Blue Cross® and Blue Shield® Service Benefit Plan
FEP® Blue Focus

www.fepblue.org

2026

A Fee-for-Service Plan (FEP Blue Focus) with a Preferred Provider Organization

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See PSHB Facts for details. This plan is accredited. See Section 1.

Sponsored and administered by: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

IMPORTANT
- Rates: Back Cover
- Changes for 2026: Page 16
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Who may enroll in this Plan: Postal Employees and Annuitants

Enrollment codes for this Plan:

35A FEP Blue Focus – Self Only
35C FEP Blue Focus – Self Plus One
35B FEP Blue Focus – Self and Family

PSHB

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 71-025

Important Notice

Important Notice for Medicare-eligible Active Employees from the Blue Cross and Blue Shield Service Benefit Plan About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Blue Cross and Blue Shield Service Benefit Plan's prescription drug coverage for active employees is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means active employees and their covered family members do not need to enroll in an open market Medicare Part D plan and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your PSHB coverage as an active employee.

However, if you (as an active employee and your covered Medicare Part D-eligible family members) choose to enroll in an open market Medicare Part D plan, you can keep your PSHB coverage and your PSHB plan will coordinate benefits with Medicare.

Please be advised

If you lose or drop your PSHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, TTY: 711.

You can get more information about open market Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY: 711

Potential Additional Premium for Medicare's High Income Members Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your PSHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return.** You do not make any IRMAA payment to your PSHB plan. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/cost-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan – FEP Blue Focus** under contract (CS 1039PS) between the Blue Cross and Blue Shield Association and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits (FEHB) law as amended by the Postal Service Reform Act, which created the Postal Services Health Benefits (PSHB) program. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan in their individual localities. If you are deaf, hearing impaired or speech impaired or need to reach customer service for assistance, visit our website, www.fepblue.org, or contact your Local Plan at the phone number on the back of your ID card or TTY 711. If you need ASL providers visit www.fepblue.org/provider to access our National Doctor & Hospital Finder.

The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan
750 9th Street NW
Washington, DC 20001-4524

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. If you are a Postal Service annuitant and you are eligible for Medicare Part D, or a covered Medicare Part D-eligible family member of a Postal Service annuitant, your prescription drug benefits are provided under our Medicare Part D Prescription Drug Plan (PDP) Employer Group Wavier Plan (EGWP). You do not have a right to benefits that were available before January 1, 2026, under the PSHB Program, unless those benefits are also shown in this PSHB Plan brochure.

OPM negotiates benefits and rates for each plan annually. Benefits are effective January 1, 2026, and changes are summarized in Section 2. Rates are shown on the back cover of this brochure.

Plain Language

All PSHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member; “we” means the Blue Cross and Blue Shield Service Benefit Plan.
- We limit acronyms to ones you know. OPM is the United States Office of Personnel Management. The FEHB Program is the Federal Employees Health Benefits Program administered by OPM and established under 5 U.S.C. chapter 89. The PSHB Program is the Postal Service Health Benefits Program established within the FEHB Program under 5 U.S.C. section 8903c. PSHB Plan means a health benefits plan offered under the PSHB Program. PSHB means Postal Service Health Benefits. If we use others, we tell you what they mean.
- Our brochure and other PSHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the PSHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call the FEP Fraud Hotline at 800-FEP-8440 (800-337-8440) and explain the situation.
  - If we do not resolve the issue:

CALL THE HEALTHCARE FRAUD HOTLINE
877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form

The online form is the desired method of reporting fraud in order to ensure accuracy, and a quick response time.

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless they were disabled and incapable of self-support prior to age 26).
- A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.
- If you have any questions about the eligibility of a family member, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain PSHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information. We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information.

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

We:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator of your Local Plan by contacting your Local Plan at the phone number appearing on the back of your ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information, you can file a grievance with the Civil Rights Coordinator of your Local Plan. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, your Local Plan's Civil Rights Coordinator is available to help you.

Members may file a complaint with the HHS Office for Civil Rights, OPM, or PSHB Program Carriers.

For further information about how to file a civil rights complaint, go to www.fepblue.org/en/rights-and-responsibilities/, or call the customer service phone number on the back of your ID card. For TTY, dial 711.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medication and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understanding both the generic and brand names for all of your medication(s) is important. This helps ensure you do not receive double dosing from taking both a generic and a brand of the same medication. It also helps you avoid taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  "Exactly what will you be doing?"
  "About how long will it take?"
  "What will happen after surgery?"
  "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links
For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- http://www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your PSHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services when care is related to treatment of specific hospital-acquired conditions if you use Preferred hospitals. This policy helps to protect you from having to pay for the cost of treating these conditions, and it encourages hospitals to improve the quality of care they provide.

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the PSHB Program**

See https://health-benefits.opm.gov/PSHB/ for enrollment information as well as:

- Information on the PSHB Program and plans available to you
- A health plan comparison tool

Note: Contact the USPS for information on how to enroll in a PSHB program Plan through the PSHB System.

Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your PSHB coverage. These materials tell you:

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- What happens when your enrollment ends
- When the next Open Season for enrollment begins

We do not determine who is eligible for coverage. You will be responsible for making changes to your enrollment status through the PSHB system. In some cases, your employing or retirement office may need to submit documentation. For information on your premium deductions, you must also contact your employing or retirement office.

Once enrolled in your PSHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member.

You enroll in a PSHB Program Plan and make enrollment changes in the PSHB System located at https://health-benefits.opm.gov/PSHB/. For assistance with the PSHB System, call the PSHB Helpline at (844) 451-1261. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment request. Benefits will not be available until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Use the PSHB System if you want to change from Self Only to Self Plus One or Self and Family and to add or remove a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits. Please report changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26 through the PSHB System. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday, unless your child is eligible for continued coverage because they are incapable of support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one PSHB plan you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB or PSHB plan.

If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the PSHB Program, change your enrollment, or cancel coverage using the PSHB System. For a complete list of QLEs, visit the PSHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

Family Member Coverage

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the PSHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child or children.

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no PSHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the PSHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for PSHB coverage, you must continue your PSHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

For annuitants who are required to be enrolled in Medicare Part B as a condition to continue PSHB coverage in retirement: If you enroll in Medicare Part B and continue PSHB coverage in retirement, the child equity law applies to you and you cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your child(ren) live as long as the court/administrative order is in effect. You cannot be compelled to enroll or remain enrolled in Medicare Part B to maintain your PSHB enrollment as a condition to satisfy a court/administrative order. However, if you do not enroll (or remain enrolled) in Medicare Part B as required to continue your PSHB coverage in retirement (notwithstanding an existing court/administrative order), you will not be able to continue your PSHB coverage in retirement.

- **Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)**

Our PDP EGWP is only available to Postal Service annuitants who are Medicare Part D-eligible and their covered Medicare Part D-eligible family members. Our PDP EGWP is not an open market Medicare Part D Plan. If you are an active Postal Service employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP. Please contact CMS for assistance 1-800-MEDICARE (1-800-633-4227).

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage and premiums begin on January 1. If you joined at any other time during the year, your employing or retirement office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service), and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or family members are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the PSHB Program. Generally, you must have been enrolled in the FEHB and/or PSHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When PSHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

If you are eligible for coverage under spouse equity, you are only eligible to enroll in the FEHB program. If you are not eligible for coverage under spouse equity and you are otherwise eligible for Temporary Continuation of Coverage (TCC), then you could enroll in TCC under the PSHB program.

- **Upon divorce**

If you are an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must enter the date of the divorce or annulment and remove your ex-spouse in the PSHB System. We may ask for a copy of the divorce decree as proof. If you need to change your enrollment type, you must use the PSHB System. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health benefits coverage for you. However, you may be eligible for your own coverage under the spouse equity law or TCC. Former spouses eligible for coverage under the spouse equity law are not eligible to enroll in the PSHB program. However, former spouses eligible for coverage under the spouse equity law may enroll in the FEHB program. (Former spouses seeking but not yet adjudicated as eligible for Spouse Equity may be entitled to TCC under a PSHB plan in the interim).

Former spouses not meeting the spouse equity requirements may be eligible for TCC under the PSHB program provided you otherwise meet the eligibility requirements for TCC. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website, www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced#url-health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- **Medicare PDP EGWP**

When a Postal Service annuitant who is Medicare Part D-eligible or their covered Medicare-eligible family member opts out of or disenrolls from our PDP EGWP, they will not have our prescription drug coverage under this plan. If you do not maintain creditable coverage, reenrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for additional information at 888-338-7737.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your PSHB enrollment after you retire, if you lose your Federal job, or if you are a covered child and you turn age 26, regardless of marital status, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing PSHB coverage.

We also want to inform you that the Patient Protection and ACA did not eliminate TCC or change the TCC rules.

- **Finding replacement coverage**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please refer to the next Section of this brochure. We will help you find replacement coverage inside or outside the Marketplace. For assistance, please contact your Local Plan at the phone number appearing on the back of your ID card, or visit www.bcbs.com to access the website of your Local Plan.

