Board Approved 8/28/2025

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

2026 Health Plan and Premium Structure

BlueCross BlueShield of Texas

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	*n/a - emergency situations only*	$10,000 individual/$20,000 Family	$6,000 Individual/$12,000 Family
Out-of-Pocket Maximum (Covered services only.)	***All insureds require a PCP.**		
(per plan year; medical and prescription drug	***All insureds require a PCP referral**		
deductibles, copays, and coinsurance count	**to see a Specialist.**		
toward the out-of-pocket maximum)			
In-Network	$9,000 Individual/$18,000 Family	$7,000 Individual/$14,000 Family	$6,000 Individual/$12,000 Family
Out-of-Network	*n/a - emergency situations coverage only*	$14,000 Individual/$28,000 Family	$12,000 Inividual/$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)	*n/a - emergency situation coverage only*	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.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
	(In-Network, covered services only.)	(Covered services only.)	(Covered services only.)
Preventive Care (In-Network)	Plan pays 100%. (Billed as preventive.)	Plan pays 100%. (Billed as preventive.)	Plan pays 100%. (Billed as preventive.)
Examples: Routine Physicals, Mammograms,	(In-Network only.)	(In-Network only.)	(In-Network only.)
Well-child care, Colonoscopy, Well-women exams,	(Covered services only.)	(Covered services only.)	(Covered services only.)
and Prostate screenings, etc. (Some age limits apply.)	(Once annually.)	(Once annually.)	(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	*n/a - emergency situation coverage only*	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)	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
(Not all are In-Network.)	**(True emergency use.)**		
Emergency Room (Insured pays)			
(True emergency use.)	$500 copay Emergency Department + deductible	Goes toward deductible/coinsurance.	Goes toward deductible/coinsurance.
(Covenant and UMC hospitals In-Network.)	**(True emergency use.)**		
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 Administered by CVS/Caremark. (1-844-286-1902)	**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			**$35 Brand Formulary Copay**
supply with CVS local retail or CVS mail-order.			**$65 Brand Non-Formulary Copay**
			30% after deductible for Specialty meds
$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	**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	$300.00	$250.00	$ 500.00	$ 450.00
Employee and Children	$250.00	$200.00	$550.00	$500.00	$ 850.00	$ 800.00
Employee and Spouse	$675.00	$625.00	$750.00	$700.00	$1200.00	$ 1150.00
Employee and Family	$725.00	$675.00	$800.00	$750.00	$1500.00	$ 1450.00

*The Standard Premium will be adjusted by a $50 Wellness Credit with FULL Participation/Compliance in the Health Screening and Wellness Program