount	Plan Pays 100% of Allowable Amount	Plan Pays 100% of Allowable Amount
High-tech Radiology (CT scan, MRI, nuclear medicine) Participant pays	20% after deductible	No deductible	20% after deductible	10% after deductible
Inpatient Hospital(facility charge) Participant pays	20% after deductible	30% after deductible	20% after deductible	10% after deductible
Emergency Room Participant pays	20% after deductible	30% of Allowable Amount After $200 Copayment amount, deductible applies (Copay waived if admitted, inpatient hospital expenses will apply)	20% of Allowable Amount After $150 Copayment amount, deductible applies (Copay waived if admitted, inpatient hospital expenses will apply)	10% of Allowanble Amount After $75 Copayment amount, deductible applies (Copay waived if admitted, inpatient hospital expenses will apply)
Urgent Care Copay Participant pays	20% after deductible	$50	$75	$50
Outpatient Surgery Participant pays	20% after deductible	30% after deductible	20% after deductible	10% after deductible
Prescription Drugs Drug Deductible (per plan year)	Subject to plan year deductible	None	None	None
Retail Short-Term (up to a 30-day supply) • Generic Copay • Brand Copay (preferred list) • Brand Copay (non-preferred list)	Participant pays 20% after deductible	Participant pays $15 $30 $50	Participant pays $15 $30 $50	Participant pays $10 $20 $35
Retail Maintenance (up to 90-day supply) • Generic Copay • Brand Copay (preferred list) • Brand Copay (non-preferred list)	Participant pays 20% after deductible	Participant pays $15 $30 $50	Participant pays $15 $30 $50	Participant pays $10 $20 $35
Mail Order (up to a 90-day supply) • Generic Copay • Brand Copay (preferred list) • Brand Copay (non-preferred list)	Participant pays 20% after deductible	Participant pays $30 $60 $100	Participant pays $30 $60 $100	Participant pays $20 $40 $70
Specialty Drugs	Covered	Covered	Covered	Covered
Bariatrict Surgery	Not Covered	Not Covered	Not Covered	Not Covered
Employer Contribution	$355.00	$355.00	$355.00	$355.00
Monthly Employee Premium Employee Only Employee and Spouse Employee and Child(ren) Employee and Family	**$80.59** **$515.22** **$428.03** **$960.51**	**$109.94** **$575.33** **$481.98** **$1,052.19**	**$218.02** **$752.27** **$641.56** **$1,317.87**	**$686.88** **$1,646.57** **$1,480.12** **$2,659.96**

Questions: Call 1-800-521-2227 or visit www.bcbstx.com.

Refer to Summary of Benefits and Coverage for details; call 1-855-756-4448 to request a copy.

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