Note: We do not determine who is eligible to purchase health benefits coverage inside the Affordable Care Act's Health Insurance Marketplace. These rules are established by the Federal Government agencies that have responsibility for implementing the Affordable Care Act and by the Marketplace.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a fee-for-service (FFS) plan that offers covered services through Preferred providers. You can choose your own physicians, hospitals, and other healthcare providers within our Preferred Provider Organization (PPO) network. 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 PSHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. The local Plans and vendors that support 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 FEP Blue Focus

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." 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 PSHB website, www.opm.gov/healthcare-insurance.

You must use Preferred providers in order to receive benefits. See Section 3 for the exceptions to this requirement.

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. When you use Preferred providers your out-of-pocket costs are limited to your copayment, deductible, and/or coinsurance. See Sections 3 and 5(d) *Emergency Services/Accidents* for the exceptions to this requirement.

  In Local Plan areas, Preferred providers who contract with us will accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable deductible, coinsurance or copayments for covered services, and any charges for noncovered services.

- **Non-preferred providers.** This is a PPO-only contract. There are no benefits for care performed by Non-preferred providers (Participating/Non-participating) or Non-preferred facilities (Member/Non-member). You must use Preferred providers in order to receive benefits. See Section 3 for the exceptions to this requirement.

- **Pilot Programs.** We may implement pilot programs in one or more Local Plan areas and overseas to test the feasibility and examine the impact of various initiatives. The pilot programs do not affect all Plan areas. Information on specific pilots is not published in this brochure; it is communicated to members and network providers in accordance with our agreement with OPM. Certain pilot programs may incorporate benefits that are different from those described in this brochure.

Your rights and responsibilities

OPM requires that all PSHB plans provide certain information to their PSHB members. You may get information about us, our networks, and our providers. OPM's PSHB website, www.opm.gov/insure, lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status
- Care management, including case management and disease management programs
- How we determine if procedures are experimental or investigational

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, at www.fepblue.org/en/rights-and-responsibilities.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.fepblue.org/en/terms-and-privacy/notice-of-privacy-practices to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

If you want more information about us, call or write to us. Our phone number is shown on the back of your ID card. You may also visit our website at www.fepblue.org.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. We may use aggregated medical record information that does not disclose your identity for bona fide medical research or education.

Note: As part of our administration of this contract, we may disclose your medical and claims information (including your prescription drug utilization) to any treating physicians or dispensing pharmacies. You may view our Notice of Privacy Practice for more information about how we may use and disclose member information by visiting our website at www.fepblue.org.

Section 2. Changes for 2026

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 (Benefits). Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to our FEP Blue Focus

- Prior approval for genetic testing will be required when the test is being performed to assess the risk of passing a genetic condition to a child, or when the member has no active disease or signs or symptoms of the disease that is being screened. Prior approval is not required when a member has an active disease, signs and symptoms of a genetic condition that could be passed to a child, or when the test is needed to determine a course of treatment for a disease. (See page 21.)
- For Self Only contracts, the calendar year deductible is now $750. For Self Plus One and Self and Family Contracts, the deductible is now $1,500. (See pages 28, 35, 53, 62, 74, 78, 99, 122, 127 and 139.)
- For Self only contracts, your Preferred Provider catastrophic out-of-pocket maximum is now $10,000. For Self Plus One and Self and Family Contracts, your Preferred Provider catastrophic out-of-pocket maximum is now $20,000. (See pages 30, 127 and 141)
- Surgical and pharmacy services related to sex-trait modifications are no longer covered under this program. (See page 110.)
- Your copay for maternity services billed by a Preferred facility is $3,500 per pregnancy. (See page 64.)
- Prior approval for outpatient hospice services will no longer be required. (See pages 70-72.)
- For members enrolled in our regular pharmacy drug program, Tier 2 Preferred Brand-Name Drugs purchased at a Preferred retail pharmacy you are responsible for 40% of the Plan allowance (up to a maximum of $550) for a 30-day supply and 40% of the Plan allowance (up to a maximum of $1,650) for 31 to 90-day supply. (See page 86.)
- For members enrolled in our regular pharmacy drug program, Tier 2 Preferred Specialty Drugs purchased at Preferred retail pharmacies and through the Specialty Drug Pharmacy Program for generic and brand-name drugs you are now responsible for 40% of the Plan allowance (up to the maximum of $550) for a 30-day supply and 40% of the Plan allowance (up to a maximum of $1,650) for 31 to 90-day supply. (See page 87.)
- For those enrolled in our Medicare Prescription Drug Program, the prescription out-of-pocket maximum is now $2,100. (See pages 30 and 92.)

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You will need it whenever you receive services from a covered provider, or fill a prescription through a Preferred retail pharmacy. Until you receive your ID card, use your copy of the PSHB System enrollment confirmation.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call the Local Plan serving the area where you reside and ask them to assist you, or write to us directly at: FEP® Enrollment Services, 840 First Street NE, Washington, DC 20065. You may also request replacement cards through our website, www.fepblue.org.

Where you get covered care

You must use those "covered professional providers" or "covered facility providers" that are Preferred providers for FEP Blue Focus in order to receive benefits. Benefits are not available for care from Non-preferred providers, except in very limited situations. Please read further in this section for the exceptions to this requirement.

You can also get care for the treatment of minor acute conditions, dermatology care, and counseling for behavioral health and substance use disorder, and nutritional counseling, using teleconsultation services delivered via phone by calling 855-636-1579, TTY: 711, or via secure online video/ messaging at www.fepblue.org/telehealth.

Balance Billing Protection

PSHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or in some cases for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in-network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, coinsurance) contact your Carrier to enforce the terms of its provider contract.

- **Covered professional providers**

We provide benefits for the services of covered professional providers, as required by Section 2706(a) of the Public Health Service Act. Covered professional providers within the United States, Puerto Rico, and the U.S. Virgin Islands are healthcare providers who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their healthcare services in the normal course of business. Covered services must be provided in the state in which the provider is licensed or certified. **If the state has no applicable licensing or certification requirement, the provider must meet the requirements of the Local Plan.** Your Local Plan is responsible for determining the provider's licensing status and scope of practice. As reflected in Section 5, the Plan does limit coverage for some services, in accordance with accepted standards of clinical practice regardless of the geographic area.

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information.

If you have questions about covered providers, would like the names of PPO (Preferred) providers, or need a Care Coordinator for complex conditions, please contact the Local Plan where services will be performed.

- **Covered facility providers**

Covered Preferred (PPO) facilities include those listed below, when they meet the state's applicable licensing or certification requirements.

Hospital – An institution, or a distinct portion of an institution, that:

1. Primarily provides diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons provided or supervised by a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.), for compensation from its patients, on an inpatient or outpatient basis;
2. Continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and

3. Is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, or those who suffer from substance use disorders; or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

Note: You must use Preferred providers to receive benefits. We consider college infirmaries to be Non-preferred (Member/Non-member) hospitals. In addition, we may, at our discretion, recognize any institution located outside the 50 states and the District of Columbia as a Non-preferred (Member/Non-member) hospital.

Freestanding Ambulatory Facility – A freestanding facility, such as an ambulatory surgical center, freestanding surgicenter, freestanding dialysis center, or freestanding ambulatory medical facility, that:

1. Provides services in an outpatient setting;
2. Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;
3. Provides treatment performed or supervised by doctors and/or nurses, and may include other professional services performed at the facility; and
4. Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

Note: We may, at our discretion, recognize any other similar facilities, such as birthing centers, as freestanding ambulatory facilities.

Residential Treatment Center – Residential treatment centers (RTCs) are licensed by the state, district, or territory and may be accredited, where required, by a nationally recognized organization to provide residential treatment for medical conditions, mental health conditions, and/or substance use disorder. Accredited healthcare facilities (excluding hospitals, skilled nursing facilities, group homes, halfway houses, and similar types of facilities) provide 24-hour residential evaluation, treatment and comprehensive specialized services relating to the individual’s medical, physical, mental health, and/or substance use disorder therapy needs. RTCs offer programs for persons who need short-term transitional services designed to achieve predicted outcomes focused on fostering improvement or stability in functional, physical and/or mental health, recognizing the individuality, strengths, and needs of the persons served. If you have questions about treatment at an RTC or need assistance coordinating this care, please contact us at the customer service phone number listed on the back of your ID card.

Blue Distinction® Specialty Care

Blue Distinction Specialty Care, our centers of excellence program, focuses on effective treatment for specialty procedures, such as: Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, Transplants, Cancer Care, Cellular Immunotherapy (CAR-T), Maternity Care, and Substance Use Treatment and Recovery. Using national evaluation criteria developed with input from medical experts, the Blue Distinction Centers offer comprehensive care delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise. Providers demonstrate quality care, treatment expertise and better overall patient results.

Bariatric and Transplant care benefits are limited to services provided in a Blue Distinction Center. For more information, including the list of transplants that must be performed at a Blue Distinction Center, see Section 5(b).

For listings of Blue Distinction Centers, visit https://www.bcbs.com/about-us/programs-initiatives/blue-distinction-specialty-care/centers-and-physicians-search; access our National Doctor & Hospital Finder via www.fepblue.org/provider; or call us at the customer service phone number listed on the back of your ID card.

