

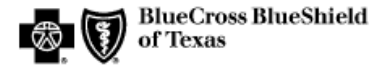
MEDICAL BENEFIT SUMMARY
Effective Date: January 1, 2026

BlueChoice
PPO Network

This is a general summary of our proposed benefits. Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions.

Overall Payment Provisions		PPO (In-Network)	Non-PPO (Out-of-Network)
Lifetime Maximum		Unlimited	
Medical Individual/Family Coverage Deductible			
	Applies to all Eligible Medical Expenses, unless otherwise indicated.	\$ 2,250 Individual \$4,500 Family	\$4,500 Individual \$9,000 Family
Coinsurance		25%	40%
Individual/Family Medical Coverage Out-of-Pocket Expense (OPX) Limit			
	Deductible and Copayment applies to Out-of-Pocket ** Copayment Amounts and per admission Deductibles are applied but will continue to be required after the benefit percentage increases to 100%.	\$6,750 Individual \$13,500 Family	\$12,500 Individual** \$ 25,000 Family**
Physician Services		PPO (In-Network)	Non-PPO (Out-of-Network)
Physician Office Visits			
	Primary Care Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians	\$60 PCP Copay*	40% of Allowable Amount after Deductible
	Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider (Does not include Certain Diagnostic Procedures and surgical services). Copayment applies for each visit to the physician's office. Surgeries, therapies, and certain diagnostic procedures performed in a physician's office may be subject to the Deductible and/or coinsurance.	\$100 Specialist Copay*	40% of Allowable Amount after Deductible
Preventive Care			
	Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, and any other preventive health services as determined by USPSTF	100% of Allowable Amount	Not Covered
	Immunizations for Dependent children through the date of the child's 6 th birthday	100% of Allowable Amount	Not Covered
Medical / Surgical Services			
	Physician inpatient hospital visits or surgical services performed in any setting	25% of Allowable Amount after Deductible	40% of Allowable Amount after Deductible
Hospital Services- Inpatient and Outpatient		PPO (In-Network)	Non-PPO (Out-of-Network)
Penalty for failure to preauthorize services		None	\$1000
For Inpatient Facility Services, Blue Cross Blue Shield of TX Participating Provider is required to obtain preauthorization. If preauthorization is not obtained, the Participating Provider will be sanctioned based on Blue Cross Blue Shield of TX contractual agreement with the Provider, therefore the member will be held harmless for the Provider sanction			
Hospital Admission Deductible			
	Per admission, per individual	None	\$250 per admission deductible
Inpatient Hospital Services			
	All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units Room allowances based on the hospital's most common semi-private room rates.	25% of Allowable Amount after Deductible	40% of Allowable Amount after per admission Deductible and medical deductible
Outpatient Hospital Services			
	Coverage for services performed in an outpatient facility or ambulatory surgical center. All other outpatient services and supplies Home Infusion Therapy (Services must be preauthorized)	25% of Allowable Amount after Deductible	40% of Allowable Amount after Deductible
Lab/X-Ray in other Outpatient Facilities , excluding Certain Diagnostic Procedures		25% of Allowable Amount	40% of Allowable Amount after Deductible

Ector County ISD
Option I PPO Plan



Certain Diagnostic Procedures such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan		25% of Allowable Amount after Deductible	40% of Allowable Amount after Deductible
Extended Care Services		PPO (In-Network)	Non-PPO (Out-of-Network)
Skilled Nursing (60 visits per benefit period)		25% of Allowable Amount after Deductible	40% of Allowable Amount after Deductible
Home Health Care (100 visits per benefit period)		25% of Allowable Amount after Deductible	40% of Allowable Amount after Deductible
Hospice Services		25% of Allowable Amount after Deductible	40% of Allowable Amount after Deductible
Special Provisions Expenses		PPO (In-Network)	Non-PPO (Out-of-Network)
Mental Health & Chemical Dependency Treatment Services		Same as any other illness	
Penalty for failure to preauthorize services		Same as Inpatient Penalty (None INN / \$1000 OON)	
Emergency Room/Treatment Room			
	Facility Charges	\$200 Copayment plus 25% of Allowable Amount after deductible	
	Physician Charges	25% of Allowed Amount after Deductible	
Urgent Care Services Urgent Care center visit (Copayment does not include Certain Diagnostic Procedures and surgical services)		\$60 Copayment, deductible does not apply	40% of Allowed Amount after Deductible
Ground and Air Ambulance Services		25% of Allowable Amount after Deductible	
Physical Medicine Services – Occupational, Physical, Speech and Chiropractic			
	Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy) Coverage for services provided by a physician or therapist. Includes Physical, Occupational, and Speech Services. <i>Limited to a combine 100 visits for Physical, Occupational and Speech services per benefit period</i>		
	Physical Medicine Services in the Physician's Office	\$60 PCP Copay \$100 Specialist Copay	40% of Allowable Amount after Deductible
	Physical Medicine Services in an Outpatient Facility	25% of Allowable Amount after Deductible	40% of Allowable Amount after Deductible
	Chiropractic Care (limited to 24 visits per benefit period)	\$60 PCP Copay \$100 Specialist Copay	40% of Allowable Amount after Deductible
Hearing Aid Maximum		Hearing Aids are limited to 1 per ear every 36 months	
Organ and Tissue Transplant Services		Covered same as any other illness if treatment provided at a Blue Distinction Center	
Bariatric Surgery/Treatment of Morbid Obesity		Medical/Surgical covered same as any other sickness if treatment is provided at a Blue Distinction Center	