

**Austin Independent School District
2008 - 2009 Health Benefits Program Plan Summary**

The following plan summary information is provided only to assist AISD employees in reviewing health plan coverage for 2008-2009. This comparison is not meant to replace the detailed description available from Blue Cross Blue Shield of Texas (BCBSTX). The BCBSTX plan coverage, payments, exclusions and benefit limitations will be determined solely on the basis of the detailed benefit description prepared and distributed by BCBSTX.

	HMO PLAN		PPO PLAN	
			In-Network	Out of Network
Lifetime Maximum		Unlimited		\$2,000,000
Calendar Year Deductible:				
<i>Individual</i>		N/A	\$500	\$500
<i>Family</i>		N/A	\$1,000	\$1,000
Coinsurance Percentage		100%	90%	70%
Out of Pocket:				
<i>Individual</i>		\$1,500	\$1,500	\$3,000
<i>Family</i>		\$3,000	\$3,000	\$6,000
Physician Services				
<i>Primary Care and Specialist Office Visits</i>		Covered at 100% after \$20 copay per visit	Covered at 100% after \$20 copay per visit	Covered at 70% after deductible
<i>Maternity</i>		Covered at 100% after \$20 copay for initial visit	Covered at 100% after \$20 copay for initial visit	Covered at 70% after deductible
<i>Office Surgery</i>		Covered at 100% after \$20 copay per visit	Covered at 90% after deductible	Covered at 70% after deductible
<i>In-Hospital Visits</i>		Covered at 100%	Covered at 90% after deductible	Covered at 70% after deductible
Preventive Care				
<i>Adult Physicals</i>		Covered at 100% after \$20 copay per visit	Covered at 100% after \$20 copay per visit	Covered at 70% after deductible
<i>Well Child Care</i>		Covered at 100% up through age 17	Covered at 100% after \$20 copay per visit	Covered at 70% after deductible
<i>Immunizations</i>		Covered at 100% - All ages	Covered at 100% for ages 0 through 6th birthday; Covered at 100% after \$20 copay for ages after age 6	Covered at 100% for ages 0 through 6th birthday; Covered at 70% after deductible for ages after age 6
Allergy Care Services		Covered at 50% of Allowable Charges for Testing, Evaluations, Injections and Serum	Covered at 100% after \$20 copay per visit for testing and evaluation	Covered at 70% after deductible
Diabetic Equipment & Supplies		Covered at 100% after 20% copay	Covered at 90% after deductible	Covered at 70% after deductible
Hospital Services				
<i>Inpatient, including Maternity</i>		Covered at 100% after \$500 copayment per confinement	Covered at 90% after \$500 per confinement deductible	Covered at 70% after \$500 per confinement deductible
<i>Outpatient</i>		Covered at 100% after \$200 copay per procedure	Covered at 90% after deductible	Covered at 70% after deductible
Emergency Room				
<i>Facility & Physician Services (within 48 hours of event)</i>		Covered at 100% after \$75 copay per visit; copay waived if admitted directly to same facility as inpatient	Covered at 100% after \$75 copay per visit; copay waived if admitted directly to same facility as inpatient	Covered at 100% after \$75 copay per visit; copay waived if admitted directly to same facility as inpatient
<i>Facility & Physician Services (after 48 hours of event)</i>		Covered at 100% after \$75 copay per visit; copay waived if admitted directly to same facility as inpatient	Facility - Covered at 100% after \$75 copay per visit; copay waived if admitted directly to same facility as inpatient / Physician - Covered at 90% after deductible	Facility - Covered at 100% after \$75 copay per visit and deductible; copay waived if admitted directly to same facility as inpatient / Physician - Covered at 70% after deductible
<i>Urgent Care</i>		Covered at 100% after \$40 copay per visit	Covered at 90% after deductible	Covered at 70% after deductible
<i>Ambulance</i>		Covered at 100% after \$100 copayment per service	Covered at 90% after deductible	Covered at 90% after deductible
Diagnostic X-ray and Lab Charges		Covered at 100%	Covered at 100% (excludes Diagnostic Tests)	Covered at 70% after deductible
Outpatient Prescription Drugs⁽¹⁾				
<i>Generic</i>		Covered at 100% after \$15 copay per prescription	Covered at 100% after \$15 copay per prescription	Covered at 80% of allowable after \$15 copay
<i>Preferred Brand</i>		Covered at 100% after \$30 copay per prescription	Covered at 100% after \$30 copay per prescription	Covered at 80% of allowable after \$30 copay
<i>Non-Preferred Brand</i>		Covered at 100% after \$45 copay per prescription	Covered at 100% after \$45 copay per prescription	Covered at 80% of allowable after \$45 copay
<i>Mail Order - 90 Day Supply</i>		Covered at 100% after \$30 generic copay / \$60 preferred brand copay / \$90 non-preferred copay per prescription	Covered at 100% after \$30 generic copay / \$60 preferred brand copay / \$90 non-preferred copay per prescription	Not Covered
Standard Mental/Nervous Benefit⁽²⁾				
<i>Inpatient (30 days per calendar year)</i>		Covered at 100% after \$500 copay per confinement	Covered at 90% after \$500 per confinement deductible	Covered at 70% after \$500 per confinement deductible
<i>Outpatient (visits per calendar year)</i>		Covered at 100% after \$25 copay per visit (20 visits)	Covered at 100% after \$20 copay per visit (30 visits)	Covered at 70% after deductible
Monthly District Contribution		\$447.00		\$447.00
Monthly Employee Cost				
12 month employee			12 month employee	9 month employee
<i>Employee Only</i>		\$ 0.00	\$ 263.00	\$ 350.67
<i>Employee & Children</i>		\$444.00	\$ 972.00	\$1,296.00
<i>Employee & Spouse</i>		\$578.00	\$ 1,185.00	\$1,580.00
<i>Employee & Family</i>		\$891.00	\$ 1,683.00	\$2,244.00

