Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

2025 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
Section 4. Your Costs for Covered Services
Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

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Under Standard and Basic Options, we limit your annual out-of-pocket expenses for the covered services you receive to protect you from unexpected healthcare costs. When your eligible out-of-pocket expenses reach this catastrophic protection maximum, you no longer have to pay the associated cost-sharing amounts for the rest of the calendar year. For Self Plus One and Self and Family enrollments, once any individual family member reaches the Self Only catastrophic protection out-of-pocket maximum during the calendar year, that member's claims will no longer be subject to associated cost-sharing amounts for the rest of the year. All other family members will be required to meet the balance of the catastrophic protection out-of-pocket maximum.

Note: Certain types of expenses do not accumulate to the maximum (see below).

Standard Option maximums:

Preferred Provider maximum – For a Self Only enrollment, your out-of-pocket maximum for your deductible, eligible coinsurance and copayment amounts is $6,000 when you use Preferred providers. For a Self Plus One or Self and Family enrollment, your out-of-pocket maximum for these types of expenses is $12,000 for Preferred provider services. Only eligible expenses for Preferred provider services, and the cost-shares associated with care from Non-participating providers under the NSA, see information earlier in this section, count toward these limits.

For members enrolled in our Plan's associated PDP EGWP, we are required to accumulate all members' actual out-of-pocket costs for Medicare-covered drugs, services and supplies toward the PSHB catastrophic maximum(s), unless specifically excluded below.

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription out-of-pocket maximum is $2,000. After this maximum is met, we pay 100% of all covered prescription drug benefits.

Non-preferred Provider maximum – For a Self Only enrollment, your out-of-pocket maximum for your deductible, eligible coinsurance and copayment amounts is $8,000 when you use Non-preferred providers. For a Self Plus One or Self and Family enrollment, your out-of-pocket maximum for these types of expenses is $16,000 for Non-preferred provider services. For either enrollment type, eligible expenses for the services of Preferred providers also count toward these limits.

Basic Option maximum:

Preferred Provider maximum – For a Self Only enrollment, your out-of-pocket maximum for eligible coinsurance and copayment amounts is $7,500 when you use Preferred providers. For a Self Plus One or a Self and Family enrollment, your out-of-pocket maximum for these types of expenses is $15,000 when you use Preferred providers. Only eligible expenses for Preferred provider services count toward these limits.

For members enrolled in our Plan's associated PDP EGWP, we are required to accumulate all members' actual out-of-pocket costs for Medicare-covered drugs, services and supplies toward the PSHB catastrophic maximum(s), unless specifically excluded below.

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription out-of-pocket maximum is $2,000. After this maximum is met, we pay 100% of all covered prescription drug benefits.

The following expenses are not included under this feature. These expenses do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay them even after your expenses exceed the limits described above.

- The difference between the Plan allowance and the billed amount. See earlier information in this section;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;
- Under Standard Option, your 35% coinsurance for inpatient care in a Non-member facility;
- Under Standard Option, your 35% coinsurance for outpatient care by a Non-member facility;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(g);
- The $500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements; and

- Under Basic Option, your expenses for care received from Participating/Non-participating professional providers or Member/Non-member facilities, except for coinsurance and copayments you pay in those situations where we do pay for care provided by Non-preferred providers. Please see Section 3, *What you must do to get covered care*, for the exceptions to the requirement to use Preferred providers.

If your provider's prescription allows for generic substitution and you select a brand-name drug, your expenses for the difference in cost-share do not count toward your catastrophic protection out-of-pocket maximum (see Section 5(f) for additional information).