

2023 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option**Section 1. How This Plan Works**

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This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other healthcare providers. We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

OPM requires that FEHB plans be accredited to validate that Plan operations and/or care management meet nationally recognized standards. The local Plans and vendors that support the Blue Cross and Blue Shield Service Benefit Plan hold accreditation from National Committee for Quality Assurance (NCQA) and/or URAC. To learn more about this Plan's accreditations, please visit the following websites:

- National Committee for Quality Assurance (www.ncqa.org);
- URAC (www.URAC.org).

General features of our Standard and Basic Options**We have a Preferred Provider Organization (PPO)**

Our fee-for-service Plan offers services through a PPO. This means that certain hospitals and other healthcare providers are "Preferred providers." When you use our PPO (Preferred) providers, you will receive covered services at a reduced cost. Your Local Plan (or, for Preferred retail pharmacies, CVS Caremark) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO (Preferred) providers and to verify their continued participation. You can also visit www.fepblue.org/provider/ to use our National Doctor & Hospital Finder. You can reach our website through the FEHB website, www.opm.gov/healthcare-insurance.

Under Standard Option, PPO (Preferred) benefits apply only when you use a PPO (Preferred) provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO (Preferred) provider is available, or you do not use a PPO (Preferred) provider, non-PPO (non-preferred) benefits apply.

Under Basic Option, you must use Preferred providers in order to receive benefits. See page [20](#) for the exceptions to this requirement.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit

provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service phone number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

How we pay professional and facility providers

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other healthcare facilities, physicians, and other healthcare professionals in its service area, and is responsible for processing and paying claims for services you receive within that area. Many, but not all, of these contracted providers are in our PPO (Preferred) network.

- **PPO providers.** PPO (Preferred) providers have agreed to accept a specific negotiated amount as payment in full for covered services provided to you. **We refer to PPO facility and professional providers as “Preferred.”** They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive covered services from Preferred providers, and are limited to your coinsurance or copayments (and, under **Standard Option** only, the applicable deductible).
- **Participating providers.** Some Local Plans also contract with other providers that are not in our Preferred network. **If they are professionals, we refer to them as “Participating” providers. If they are facilities, we refer to them as “Member” facilities.** They have agreed to accept a different negotiated amount than our Preferred providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our Non-preferred benefit levels. Your out-of-pocket costs will be greater than if you use Preferred providers.

Note: Not all areas have Participating providers and/or Member facilities. To verify the status of a provider, please contact the Local Plan where the services will be performed.

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