Killeen Independent School District

2020 Scott and White Health Plan Options

Plan Design	**Plan 1** **BSW Preferred HMO Network** In-Network Only	**Plan 2** **BSW Preferred HMO Network** In-Network Only	**Plan 4** **SWHP HMO Network** In-Network Only	**Plan 5** **BSW Preferred HMO Network** In-Network Only	**Plan 6** **PPO Choice Network** Tier 1: ICSW PPO Tier 2: Cigna PPO OON: Out of Network
Calendar Year Deductible	**Individual:** $500 **Family:** $1,000	**Individual:** $2,700 **Family:** $5,400	**Individual:** $1,000 **Family:** $2,000	**Individual:** $5,000 **Family:** $10,000	**Individual**: $0/$0/$5,000 **Family:** $0/$0/$10,000
Preventive Visits	No Charge	No Charge	No Charge	No Charge	**Tier1:** No Charge **Tier 2:** No Charge **OON:** 50% *
Primary Care Visit	1st Sick Visit $0 $35 Copay	20% After Deductible	1st Sick Visit $0 $35 Copay	20% After Deductible	**Tier 1:** 1st Sick Visit $0 $30 Copay **Tier 2:** $35 Copay **OON:** 50% *
Specialist Visit	$50 Copay	20% After Deductible	$80 Copay	20% After Deductible	**Tier 1:** $70 Copay **Tier 2:** $80 Copay **OON:** 50% *
Diagnostic Test (Lab and X-ray)	No Charge	20% After Deductible	No Charge	20% After Deductible	**Tier 1:** No Charge **Tier 2:** No Charge **OON:** 50% *
Complex Imaging (CT, MRI, etc.)	20% After Deductible	20% After Deductible	$500 Copay	20% After Deductible	**Tier 1:** $400 Copay **Tier 2:** $500 Copay **OON:** 50% *
Walk-In Clinic	$35 Copay	20% After Deductible	$35 Copay	20% After Deductible	**Tier 1:** $30 **Tier 2:** $35 **OON:** 50% *
Urgent Care	$75 Copay	20% After Deductible	$75 Copay	20% After Deductible	$75 Copay
Emergency Room Care	$300 Copay (Waived if admitted)	20% After Deductible	$500 Copay (Waived if admitted)	20% After Deductible	$500 Copay (Waived if admitted)

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Inpatient Hospital	20% After Deductible	20% After Deductible	$1,500/Day Copay (Max 3 Days)	20% After Deductible	**Tier 1:** $800/Day Copay (Max 3 Days) **Tier 2:** $1,000/Day Copay (Max 3 Days) **OON:** 50% *
Maximum Out of Pocket	Individual: $7,350 Family: $14,700	Individual: $6,650 Family: $13,300	Individual: $7,350 Family: $14,700	Individual: $6,650 Family: $13,300	**Tier 1:** Individual: $6,500 Family: $13,000 **Tier 2:** Individual: $7,350 Family: $14,700 **OON:** Individual: $15,000 Family: $30,000
Prescription Medications					
Preferred Generic/ Preferred Brand/ Non-Preferred Generic & Brand	$10 / $45 / $90 Copay, 30-Day Supply	20% After Deductible	$10 / $45 / $90 Copay, 30-Day Supply	20% After Deductible	**INN Tiers 1 & 2:** $10 / $45 / $90 Copay, 30-Day Supply **OON:** Not Covered
Monthly Premiums After District ($325) and State ($75) Contributions					
Employee Only	$241.88	$120.78	$265.86	$32.73	$323.80
Employee + Spouse	$1,268.89	$954.04	$1,331.22	$727.14	$1,481.89
Employee + Child(ren)	$781.06	$558.24	$825.17	$397.68	$931.80
Employee + Family	$1,615.51	$1,235.26	$1,690.78	$961.24	$1,872.73

*After deductible has been met

INN = In-Network Provider

OON = Out of Network Provider