Medical Coverage
High Plan

High Plan	Premium Per Month	LTISD Contribution Per Month	Employee Total
Employee	$906.00	$500.00	$406.00
Employee + Spouse	$1,593.00	$500.00	$1,093.00
Employee + Children	$1,468.00	$500.00	$968.00
Employee + Family	$2,031.00	$500.00	$1,531.00

	In-Network	Out-of-Network
Annual Deductible	$1,250 / Person $2,500 / Family	$250 / Admission deductible $1,725 / Person $3,500 / Family
Out-of-Pocket Maximum	$3,750 / Individual $7,500 / Family	$5,250 Individual $10,500 / Family
Office Visit Copayment	$25 for PCP	None
Generic (Retail, 30-day Supply)	$15 Copayment Amount	80% of Allowable Amount minus copay
Preferred, Brand Name (Retail, 30-day Supply)	$25 Copayment Amount	80% of Allowable Amount minus copay
Non-Preferred, Brand Name (Retail, 30-day Supply)	$40 Copayment Amount	80% of Allowable Amount minus copay
Speciality Drug	90% of Allowable Amount	80% of Allowable Amount

The participating pharmacies are HEB, Walmart, Walgreens, Randalls, Albertsons (and affiliates).

Drug Deductible and out-of-pocket is the same as the medical deductible and out-of-pocket. All benefits, including prescription drug benefits (retail and mail order) must apply to the plan's overall deductible and out-of-pocket maximum.

Information included in this section summarizes health and medical coverages provided by Blue Cross Blue Shield and is provided for general purposes only. HIPAA and Medicare information, as well as terms, coverages, exclusions, limitations, and other specifics defined in individual plan policies and contracts, can be obtained by contacting Blue Cross Blue Shield at **800-521-2227** or **bcbstx.com**.