Other facilities specifically listed in the benefits descriptions in Section 5(c).

What you must do to get covered care

You must use Preferred providers in order to receive benefits, except under the situations listed below. In addition, we must approve certain types of care in advance. Please refer to Section 4, *Your Costs for Covered Services*, for related benefits information.

Exceptions:

1. Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d), *Emergency Services/Accidents*;
2. Professional care provided at Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, neonatologists, emergency room physicians, and assistant surgeons;
3. Laboratory and pathology services, X-rays, and diagnostic tests billed by Non-preferred laboratories, radiologists, and outpatient facilities;
4. Services of assistant surgeons;
5. Care received outside the United States, Puerto Rico, and the S. Virgin Islands; or
6. Special provider access situations, other than those described above. We encourage you to contact your Local Plan for more information in these types of situations before you receive services from a Non-preferred provider.

Unless otherwise noted in Section 5, when services are covered as an exception for Non-preferred provider care, you are responsible for the applicable coinsurance or copayment, and may also be responsible for any difference between our allowance and the billed amount.

- **Transitional care**

Specialty care: You may continue seeing your specialist and receiving any PPO benefits for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:

- we drop out of the Postal Service Health Benefits (PSHB) Program and you enroll in another PSHB plan, or
- we terminate our contract with your specialist for reasons other than for cause,

you may be able to continue seeing your specialist and receiving any Preferred benefits for up to 90 days after you receive notice of the change. Contact us at the number on the back of your ID card or, if we drop out of the Program, contact your new plan.

If you are pregnant and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your Preferred benefits will continue until the end of your postpartum care, even if it is beyond the 90 days.

Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

Sex-Trait Modification: If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. If you have questions about the exception process, contact us using the customer service phone number listed on the back of your ID card. If you disagree with our decision, please see Section 8 of this brochure for the disputed claims process. Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call us immediately. If you have not yet received your ID card, you can contact your Local Plan at the phone number listed in your local phone directory. If you already have your new ID card, call us at the phone number on the back of your ID card. If you are new to the PSHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

However, if you changed from another PSHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the PSHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for Other services (called prior approval) are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us before you receive medical care or services. In other words, a pre-service claim for benefits may require precertification and prior approval. If you do not obtain precertification or prior approval as required, there may be a reduction or denial of benefits. Be sure to read all of the following precertification and prior approval information. Our FEP medical policies may be found by visiting www.fepblue.org/policies.

- **Inpatient hospital admission, inpatient residential treatment center admission**

Precertification is the process by which – prior to your inpatient admission – we evaluate the medical necessity of your proposed stay, the procedure(s)/service(s) to be performed, the number of days required to treat your condition, and any applicable benefit criteria. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or facility will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician, hospital or inpatient residential treatment center if they have contacted us and provided all necessary information. You may also contact us at the phone number on the back of your ID card to ask if we have received the request for precertification. Later in this section, there is more information about precertification of an *Emergency inpatient admission*.

Note: Special rules apply when Medicare or another payer is primary, as explained later in this section.

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  - **Warning:**

We will reduce our benefits for the inpatient hospital stay by $500, even if you have obtained prior approval for the service or procedure being performed during the stay, if no one contacts us for precertification. If the stay is not medically necessary, we will not provide benefits for inpatient hospital room and board or inpatient physician care; we will only pay for covered medical services and supplies that are otherwise payable on an outpatient basis.

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  - **Exceptions:**

You do not need precertification in these cases:

You are admitted to a hospital outside the United States; with the exception of admissions to residential treatment centers.

Note: Special rules apply when Medicare or another payer is primary, as explained later in this section.

- **Other services**

You must obtain prior approval for these services in all outpatient and inpatient settings unless otherwise noted. Failure to obtain prior approval will result in a $100 penalty. Precertification is also required if the service or procedure requires an inpatient hospital admission. However, special rules apply when Medicare or another payer is primary, as explained later in this section. If an inpatient admission is necessary, precertification is also required. Contact us using the customer service phone number listed on the back of your ID card before receiving these types of services, and we will request the medical evidence needed to make a coverage determination:

- **Gene Therapy and Cellular Immunotherapy,** including Car-T and T-cell receptor therapy

- **Medical benefit drugs** – We require prior approval for certain drugs that will be submitted on a medical claim for reimbursement. Contact the customer service number on the back of your ID card or visit us at www.fepblue.org/medicalbenefitdrugs for a list of these drugs.
- **Air Ambulance Transport (non-emergent)** – Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval.
- **Applied behavior analysis (ABA)** – Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
- **Genetic testing -** Prior approval for genetic testing will be required when the test is being performed to assess the risk of passing a genetic condition to a child, or when the member has no active disease or signs or symptoms of the disease that is being screened. Prior approval is not required when a member has an active disease, signs and symptoms of a genetic condition that could be passed to a child, or when the test is needed to determine a course of treatment for a disease.
- **Surgical services –** The surgical services on the following list require prior approval and when care is provided in an inpatient setting, precertification is required for the hospital stay.
  - Procedures to treat severe obesity
    Note: Benefits for the surgical treatment of severe obesity – performed on an inpatient or outpatient basis – are subject to the pre-surgical requirements listed in our *Bariatric* medical policy. See Section 5(b). Benefits are only available for the surgical treatment of severe obesity when provided at a Blue Distinction Specialty Care Center for Bariatric (weight loss) Surgery.
  - Breast reduction or augmentation not related to treatment of cancer
  - Oral maxillofacial surgeries/surgery on the jaw, cheeks, lips, tongue, roof and floor of the mouth, and related procedures
  - Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ)
  - Orthopedic procedures: hip, knee, ankle, spine, shoulder and all orthopedic procedures using computer-assisted musculoskeletal surgical navigation
  - Reconstructive surgery for conditions other than breast cancer
  - Rhinoplasty
  - Septoplasty
  - Varicose vein treatment
- **Proton beam therapy** – Prior approval is required for all proton beam therapy services except for members aged 21 and younger, or when related to the treatment of neoplasms of the nervous system including the brain and spinal cord; malignant neoplasms of the thymus; Hodgkin and non-Hodgkin lymphomas.
- **Stereotactic radiosurgery** – Prior approval is required for all stereotactic radiosurgery except when related to the treatment of malignant neoplasms of the brain and of the eye specific to the choroid and ciliary body; benign neoplasms of the cranial nerves, pituitary gland, aortic body, or paraganglia; neoplasms of the craniopharyngeal duct and glomus jugular tumors; trigeminal neuralgias, temporal sclerosis, certain epilepsy conditions, or arteriovenous malformations.
- **Stereotactic body radiation therapy**
- **Reproductive services** – Prior approval is required for intracervical insemination (ICI), intrauterine insemination (IUI), and intravaginal insemination (IVI)
- **Sperm/egg storage** – Prior approval is required for the storage of sperm and eggs for individuals facing iatrogenic infertility.
- **Cardiac rehabilitation**
- **Cochlear implants**
- **Residential treatment center care** for any condition

- **Prosthetic devices (external),** including: microprocessor controlled limb prosthesis; electronic and externally powered prosthesis
- **Pulmonary rehabilitation**
- **Radiology, high technology** including:
  - Magnetic resonance imaging (MRI)
  - Computed tomography (CT) scan
  - Positron emission tomography (PET) scan

    Note: High technology radiology related to immediate care of a medical emergency or accidental injury does not require prior approval.
- **Specialty durable medical equipment (DME),** rental or purchase, to include:
  - Specialty hospital beds
  - Deluxe wheelchairs, power wheelchairs and mobility devices and related supplies
- **Transplants:** Prior Approval is required for all transplants. **Prior approval is required for** both the procedure and if benefits require, the transplant program; precertification is required for inpatient care.
- **Blood or marrow stem cell transplants** listed in Section 5(b) must be performed in a transplant program designated as a Blue Distinction Center for Transplants. Read earlier in this section for more information about these types of programs.

  Not every transplant program provides transplant services for every type of transplant procedure or condition listed, or is designated or accredited for every covered transplant. Benefits are not provided for a covered transplant procedure unless the transplant program is specifically designated as a Blue Distinction Center for Transplants for that procedure. Before scheduling a transplant, call your Local Plan at the customer service phone number appearing on the back of your ID card for assistance in locating an eligible facility and requesting prior approval for transplant services.
- **Clinical trials for certain** blood or marrow stem cell **transplants** – in Section 5(b) we provide a **list of conditions covered only in clinical trials**.
  - Contact us at the customer service phone number on the back of your ID card for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination.

  Even though we may state benefits are available for a specific type of clinical trial, you may not be eligible for inclusion in these trials or there may not be any trials available in a Blue Distinction Center for Transplants to treat your condition. If your physician has recommended you receive a transplant or that you participate in a transplant clinical trial, we encourage you to contact the Case Management Department at your Local Plan.

  Note: For the purposes of the blood or marrow stem cell clinical trial transplants covered under this Plan, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board (IRB) of the Blue Distinction Center for Transplants where the procedure is to be performed.

