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

Plan and Premium Structure 2022

Medical Coverage	Blue Essentials Bronze (HMO) Customer Service (1-877-299-2377)	Blue Essentials Silver (HMO) Customer Service (1-877-299-2377)	Blue Choice Bronze (PPO) Customer Service (1-800-521-2227)	Blue Choice Silver (PPO) Customer Service (1-800-521-2227)
Deductible (per plan year) (Covered services only.)				
In-Network	$5000 Individual/$10,000 Family	$4,000 Individual/$8,000 Family	$6,650 Individual/$13,300 Family	$4,000 Individual/$8,000 Family
Out-of-Network	*n/a - emergency situations only*	*n/a - emergency situations only*	$6,650 Individual/$13,300 Family	$4,000 Individual/$8,000 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.**	***All insureds require a PCP.** ***All insureds require a PCP referral to see a Specialist.**		
In-Network	$5000 individual/$10,000 family	$7,050 Individual/$14,100 Family	$6,650 Individual/$13,300 Family	$7,050 Individual/$14,100 Family
Out-of-Network	*n/a - emergency situations coverage only*	*n/a - emergency situations coverage only*	$10,000 Individual/$20,000 Family	$8,000 Inividual/$16,000 Family
Coinsurance				
In-Network (Owed after deductible)	Plan pays at 100% post-deductible.	Plan pays at 80% until Out-of-Pocket met.	Plan pays at 100% post-deductible.	Plan pays at 80% until Out-of-Pocket met.
Out-of-Network (Owed after deductible)	*n/a - emergency situation coverage only*	*n/a - emergency situation coverage only*	Plan pays at 40% until Out-of-Pocket met.	Plan pays at 50% until Out-of-Pocket met.
Office Visit (Insured pays)	$60 primary care/$100 specialist	$60 primary care/$100 specialist	Goes toward deductible.	Goes toward deductible/coinsurance.
$0 Copay Clinics	*** Available to insureds and covered dependents on all Lubbock ISD Health Plans. Excludes the Hospital Income Plan. ***			
Diagnostic Lab (Insured pays)	Goes toward deductible. (In-Network, covered services only.)	Goes toward deductible/coinsurance. (In-Network, covered services only.)	Goes toward deductible. (Covered services only.)	Goes toward deductible/coinsurance. (Covered services only.)
Preventive Care (In-Network) Examples: 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.) (Every 12 months.)	Plan pays 100%. (Billed as preventive.) (In-Network only.) (Covered services only.) (Every 12 months.)	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.	Goes toward deductible/coinsurance.	Goes toward deductible.	Goes toward deductible/coinsurance.
Out-of-Network	*n/a - emergency situation coverage only*	*n/a - emergency situation coverage only*	Goes toward deductible.	Goes toward deductible/coinsurance.
Urgent Care Visits (In-Network) (True emergency use.)	Goes toward deductible.	Goes toward deductible/coinsurance.	Goes toward deductible.	Goes toward deductible/coinsurance.
Freestanding Emergency Room (Insured pays) (Not all are In-Network.)	Goes toward deductible. **(True emergency use.)**	Goes toward deductible/coinsurance. **(True emergency use.)**	Goes toward deductible.	Goes toward deductible/coinsurance.
Emergency Room (Insured pays) (True emergency use.) (Covenant and UMC hospitals In-Network.)	Goes toward deductible. **(True emergency use.)**	Goes toward deductible/coinsurance. **(True emergency use.)**	Goes toward deductible.	Goes toward deductible/coinsurance.
Outpatient Surgery: In-Network (Insured pays)	Goes toward deductible.	Goes toward deductible/coinsurance.	Goes toward deductible.	Goes toward deductible/coinsurance.
Mental Health/Substance Abuse Services **(In-Network only.)** (May require preauthorization.) **Inpatient/Outpatient**	Goes toward deductible.	Goes toward deductible/coinsurance.	Goes toward deductible.	Goes toward deductible/coinsurance.

