Health Benefit Plan Summary
Blue Cross Blue Shield of Texas
1-800-521-2227
www.bcbstx.com

Updated: 06/30/15

September 1, 2015 through December 31, 2016

DESCRIPTION	BASIC	LOW	HIGH	STATE
Deductible (per plan year)	$2,500 employee-only $2,500 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)	$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**; deduductible and co-insurance apply to non-office visit charges	**$25 office visit copay**; deduductible 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	30% after 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)
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
Bariatrict Surgery	Not Covered	Not Covered	Not Covered	Not Covered
Employer Contribution	$336.17	$336.17	$336.17	$336.17
Monthly Employee Premium Employee Only Employee and Spouse Employee and Child(ren) Employee and Family	**$60.72** **$471.84** **$389.37** **$893.05**	**$109.74** **$567.91** **$476.01** **$1,037.38**	**$216.77** **$743.34** **$634.22** **$1,300.80**	**$634.72** **$1,539.92** **$1,382.92** **$2,495.77**

Summary information only, refer to plan documents for details.

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