- **Organ/tissue transplants**
  Benefits for certain transplants are limited to designated transplant centers or programs.

  Some transplants listed in Section 5(b) must be performed in a transplant program designated as a Blue Distinction Center for Transplants.

  Some organ transplants are not available in a Blue Distinction Center for Transplants and must be performed at a Preferred facility with a Medicare-Approved Transplant Program, if one is available.Transplants involving more than one organ must be performed in a facility that offers a Medicare-Approved Transplant Program for each organ transplanted. Contact your local Plan for Medicare's approved transplant programs.

  If Medicare does not offer an approved program for a certain type of organ transplant procedure, this requirement does not apply and you may use any covered Preferred facility and Preferred provider that performs the procedure.

  Contact us at the customer service phone number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. Our review will include whether you meet the facility and transplant program criteria for the particular transplant.

  All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service phone number listed on the back of their ID card before obtaining services.
- **Transplant travel –** If you travel to a Blue Distinction Center for Transplants, we reimburse up to $5,000 per transplant for costs of transportation (air, rail, bus, and/or taxi) and lodging (for you and your traveling companions) if you live 50 miles or more from the facility.
- **Prescription drugs and supplies –** Certain prescription drugs and supplies, including medical foods administered orally, require prior approval. Contact CVS Caremark, our Pharmacy Program administrator, at 800-624-5060, TTY: 711, to request prior approval, or to obtain a list of drugs and supplies that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See Section 5(f) for more information about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

  Notes:
  - Updates are made periodically throughout the year to the list of drugs and supplies requiring prior approval. New drugs and supplies may be added to the list and prior approval criteria may change. Changes to the prior approval list or to prior approval criteria are not considered benefit changes.
  - Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy or through our specialty drug pharmacy – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.
  - The Specialty Drug Pharmacy Program will not fill your prescription until you have obtained prior approval. CVS Caremark, the program administrator, will hold your prescription for you up to 30 days. If prior approval is not obtained within 30 days, your prescription will be returned to you along with a letter explaining the prior approval procedures.

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  - **Warning:**

We will reduce our benefits by $100 for medically necessary services that require prior approval, if no one contacts us for prior approval. If the service is not medically necessary, we will not provide benefits. This benefit reduction does not apply to prescription drugs that require prior approval.

- **Special prior authorization situations related to coordination of benefits (COB)**

The examples below provide the special situations regarding prior approval and precertification when Medicare is the primary payor.

Service Type: Inpatient hospital admission
Primary Payor: Medicare Part A
Precertification: No
Prior Approval: Not applicable

Service Type: Medicare hospital benefits exhausted and you do not want to use your Medicare lifetime reserve days
Primary Payor: Medicare Part A benefits not provided
Precertification: Yes
Prior Approval: Not applicable

Service Type: Severe obesity surgery when performed during an inpatient admission
Primary Payor: Medicare Part A
Precertification: No
Prior Approval: Yes

Service Type: Severe obesity surgery in an outpatient hospital or ambulatory surgical center (ASC)
Primary Payor: Medicare Part B
Precertification: Not applicable
Prior Approval: Yes

Service Type: Residential treatment center admission – inpatient
Primary Payor: Medicare Part A
Precertification: Yes
Prior Approval: Not applicable

Service Type: Residential treatment center – outpatient care
Primary Payor: Medicare Part B
Precertification: Not applicable
Prior Approval: Yes

The examples below provide the special situations regarding prior approval and precertification when another healthcare insurance is the primary payor.

Service Type: Inpatient hospital admission
Primary Payor: Other healthcare insurance
Precertification: No
Prior Approval: Not applicable

Service Type: Severe obesity surgery when performed during an inpatient admission
Primary Payor: Other healthcare insurance
Precertification: No
Prior Approval: Yes

Service Type: Severe obesity surgery in an outpatient hospital or ambulatory surgical center (ASC)
Primary Payor: Other healthcare insurance
Precertification: Not applicable
Prior Approval: Yes

Service Type: Residential treatment center admission – inpatient
Primary Payor: Other healthcare insurance
Precertification: Yes
Prior Approval: Not applicable

Service Type: Residential treatment center – outpatient care
Primary Payor: Other healthcare insurance
Precertification: Not applicable
Prior Approval: Yes

- **Prior notification – Maternity care**

We encourage you to notify us of your pregnancy during the first trimester. Please contact us at the phone number on the back of your ID card and provide the following information:

- Enrollee's name and Plan identification number
- Expected delivery date
- Date of your first prenatal appointment
- Name and phone number of the provider (i.e., physician, nurse practitioner, nurse midwife) providing your prenatal, delivery, and postnatal care
- Name and location of the place you intend to deliver (i.e., hospital, birthing center, your home)
- If you plan to deliver in a hospital, the type of delivery and the estimated number of days you will be in the hospital.

We will advise you if any additional information is needed.

How to request precertification for an admission or get prior authorization for *Other services*

You, your representative, your physician, or your hospital, residential treatment center or other covered inpatient facility must call us at the phone number listed on the back of your ID card any time prior to admission or before receiving services that require prior approval with the following information:

- Enrollee's name and Plan identification number;
- Patient's name, birth date, and phone number;
- Reason for inpatient admission, proposed treatment, or surgery;
- Name and phone number of admitting physician;
- Name of hospital or facility;
- Number of days requested for hospital stay;
- Any other information we may request related to the services to be provided

Note: If we approve the request for prior approval or precertification, you will be provided with a notice that identifies the approved services and the authorization period. You must contact us with a request for a new approval five (5) business days prior to a change to the approved original request, and for requests for an extension beyond the approved authorization period in the notice you received. We will advise you of the information needed to review the request for change and/or extension.

- **Non-urgent care claims**

For non-urgent care claims (including non-urgent concurrent care claims), we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for *Other services* that must have prior approval. We will notify you of our decision within 15 days after the receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original **15-day** period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an **urgent care claim** (i.e., when waiting for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review of the claim and notify you of our decision within 72 hours as long as we receive sufficient information to complete the review. (For concurrent care claims that are also urgent care claims, please see *If your treatment needs to be extended* later in this section.) If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at the phone number listed on the back of your ID card. You may also call OPM's Postal Service Insurance Operations (PSIO) at (202) 936-0002 between 8 a.m. and 5 p.m. Eastern Time (excluding holidays) to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at the phone number listed on the back of your ID card. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the request.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not phone us within two business days, a $500 penalty may apply – see *Warning* under *Inpatient hospital admissions* earlier in this Section and *If your facility stay needs to be extended* on this page below.

Admissions to residential treatment centers do not qualify as emergencies.

- **Maternity care**

We encourage you to notify us of your pregnancy during the first trimester. You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, your physician or the hospital must contact us for precertification of additional days. Further, if your newborn stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your newborn.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your hospital stay needs to be extended**

If your **hospital** stay – including for maternity and RTC care – needs to be extended, you, your representative, your physician, or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

- for the part of the admission that was medically necessary, we will pay inpatient benefits, but
- for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and we will not pay inpatient benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of *Other services*, you may request a review by following the procedures listed on the next page. Note that these procedures apply to requests for reconsideration of concurrent care claims as well. If you have already received the service, supply, or treatment, then your claim is a **post-service claim** and you must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a **pre-service claim** and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your inpatient admission or, if applicable, approve your request for prior approval for the service, drug, or supply; or
2. Write to you and maintain our denial; or
3. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows verbal or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your pre-service claim, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Note: If you are enrolled in our Medicare PDP EGWP and do not agree with our benefit coverage decision, you have the right to appeal. See Section 8(a) for information about the PDP EGWP appeal process.

Section 4. Your Costs for Covered Services

This is what you will pay out-of-pocket for your covered care:

Cost-share/Cost-sharing	Cost-share or cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive. Note: You may have to pay the deductible, coinsurance, and/or copayment amount(s) that apply to your care at the time you receive the services.
Copayment	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your Preferred professional provider for physical therapy, you pay a copayment of $25 for the visit, and we then pay the remainder of the amount we allow for the visit. (You may have to pay separately for other services you receive while in the provider's office.) Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount. Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward your deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply that you then pay counts toward meeting your deductible. The calendar year deductible is $750 per person. After the deductible amount is satisfied for an individual, covered services are payable for that individual. Under a Self Plus One enrollment, both family members must meet the individual deductible. Under a Self and Family enrollment, an individual may meet the individual deductible, or all family members' individual deductibles are considered to be satisfied when the family members' deductibles are combined and reach $1,500. Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount. Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your $750 calendar year deductible has been satisfied. Note: If you change PSHB plans during Open Season, the effective date of your new PSHB plan is January 1 of the next year, and a new deductible starts on January 1. If you change plans at another time during the year, you must begin a new deductible under your new plan.
Coinsurance	Coinsurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance, or billed amount, whichever is less. Coinsurance does not begin until you have met your calendar year deductible. Example: You pay 30% of the Plan allowance for durable medical equipment obtained from a Preferred provider, after meeting your $750 calendar year deductible.
If your provider routinely waives your cost	**If your provider routinely waives** (does not require you to pay) your applicable copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived. Example: If your physician ordinarily charges $100 for a service but routinely waives your 30% coinsurance, the actual charge is $70. We will pay $49 (70% of the actual charge of $70).

