
2024 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
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This is what you will pay out-of-pocket for your covered care:

Cost-share/Cost-sharing

Cost-share or cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Note: You may have to pay the deductible, coinsurance, and/or copayment amount(s) that apply to your care at the time you receive the services.

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: If you have Standard Option when you see your Preferred physician, you pay a copayment of \$30 for the office visit, and we then pay the remainder of the amount we allow for the office visit. (You may have to pay separately for other services you receive while in the physician’s office.) When you go into a Preferred hospital, you pay a copayment of \$350 per admission. We then pay the remainder of the amount we allow for the covered services you receive.

Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

Note: When multiple copayment services are performed by the same professional or facility provider on the same day, only one copayment applies per provider per day. When the copayment amounts are different, the highest copayment is applicable. You may be responsible for a separate copayment for

some services.

Correction, 3/13/2024

Example: If you have Basic Option when you visit the outpatient department of a Preferred hospital for non-emergency treatment services, your copayment is **typically** \$150. If you also receive an ultrasound in the outpatient department of the same hospital on the same day, you will not be responsible for the \$40 copayment typically applied to the ultrasound.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward your deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply that you then pay counts toward meeting your deductible.

Under Standard Option, the calendar year deductible is \$350 per person. After the deductible amount is satisfied for an individual, covered services are payable for that individual. Under a Self Plus One enrollment, both family members must meet the individual deductible. Under a Self and Family enrollment, an individual may meet the individual deductible, or all family members' individual deductibles are considered to be satisfied when the family members' deductibles are combined and reach \$700.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is \$100, the provider has an agreement with us to accept \$80, and you have not paid any amount toward meeting your Standard Option calendar year deductible, you must pay \$80. We will apply \$80 to your deductible. We will begin paying benefits once the remaining portion of your Standard Option calendar year deductible (\$270) has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Under Basic Option, there is **no calendar year deductible**.

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