MEDICAL INSURANCE

Plan 1 $4000 Choice HDHP Plan	Monthly Premium	District Monthly Contribution	Employee Monthly Cost	Employee Cost Per Check
Employee Only	$455.88	$455.88	$0.00	$0.00
Employee/Spouse	$1,055.40	$456.00	$599.40	$299.70
Employee/Child(ren)	$809.96	$456.00	$353.96	$176.98
Employee/Family	$1,345.38	$456.00	$889.38	$444.69

Plan 2 $3500 Nexus Plan	Monthly Premium	District Monthly Contribution	Employee Monthly Cost	Employee Cost Per Check
Employee Only	$547.13	$456.00	$91.13	$45.57
Employee/Spouse	$1,223.99	$456.00	$767.99	$384.00
Employee/Child(ren)	$937.85	$456.00	$481.85	$240.93
Employee/Family	$1,562.07	$456.00	$1,106.07	$553.04

Plan 3 $2500 Choice EPO Plan	Monthly Premium	District Monthly Contribution	Employee Monthly Cost	Employee Cost Per Check
Employee Only	$675.71	$456.00	$219.71	$109.86
Employee/Spouse	$1,454.21	$456.00	$998.21	$499.11
Employee/Child(ren)	$1,124.83	$456.00	$668.83	$334.42
Employee/Family	$1,843.41	$456.00	$1,387.41	$693.71

Waco ISD 2024 Medical Insurance Plans

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

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