Waivers

In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether or not you are responsible for the total charge depends on the contracts that the Local Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at the customer service phone number on the back of your ID card.

Differences between our allowance and the bill

Our "**Plan allowance**" is the amount we use to calculate our payment for certain types of covered services. Fee-for-service plans arrive at their allowances in different ways, so allowances vary. For information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service Plan's allowance. It is possible for a provider's bill to exceed the Plan's allowance by a significant amount. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. Providers that have agreements with this Plan are Preferred and will not bill you for any balances that are in excess of our allowance for covered services. See the descriptions appearing below for the types of providers available in this Plan.

- **Preferred** These types of providers have agreements with the Local Plan to limit what they bill our members. Because of that, when you use a Preferred provider, your share of the provider's bill for covered care is limited.

  Your share consists only of your deductible, coinsurance, and/or copayment. Here is an example about coinsurance: You see a Preferred physician who charges $250, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just 30% of our $100 allowance ($30). Because of the agreement, your Preferred physician will not bill you for the $150 difference between our allowance and their bill.

Remember, you must use Preferred providers in order to receive benefits.

- **Non-preferred Providers:**
  - **Participating provider/Member facility. There are no benefits for care performed by Participating providers; you pay all charges.**
  - **Non-participating providers/Non-member facility. There are no benefits for care performed by Non-participating providers; you pay all charges.**

    Remember you must use Preferred providers in order to receive benefits. There are no benefits for care performed by Participating and Non-participating providers. See Section 3 for exceptions under *What you must do to get covered care.*

    You should also see section *Important Notice About Surprise Billing – Know Your Rights* below that describes your protections against surprise billing under the No Surprises Act.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out of network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care - when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating healthcare facilities, or for
- air ambulance services furnished by nonparticipating air ambulance providers

Balance billing happens when you receive a bill from the non-participating provider, facility, or air ambulance service for the difference between the Non-participating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.fepblue.org/NSA or contact the customer service phone number on the back of your ID card.

Your costs for other care

Overseas care: Services provided outside the United States, Puerto Rico, and the U.S. Virgin Islands are considered overseas care. We pay overseas claims at Preferred benefit levels, so the requirement to use Preferred providers in order to receive benefits does not apply. See Section 5(i) for specific information about our overseas benefits.

Inpatient facility care: You must use **Preferred** facilities in order to receive benefits. See Section 3 for the exceptions to this requirement.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

We limit your annual out-of-pocket expenses for the covered services you receive to protect you from unexpected healthcare costs. When your eligible out-of-pocket expenses reach this catastrophic protection maximum, you no longer have to pay the associated cost-sharing amounts for the rest of the calendar year. For Self Plus One and Self and Family enrollments, once any individual family member reaches the Self Only catastrophic protection out-of-pocket maximum during the calendar year, that member's claims will no longer be subject to associated cost-sharing amounts for the rest of the year. All other family members will be required to meet the balance of the catastrophic protection out-of-pocket maximum.

Note: Certain types of expenses do not accumulate to the maximum (see below).

Preferred Provider maximum – For a Self Only enrollment, your out-of-pocket maximum for your deductible, and for eligible coinsurance and copayment amounts is $10,000 when you use Preferred providers. For a Self Plus One or a Self and Family enrollment, your out-of-pocket maximum for these types of expenses is $20,000 for Preferred provider services. Only eligible expenses for Preferred provider services count toward these limits.

For members enrolled in our Plan's associated PDP EGWP, we are required to accumulate all members' actual out-of-pocket costs for Medicare-covered drugs, services and supplies toward the PSHB catastrophic maximum(s), unless specifically excluded below.

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug true out-of-pocket cost (TrOOP) is $2,100. After this is met, we pay 100% of all covered prescription drug benefits.

The following expenses are not included under this feature. These expenses do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay them even after your expenses exceed the limits described above.

- The difference between the Plan allowance and the billed amount described earlier in this section;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;
- The $500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements;
- The $100 penalty for failing to obtain prior approval, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements;
- If there is a generic substitution available and you or your provider requests a brand-name drug, your expenses for the difference between the cost of the generic medication and the brand-name medication do not count toward your catastrophic protection out-of-pocket maximum (see Section 5 (f) for additional information); and

- Expenses for care received from Non-preferred providers (Participating/Non-participating professional providers or Member/Non-member facilities), except for your deductible, coinsurance and/or copayments you pay in those situations where we do pay for care provided by Non-preferred providers. Please see Section 3 for the exceptions to the requirement to use Preferred providers.

Carryover

If you change to this PHSB plan during Open Season from a plan with a catastrophic protection benefit, the effective date of the change is January 1 and covered expenses that apply to this Plan's catastrophic protection benefit starts on January 1.

Note: If you change PSHB Plans during Open Season, the effective date of your new PSHB Plan is January 1 of the next year, and a new catastrophic protection accumulation starts on January 1. If you change plans at another time during the year, you must begin a new catastrophic protection accumulation under your new plan.

Because benefit changes are effective January 1, we will apply our next year's benefits to any expenses you incur in January.

If you change options in this Service Benefit Plan during the year, we will credit the amounts already accumulated toward the catastrophic protection out-of-pocket limit of your old option to the catastrophic protection out-of-pocket limit of your new option. If you change from Self Only to Self Plus One or Self and Family, or vice versa, during the calendar year, please call us about your out-of-pocket accumulations and how they carry over.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

If we provided coverage in error, but in good faith, for prescription drugs purchased through one of our pharmacy programs, we will request reimbursement from the contract holder.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. FEP Blue Focus Benefits

See Section 2 for how our benefits changed this year. The Summary of Benefits is the benefits summary of each option. Make sure to review the benefits that are available under the option in which you are enrolled. Section 5 provides an overview of FEP Blue Focus.

Section 5. FEP Blue Focus Overview

The benefit package for FEP® Blue Focus is described in Section 5, which is divided into subsections 5(a) through 5(i).

Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about FEP Blue Focus benefits, contact us at the customer service phone number on the back of your ID card or go to our website at www.fepblue.org.

We have provided a new way for you to consider the benefits available to you under FEP Blue Focus to determine whether this product will be a good choice for you and your family. We have divided the benefits under FEP Blue Focus into three basic categories: CORE, NON-CORE and WRAP. The following information describes the portion you pay, based on the benefits you use. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Note: For more information about services received overseas, see Section 5(i).

The "***CORE***" benefits are those under this program that form the most important level – the base of the program. These benefits have only a low or no copayment and are not subject to a deductible or coinsurance for the care received. These benefits are most commonly used to receive general care and to maintain your overall health and well-being, in addition to coverage for accidental injuries. For example, your first 10 healthcare visits with a primary care provider, specialist or other healthcare professional will be subject to a $10 copayment for each visit.

The "***NON-CORE***" benefits are there to provide coverage for any unexpected medical costs you may incur during the calendar year. These share the same annual deductible and the same co-insurance level (see *Annual Cost-Shares* below). When the catastrophic out-of-pocket maximum has been satisfied, we pay 100% of the Plan allowance for the remainder of the calendar year (see Section 4 for more information). For example, after your first 10 visits (primary care, specialist or other healthcare provider), you will have a deductible to satisfy of $750 and then you will pay 30% of the Plan allowance for the visit. You may or may not have a need to use these benefits during the year.

"***WRAP***" benefits provide the final layer of protection and complete or "wrap-up" the FEP Blue Focus benefit package. These are benefits you may or may not have a need to use during the year. These benefits have visit limitations and/or different copayments or co-insurance levels than the "CORE" or "NON-CORE" benefit levels. The calendar year deductible does not apply to these benefits.

In addition to the general exclusions found in Section 6, this program does not provide benefits for some services that are covered under the Service Benefit Plan Standard or Basic Options. An example of services excluded under FEP Blue Focus is coverage for routine dental care.

You must use Preferred providers for your care to be eligible for benefits, except in certain circumstances, such as medical emergency or accidental injury services. Preferred providers will submit claims to us on your behalf.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

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.
- Please refer to Section 3, *How You Get Care*, for information on covered professional providers and other healthcare professionals.
- 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 or facility bills for the service.
- The services listed in this Section are for the charges billed by a physician or other healthcare professional for your medical care. See Section 5(c) for charges associated with the facility (i.e., hospital or other outpatient facility, etc.).
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drugs when obtained from a covered provider other than a pharmacy under the pharmacy benefit. You must use a Preferred pharmacy thereafter. 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), or 5(f)(a) if applicable, for information about Tier 2 specialty drug fills from a Preferred pharmacy. Medications restricted under this benefit are available on our FEP Blue Focus Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731.
- The calendar year deductible is $750 per person ($1,500 per Self Plus One or Self and Family enrollment). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- **You must use Preferred providers in order to receive benefits.** See below and Section 3 for the exceptions to this requirement.
- We provide benefits at Preferred benefit levels 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 should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- There is a $10 visit copayment for each of the first 10 visits to a professional provider per calendar year. This applies to a combined total for medical and mental health and substance use disorder visits.
- **If you receive both preventive and diagnostic services from your Preferred provider on the same day**, you are responsible for paying your cost-share for the diagnostic services. This includes applicable cost-share for diagnostic procedures such as an injection, laboratory, and X-ray services.
- An incentive award is available for those members (member and/or spouse over age 18) who receive an annual routine physical in 2026. Please see Section 5(h) for more information.

