PPO NO OOA MEDICAL BENEFIT SUMMARY – INSURED

ACCOUNT INFORMATION
Legal Group Name: **SSCP Management & Affiliates** Account # TX436693 Benefit Agreement# 0001 Anniversary Date: **01/01**

Prepared By: Tracy Marshall
New – Original Effective Date 01/01/2026
Grandfathered Status: Non-Grandfathered

Comment	TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
	GENERAL PROVISIONS		
	Deductible		
	Cross-feeding:		
	Stand-Alone (No cross-feeding. In-Network updates IN only; OON updates OON only)		
	Type:		
	Common (One deductible that applies to all eligible expenses)		
	Individual	$1000	$5000
	Family	$2000	$10000
	Three Month Deductible Carryover Applies	No	No
	Coshare / Out-of-Pocket		
	Cross-feeding:		
	Stand-Alone (No cross-feeding. In-Network updates IN only; OON updates OON only)		
	Individual	$6500	$10000
	Family	$13000	$20000
	Deductibles apply to Coshare/OPX	Yes (no option)	Yes
	Copayments apply to Coshare/OPX	Yes (no option)	Yes
	Lifetime Dollar Maximum Benefit	Unlimited (no option)	
	Benefit Period	Calendar Year	
	Prior Carrier Credit applies	None	
Comments:			
	FACILITY ONLY: INPATIENT HOSPITAL (Preauthorization required)		
	Semiprivate Room & Board / Ancillaries (Corporate Standard)	80% after deductible	50% after deductible
Comments:			
	FACILITY ONLY: OUTPATIENT HOSPITAL		
	Accident / Medical or Behavioral Health Emergency	Copay waived if admitted	
	Emergency Room (ER) / Treatment Room / Ancillary	80% after $250 copay and ded	
	Lab & X-ray – without ER or Treatment Room	100%	
	Non-Emergency Care	Copay waived if admitted	
	Emergency Room / Treatment Room / Ancillary	80% after $250 copay and ded	50% after $250 copay and ded
	Lab & X-ray – without ER or Treatment Room	100%	50% after deductible
	Other Outpatient Services, includes Diagnostic Medical Procedures – No Copay		

Comment	TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
	Certain Diagnostic Procedures (Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan)	80% after deductible	50% after deductible
Comments:			
	EXTENDED CARE INPATIENT/HOME (Preauthorization required)		
	Skilled Nursing Facility (ECF – Extended Care Facility)	80% after deductible	50% after deductible
	Visit Maximum	60 day maximum per calendar year	
	Home Health (Mandated offer)	80% after deductible	50% after deductible
	Visit Maximum	60 visit maximum per cal. yr.	
	Hospice	80% after deductible	50% after deductible
	Visit Maximum	Unlimited	
Comments:			
	INPATIENT PHYSICIAN'S CHARGES		
	Inpatient Visits		
	Hospital Visit	80% after deductible	50% after deductible
	Consultation	80% after deductible	50% after deductible
	Surgery		
	General	80% after deductible	50% after deductible
Comments:			
	OUTPATIENT PHYSICIAN'S CHARGES		
	Lab & X-ray	100%	50% after deductible
	Surgery	80% after deductible	50% after deductible
	Certain Diagnostic Procedures (Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan)	80% after deductible	50% after deductible
	Accident / Medical or Behavioral Health Emergency	Pays as any other outpatient service	OON pays at in-network level
	Non-Emergency Care	Pays as any other outpatient service	Pays as any other outpatient service
	In-Vitro Fertilization (paid AAOI – mandated offer) N (If "N" is elected, in-vitro is not covered)		
Comments:			
	PHYSICIAN'S CHARGES IN THE OFFICE		
	Lab & X-ray	100% after $0 / $100 Copay	50% after deductible
	Office Visit/ Consultation	100% after $0 / $100 Copay	50% after deductible
	Office Visit / Consultation performed in a contracted Urgent Care Center	100% after $50 Copay	50% after deductible
	Surgery	80% after deductible	50% after deductible
	In-Vitro Fertilization (paid AAOI – mandated offer) N **(If "N" is elected, in-vitro is not covered)**		
	Certain Diagnostic Procedures (Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan)	80% after deductible	50% after deductible
Comments:			
	PROVIDER CHARGES IN THE HOME		

