

Austin Independent School District
2011-2012 HSA Benefits Summary

The following plan summary information is provided only to assist AISD employees in reviewing health plan coverage for 2011-2012. This comparison is not meant to replace the detailed description available from Blue Cross Blue Shield of Texas (BCBSTX). The plan coverage, payments, exclusions and benefit limitations will be determined solely by information prepared and distributed by BCBSTX.

Plan Provisions	PPO 3 HSA	
	In Network	Out of Network
Health Account	Employer Contribution Amount (\$)	
Lifetime Maximum	Unlimited	
Annual Maximum on Essential Health Benefits	\$2,000,000	
Deductible:		
Individual Only	\$1,500 or	\$3,000 or
Individual + Any Family Members	\$3,000	\$6,000
Out of Pocket including deductible		
Individual Only	\$4,500 or	\$9,000 or
Individual + Any Family Members	\$9,000	\$18,000
Office Visit (<i>Primary Care or Specialist</i>)	Ded + 20%	Ded + 40%
Lab / X-ray Charges in other outpatient facilities	Ded + 20%	Ded + 40%
Diagnostic Testing (<i>MRI, Ctscan, PET scan, etc.</i>)	Ded + 20%	Ded + 40%
Allergy Injections & Serum	Ded + 20%	Ded + 40%
Allergy Testing	Ded + 20%	Ded + 40%
Preventive Care (as determined by US Preventive Services Task Force)		
Adult Physicals	Covered at 100%	Ded + 30%
Mammogram	Covered at 100%	Ded + 30%
Well Child Care	Covered at 100%	Ded + 30%
Immunizations	Covered at 100%	\$0 up to age 6 Ded + 30% age 6+
Inpatient Hospital Charges:		
Physician Visit	Ded + 20%	Ded + 40%
Facility Charge	Ded + 20%	Ded + 40%
Emergency Room (<i>Accident / Emergency within 48 hrs</i>)		
Facility	Ded + 20%	Ded + 20%
Urgent Care	Ded + 20%	Ded + 40%
Ambulance	Ded + 20%	Ded + 20%
Surgery:		
PCP's Office	Ded + 20%	Ded + 40%
Outpatient Hospital	Ded + 20%	Ded + 40%
Maternity:		
Physician	Ded + 20%	Ded + 40%
Facility	Ded + 20%	Ded + 40%
Prescription Drugs:		
Generic	Ded + 20%	Ded + 20%
Brand	Ded + 20%	Ded + 20%
Non-Preferred	Ded + 20%	Ded + 20%
Mail Order	Ded + 20%	Ded + 20%
Mental/Nervous Benefit		
Inpatient	Ded + 20%	Ded + 40%
Outpatient	Ded + 20%	Ded + 40%
Chemical Dependency Benefit		
Inpatient	Ded + 20%	Ded + 40%
Outpatient	Ded + 20%	Ded + 40%
Vision Care Routine Eye Exam (<i>excludes materials and contact lenses</i>)*	Ded + 20%	Ded + 40%
Pre-existing Limits (<i>refer to BCBSTX documentation for explanation</i>)**	6/12	6/12

*Routine eye exam is provided through Blue Cross providers. Materials and Contact Lenses are provided at a discounted rate

**All pre-ex limits will apply for any newly enrolled employees or dependents over the age of 19 with an effective date of 9/1/11, unless a certificate of creditable coverage can be provided showing prior coverage credit.