Preventive Care Benefits - Here are some things to keep in mind:

- Preventive care refers to medical services, counseling, and screenings related to the prevention of disease and health-related problems, rather than curing disease or treating its symptoms.
- You must use Preferred providers in order to receive preventive benefits without cost-share, see Section 3 for exceptions to this requirement.

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this section.	
Diagnostic and Treatment Services	**FEP Blue Focus**
Outpatient professional services of physicians and other healthcare professionals: • Consultations • Genetic counseling • Second surgical opinions • Clinic visits • Office visits • Home visits • Initial examination of a newborn child • Pharmacotherapy (medication management) (See Section 5(f) for prescription drug coverage) • Phone consultations and online medical evaluation and management services (telemedicine) Note: Please see Section 5(c) for our coverage of these services when billed for by a facility, such as the outpatient department of a hospital.	Preferred provider: $10 copayment (no deductible) per visit up to a combined total of 10 visits per calendar year (benefits combined with visits in Section 5(e)) Preferred provider, visits after the 10th visit: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges Note: You pay 30% of the Plan allowance (deductible applies) for agents, drugs, and/or supplies administered or obtained in connection with your care.
Telehealth professional services for: • Minor acute conditions • Dermatology care Notes: • Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access a provider. • Copayments are waived for members with Medicare Part B primary.	Preferred Telehealth Provider: Nothing (no deductible) Non-preferred (Participating/Non-participating): You pay all charges
Inpatient professional services: • During a covered hospital stay • Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission • Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay hospital benefits Note: A consulting physician employed by the hospital is not the attending physician. • Consultations when requested by the attending physician • Nutritional counseling when billed by a covered provider • Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care • Physical therapy by a physician other than the attending physician • Initial examination of a newborn needing definitive treatment when covered under a Self Plus One or Self and Family enrollment • Pharmacotherapy (medication management) (See Section 5(c) for our coverage of drugs you receive while in the hospital.)	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges

Diagnostic and Treatment Services - continued on next page

Benefit Description	You Pay
Diagnostic and Treatment Services (cont.)	**FEP Blue Focus**
• Second surgical opinion	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Not covered: • *Routine services except for those Preventive care services described later in this section* • *Costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies, non-interactive telecommunication such as email communications, or asynchronous store-and-forward telehealth services* • *Private duty nursing* • *Standby physicians* • *Routine radiological and staff consultations required by facility rules and regulations* • *Inpatient physician care when your admission or portion of an admission is not covered (See Section 5(c).* *Note: If we determine that an inpatient admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.*	*All charges*
Lab, X-ray and Other Diagnostic Tests	**FEP Blue Focus**
Diagnostic tests, such as: • Laboratory tests (such as blood tests and urinalysis) • Pathology services • EKGs • Cardiovascular monitoring • EEGs • Neurological testing • Ultrasounds • X-rays (including set-up of portable X-ray equipment) • Bone density tests • CT scans*/MRIs*/PET scans* • Angiographies • Genetic testing - prior approval is required for genetic testing performed in the absence of signs, symptoms, or diagnosis of an active disease, or to assess the risk of passing genetic conditions to a child. • Nuclear medicine • Sleep studies Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital. ***Prior approval is required**	Preferred: 30% of the Plan allowance (deductible applies) Note: $0 member cost-share for the first 10 laboratory tests performed in each of these different laboratory test categories (Basic metabolic panels; Cholesterol screenings; Complete blood counts, Fasting lipoprotein profiles; General health panels; Urinalysis) and 10 Venipunctures when not associated with preventive maternity or accidental injury care. Non-preferred (Participating/Non-participating): You pay all charges Note: When care is provided by a Non-preferred laboratory and/or radiologist, as stated in Section 3 for an exception, you pay: • Participating laboratories or radiologists: 30% of the Plan allowance (deductible applies) • Non-participating laboratories or radiologists: 30% of the Plan allowance, plus any difference between our allowance and the billed amount (deductible applies)

<table>
<tr><th>Benefit Description</th><th>You Pay</th></tr>
<tr><th>Preventive Care, Adult</th><th>FEP Blue Focus</th></tr>
<tr><td>
Benefits are provided for preventive care services for adults age 22 and over.

Covered services include:
• Counseling on prevention and reducing health risks
• Nutritional counseling
Note: When nutritional counseling is via the contracted telehealth provider network, we provide benefits as shown here for Preferred providers. Refer to Section 5(h), Wellness and Other Special Features, for information on how to access a telehealth provider.
• Visits/exams for preventive care
Note: See the definition of Preventive Care, Adult, for included health screening services.

Preventive care benefits for each of the services listed below are limited to one per calendar year.
• Administration and interpretation of a Health Risk Assessment (HRA) questionnaire (see Definitions)
Note: As a member of FEP Blue Focus, you have access to the Blue Cross and Blue Shield HRA, called the “Blue Health Assessment” questionnaire. See Section 5(h) for more information.
• Basic or comprehensive metabolic panel test
• CBC
• Cervical cancer screening tests
- Human papillomavirus (HPV) tests of the cervix
- Pap tests of the cervix
• Colorectal cancer tests, including:
- Colonoscopy with or without biopsy (see Section 5(b) for our payment levels for diagnostic colonoscopies)
- CT colonography
- DNA analysis of stool samples
- Double contrast barium enema
- Fecal occult blood test
- Sigmoidoscopy
• Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides)
• General health panel
• Prostate cancer tests – Prostate Specific Antigen (PSA) test
• Screening for chlamydial infection
• Screening for diabetes mellitus
• Screening for gonorrhea infection
• Screening for human immunodeficiency virus (HIV)
• Screening mammograms, including mammography using digital technology
• Ultrasound for abdominal aortic aneurysm for adults, ages 65 to 75, limited to one screening per lifetime
</td><td>
Preferred: Nothing (no deductible)

Non-preferred (Participating/Non-participating): You pay all charges

Note: When care is provided by a Non-preferred laboratory and/or radiologist, as stated in Section 3 for an exception, you pay:
• Participating laboratories or radiologists: Nothing (no deductible)
• Non-participating laboratories or radiologists: The difference between our allowance and the billed amount (no deductible)

Note: See Section 5(c) for our payment levels for covered cancer screenings and ultrasound screening for abdominal aortic aneurysm billed for by Member or Non-member facilities and performed on an outpatient basis.

Note: For services billed by Non-preferred providers (Participating/Non-participating) related to influenza (flu) vaccines, we pay the Plan allowance. If you receive the influenza (flu) vaccine from a Non-participating provider, you pay any difference between our allowance and the billed amount (no deductible).
</td></tr>
</table>

Preventive Care, Adult - continued on next page

Benefit Description	You Pay
Preventive Care, Adult (cont.)	**FEP Blue Focus**
• Urinalysis The following preventive services are covered at the time interval recommended at each of the links below. Please also visit us at www.fepblue.org and type in preventive care for additional information about your preventive coverage. • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule such as COVID-19, Pneumococcal, influenza, shingles, tetanus/Tdap) and human papillomavirus (HPV). For a complete list of immunizations, go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/imz-schedules/index.html. Note: U.S. FDA licensure may restrict the use of the immunizations and vaccines listed above to certain age ranges, frequencies, and/or other patient-specific indications, including gender. • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, and high blood pressure. For a complete list of covered A and B recommendation screenings and age and frequency limitations, go to the website at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Well woman care such as gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services, go to the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines/ • To build your personalized list of preventive services, go to https://health.gov/myhealthfinder Notes: • We pay preventive care benefits on the first claim we process for each of the above tests you receive in the calendar year. Regular coverage criteria and benefit levels apply to subsequent claims for those types of tests if performed in the same year. If you receive both preventive and diagnostic services from your Provider on the same day, you are responsible for paying your cost-share for the diagnostic services. Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance and deductible. • Unless otherwise noted, the benefits discussed under *Preventive Care, Adult*, do not apply to individuals aged 21 and under. (See benefits under *Preventive Care, Child*, in this section.) • See Section 5(b) for the benefits available for the surgical removal of breast, ovaries, or prostate when screening reveals a BRCA mutation; preventive care benefits are not available.	Preferred: Nothing (no deductible) Non-preferred (Participating/Non-participating): You pay all charges Note: When care is provided by a Non-preferred laboratory and/or radiologist, as stated in Section 3 for an exception, you pay: • Participating laboratories or radiologists: Nothing (no deductible) • Non-participating laboratories or radiologists: The difference between our allowance and the billed amount (no deductible) Note: See Section 5(c) for our payment levels for covered cancer screenings and ultrasound screening for abdominal aortic aneurysm billed for by Member or Non-member facilities and performed on an outpatient basis. Note: For services billed by Non-preferred providers (Participating/Non-participating) related to influenza (flu) vaccines, we pay the Plan allowance. If you receive the influenza (flu) vaccine from a Non-participating provider, you pay any difference between our allowance and the billed amount (no deductible).
Obesity counseling, screening and referral to intensive nutrition and behavioral weight-loss therapy, or counseling under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows:	Preferred: Nothing (no deductible) Non-preferred (Participating/Non-participating): You pay all charges