(1)HMO Generic Incentive Rx Program - If a generic equivalent is available and a preferred / non-preferred brand medication is purchased, the member will be required to pay the generic copay plus the difference in cost between the generic medication and the preferred / non-preferred brand medication.

(1)PPO Generic Incentive Rx Program - If a generic equivalent is available and a preferred brand medication is purchased, the member will be required to pay the preferred brand copay plus the difference in cost between the generic medication and the preferred brand medication even if the prescription is written "Brand Necessary or Brand Medically Necessary."

(2)Serious mental illness, as defined in the Texas Insurance Code, is covered same as any other illness under all plans.

For the PPO / HSA Plan, eligible claims for services rendered out of network are subject to the Blue Cross allowable charge; deductibles and coinsurance payment apply separately to in-network and out of network benefits.

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Healthcare Savings Account Plan (HSA)		
	In-Network	Out of Network
Health Account	Employer Contribution Amount (\$)	
Lifetime Maximum	\$2,000,000	
Calendar Year Deductible:		
<i>Employee Only</i>	\$1,500 or	\$3,000 or
<i>Employee + Any Family Members</i>	\$3,000	\$6,000
Coinsurance Percentage	80%	60%
Out of Pocket:		
<i>Employee Only</i>	\$4,500 or	\$9,000 or
<i>Employee + Any Family Members</i>	\$9,000	\$18,000
Physician Services		
<i>Primary Care and Specialist Office Visits</i>	Covered at 80% after deductible	Covered at 60% after deductible
<i>Maternity</i>	Covered at 80% after deductible	Covered at 60% after deductible
<i>Office Surgery</i>	Covered at 80% after deductible	Covered at 60% after deductible
<i>In-Hospital Visits</i>	Covered at 80% after deductible	Covered at 60% after deductible
Preventive Care		
<i>Adult Physicals</i>	Covered at 100%	Covered at 70%
<i>Well Child Care</i>	Covered at 100%	Covered at 70%
<i>Immunizations</i>	Covered at 100% for ages 0 through 6th birthday	Covered at 100% for ages 0 through 6th birthday;
	Covered at 100% for ages after age 6	Covered at 70% for ages after age 6
Allergy Care Services	Covered at 80% after deductible	Covered at 60% after deductible
Diabetic Equipment & Supplies	Covered at 80% after deductible	Covered at 60% after deductible
Hospital Services		
<i>Inpatient, including Maternity</i>	Covered at 80% after deductible	Covered at 60% after deductible
<i>Outpatient</i>	Covered at 80% after deductible	Covered at 60% after deductible
Emergency Room (within 48 hours of event)		
<i>Facility & Physician Services (within 48 hours of event)</i>	Covered at 80% after deductible	Covered at 80% after deductible
<i>Facility & Physician Services (after 48 hours of event)</i>	Covered at 80% after deductible	Covered at 60% after deductible
 <i>Urgent Care</i>	Covered at 80% after deductible	Covered at 60% after deductible
<i>Ambulance</i>	Covered at 80% after deductible	Covered at 80% after deductible
All Diagnostic X-ray and Lab Charges	Covered at 80% after deductible	Covered at 60% after deductible
Outpatient Prescription Drugs		
<i>Retail 30-90 Day Supply</i>	Covered at 80% after deductible	Covered at 80% after deductible
<i>Mail Order 30-90 Day Supply</i>	Covered at 80% after deductible	Covered at 80% after deductible
Standard Mental/Nervous Benefit⁽²⁾		
<i>Inpatient (30 days per calendar year)</i>	Covered at 80% after deductible	Covered at 60% after deductible
<i>Outpatient (30 visits per calendar year)</i>	Covered at 80% after deductible	Covered at 60% after deductible
Monthly District Contribution	\$288.25 (\$158.75 to H S A)	
Monthly Employee Cost	12 month employee	9 month employee
<i>Employee Only</i>	\$ 0.00	\$ 0.00
<i>Employee & Children</i>	\$293.00	\$390.67
<i>Employee & Spouse</i>	\$381.00	\$508.00
<i>Employee & Family</i>	\$586.00	\$781.34