



Laredo Independent School District
Health Benefit Plan Summary
Blue Cross Blue Shield of Texas, Group #116531
January 1, 2017 through December 31, 2017

Updated: 01/11/2017

DESCRIPTION	BASIC	LOW	HIGH	STATE
Deductible (per plan year)	\$2,600 employee-only \$2,600 employee & spouse, child(ren) & family	\$2,000 per individual \$4,000 per family	\$1,000 per individual \$2,000 per family	\$0 per individual \$0 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	\$6,350 per individual \$12,700 per family	\$3,000 per individual \$6,000 per family	\$1,000 per individual \$2,000 per family
Coinsurance Plan pays (up to allowable amount) Participant pays (after deductible)	80% 20%	70% 30%	80% 20%	90% 10%
Office Visit Copay Participant pays	20% after deductible	\$30 office visit copay; deductible and co-insurance apply to non-office visit charges	\$25 office visit copay; deductible and co-insurance apply to non-office visit charges	\$10 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 Allowable Amount After \$75 Copayment amount, deductible applies (Copay waived if admitted, inpatient hospital expenses will apply)
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 \$10 \$25 \$45	Participant pays \$10 \$25 \$45	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 \$10 \$25 \$45	Participant pays \$10 \$25 \$45	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 \$20 \$50 \$90	Participant pays \$20 \$50 \$90	Participant pays \$20 \$40 \$70
Specialty Drugs	Covered	Covered	Covered	Covered
Bariatric Surgery	Not Covered	Not Covered	Not Covered	Not Covered
Employer Contribution	\$348.00	\$348.00	\$348.00	\$348.00
Monthly Employee Premium				
Employee Only	\$60.72	\$109.74	\$216.77	\$634.72
Employee and Spouse	\$471.84	\$567.91	\$743.34	\$1,539.92
Employee and Child(ren)	\$389.37	\$476.01	\$634.22	\$1,382.92
Employee and Family	\$893.05	\$1,037.38	\$1,300.80	\$2,495.77

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.

Representative: R.J. Laurel Insurance 956-724-9083 • fax 956-726-1873 • 4519 San Bernardo, Laredo, TX 78041