LTISD Health Insurance Benefits Comparison
For 2025-26 Plan Year
Medical and Pharmacy Out-Of Pocket Cost

	2025-26 Plan Year					
	Low Plan		High Plan		High Deductible Plan	
Plan Type	**Blue Essentials - HMO**		**PPO**		**HSA**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network Only**	**Out-of-Network**
Coinsurance *Participant pays (after deductible)*	**25%**	**No Coverage**	**20%**	**40%**	**20%**	**40%**
Deductible *(per plan year)*	**$1,750** *Employee* **$5,250** *Family*	**No Coverage**	**$2,000** *Employee* **$4,000** *Family*	**$2,500** *Employee* **$5,000** *Family*	**$3,500** *Employee* **$7,000** *Family*	**$7,000** *Employee* **$14,000** *Family*
Maximum Out of Pocket Limits: *To include copays, coinsurance any charges that apply to your deductible*	**$7,000** *Employee* **$14,000** *Family*	**No Coverage**	**$6,000** *Employee* **$12,000** *Family*	**$9,000** *Employee* **$15,000** *Family*	**$6,900** *Employee* **$13,800** *Family*	**$13,800** *Employee* **$27,600** *Family*
Physician Office Visit Copay	**$40 Copay**	**No Coverage**	**$30 Copay**	**40%** *After Deductible*	**20%** *After Deductible*	**40%** *After Deductible*
Specialist Office Visit Copay	**$75 Copay**	**No Coverage**	**$50 Copay**	**40%** *After Deductible*	**20%** *After Deductible*	**40%** *After Deductible*
Telemedicine / MD Live	**$20 Copay**		**$20 Copay**		**$20 Copay**	
Urgent Care Visit	**$75 Copay**	**No Coverage**	**$75 Copay**	**40%** *After Deductible*	**20%** *After Deductible*	**40%** *After Deductible*
Emergency Room Visit	**25%** *after $300 Copay*	**No Coverage**	**20%** *after $300 Copay*	**20%** *after $300 Copay*	**20%**	**20%**
Inpatient Hospital Expenses	**25% After Deductible**	**No Coverage**	**80% of Allowable Amount**	**40%** *of Allowable Amount after Pre-admission Deductible $250*	**20%** *After Deductible*	**40%** *After Deductible*
Drug Deductible	**$0**	**No Coverage**	**$0**	**$0**	**$0**	**$0**
Pharmacy *(Generic Drug/Preferred Brand Name Drug/Non-Preferred Brand Name)*	**$25/$50/$75**	**No Coverage**	**$25/$40/$55**	**$30/$55/$60 + 30% coinsurance**	*20% After Deductible*	*25%/30%/30% After Deductible*
Specialty Medications	**25% Coinsurance**	**No Coverage**	**20% Coinsurance**	**No Coverage**	*20% After Deductible*	**Not Covered**
	Employee Rate		**Employee Rate**		**Employee Rate**	
Employee Only	**$171.00**		**$291.00**		**$55.00**	
Employee/Spouse	**$764.00**		**$859.00**		**$657.00**	
Employee/Children	**$655.00**		**$754.00**		**$500.00**	
Employee/Family	**$1,138.00**		**$1,215.00**		**$893.00**	