2025 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
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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.
- 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 bills for the service.
- The services listed in this Section are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for the following surgical services: surgery for severe obesity; 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 MUST GET PRIOR APPROVAL for all organ transplant surgical procedures; and if your surgical procedure requires an inpatient admission, YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- **YOU MUST GET PRIOR APPROVAL for gender affirming surgery. Prior to any gender affirming surgery, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan (including changes to the procedures to be performed or the anticipated dates for the procedures). See Section 3 and later in this section for additional information. If your surgical procedure requires an inpatient admission, YOU MUST ALSO GET**

PRECERTIFICATION of the inpatient care.

- 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 once per lifetime 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 $350 per person ($700 per Self Plus One or Self and Family enrollment).

    - We provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, neonatologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You may be responsible for any difference between our payment and the billed amount. See Section 4, NSA, for information on when you are not responsible for this difference.

    - You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See Section 3 for more information.

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