BLUE CROSS AND BLUE SHIELD FEDERAL EMPLOYEE PROGRAM
FEDERAL EMPLOYEES HEALTH BENEFITS

2027 BENEFITS AT A GLANCE

BlueCross BlueShield FEP Medical

Benefit	FEP Blue Focus®	FEP Blue Basic®	FEP Blue Standard®
Preventive care	**$0**	**$0**	**$0**
Virtual doctor visits through Teladoc Health®	**$0**	**$0**	**$0**
Primary care doctor & mental health visits	**$10** per visit for the first 10 primary care and/or specialist visits for each person on your plan[2]	**$35**[1]	**$30**
Specialists		**$50**[1]	**$40**
Urgent care centers	**$25**	**$50**	**$30**
Chiropractic care	**$25** for up to 10 total visits per year[2,4]	**$35** for up to 20 total visits per year	**$30** for up to 12 total visits per year
Acupuncture care		**$35** for up to 12 total visits per year	**15%** for up to 24 total visits per year*
Maternity care & family planning (You pay nothing for birth control; if you're growing your family, you have access to a WINFertility discount through Blue365®)	**$3,000** for maternity care	**$0** for doctor's visits **$0** for delivery at Blue Distinction Centers **$500** for delivery at all other facilities	**$0** for maternity care **15%** of up to **$25,000** for IVF*
Inpatient admission (Services where you stay overnight)	**30%***	**$500** per day; up to **$3,500** per admission	**$450** per admission
Outpatient care (Services done within a day)	**30%***	**$250** per day per facility[1]	**15%***
Surgeons	**30%***	**$150** per surgeon in an office[1] **$200** per surgeon in other settings[1]	**15%***
ER (Accidental injury)	**$0** within 72 hours of injury	**$500** per day per facility	**$0** within 72 hours of injury
ER (Medical emergency)	**30%***	**$500** per day per facility	**15%***
Lab work (Such as blood tests)	**$0** for first 10 specific lab tests[3]	**20%**[1]	**15%***
Diagnostic services (Such as sleep studies, X-rays, CT scans)	**30%***	**$100** in an office[1] **$250** in a hospital[1]	**15%***

If you have Medicare primary or receive care overseas, different cost share amounts may apply.

**Deductible applies. [1]You pay 35% coinsurance for agents, drugs, and/or supplies you receive during your care. [2]You pay 30% coinsurance for agents, drugs and/or supplies you receive during your care. [3]Please see brochure for covered lab services. [4]Up to 10 visits combined for chiropractic care and acupuncture.*

Understanding your prescription costs

	Least Coverage FEP Blue Focus	More Coverage FEP Blue Basic	Most Coverage FEP Blue Standard
FEP Retail Pharmacy (For up to a 30-day supply). You can only buy one fill of a Tier 4 or 5 drug at a retail pharmacy. Additional fills must be through the Specialty Pharmacy.	**Tier 1: $5** **Tier 2: 40%**, up to **$500** **Tier 3: 40%**, up to **$600**	**Tier 1: $15** **Tier 2: 35%**, up to **$175** **Tier 3: 60%** **Tier 4: 35%**, up to **$350** **Tier 5: 35%**, up to **$550**	**Tier 1: $7.50** **Tier 2: 30%** **Tier 3: 50%** **Tier 4: 30%**, up to **$250** **Tier 5: 30%**, up to **$450**
FEP Mail Service Pharmacy (For up to a 90-day supply)	Not a benefit	Available to members in the FEP Medicare Prescription Drug Program.	**Tier 1: $15** **Tier 2: 15%**, up to **$150** **Tier 3: 20%**, up to **$250**
FEP Specialty Pharmacy (For up to a 30-day supply)	**Tier 3: 40%**, up to **$600**	**Tier 4: 35%**, up to **$325** **Tier 5: 35%**, up to **$550**	**Tier 4: $150** **Tier 5: $200**

Note: Different cost share amounts may apply if you have Medicare primary coverage. For more information on the FEP Medicare Prescription Drug Program, visit ***fepblue.org/medicarerx.***

FEHB Program bi-weekly premiums, deductibles and out-of-pocket maximums

	FEP Blue Focus	FEP Blue Basic	FEP Blue Standard
SELF ONLY	$74.16	$145.46	$204.65
Enrollment code	**131**	**111**	**104**
SELF + ONE	$159.43	$350.48	$449.89
Enrollment code	**133**	**113**	**106**
SELF & FAMILY	$175.35	$387.54	$496.90
Enrollment code	**132**	**112**	**105**
Deductible	**$1,000** for Self Only **$2,000** for Self + One and Self & Family	**No deductible**	**$500** for Self Only **$1,000** for Self + One and Self & Family
Out-of-Pocket maximum (In-network)	**$11,000** for Self Only **$22,000** for Self + One and Self & Family	**$8,500** for Self Only **$17,000** for Self + One and Self & Family	**$7,000** for Self Only **$14,000** for Self + One and Self & Family

These rates don't apply to all enrollees. If you are in a specific enrollment category, please contact the agency or Tribal employer that maintains your health benefits enrollment.

To see our monthly premiums, visit fepblue.org/premiums.

Explore the interactive version of our FEHB Benefits Summary Book and others online at **fepblue.org/flipbooks.**

This is a summary of the features of the Blue Cross and Blue Shield Service Benefit Plan. Before making a final decision, please read the Plan's Federal brochures (FEP Blue Standard and FEP Blue Basic: RI 71-005; FEP Blue Focus: RI 71-017). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochures.

The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield companies.

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