

EMPLOYEE BENEFIT PLANS
Effective 09/01/2022 – 08/31/2023

(This is a summary of benefits only. For a detailed description of benefits, please visit BTNet/Human Resources/Documents)



ELIGIBILITY

The following benefits are available on the first day of the month after completing 60 days of employment for employees working at least 30 hours per week, excluding Relief Pool, PRN or Interns.

HEALTH

Blue Cross Blue Shield – participating providers can be found at www.bcbstx.com

General provisions: Benefit percentage payable

	Plan Pays	Employee Pays
In Network	80%	20%
Out of Network	50%	50%

Preventative Care: 100% after \$20/\$35 copay (in network) / 70% after deductible (out of network)

Calendar Year Deductible: \$3,000 individual (in network) / \$6,000 individual (out of network) / Family Deductible: \$6,000 (in network) / \$12,000 (out of network)

Deductible must be met for all medical care per calendar year except prescriptions, preventive service and office visits

<u>Out of pocket expense limit</u>	<u>Per Person</u>	<u>Per Family</u>
In Network: (includes deductibles and copays)	\$7,000	\$14,000
Non-Network	\$21,000	\$42,000

Emergency Room: \$500 copay, 80% after deductible

Urgent Care:

In Network: \$75 copay; certain diagnostics are covered 80% after deductible

Non-Network: 70% after deductible

Office Visit: \$20 copay for primary care / \$35 copay for specialists

Prescription Copays:

Generic drug: \$10; 80% after applicable copay amount (out of network)

Preferred / Brand drugs: \$40; 80% after applicable copay amount (out of network)

Non-preferred drug: \$60; Specialty drugs: 35% - 50% after deductible (out of network)

SECTION 125 PLAN

Higginbotham – higginbotham.wealthcareportal.com

Flexible Spending Account - up to \$2,850 / year

Dependent Care Account - up to \$5,000 / year

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DENTAL

Dental Select – Gold Network

Waiting period – No waiting period
Benefits – No annual maximum limit per year, per covered person
Preventative services – In Network: Covered at 100%, no deductible; Out of Network: up to \$42
Basic procedures – In Network: Copay ranges from \$0 to \$161; Out of Network: up to \$74
Major procedures – No deductible, fixed copays (refer to Patient copay schedule)
Orthodontics – In Network: 20% discount with listed providers; Out of Network: Not Covered

Dental Select – Platinum Network

Waiting period for basic services – No waiting period
Waiting period for major services – 12 months
Benefits - \$1,000 maximum per year, per covered person
Calendar year deductible - \$50 / individual; \$150 / family
Preventative services – In Network: Covered at 100%, no deductible; Out of Network: 100% of R&C
Basic procedures – In Network: 50%; Out of Network: 50% of R&C
Major procedures – In Network: 50%; Out of Network: 50% of R&C
Orthodontics - \$1,000 maximum; In Network: 50%; Out of Network: 50% of R&C

VISION

Blue Cross Blue Shield

Office visit copay: \$10 In Network; up to \$30 Non-Network
Frame Allowance: \$100 allowance, 20% off balance In Network; up to \$50 Non-Network
Single Vision/Bifocal Lens/Trifocal Lens copay: \$25 In Network; up to \$55 Non-Network

EMPLOYEE ASSISTANCE PROGRAM

Alliance Work Partners

www.alliancewp.com – register code AWP-BT-272
1-800-343-3822
1-800-334-TEEN (8336) teen line

The plan includes an Employee Assistance Program through Alliance Work Partners. The EAP provides a resource to resolve personal family, financial and legal problems for participants and their dependents.

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OPTIONAL INSURANCE

Dearborn National

www.dearbornnational.com
800-348-4512

Long term disability, Accident, Critical Illness

LIFE INSURANCE

All eligible employees will receive an employer-sponsored basic life insurance policy of \$5,000 through Dearborn National. Optional supplemental coverage as well as spouse and eligible dependent policies are available to purchase. Dearborn National includes beneficiary and travel resource services with all basic policies. All policies are subject to an age reduction schedule. Employee is responsible for submitting an Evidence of Insurability Form, if necessary for the policy. Contact your Benefits Coordinator for plan details and costs.

RETIREMENT

Institutional Securities Corporation

www.iscgroup.com
800-888-3520

Plans available through One America: 457, 403(b) and 457 Roth Deferral.

Eligible employees are auto-enrolled upon employment in this benefit at the minimum of 5% contribution. BTCS contributes 7% in a 401(a) plan.

Graduated vesting schedule up to 100% upon five years of full-time employment.

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EMPLOYEE BENEFIT COSTS

HEALTH COVERAGE COST	EMPLOYEE COST (PER MONTH)	CENTER COST (PER MONTH)
		TOTAL INS CENTER COST (PER YR)
Employee Only	\$10.00	\$697.29
		\$8,637.48
Employee + Child(ren)	\$237.58	\$1,014.25
		\$12,171.00
Employee + Spouse	\$346.98	\$1,166.63
		\$13,999.56
Employee + Family	\$577.54	\$1,124.56
		\$13,494.72

DENTAL COVERAGE COST	EMPLOYEE COST (PER MONTH)	
	GOLD / PLATINUM	
Employee Only	\$12.98 / \$30.79	
Employee + Child(ren)	\$31.52 / \$86.17	
Employee + Spouse	\$29.18 / \$61.60	
Employee + Family	\$42.02 / \$117.57	

VISION COVERAGE COST	EMPLOYEE COST (PER MONTH)	
Employee Only	\$5.53	
Employee + Child(ren)	\$11.05	
Employee + Spouse	\$10.51	
Employee + Family	\$16.25	

Payroll/Benefits Coordinator: Ernest Garcia. ernest.garcia@bbtrails.org; (512) 227-0220