Preventive Care, Adult - continued on next page

Benefit Description	You Pay
Preventive Care, Adult (cont.)	**FEP Blue Focus**
• Unlimited nutritional counseling including nutritional counseling via the contracted telehealth provider network • Unlimited visits for counseling on prevention and reducing health risks • Unlimited visits for individual and group behavioral counseling for obesity • Unlimited family-centered programs when medically identified to support obesity prevention and management by an in-network provider. Notes: • Benefits are available for anti-obesity medications. See Section 5(f) or 5(f)(a). • See Section 5(b) for information related to benefits for the surgical treatment of severe obesity.	Preferred: Nothing (no deductible) Non-preferred (Participating/Non-participating): You pay all charges
Not covered: • *Self-administered health risk assessments (other than the Blue Health Assessment)* • *Screening services requested solely by the member, such as commercially advertised heart scans, body scans, and tests performed in mobile traveling vans* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel* • *Medications for travel or work-related exposure. Medical benefits may be available for these services.* • *Phone consultations and online medical evaluation and management services (telemedicine) for preventive services, except as noted earlier for nutritional counseling*	*All charges*
Preventive Care, Child	**FEP Blue Focus**
Benefits are provided for preventive care services for children up to age 22. This includes: • Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines as provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Future Guidelines, go to https://brightfutures.aap.org • Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations, go to the website at https://www.cdc.gov/vaccines/imz-schedules/index.html Note: U.S. FDA licensure may restrict the use of certain vaccines to specific age ranges, frequencies, and/or other patient-specific indications, including gender. • You may also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. • To build your personalized list of preventive services, go to https://health.gov/myhealthfinder • Nutritional counseling	Preferred: Nothing (no deductible) Non-preferred (Participating/Non-participating): You pay all charges Note: When care is provided by a Non-preferred laboratory and/or radiologist, as stated in Section 3 for an exception, you pay: • Participating laboratories or radiologists: Nothing (no deductible) • Non-participating laboratories or radiologists: The difference between our allowance and the billed amount (no deductible)

Preventive Care, Child - continued on next page

<table>
<tr><th>Benefit Description</th><th>You Pay</th></tr>
<tr><th>Preventive Care, Child (cont.)</th><th>FEP Blue Focus</th></tr>
<tr><td>Note: Preventive care benefits for each of the services listed below are limited to one per calendar year:
• Screening for hepatitis B for children age 13 and over
• Screening for chlamydial infection
• Screening for gonorrhea infection
• Cervical cancer screening tests
- Human papillomavirus (HPV) tests of the cervix
- Pap tests of the cervix
• Screening for human immunodeficiency virus (HIV) infection
• Screening for syphilis infection
• Screening for latent tuberculosis infection for children ages 18 through 21

Note: If your child receives both preventive and diagnostic services from a Preferred provider on the same day, you are responsible for paying the cost-share for the diagnostic services.

Note: When nutritional counseling is via the contracted telehealth provider network, we provide benefits as shown here for Preferred providers. Refer to Section 5(h), Wellness and Other Special Features, for information on how to access a telehealth provider.

Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</td><td>Continued from previous page:

Notes:
• For services billed by Non-preferred providers (Participating/Non-participating) related to influenza (flu) vaccines, we pay the Plan allowance. If you receive the influenza (flu) vaccine from a Non-participating provider, you pay any difference between our allowance and the billed amount (no deductible).
• When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</td></tr>
<tr><td>Obesity counseling, screening and referral to intensive nutrition and behavioral weight-loss therapy, or counseling under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows:
• Unlimited nutritional counseling including nutritional counseling via the contracted telehealth provider network
• Unlimited visits for counseling on prevention and reducing health risks
• Unlimited visits for individual and group behavioral counseling for obesity
• And, for those children or adolescents with a body mass index (BMI) at or above the 85th percentile, unlimited family-centered programs when medically identified to support obesity prevention and management by an in-network provider.

Notes:
• Benefits are available for anti-obesity medications. See Section 5(f) or 5(f)(a).
• See Section 5(b) for information related to benefits for the surgical treatment of severe obesity.</td><td>Preferred: Nothing (no deductible)

Non-preferred (Participating/Non-participating): You pay all charges</td></tr>
<tr><td>Not covered:
• Self-administered health risk assessments (other than the Blue Health Assessment)</td><td>All charges</td></tr>
</table>

Preventive Care, Child - continued on next page

<table>
<tr><th>Benefit Description</th><th>You Pay</th></tr>
<tr><td>Preventive Care, Child (cont.)</td><td>FEP Blue Focus</td></tr>
<tr><td>

Screening services requested solely by the member, such as commercially advertised heart scans, body scans, and tests performed in mobile traveling vans
Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel
Medications for travel or work-related exposure. Medical benefits may be available for these services.
Phone consultations and online medical evaluation and management services (telemedicine) for preventive services, except as noted above for nutritional counseling.

</td><td>All charges</td></tr>
<tr><td>Maternity Care</td><td>FEP Blue Focus</td></tr>
<tr><td>
We encourage you to notify us of your pregnancy during the first trimester, see Section 3.

Maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage, such as:

Prenatal and postpartum care (including ultrasound, laboratory, and diagnostic tests)
Note: We cover up to 8 visits per year in full to treat depression associated with pregnancy (i.e., depression during pregnancy, postpartum depression, or both) when you use a Preferred provider. See Section 5(e) for our coverage and benefits for additional mental health services.
Delivery
Assistant surgeons/surgical assistance if required because of the complexity of the delivery
Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant
Tocolytic therapy and related services when provided on an inpatient basis during a covered hospital admission or during a covered observation stay
Breastfeeding education and individual coaching on breastfeeding by healthcare providers such as physicians, physician assistants, midwives, nurse practitioners/clinical specialists, and lactation specialists for each birth
Note: See below for our coverage of breast pump kits.
Home nursing visits (skilled), subject to visit limitation stated later in this section

Notes:

See earlier in this section for our coverage of nutritional counseling.
Maternity care benefits are not provided for prescription drugs required during pregnancy, except as recommended under the Affordable Care Act. See Section 5(f), or 5(f)(a) if applicable, for other prescription drug coverage.

Notes:

You do not need to precertify your delivery; see Section 3 for other circumstances, such as extended stays for you or your newborn.

</td><td>
Preferred: Nothing (no deductible)

Note: For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered facility care is limited to $3,500 per pregnancy. See Section 5(c).

Non-preferred (Participating/Non-participating): You pay all charges

Note: When care is provided by a Non-preferred laboratory and/or radiologist, as stated in Section 3 for an exception, you pay:

Participating laboratories or radiologists: Nothing (no deductible)
Non-participating laboratories or radiologists: The difference between our allowance and the billed amount (no deductible)

</td></tr>
</table>

Maternity Care - continued on next page

Benefit Description	You Pay
Maternity Care (cont.)	**FEP Blue Focus**
• You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will cover an *extended* stay if medically necessary. • We cover routine nursery care of the newborn when performed during the covered portion of the mother's maternity stay and billed by the facility. We cover other care of a newborn who requires professional services or non-routine treatment, only if we cover the newborn under a Self Plus One or Self and Family enrollment. Surgical benefits apply to circumcision when billed by a professional provider for a male newborn. • Hospital services are listed in Section 5(c) and Surgical benefits are in Section 5(b). • See Section 10 for our allowance for inpatient stays resulting from an emergency delivery at a hospital or other facility not contracted with your Local Plan. • When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. Regular medical or surgical benefits apply rather than maternity benefits. • See Section 5(b) for our payment levels for circumcision.	Preferred: Nothing (no deductible) Note: For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered facility care is limited to $3,500 per pregnancy. See Section 5(c). Non-preferred (Participating/Non-participating): You pay all charges Note: When care is provided by a Non-preferred laboratory and/or radiologist, as stated in Section 3 for an exception, you pay: • Participating laboratories or radiologists: Nothing (no deductible) • Non-participating laboratories or radiologists: The difference between our allowance and the billed amount (no deductible)
• Breast pump limited to one per calendar year for members who are pregnant and/or nursing • Blood pressure monitor, limited to one every two years Note: Benefits for the breast pump, milk storage bags, and blood pressure monitors are only available when you order them through our fulfillment vendor by visiting www.fepblue.org/maternity or calling 1-800-411-2583. Milk storage bags will be included with your breast pump.	Nothing
Not covered: • *Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest* • *Childbirth preparation, Lamaze, and other birthing/parentingclasses* • *Breast pumps and milk storage bags except as previously described* • *Breastfeeding supplies other than those contained in the breast pump kit described previously including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or convenience (e.g., nursing pads)* • *Tocolytic therapy and related services except as previously described* • *Maternity care for individuals not enrolled in the Service Benefit Plan*	*All charges*
Family Planning	**FEP Blue Focus**
A range of voluntary family planning services, without cost-sharing, that includes at least one form of contraception in each of the categories in the HRSA-supported guidelines. This list includes: • Contraceptive counseling • Diaphragms and contraceptive rings • Injectable contraceptives • Intrauterine devices (IUDs)	Preferred: Nothing (no deductible) Non-preferred (Participating/Non-participating): You pay all charges

