Ector County ISD
Option III HDHP PPO Plan

MEDICAL BENEFIT SUMMARY
Effective Date: January 1, 2026

BlueCross BlueShield of Texas

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.	*$ 2,000 Individual $4,000 Family*	*$6,500 Individual $13,000 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%.	*$6,000 Individual $12,000 Family*	*$15,000 Individual** $30,000 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	*25% of Allowable Amount after Deductible*	*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.	*25% of Allowable Amount after Deductible **	*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 6th 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 after Deductible*	*40% of Allowable Amount after Deductible*

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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)*		*25% of Allowable Amount after Deductible*	*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. *Limited to a combine 100 visits for Physical, Occupational and Speech services per benefit period*		
	Physical Medicine Services in the Physician's Office	*25% of Allowable Amount after Deductible*	*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)	*25% of Allowable Amount after Deductible*	*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*	