2027 Blue Cross and Blue Shield Service Benefit Plan
FEP Blue Standard and FEP Blue Basic
Section 5(c). Overview

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- Note: **Observation services** are billed as outpatient facility care. Benefits for observation services are provided at the outpatient facility benefit levels described in this section. See Section 10, *Definitions*, for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following services: facility-based sleep studies; surgery for severe obesity; elective non-urgent hip, knee, and spine surgeries; and surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth, except when care is provided within 72 hours of the accidental injury. Please refer to Section 3 for more information.**
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- We base payment on whether a facility or a healthcare professional bills for the services or supplies. You will find that some benefits are listed in more than one Section of the brochure. This is because how they are paid depends on what type of provider or facility bills for the service.
- The services listed in this Section are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service, for your inpatient or outpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Sections 5(a) or 5(b).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Benefits for certain self-injectable drugs are limited to one time per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit.

This benefit limitation does not apply if you have primary Medicare Part B coverage or are enrolled in the FEP Medicare Prescription Drug Program. See Section 5(f) for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731.

- **Under Standard Option,**
    - The calendar year deductible is $500 per person ($1,000 per Self Plus One or Self and Family enrollment).
- **Under Basic Option,**
    - There is **no calendar year deductible**.
    - **You must use Preferred providers in order to receive benefits.** See Section 3 for the exceptions to this requirement.
    - Your cost-share for care performed and billed by Preferred professional providers in the outpatient department of a Preferred hospital is waived for services other than surgical services, drugs, supplies, orthopedic and prosthetic devices, and durable medical equipment. You are responsible for the applicable cost-sharing amount(s) for the services performed and billed by the hospital.