Blue Cross Blue Shield Of Texas
Group Number: 167073
Website: http://www.bcbstx.com/

UISD Health Schedule of Benefits: 2024-2025
Effective Dates: 9/1/2024 to: 8/31/2025
Risk Management: 956-473-6390 Website: https://www.uisd.net/risk-management

DESCRIPTIONS		BRONZE *HMO PLAN	SILVER PPO CORE PLAN		GOLD PPO CORE PLUS	
Network Type		In-Network ONLY (Service Only In Texas)	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	In-Network (You will pay the least)	Out-of-Network (You will pay the most)
Plan Limits	Overall deductibles limits	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
	Out-of-pocket limits	$8,150 Individual $16,300 Family	$8,150 Individual $16,300 Family	$17,000 Individual $34,000 Family	$8,150 Individual $16,300 Family	$17,000 Individual $34,000 Family
	Co-insurance Responsibility (Employee/Provider)	30% / 70%	30% / 70%	50% / 50%	30% / 70%	50% / 50%
Visit to a Health Care Provider's Clinic or Office (HMO Plan requires a PCP referral to see an specialist)						
MD Visits	Virtual visit (MD Live)	Not Available	$15 Copay	N/A	$15 Copay	N/A
	Primary care visit	$35 Copay	$35 Copay	50% Coinsurance	$35 Copay	50% Coinsurance
	Specialist visit	$60 Copay	$60 Copay		$45 Copay	
	Preventive Care/Screening/Immunization	$0	$0		$0	
If You Have A Test						
Costs	Diagnostic test (x-ray, blood work)	No Charge	No Charge	50% Coinsurance	No Charge	50% Coinsurance
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	30% Coinsurance		30% Coinsurance	
	Home Health Care	No Charge; deductible does not apply	No Charge; deductible does not apply		No Charge; deductible does not apply	
Mental Health, behavioral health, or substance abuse services (Certain services must be preauthorized)						
Mental Health	Outpatient services	$35 copay/office visit; deductible does not apply 30% coinsurance for other services	$35 copay/office visit; deductible does not apply 30% coinsurance for other services	50% coinsurance	$35 copay/office visit; deductible does not apply 30% coinsurance for other services	50% coinsurance
	Inpatient services	30% coinsurance; deductible does not apply	30% coinsurance; deductible does not apply	50% coinsurance (Other fees & penalties may apply)	30% coinsurance; deductible does not apply	50% coinsurance (Other fees & penalties may apply)
Emergency Services (for a list of urgent care clinics please visit the RM Website)						
Emergency	Emergency Room Care (Copay waived if admitted)	$500 Copay/plus 30% Coinsurance	$500 Copay/plus 30% Coinsurance	$500 Copay/plus 30% Coinsurance	$500 Copay/plus 30% Coinsurance	$500 Copay/plus 30% Coinsurance
	Emergency medical transportation	30% Coinsurance	30% Coinsurance	30% Coinsurance	30% Coinsurance	30% Coinsurance
	Urgent Care Clinics	$35 - $75 Copay Visit*	$35 - $75 Copay Visit*	50% Coinsurance	$35 - $75 Copay Visit*	50% Coinsurance
Hospital Services						
Hospital	Doctor's Hospital/Laredo Medical	Yes (In-network)	Yes (In-network)	N/A	Yes (In-network)	N/A
	Facility Fee **(if you stay in the hospital)**	30% Coinsurance	30% Coinsurance	50% Coinsurance	30% Coinsurance	50% Coinsurance
	Physician/Surgeon Fees					
Recovery Services (Preauthorizations and limited visits are in force, for more info visit the RM Website)						
Special Care Needs	Home Health Care	No Charge; Deductible does not apply	No Charge; Deductible does not apply	50% Coinsurance	No Charge; Deductible does not apply	50% Coinsurance
	Skilled nursing care					
	Rehabilitation Services	$35 copay PCP/ $60 copay SPC; deductible does not apply	$35 copay PCP/ $60 copay SPC; deductible does not apply	50% Coinsurance	$35 copay PCP/ $45 copay SPC; deductible does not apply	50% Coinsurance
	Habilitation Services					
	Durable Medical Equipment	30% Coinsurance	30% Coinsurance	50% Coinsurance	30% Coinsurance	50% Coinsurance
RX Costs (Generic/Preferred/Non-Preferred/Specialty Drugs)						
Costs	Retail	$10/$60/$105 Copay	$10/$60/$105 Copay	$10/$60/$105 plus 50% Coinsurance	$10/$50/$80 Copay	$10/$50/$80 plus 50% Coinsurance
	Mail-order (90-Day Supply)	$20/$120/$210 Copay	$20/$120/$210 Copay	Not Covered	$20/$100/$160 Copay	Not Covered
	Specialty Drugs	$250 Copay	$250 Copay	Not Covered	$250 Copay	Not Covered
District Contribution		**$525.00**	**$525.00**		**$525.00**	
Costs	**Plan Type**	**Employee** / District	**Employee** / District		**Employee** / District	
	Employee Only	**$41.12** / $566.12	**$81.12** / $606.12		**$170.62** / $695.62	
	Employee & Children Only	**$256.36** / $781.36	**$296.36** / $821.36		**$434.83** / $959.83	
	Employee & Spouse Only	**$448.04** / $973.04	**$488.04** / $1,013.04		**$665.95** / $1,190.95	
	Employee & Family	**$650.04** / $1,175.04	**$690.04** / $1,215.04		**$911.86** / $1,436.86	
	***Dual Family**	**$125.04** / $1,175.04	**$165.04** / $1,215.04		**$386.86** / $1,436.86	

*NEW HMO PLAN: Employees will need to select a PCP for them and their dependents. Categories available are: Family Medicine, OB/GYN, Pedicatrics & Geriatrics. PCP can be changed once a month

**Night Urgent Clinics: Cost may vary from $35.00 to $60.00 depending on service hours.

***Dual Family Plan is only for legally married couples (with children) who both are full time employees for UISD. Must contact Risk Management to enroll in plan.