Maternity Care (In-Network) (covered services)				
Office Visits	Goes toward deductible.	Goes toward deductible/coinsurance.	Goes toward deductible.	Goes toward deductible/coinsurance.
Childbirth/delivery professional services	Goes toward deductible.	Goes toward deductible/coinsurance.	Goes toward deductible.	Goes toward deductible/coinsurance.
Childbirth/delivery facility services	Goes toward deductible.	Goes toward deductible/coinsurance.	Goes toward deductible.	Goes toward deductible/coinsurance.
****Bronze Plan Maternity Reimbursement****	**Caps In-Network Deductible at $4,000 for covered maternity expenses.**		**Caps In-Network Deductible at $4,000 for covered maternity expenses.**	
Special Health Needs (In-Network) (Covered services only.) (May require preauthorization.)				
Home Health Care *Limit 60 days/calendar year.	Goes toward deductible.	Goes toward deductible/coinsurance.	Goes toward deductible.	Goes toward deductible/coinsurance.
Rehabilitation Services	Goes toward deductible.	Goes toward deductible/coinsurance.	Goes toward deductible.	Goes toward deductible/coinsurance.
Habilitation Services	Goes toward deductible.	Goes toward deductible/coinsurance.	Goes toward deductible.	Goes toward deductible/coinsurance.
Skilled Nursing Care *Limit 25 days/calendar year.	Goes toward deductible.	Goes toward deductible/coinsurance.	Goes toward deductible.	Goes toward deductible/coinsurance.
Durable Medical Equipment	Goes toward deductible.	Goes toward deductible/coinsurance.	Goes toward deductible.	Goes toward deductible/coinsurance.
Hospice Services	Goes toward deductible.	Goes toward deductible/coinsurance.	Goes toward deductible.	Goes toward deductible/coinsurance.

Pre-Tax Savings Account Options	Blue Essentials Bronze (HMO)	Blue Essentials Silver (HMO)	Blue Choice Bronze (PPO)	Blue Choice Silver (PPO)
Health Savings Account (H.S.A) *$500 Annual H.S.A Employer Match. **Balance rolls year to year.	Not eligible.	Not eligible.	Health Savings Account eligible. H.S.A Annual Contribution Limits: $3,650 Individual/$7,300 Family	Not eligible.
Flexible Spending Account (F.S.A) *Through First Financial - use or lose.	Flexible Spending Account eligible. $2,750 Annual Limit.	Flexible Spending Account eligible. $2,750 Annual Limit.	Flexible Spending Account eligible. $2,750 Annual Limit.	Flexible Spending Account eligible. $2,750 Annual Limit.

Prescription Coverage (Administered by CVS/Caremark. (1-844-286-1902))	Blue Essentials Bronze (HMO) Group 251495-1000	Blue Essentials Silver (HMO) Group 251496-2000	Blue Choice Bronze (PPO) Group 107576-0010	Blue Choice Silver (PPO) Group 220289-0000
Drug Deductible (per person per plan year) Monthly Maintenance Medications 90-day supply with CVS local retail or CVS mail-order.	Covered medications paid by insured until plan deductible is satisfied.	$100 Prescription Deductible $15 Generic Copay $35 Brand Formulary Copay $65 Brand Non-Formulary Copay	Covered medications paid by insured until plan deductible is satisfied.	$100 Prescription Deductible $15 Generic Copay $35 Brand Formulary Copay $65 Brand Non-Formulary Copay
$0 Copay Generics	*** Prescriptions must be from a $0 Copay Clinic provider, filled at a United Pharmacy, and listed on the $0 Copay Generic list. ***			
Living Better Diabetes Program	*** Program participation required for reimbursement of up to $2,500 of diabetic program eligible expenses annually. ***			

Coverage Level Cost	Blue Essentials Bronze (HMO) Monthly Premium		Blue Essentials Silver (HMO) Monthly Premium		Blue Choice Bronze (PPO) Monthly Premium		Blue Choice Silver (PPO) Monthly Premium	
	Standard Rate	Wellness Rate	Standard Rate	Wellness Rate	Standard Rate	Wellness Rate	Standard Rate	Wellness Rate
Employee Only	**$95**	**$20**	**$294**	**$219**	**$144**	**$69**	**$354**	**$279**
Employee and Children	**$128**	**$53**	**$427**	**$352**	**$234**	**$159**	**$523**	**$448**
Employee and Spouse	**$227**	**$152**	**$559**	**$484**	**$295**	**$220**	**$681**	**$606**
Employee and Family	**$371**	**$296**	**$816**	**$741**	**$468**	**$393**	**$987**	**$912**

*The Standard Premium will be adjusted by a $75 Wellness Credit with full Participation/Compliance in the Health Screening and Wellness Program.

Hospital Income Plan (HIP)	*Supplemental policy, zero cost to the employee, pays $250 for each day billed during an employee hospital stay. Waives major medical.*