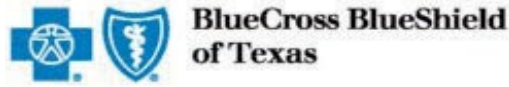




MANOR INDEPENDENT SCHOOL DISTRICT
Business and Finance Department - Payroll & Benefits



2024-2025 MONTHLY & SEMI-MONTHLY MEDICAL INSURANCE RATES

Effective September 1, 2024 - August 31, 2025

Blue Essentials HMO 2500				
Coverage Tier	2024-2025 Plan Year	MISD Contribution	Monthly Employee Contribution	Semi-Monthly Employee Contribution
<i>Employee Only</i>	\$ 471.52	\$ 471.52	\$0.00	\$0.00
<i>Employee and Spouse</i>	\$ 1,317.08	\$ 471.52	\$845.56	\$422.78
<i>Employee and Child(ren)</i>	\$ 889.83	\$ 471.52	\$418.31	\$209.16
<i>Employee and Family</i>	\$ 1,571.11	\$ 471.52	\$1,099.59	\$549.80

BlueChoice HDHP PPO 3000				
Coverage Tier	2024-2025 Plan Year	MISD Contribution	Monthly Employee Contribution	Semi-Monthly Employee Contribution
<i>Employee Only</i>	\$ 449.12	\$ 471.52	\$0.00	\$0.00
<i>Employee and Spouse</i>	\$ 1,334.40	\$ 471.52	\$862.88	\$431.44
<i>Employee and Child(ren)</i>	\$ 866.73	\$ 471.52	\$395.21	\$197.61
<i>Employee and Family</i>	\$ 1,594.21	\$ 471.52	\$1,122.69	\$561.35

Blue Essentials HMO2				
Coverage Tier	2024-2025 Plan Year	MISD Contribution	Employee Contribution	Semi-Monthly Employee Contribution
<i>Employee Only</i>	\$ 584.17	\$ 471.52	\$112.65	\$56.33
<i>Employee and Spouse</i>	\$ 1,717.71	\$ 471.52	\$1246.19	\$623.10
<i>Employee and Child(ren)</i>	\$ 1,135.28	\$ 471.52	\$663.76	\$331.88
<i>Employee and Family</i>	\$ 1,736.48	\$ 471.52	\$1264.96	\$632.48

BlueChoice PPO 1200				
Coverage Tier	2024-2025 Plan Year	MISD Contribution	Employee Contribution	Semi-Monthly Employee Contribution
<i>Employee Only</i>	\$ 604.04	\$ 471.52	\$132.52	\$66.26
<i>Employee and Spouse</i>	\$ 1,478.74	\$ 471.52	\$1007.22	\$503.61
<i>Employee and Child(ren)</i>	\$ 1,016.85	\$ 471.52	\$545.33	\$272.67
<i>Employee and Family</i>	\$ 1,790.51	\$ 471.52	\$1318.99	\$659.50

2024-2025 BCBSTX Plans	HMO \$2,500	HDHP PPO \$3,000	HMO2 \$1,200	PPO \$1,200
PLAN FEATURES				
Type of Coverage	In-network only	In-network and out-of-network	In-network only	In-network and out-of-network
Individual/Family Deductible *Calendar year*	\$2,500/\$5,000	In: \$3,200 / \$6,400 Out: \$5,500 / \$11,000	\$1,200/\$3,600	In: \$1,200 / \$3,600 Out: \$2,000 / \$6,000
Coinsurance	70%	In: 70% Out: 50%	80%	In: 80% Out: 60%
Individual/Family Out of Pocket	\$8,150 / \$16,300	In: \$7,050 / \$14,100 Out: \$20,250 / \$40,500	\$6,900 / \$13,800	In: \$6,900 / \$13,800 Out: \$23,700 / \$47,400
Network	Blue Essentials HMO	BlueChoice PPO	Blue Essentials HMO	BlueChoice PPO
PCP Required	Yes	No	Yes	No
DOCTOR VISITS				
Primary Care	\$30 copay	70% after ded.	\$30 copay	\$30 copay
Specialist	\$70 copay	70% after ded.	\$70 copay	\$70 copay
IMMEDIATE CARE				
Urgent Care	\$50 copay	70% after ded.	\$50 copay	\$50 copay
Emergency Care	70% after ded.	70% after ded.	80% after ded.	80% after \$250 copay
Virtual Health	\$30 copay	70% after ded.	\$30 copay	\$15 copay
PRESCRIPTION DRUGS				
Drug Deductible	N/A	N/A	\$200 brand	\$200
Generics (30 Day/90 Day Supply)	\$15/\$30	80% after ded.	\$15/\$45	\$20/\$50
Preferred Brand/Non-Preferred Brand	70%/50% after ded.	75%/50% after ded.	75%/50% after ded.	\$45/\$95
Specialty	Covered at applicable tier	80% after ded.	70% after ded.	Covered at applicable tier
Insulin Out of Pocket Costs	Covered at applicable tier	Covered at applicable tier	Covered at applicable tier	Covered at applicable tier
DIAGNOSTIC LABS				
Office/Independent	70% after ded.	70% after ded.	80% after ded.	Lab/x-ray: 100% Other: 80% after ded.
Outpatient	70% after ded.	70% after ded.	80% after ded.	80% after ded.
HIGH TECH RADIOLOGY	70% after ded.	70% after ded.	80% after ded.	80% after ded.
OUTPATIENT COSTS	70% after ded.	70% after ded.	80% after ded.	80% after ded.
INPATIENT HOSPITAL COSTS	70% after ded.	70% after ded.	80% after ded.	80% after ded.
FREESTANDING EMERGENCY ROOM	70% after ded.	70% after ded.	80% after ded.	80% after ded.
ANNUAL VISION EXAM	\$30 copay PCP / \$70 copay specialist (annual through age 17, every two years age 18+)	N/A	\$30 copay PCP / \$70 copay specialist (annual through age 17, every two years age 18+)	N/A
ANNUAL HEARING EXAM	\$30 copay PCP / \$70 copay specialist (annual through age 17, every two years age 18+)	N/A	\$30 copay PCP / \$70 copay specialist (annual through age 17, every two years age 18+)	N/A

BlueCross BlueShield of Texas
MEDICAL PLAN # 370294
1-800-521-2227
[HTTPS://MYBAM.BCBSTX.COM](https://mybam.bcbstx.com)