Carrier:	BCBS TX		BCBS TX		BCBS TX		BCBS TX	
Network:	BlueChoice PPO		BlueChoice PPO		BlueChoice PPO		BlueAdvantage HMO	
Plan ID	PPO 2000		PPO 4000		PPO H.S.A 7000		HMO 6000	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Deductible - Single	$2,000	$4,000	$4,000	$6,000	$7,000	$14,000	$6,000	N/A
Deductible - Family	$4,000	$8,000	$8,000	$18,000	$14,000	$28,000	$12,000	N/A
Member Coinsurance	20%	50%	30%	50%	40%	50%	40%	N/A
Annual Maximum - Individual (Deductible Included)	$5,000	$10,000	$8,000	$16,000	$8,000	Unlimited	$9,450	N/A
Annual Maximum - Family (Deductible Included)	$10,000	$20,000	$16,000	$32,000	$16,000	Unlimited	$18,900	N/A
Primary Care Office Visit	$50 Copay	50% after Deductible	$50 Copay	50% after Deductible	40% after Deductible	50% after Deductible	$50 Copay	Not Covered
Specialist Office Visit	$75 Copay	50% after Deductible	$75 Copay	50% after Deductible	40% after Deductible	50% after Deductible	$75 Copay	Not Covered
Lab & X-Ray	20% after Deductible	50% after Deductible	30% after Deductible	50% after Deductible	40% after Deductible	50% after Deductible	40% after Deductible	Not Covered
Urgent Care	$75 Copay	50% after Deductible	$75 Copay	50% after Deductible	40% after Deductible	50% after Deductible	$100 Copay	Not Covered
Emergency Room	20% after Deductible		30% after Deductible		40% after Deductible		40% after Deductible	
Outpatient Surgery	20% after Deductible	50% after Deductible	30% after Deductible	50% after Deductible	40% after Deductible	50% after Deductible	40% after Deductible	Not Covered
Inpatient Hospitalization	20% after Deductible	50% after Deductible	30% after Deductible	50% after Deductible	40% after Deductible	50% after Deductible	40% after Deductible	Not Covered
Prescription - 30 Day Supply	$20 / $60 / $100 Copay after $200 Deductible (Individual) $400 Deductible (Family)	$20 / $60 / $100 Copay after $200 Deductible (Individual) $400 Deductible (Family) + 50% Coinsurance	$20 / $60 / $100 Copay after $200 Deductible (Individual) $400 Deductible (Family)	$20 / $60 / $100 Copay after $200 Deductible (Individual) $400 Deductible (Family) + 50% Coinsurance	40% after Deductible	40% after Deductible + 50% additional Coinsurance	$20 / $60 / $100 Copay after $200 Deductible (Individual) $400 Deductible (Family)	Not Covered
Prescription - 90 Day Supply	$50 / $150 / $250 Copay after $200 Deductible (Individual) $400 Deductible (Family)	N/A	$50 / $150 / $250 Copay after $200 Deductible (Individual) $400 Deductible (Family)	N/A	40% after Deductible	40% after Deductible + 50% additional Coinsurance	$50 / $150 / $250 Copay after $200 Deductible (Individual) $400 Deductible (Family)	Not Covered
Prescription - Specialty Drugs	$200 Copay after $200 Deductible (Invdvidual) $400 Deductible (Family)	$200 Copay after $200 Deductible (Individual) $400 Deductible (Family) + 50% Coinsurance	$200 Copay after $200 Deductible (Invdvidual) $400 Deductible (Family)	$200 Copay after $200 Deductible (Individual) $400 Deductible (Family) + 50% Coinsurance	40% after Deductible	40% after Deductible + 50% additional Coinsurance	$200 Copay after $200 Deductible (Invdvidual) $400 Deductible (Family)	Not Covered

Carrier:		BCBS TX	
Network:		EyeMed	
Plan ID		Vision	
		In-Network	Out-Network
Exam with dilation as necessary		$10 Copay	Up to $30
		Frequency	
Examination		Once every 12 months	
Lenses or Contact Lenses		Once every 12 months	
Frame		Once every 24 Months	
		Exam Options	
Contact lens fit and follow up		Up to $40 for standard; 10% off retail price for premium	N/A
		Frames	
Any available frame at provider location		$0 Copay / $100 Allowance / 20% off balance over $100	Up to $50
		Standard Plastic Lenses	
Single Vision		$25 Copay	Up to $25
Bifocal		$25 Copay	Up to $40
Trifocal		$25 Copay	Up to $55
Lenticular		$25 Copay	Up to $55
Standard progressive lens		$90 Copay	Up to $40
Premium progressive lens		See table on page 2	Up to $40
		Lens options	
UV Treatment		$15	N/A
Tint (solid and gradient)		$15	N/A
Standard plastic scratch coating		$15	N/A
Standard polycarbonate - adults		$40	N/A
Standard polycarbonate - kids under 19		$40	N/A
Standard anti-reflective coating		$45	N/A
Polarized		20% off retail price	N/A
Photochromatic/transitions plastic		$75	N/A
Premium anti-reflective		see below table	N/A
		Contact lenses (contact lens allowance includes materials only)	
Conventional		$0 Copay / $100 Allowance / 15% off balance	Up to $80
Disposable		$0 Copay / $100 Allowance / Plus balance over $100	Up to $80
Medically Necessary		$0 Copay, Paid in full	Up to $210
		Other	
Lasik or PRK from U.S. Laser Network		15% off retail price or 5% off promotional price	N/A
Additional Pairs benefit		Members also receive a 40% discount off complete pair eyeglass purchase and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
		Progressive Price List	
Standard Progressive		$90 Copay	N/A
		Premium Progressives	
Tier 1		$110	N/A
Tier 2		$120	N/A
Tier 3		$135	N/A
Tier 4		$90 Copay, 80% of charge less $120 Allowance	N/A
		Anti-reflective coating price list*	
Standard anti-reflective coating		$45	N/A
		Premium anti-reflective coatings as follows	
Tier 1		$57	N/A
Tier 2		$68	N/A
Tier 3		80% of charge	N/A
Other add-ons price list		Member cost	
Photochromic (Plastic)		$75	N/A
Polarized		80% of charge	N/A
Employee Only		$6.19	
Employee + Spouse		$11.77	
Employee + Child(ren)		$12.38	
Family		$18.20	

Carrier:		BCBS	
Network:		BlueCare Dental	
Plan ID		Dental PPO	
		In-Network	**Out-Network**
Preventive		80%	80% of UCR
Preventive Includes		Routine Exam, Cleanings, Fluoride, X-Rays, Sealants	
Basic		80%	80% of UCR
Basic Includes		X Rays, Labs, Fillings.	
Major		50%	50% of UCR
Major Includes		Crowns, Bridges, Endodontics, Periodontics, Root Canal, Surgical Extractions	
Orthodontics		Not Covered	
Individual Deductible		$50	
Family Deductible		$150	
Deductible Applies To		Preventive and Diagnostic Service	
Maximum Benefit - Per Member		$1,500	
Maximum Benefit - Applies To		Preventive, Basic and Major Services	