



Lubbock ISD Health Plans Administered by Blue Cross and Blue Shield of Texas



7/23/2026

2027 Health Plan and Premium Structure

Medical Coverage	Basic HMO Group 324956-1000 Customer Service (1-877-299-2377)	Basic PPO Group 107576-0010 Customer Service (1-800-521-2227)	Premier PPO Group 220289-0000 Customer Service (1-800-521-2227)
Deductible (per plan year) (Covered services only.)			
In-Network	\$7,000 Individual/\$14,000 Family	\$5,000 Individual/\$10,000 Family	\$3,000 Individual/\$6,000 Family
Out-of-Network	<i>n/a - emergency situations only</i>	\$10,000 individual/\$20,000 Family	\$6,000 Individual/\$12,000 Family
Out-of-Pocket Maximum (Covered services only.) (per plan year; medical and prescription drug deductibles, copays, and coinsurance count toward the out-of-pocket maximum)	*All insureds require a PCP. *All insureds require a PCP referral to see a Specialist.		
In-Network	\$9,000 Individual/\$18,000 Family	\$7,000 Individual/\$14,000 Family	\$6,000 Individual/\$12,000 Family
Out-of-Network	<i>n/a - emergency situations coverage only</i>	\$14,000 Individual/\$28,000 Family	\$12,000 Individual/\$24,000 Family
Coinsurance			
In-Network (Owed after deductible)	Plan pays at 80% post-deductible.	Plan pays 80% until Out-of-Pocket met.	Plan pays at 80% until Out-of-Pocket met.
Out-of-Network (Owed after deductible)	<i>n/a - emergency situation coverage only</i>	Plan pays at 60% until Out-of-Pocket met.	Plan pays at 60% until Out-of-Pocket met.
Office Visit (Insured pays)	\$60 primary care/\$100 specialist	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
\$0 Copay Clinics	*Available to insureds and covered dependents on all Lubbock ISD Health Plans. Excludes non-medical plan enrolled staff/family members.*		
Diagnostic Lab (Insured pays)	Goes toward deductible/coinsurance. (In-Network, covered services only.)	Goes toward deductible/coinsurance. (Covered services only.)	Goes toward deductible/coinsurance. (Covered services only.)
Preventive Care (In-Network) <i>Examples:</i> Routine Physicals, Mammograms, Well-child care, Colonoscopy, Well-women exams, and Prostate screenings, etc. (Some age limits apply.)	Plan pays 100%. (Billed as preventive.) (In-Network only.) (Covered services only.) (Once annually.)	Plan pays 100%. (Billed as preventive.) (In-Network only.) (Covered services only.) (Once annually.)	Plan pays 100%. (Billed as preventive.) (In-Network only.) (Covered services only.) (Once annually.)
Inpatient Hospital Facility Charges Only (Preauthorization required.)			
In-Network	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Out-of-Network	<i>n/a - emergency situation coverage only</i>	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Urgent Care Visits (In-Network) (True emergency use.)	\$50 copay	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Freestanding Emergency Room (Insured pays) (Not all are In-Network.)	Goes toward deductible/coinsurance. (True emergency use.)	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Emergency Room (Insured pays) (True emergency use.) (Covenant and UMC hospitals In-Network.)	\$500 copay Emergency Department + deductible (True emergency use.)	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Outpatient Surgery: In-Network (Insured pays)	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Mental Health/Substance Abuse Services (In-Network only.) (May require preauthorization.)			
Inpatient/Outpatient	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Maternity Care (In-Network) (covered services)			
Office Visits	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Childbirth/delivery professional services	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Childbirth/delivery facility services	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Special Health Needs (In-Network) (Covered services only.) (May require preauthorization.)			
Home Health Care	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.

*Limit 60 days/calendar year.			
Rehabilitation Services	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Habilitation Services	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Skilled Nursing Care	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
*Limit 25 days/calendar year.			
Durable Medical Equipment	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Hospice Services	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
Pre-Tax Savings Account Options	Basic HMO	Basic PPO	Premier PPO
Flexible Spending Account (F.S.A)	Flexible Spending Account eligible.	Flexible Spending Account eligible.	Flexible Spending Account eligible.
*Through First Financial - use or lose.	\$3300 Annual Limit (2026 pending)	\$3300 Annual Limit (2026 pending)	\$3300 Annual Limit (2026 pending)
Prescription Coverage	Basic HMO Group 251495-1000	Basic PPO Group 107576-0010	Premier PPO Group 220289-0000
Drug Deductible	Covered medications paid by insured until plan deductible is satisfied. Specialty medications require deductible + 30% coinsurance.	Covered medications paid by insured until plan deductible is satisfied. Specialty medications require deductible + 30% coinsurance.	\$100 Prescription Deductible
(per person per plan year)			\$15 Generic Copay
Monthly Maintenance Medications 90-day supply with CVS local retail or CVS mail-order.			\$35 Brand Formulary Copay
			\$65 Brand Non-Formulary Copay
			30% after deductible for Specialty meds
<i>\$0 Copay Generics</i>	<i>* Prescriptions must be from a \$0 Copay Clinic provider, filled at a United Pharmacy, and listed on the \$0 Copay Generic list. *</i>		
<i>Living Better Diabetes Program</i>	<i>* Program participation required for reimbursement of up to \$2,500 of diabetic program eligible expenses annually. *</i>		
Coverage Level Cost	Basic HMO Monthly Premium	Basic PPO Monthly Premium	Premier PPO Monthly Premium
	Standard Rate Wellness Rate	Standard Rate Wellness Rate	Standard Rate Wellness Rate
Employee Only	\$150.00 \$100.00	\$357.90 \$307.90	\$ 596.50 \$ 546.50
Employee and Children	\$298.25 \$248.25	\$656.15 \$606.15	\$1014.05 \$ 964.05
Employee and Spouse	\$805.28 \$755.28	\$894.75 \$844.75	\$1431.60 \$1381.60
Employee and Family	\$864.93 \$814.93	\$954.40 \$904.40	\$1789.50 \$1739.50
<i>*The Standard Premium will be adjusted by a \$50 Wellness Credit with FULL Participation/Compliance in the Health Screening and Wellness Program</i>			