BlueCross BlueShield of Texas

Waco ISD 2023 Medical Insurance Plans

	Plan 1 BlueCross BlueShield of TX Blue Choice with an H.S.A.		Plan 2 BlueCross BlueShield of TX Blue Essentials $3500 HMO Plan		Plan 3 BlueCross BlueShield of TX Blue Choice $2500 EPO Plan	
DOCTORS	WHAT YOU PAY IN-NETWORK	WHAT YOU PAY OUT OF NETWORK	WHAT YOU PAY IN-NETWORK	WHAT YOU PAY OUT OF NETWORK	WHAT YOU PAY IN-NETWORK	WHAT YOU PAY OUT OF NETWORK
Primary Care	20% after deductible	N/A	$40 copay	N/A	$30 copay	N/A
$0 copay for children under the age of 19	N/A		$0 no copay		$0 no copay	
Specialist Network	20% after deductible		$80 copay		$60 copay	
Preventive Care	$0 no copay		$0 no copay		$0 no copay	
HOSPITAL						
In-Patient Hospital	20% after deductible	N/A	20% after deductible	N/A	20% after deductible	N/A
Out-Patient Surgery	20% after deductible		$0 after $1,000 copay per visit		20% after deductible	
EMERGENCY HEALTH SERVICES						
Emergency Room	20% after deductible	20% after deductible	$0 after $1,250 copay per visit. Waived if admitted.	$0 after $1,250 copay per visit. Waived if admitted.	20% after $1,000 copay per visit. Waived if admitted.	20% after $1,000 copay per visit. Waived if admitted.
Ambulance	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
ADDITIONAL SERVICES						
Pregnancy	20% after deductible	N/A	$40 / $80 copay then 20% after deductible	N/A	$30 copay then 20% after deductible	N/A
Mental Health	20% after deductible		$40 copay outpatient 20% after ded. Inpatient		$30 copay outpatient 20% after ded. Inpatient	
Rehab / Habilitation Services	20% after deductible		$40 / $80 copay then 20% after deductible		$30 / $60 copay then 20% after deductible	
URGENT CARE SERVICES						
Urgent Care Facility	20% after deductible	N/A	$0 after $100 copay per visit	N/A	$0 after $75 copay per visit	N/A
LAB & X-RAY SERVICES						
Minor lab & x-ray	20% after deductible	N/A	20% after deductible	N/A	20% after deductible	N/A
Major lab & x-ray (MRI, CT Scan, PET Scan)	20% after deductible		$500 copay per service		20% after deductible	
CALENDAR YEAR DEDUCTIBLE						
INDIVIDUAL	$4,000	N/A	$3,500	N/A	$2,500	N/A
FAMILY	$8,000		$10,500		$5,000	
MAXIMUM OUT OF POCKET						
INDIVIDUAL	$7,000 **	N/A	$7,900 **	N/A	$7,500 **	N/A
FAMILY	$14,000 **		$15,800 **		$15,000 **	
LIFETIME MAXIMUM BENEFIT						
	Unlimited	N/A	Unlimited	N/A	Unlimited	Unlimited

**** Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum**