**2027 Blue Cross and Blue Shield Service Benefit Plan**
**FEP Blue Standard and FEP Blue Basic**

## Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2027

**Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a decision, please read this FEHB brochure.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see Section 3. There is no deductible for Basic Option.

You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.fepblue.org/brochure.

**Medical services provided by physicians:** Diagnostic and treatment services provided in the office
PPO: Nothing for preventive care; $35 per office visit for primary care providers and other healthcare professionals; $50 per office visit for specialists
Non-PPO: You pay all charges
38-40

**Medical services provided by physicians:** Telehealth services
PPO: Nothing
Non-PPO: You pay all charges
38, 94

**Services provided by a hospital:** Inpatient
PPO: $500 per day up to $3,500 per admission
Non-PPO: You pay all charges
76-77

**Services provided by a hospital:** Outpatient
PPO: $250 per day per facility
Non-PPO: You pay all charges
78-82

**Emergency benefits:** Accidental injury
PPO: $50 copayment for urgent care; $500 copayment for emergency room care
Non-PPO: $500 copayment for emergency room care; you pay all charges for care in settings other than the emergency room
Ambulance transport services: $250 per day for ground ambulance; $750 per day for air or sea ambulance
90-91

**Emergency benefits:** Medical emergency
Same as for accidental injury
91-92

**Mental health and substance use disorder treatment**
PPO: Regular cost-sharing, such as $35 office visit copayment; $500 per day up to $3,500 per inpatient admission
Non-PPO: You pay all charges
94-96

**Prescription drugs**
**Retail Pharmacy Program:**

- PPO: $15 generic/35% of our allowance ($175 maximum) Preferred brand-name per prescription ($150 maximum if you have primary Medicare Part B)/60% coinsurance for non-preferred brand-name drugs (up to a 30-day supply)
- Non-PPO: You pay all charges

**Specialty Drug Pharmacy Program:**

- 35% of the Plan allowance ($325 maximum) for a preferred specialty drug for a purchase of up to a 30-day supply; 35% of the Plan allowance ($550 maximum) for a non-preferred specialty drug for a purchase of up to a 30-day supply

**Mail Service Prescription Drug Program** (for primary Medicare Part B members only):

- $20 generic/35% of the Plan allowance up to a $225 maximum for Preferred brand-name/35% of the Plan allowance up to a $250 maximum for non-preferred brand-name per prescription; up to a 90-day supply

103-108

**Dental care**
PPO: $35 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; $35 copayment for associated oral evaluations required due to accidental injury; regular benefits for covered oral and maxillofacial surgery
Non-PPO: You pay all charges
125

**Wellness and other special features:** Health Tools; Blue Health Assessment; MyBlue® Customer eService; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option
See Section 5(h).
126-130

**Protection against catastrophic costs** (your catastrophic protection out-of-pocket maximum)

- Self Only: Nothing after $8,500 (PPO) per contract per year

- Self Plus One: Nothing after $17,000 (PPO) per contract per year
- Self and Family: Nothing after $17,000 (PPO) per contract per year; nothing after $8,500 (PPO) per individual per year

Note: Some costs do not count toward this protection.
Note: When one covered family member (Self Plus One and Self and Family contracts) reaches the Self Only maximum during the calendar year, that member's claims will no longer be subject to associated member cost-share amounts for the remainder of the year. All remaining family members will be required to meet the balance of the catastrophic protection out-of-pocket maximum.
32-33