Comment	TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
	Home Infusion Therapy (HIT) (Preauthorization required)	80% after deductible	50% after deductible
Comments:			
	OTHER SUPPLIERS		
	Ambulance		
	Ground/Air	80% after deductible	
	Hearing Aid up to 1 per ear per 36-month period	80% after deductible	50% after deductible
	Virtual Visit MDLIVE (standard offering) Note: **Must mirror PCP office visit benefit** Medical & Behavioral Health **Medical** Note: **Behavioral Health benefit must mirror benefit under Mental Health and Substance Use Disorder** **Behavioral Health** Note: Behavioral Health Virtual Visit applies to MHP unless plan is retiree only and exempt from MHP.	100% 100%	NA NA
Comments:			
	PREVENTIVE CARE – FACILITY / PHYSICIAN CHARGES IN OUTPATIENT FACILITY & OFFICE - Health Education/Counseling Services, Immunizations, Preventive Care Services, Routine Bone Density Test, Routine Breast Exam, Routine Colonoscopy, Routine Colorectal Cancer Screening-Lab, Routine Gynecological Exam, ACA Preventive Lab Procedures, screening and diagnostic Mammograms, Routine Pap Smears, Routine Physical, Smoking Cessation Counseling Services, Well Baby Care, Women's Preventive Care (including, but not limited to: well-woman visits, certain FDA-approved contraception methods for women, female sterilization, breast feeding support, supplies and counseling). NOTE: If eligible employer exemption/eligible organization accommodation applies, ACA federal mandates pertaining to coverage of certain women's contraception methods and counseling with no cost sharing, may not be required.		
	Outpatient Visit	100%	50% after ded.
	Office Visit	100%	50% after ded.
	ACA Preventive Lab – includes independent lab (Office & Outpatient)	100%	50% after ded.
	Routine X-rays, routine lab, routine EKG, routine diagnostic medical procedures, routine digital rectal exam, routine prostate test (Outpatient)	100%	50% after ded.
	Routine X-rays, routine lab, routine EKG, routine diagnostic medical procedures, routine digital rectal exam, routine prostate test (Office)	Other: 100% after $0 PCP/$100 SPC Copay	50% after ded.
	Routine X-rays, routine lab, routine EKG, routine diagnostic medical procedures, routine digital rectal exam, routine prostate test (Outpatient) **(Independent Lab & X-ray Providers)**	100%	50% after ded.
	Routine X-rays, routine lab, routine EKG, routine diagnostic medical procedures, routine digital rectal exam, routine prostate test (Office) **(Independent Lab & X-ray Providers)**	100%	50% after ded.
	Immunizations – after the day of the 6th birthdate	100%	50% after ded.
	Immunizations – birth to the day of the 6th birthdate – No Option	100%	100%
Comments:			
	PHYSICIAN'S CHARGES FOR PHYSICAL MEDICINE / OUTPATIENT FACILITY & OFFICE		
	Physical Therapy (Includes physical, occupational and manipulative therapies)		

Comment	TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
	All Other Services (Including Occupational Therapy) in the office	80% after deductible	50% after deductible
	All Other Services (Including Occupational Therapy) in the outpatient setting	80% after deductible	50% after deductible
	Visit Maximum	35 visit maximum per cal. yr.	
Comments:			
	MENTAL HEALTH (Serious Mental Illness (SMI) is inclusive under Mental Health (MH)		
	The following are included for MH: Crisis Stabilization Unit or Facility, Residential Treatment Center and Partial Hospitalization Program (Psychiatric Day Treatment Center).	(Paid As Any Other Illness) – NO OPTION Benefits require Pre-authorization, and when included for the treatment of Mental Health conditions, will be covered at the inpatient hospital facility benefit payment level, including any applicable limits, per Medical Necessity Criteria which provides guidelines for level of service, appropriate setting, pre authorization and concurrent review process.	
Comments:			
	CHEMICAL DEPENDENCY (SUBSTANCE USE DISORDER)		
	The following are included for Chemical Dependency: Chemical Dependency Treatment Centers/Residential Treatment Centers and Partial Hospitalization Program (Day Treatment Center)	Paid As Any Other Illness - No Option Benefits require Pre-authorization, and when included for the treatment of Chemical Dependency will be covered at the inpatient hospital facility benefit payment level, including any applicable limits, per Medical Necessity Criteria which provides guidelines for level of service, appropriate setting, pre authorization and concurrent review process.	
Comments:			
	PREAUTHORIZATION GUIDELINES **Note:** For Wellbeing Management (WBM) and/or Health Advocacy Solutions (HAS) information, review the corresponding matrix. For inpatient Facility services, the Blue Cross Blue Shield of TX or Host Blue's Participating Provider is required to obtain preauthorization. If preauthorization is not obtained, the Participating Provider will be sanctioned based on the Blue Cross Blue Shield of TX or Host Blue's contractual agreement with the Provider; therefore, the member will be held harmless for the Provider sanction	Patient Held Harmless	**Penalty Applies**
	Inpatient Admission	Preauthorization Not Required (Recommended Clinical Review)	Preauthorization Not Required (Recommended Clinical Review)
	Inpatient Admission / Partial Hospital Admission / RTC – Mental Health / Chemical Dependency	Preauthorization Not Required (Recommended Clinical Review)	Preauthorization Not Required (Recommended Clinical Review)
	Inpatient Admission – Maternity	Preauthorization Not Required (Recommended Clinical Review)	Preauthorization Not Required (Recommended Clinical Review)

Comment	TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
	Outpatient Utilization Management (UM) – Certain services may require preauthorization; refer to the Member Benefit Booklet.	Applies no penalty	Applies $250 penalty when applicable
	Home Health	Yes	Yes
	Hospice	Preauthorization Not Required (Recommended Clinical Review)	Preauthorization Not Required (Recommended Clinical Review)
	Skilled Nursing Facility	Preauthorization Not Required (Recommended Clinical Review)	Preauthorization Not Required (Recommended Clinical Review)
	Home Infusion Therapy	Yes	Yes
	The following outpatient Mental Health/Chemical Dependency (Substance Use Disorder) services may require preauthorization. - Applied Behavior Analysis (ABA) - Outpatient Electroconvulsive Therapy (ECT) - Psychological Testing * - Neuropsychological Testing * - Intensive Outpatient Programs (IOP) - Repetitive Transcranial Magnetic Stimulation (rTMS) *BCBSTX will notify the provider if preauthorization is required for these testing services.	Yes	Yes
Comments:			