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 PSHB 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 physicians and other healthcare professionals; $50 per office visit for specialists

Non-PPO: You pay all charges

42

Medical services provided by physicians: Telehealth services

PPO: Nothing

Non-PPO: You pay all charges

42, 98

Services provided by a hospital: Inpatient

PPO: $500 per day up to $3,500 per admission

Non-PPO: You pay all charges

80-81

Services provided by a hospital: Outpatient

PPO: $250 per day per facility

Non-PPO: You pay all charges

82-86

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: $100 per day for ground ambulance; $150 per day for air or sea ambulance

94-95

Emergency benefits: Medical emergency

Same as for accidental injury

95-96

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

97-101

Prescription drugs

Retail Pharmacy Program:

- PPO: $15 generic/35% of our allowance up to $250 for 30-day supply and $500 for a 31 to 90-day supply Preferred brand-name per prescription/60% coinsurance for non-preferred brand-name drugs
- Non-PPO: You pay all charges

Specialty Drug Pharmacy Program:

- 35% of the Plan allowance (up to a maximum of $450) for a preferred specialty drug for a purchase of up to a 30-day supply; 40% of the Plan allowance (up to a maximum of $550) for a non-preferred specialty drug for a purchase of a 30-day supply

107-117

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

137

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).

138-142

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.

36-37