Choosing the medical plan that is right for you

Understanding how much you can expect to pay

Your out-of-pocket costs and your deductible — the amount you must pay each year before the plan begins to pay — will be different, depending on the plan you choose.

PPO

With this plan, you pay a fixed copay for many services, which counts toward your out-of-pocket costs. Copays do not count toward the deductible.

Network deductibles	Out-of-network deductibles
For 2025, your deductible for services in the network is:	**The individual out-of-network deductible applies to each enrolled family member and does not have a family deductible limit:**
$500 for individual (single) coverage	$1,000 for each individual (single)
$1,000 for family coverage*	Unlimited for family coverage

* If you cover family members, the network family deductible is met when the combined eligible network expenses for you and/or your covered family members reach $1,000. If one family member reaches $500 but the combined family deductible of $1,000 has not been met, the member who met the $500 deductible can move to coinsurance until one more family member reaches the deductible. If no family member reaches the $500 deductible but the combined family deductible is met, all family members move to coinsurance.

Need more details?

Visit **pebcinfo.com**.

High deductible plan (HDP)

The HDP does not use copays. You pay 100% of the allowable cost for network services — including office visits, urgent care, prescription drugs, emergency room visits and other covered expenses — until your deductible is met. Once the deductible is met, you pay a portion of the costs as coinsurance.

The deductibles are another big difference between this plan and the PPO plan:

- $1,650 individual (single) deductible
- $3,300 family deductible*

* If you cover any family member, the entire network family deductible must be met before any family member can move to coinsurance. The HDP network family deductible is met when the combined eligible expenses for you and/or any covered family members reach $3,300. Even if one family member reaches the $1,650 deductible, that member cannot move to coinsurance until the full $3,300 family deductible is met.

Opting out of a medical plan

You may be able to opt out of your employer's medical plan if you submit the following to your Human Resources department before the enrollment deadline:

- Valid proof of other comparable medical plan coverage that meets minimum essential coverage rules under the Affordable Care Act (ACA), confirmed by your employer
- A completed "certification of other coverage" form

If you do not provide a certification of other coverage form, or if your proof of coverage is found to be invalid, your employer can enroll you in the PPO plan (employee-only coverage). If you opt out, you will not be eligible for continuation of medical coverage (COBRA). Examples of coverage that cannot be used to opt out of your employer's medical plan include:

- Medicaid
- TRICARE "supplemental" coverage
- Marketplace
- Student insurance
- Coverage that does not meet minimum ACA requirements

PLEASE NOTE: If your employer contributes to a health care FSA due to your medical plan opt-out status, that contribution is subject to valid proof of other comparable coverage and a current, signed certification of other coverage form. If your other coverage is found to be invalid or expired, the employer contribution is discontinued. You may be required to repay any employer contributions, and you could be subject to serious consequences.

Participation or continuation of any employer contribution program is at the discretion of the employer. **Coverage obtained through the Health Care Marketplace (Exchange) is not eligible for employer opt-out contributions.**

Transition benefits

In certain circumstances, the health plan may authorize the member to continue receiving medical care from an out-of-network provider at the in-network level of benefit for covered services. It may be necessary to request medical information from your current provider(s).

There are certain circumstances when on the date of enrollment, a new member is already getting care for a certain health issue. Transition of care (also called continuation of care) provides a brief period of in-network coverage if you are new to BCBSTX and your doctor is outside your new plan's network. Transition of care also applies if your doctor leaves the network or changes network status. Transition of care may allow you to see an out-of-network provider at in-network rates for a certain amount of time if you have certain health conditions or are participating in an active course of care.

Examples include pregnancy, hospitalization, terminal illness with life expectancy of less than six months, long term treatment of cancer, heart disease and transplants.

If you have transition of care concerns, please call BCBSTX at **888-306-5753**.