BlueEdge HSA/Qualified HIGH DEDUCTIBLE HEALTH PLAN (HDHP) NON-STANDARD MEDICAL
NON-STANDARD MEDICAL BENEFIT SUMMARY – INSURED

ACCOUNT INFORMATION
Legal Group Name: **SSCP Management & Affiliates** Account # TX436693 Benefit Agreement# 0003 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		
	Deductible Cross-feeding:		
	Stand-alone (No cross-feeding. In-network updates IN only; OON updates OON only)		
	Employee Only (Individual)	$6350	$10000
	Family coverage embedded	$12700	$20000
	Coshare / Out-of-Pocket		
	Cross-feeding:		
	Stand-Alone (No cross-feeding. In-Network updates IN only; OON updates OON only)		
	Employee Only (Individual)	$6350	$20000
	Family coverage embedded	$12700	$40000
	Deductibles, Coshare Amounts, and Copayments apply to Out-of-Pocket Max	Yes (No option)	
	Lifetime Dollar Maximum Benefit	Unlimited (no option)	
	Benefit Period	Calendar Year	
	Prior Carrier Credit	None	
Comments:			
	FACILITY ONLY: INPATIENT HOSPITAL (Preauthorization required)		
	Semiprivate Room & Board / Ancillaries (Corporate Standard)	100% after ded.	70% after ded.
Comments:			
	FACILITY ONLY: OUTPATIENT HOSPITAL		
	Accident / Medical or Behavioral Health Emergency		
	Emergency Room (ER) / Treatment Room / Ancillary	100% after ded	
	Lab & X-ray – without ER or Treatment Room	100% after ded	
	Non-Emergency Care		
	Emergency Room / Treatment Room / Ancillary	100% after ded.	70% after ded.
	Lab & X-ray – without ER or Treatment Room	100% after ded.	70% after ded.
	Other Outpatient Services, includes Diagnostic Medical Procedures	100% after ded.	70% after ded.
	Certain Diagnostic Procedures (Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan)		
Comments:			
	EXTENDED CARE INPATIENT/HOME (Preauthorization Required)		

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Comment	TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
	Skilled Nursing Facility (ECF – Extended Care Facility)	100% after ded.	70% after ded.
	Visit Maximum	60 visit maximum per cal. yr.	
	Home Health (Mandated offer)	100% after ded.	70% after ded.
	Visit Maximum	60 visit maximum per cal. yr.	
	Hospice	100% after ded.	70% after ded.
	Visit Maximum	Unlimited	
Comments:			
	INPATIENT PHYSICIAN'S CHARGES		
	Inpatient Visits		
	Hospital Visit	100% after ded.	70% after ded.
	Consultation	100% after ded.	70% after ded.
	Surgery		
	General	100% after ded.	70% after ded.
Comments:			
	OUTPATIENT PHYSICIAN'S CHARGES		
	Lab & X-ray	100% after ded.	70% after ded.
	Surgery	100% after ded.	70% after ded.
	Certain Diagnostic Procedures (Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan)	100% after ded.	70% after ded.
	Accident / Medical or Behavioral Health Emergency	Pays as any other outpatient service	OON pays at in-network level
	Non-Emergency Care	100% after ded.	70% after ded.
	In-Vitro Fertilization (paid AAOI – mandated offer) N	Not Covered	Not Covered
Comments:			
	PHYSICIAN'S CHARGES IN THE OFFICE		
	Lab & X-ray	100% after ded.	70% after ded.
	Office Visit/ Consultation	100% after ded.	70% after ded.
	Office Visit / Consultation performed in a contracted Urgent Care Center	100% after ded.	70% after ded.
	Surgery	100% after ded.	70% after ded.
	In-Vitro Fertilization (paid AAOI – mandated offer) N	Not Covered	Not Covered
	Certain Diagnostic Procedures (Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan)	100% after ded.	70% after ded.
Comments:			
	PROVIDER CHARGES IN THE HOME		
	Home Infusion Therapy (HIT) (Preauthorization required)	100% after ded.	70% after ded.
Comments:			
	OTHER SUPPLIERS		
	Ambulance		

Comment	TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
	Ground/Air	100% after ded.	
	Hearing Aid up to 1 per ear per 36-month period	100% after ded.	70% after ded.
	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% after ded. 100% after ded.	
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, Routine 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%	70% after ded.
	Office Visit	100%	70% after ded.
	ACA Preventive Lab – includes independent lab (Office & Outpatient)	100%	70% after ded.
	Routine X-rays, routine lab, routine EKG, routine diagnostic medical procedures, routine digital rectal exam, routine prostate test (Outpatient)	100%	70% after ded.
	Routine X-rays, routine lab, routine EKG, routine diagnostic medical procedures, routine digital rectal exam, routine prostate test (Office)	100%	70% 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%	70% 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%	70% after ded.
	Immunizations – after the day of the 6th birthdate	100%	70% 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 Medicine (Includes physical, occupational and manipulative therapies)		
	All other services in the office	100% after ded.	70% after ded.
	All other services in the outpatient setting	100% after ded.	70% after ded.

Comment	TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
	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)
	Outpatient Utilization Management (UM) – Certain services may require preauthorization; refer to the Member Benefit Booklet.	Applies no penalty	Applies $250 penalty when applicable

Comment	TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
	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:			