

**Austin Independent School District
2007 - 2008 Health Benefits Program Plan Summary**

The following plan summary information is provided only to assist AISD employees in reviewing health plan coverage for 2007-2008. 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 6; Covered at 100% after \$20 copay for ages 7+	Covered at 100% for ages 0 through 6; Covered at 70% after deductible for ages 7+
Allergy	Covered at 50% of Allowable Charges for Testing & Serum; Covered at 100% after \$20 copay for serum administration if seen by physician		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 Facility	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>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 Rx		Covered at 100% after \$30 generic copay / \$60 preferred brand copay / \$90 non-preferred copay per Rx	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	\$418.00		\$418.00	
Monthly Employee Cost	12 month employee	9 month employee	12 month employee	9 month employee
<i>Employee Only</i>	\$ 0.00	\$ 0.00	\$ 247.00	\$ 329.34
<i>Employee & Children</i>	\$419.00	\$ 558.67	\$ 911.00	\$1,214.67
<i>Employee & Spouse</i>	\$544.00	\$ 725.34	\$1,111.00	\$1,481.34
<i>Employee & Family</i>	\$837.00	\$1,116.00	\$1,576.00	\$2,101.34

(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 the HMO plan. Outpatient \$20 copay per visit. Inpatient \$500 per confinement.

For the PPO 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.