Coverage Period January 1st - December 31st 2021

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

BlueCross BlueShield of Texas

Medical Coverage	Blue Essentials Bronze (HMO) Group 251495-1000 Customer Service (1-877-299-2377)	Blue Essentials Silver (HMO) Group 251496-2000 Customer Service (1-877-299-2377)	Blue Choice Bronze (PPO) Group 107576-0010 Customer Service (1-800-521-2227)	Blue Choice Silver (PPO) Group 220289-0000 Customer Service (1-800-521-2227)
Deductible (per plan year) (Covered services only.)				
In-Network	$6,650 Individual/$13,300 Family	$4,000 Individual/$8,000 Family	$6,650 Individual/$13,300 Family	$4,000 Individual/$8,000 Family
Out-of-Network	N/A - This plan covers Out-of-Network in emergency situations only.	N/A - This plan covers Out-of-Network in 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	$6,650 Individual/$13,300 Family	$7,050 Individual/$14,100 Family	$6,650 Individual/$13,300 Family	$7,050 Individual/$14,100 Family
Out-of-Network	N/A - This plan covers Out-of-Network in emergency situations only.	N/A - This plan covers Out-of-Network in emergency situations 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 - This plan covers Out-of-Network in emergency situations only.	N/A - This plan covers Out-of-Network in emergency situations only.	Plan pays at 40% until Out-of-Pocket met.	Plan pays at 50% until Out-of-Pocket met.
Office Visit (Insured pays)	Goes toward deductible.	Goes toward deductible/coinsurance.	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 - This plan covers Out-of-Network in emergency situations only.	N/A - This plan covers Out-of-Network in emergency situations 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				

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(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 ****Bronze Plan Maternity Reimbursement****	Goes toward deductible. Caps In-Network Deductible at $4,000 for covered maternity expenses.	Goes toward deductible/coinsurance.	Goes toward deductible. Caps In-Network Deductible at $4,000 for covered maternity expenses.	Goes toward deductible/coinsurance.
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.	Health Savings Account eligible. H.S.A Annual Contribution Limits: $3,600 Individual/$7,200 Family	Not eligible.	Health Savings Account eligible. H.S.A Annual Contribution Limits: $3,600 Individual/$7,200 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 Brand Non-Formulary Copay effective 2/1/21	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 Brand Non-Formulary Copay effective 2/1/21
$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	**$113**	**$38**	**$280**	**$205**	**$144**	**$69**	**$337**	**$262**
Employee and Children	**$181**	**$106**	**$407**	**$332**	**$234**	**$159**	**$498**	**$423**
Employee and Spouse	**$227**	**$152**	**$532**	**$457**	**$295**	**$220**	**$649**	**$574**
Employee and Family	**$371**	**$296**	**$777**	**$702**	**$468**	**$393**	**$940**	**$865**

***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.***

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