Family Planning - continued on next page

<table>
<tr><th>Benefit Description</th><th>You Pay</th></tr>
<tr><th>Family Planning (cont.)</th><th>FEP Blue Focus</th></tr>
<tr><td>
• Implantable contraceptives
• Salpingectomy
• Tubal ligation or tubal occlusion/tubal blocking procedures only
• Vasectomy

Notes:
• We also provide benefits for professional services associated with tubal ligation/occlusion/blocking procedures, vasectomy, and with the fitting, insertion, or removal of the contraceptives as shown on the previous page including counseling and follow-up care at the payment levels shown here. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, and follow up care). Any voluntary sterilization surgery that is not already available without cost-sharing can be accessed through the contraceptive exceptions process. Simply visit www.fepblue.org, type in family planning and look for the exception form under our voluntary family planning services, or you may call the number on the back of your ID card and request a form. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.
• When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.
• See additional Family Planning and Prescription drug coverage in Section 5(f) or 5(f)(a), if applicable.
</td><td>
Preferred: Nothing (no deductible)

Non-preferred (Participating/Non-participating): You pay all charges
</td></tr>
<tr><td>
• Oral and transdermal contraceptives
Note: We waive your cost-share for generic oral and transdermal contraceptives when you purchase them at a Preferred retail pharmacy. See Section 5(f), or 5(f)(a) if applicable.
</td><td>
Preferred: 30% of the Plan allowance (deductible applies)

Non-preferred (Participating/Non-participating): You pay all charges
</td></tr>
<tr><td>
Not covered:
• Reversal of voluntary surgical sterilization
• Contraceptive devices not described above
• Over-the-counter (OTC) contraceptives, except as described in Section 5(f), or 5(f)(a) if applicable
</td><td>
All charges
</td></tr>
<tr><th>Reproductive Services</th><th>FEP Blue Focus</th></tr>
<tr><td>
Members who meet our definition of infertility in section 10, are eligible for the following reproductive services:
• Artificial insemination (AI)
  - Intracervical insemination (ICI)
  - Intrauterine insemination (IUI)
  - Intravaginal insemination (IVI)

Note: We also provide the benefits seen here when these services are billed by an outpatient facility. See Section 5(f) or 5(f)(a), Prescription Drug Benefits, for your cost-shares associated with drugs for covered AI procedures.

Fertility preservation for iatrogenic infertility:
</td><td>
Preferred: 30% of the Plan allowance (deductible applies)

Non-preferred (Participating/Non-participating): You pay all charges
</td></tr>
</table>

Reproductive Services - continued on next page

Benefit Description	You Pay
Reproductive Services (cont.)	**FEP Blue Focus**
• Procurement of sperm or eggs including medical, surgical, and pharmacy claims associated with retrieval; • Cryopreservation of sperm and mature oocytes; and • Cryopreservation storage costs for one year. Note: See other sections in this brochure for benefits associated with other service performed to diagnose and treat the cause of infertility.	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Not covered: The services listed below are not covered as treatments for infertility or as alternatives to conventional conception: • *Assisted reproductive technology (ART), including but not limited to:* - *In vitro fertilization (IVF)* - *Embryo transfer and gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)* • *Intracytoplasmic sperm injection (ICSI)* • *Services, procedures, and/or supplies that are related to ART and assisted insemination procedures except as described above* • *Cryopreservation or storage of sperm (sperm banking), eggs, or embryos except as described above* • *Preimplantation diagnosis, testing, and/or screening, including the testing or screening of eggs, sperm, or embryos* • *Drugs used in conjunction with ART and assisted insemination procedures except as described above and in Section 5(f), or 5(f)(a) if applicable, Prescription Drug Benefits* • *Services, supplies, or drugs provided to individuals not enrolled in this Plan including surrogates*	*All charges*
Allergy Care	**FEP Blue Focus**
• Allergy testing • Allergy treatment • Allergy injections • Sublingual allergy desensitization drugs as licensed by the U.S. FDA • Preparation of each multi-dose vial of antigen • Agents, drugs, and/or supplies administered or obtained in connection with your care Note: See earlier in this section for applicable office visit copayment.	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges Note: When care is provided by a Non-preferred laboratory and/or radiologist, as stated in Section 3 for an exception, you pay: • Participating laboratories or radiologists: 30% of the Plan allowance (deductible applies) • Non-participating laboratories or radiologists: 30% of the Plan allowance, plus any difference between our allowance and the billed amount (deductible applies)
Not covered: Provocative food testing	*All charges*

Benefit Description	You Pay
Treatment Therapies	**FEP Blue Focus**
Outpatient treatment therapies: • Chemotherapy and radiation therapy Note: We cover high-dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/Tissue Transplants* in Section 5(b). See also, *Other services* under *You need prior Plan approval for certain services* in Section 3. • Proton beam therapy*, stereotactic radiosurgery* and stereotactic body radiation therapy* • Renal dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy – Home IV or infusion therapy Note: Home nursing visits (skilled) associated with Home IV/infusion therapy are covered as shown under *Home Health Services* later in this section. • Outpatient cardiac rehabilitation • Pulmonary rehabilitation therapy • Applied behavior analysis (ABA)* for the treatment of an autism spectrum disorder limited to 200 hours per person, per calendar year (see prior approval requirements in Section 3) • Auto-immune infusion medications: Remicade, Renflexis or Inflectra • Agents, drugs, and/or supplies administered or obtained in connection with your care Notes: • See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital. ***Prior approval required**	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Inpatient treatment therapies: • Chemotherapy and radiation therapy Note: We cover high-dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/Tissue Transplants* in Section 5 (b). See also, *Other services* under *You need prior Plan approval for certain services* in Section 3). • Renal dialysis – Hemodialysis and peritoneal dialysis • Pharmacotherapy (medication management) (See Section 5(c) for our coverage of drugs administered in connection with these treatment therapies.) • Applied behavior analysis (ABA)* for the treatment of an autism spectrum disorder ***Prior approval required**	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges

Benefit Description	You Pay
Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy	**FEP Blue Focus**
Outpatient treatment therapies, subject to visit limits: • Physical therapy, occupational therapy, and speech therapy: - Benefits are limited to 25 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three; regardless of the provider or facility billing for the services • Cognitive rehabilitation therapy, limited to 25 visits per calendar year, regardless of the provider billing the service	Preferred: $25 copayment per visit (no deductible) Non-preferred (Participating/Non-participating): You pay all charges Notes: • You pay 30% of the Plan allowance (deductible applies) for agents, drugs, and/or supplies administered or obtained in connection with your care. • See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.
Not covered: • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Maintenance or palliative rehabilitative therapy* • *Exercise programs* • *Hippotherapy/Equine therapy* • *Massage therapy*	*All charges*
Hearing Services	**FEP Blue Focus**
Visits related to the covered hearing services listed below	Preferred: $10 copayment (no deductible) per visit up to a combined total of 10 visits per calendar year (benefits combined with visits in Section 5(a)) Preferred provider, visits after the 10th visit: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges Note: You pay 30% of the Plan allowance (deductible applies) for agents, drugs, and/or supplies administered or obtained in connection with your care.
Hearing tests related to illness or injury	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Not covered: • *Routine hearing tests* • *Hearing aids, including bone-anchored hearing aids, accessories or supplies (including remote controls and warranty packages) and all associated services* • *Hearing aid exams*	*All charges*

Benefit Description	You Pay
Vision Services (Testing, Treatment, and Supplies)	**FEP Blue Focus**
Eye examinations or visits related to a specific medical condition.	Preferred: $10 copayment (no deductible) per visit up to a combined total of 10 visits per calendar year (benefits combined with visits described at the beginning of this section) Preferred provider, visits after the 10th visit: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges Note: You pay 30% of the Plan allowance (deductible applies) for agents, drugs, and/or supplies administered or obtained in connection with your care.
Diagnostic testing and treatment, such as: • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 • Lab, X-ray, and other diagnostic tests performed or ordered by your provider.	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
• Refraction, only when the refraction is performed to determine the prescription for the one pair of eyeglasses, replacement lenses, or contact lenses provided per incident as described below. Note: See Section 5(b), *Surgical Procedures*, for coverage for surgical treatment of amblyopia and strabismus.	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed: • To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery; • If the condition can be corrected by surgery, but surgery is not an appropriate option due to age or medical condition; • For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Not covered: • *Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described above* • *Deluxe eyeglass frames or lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc.* • *Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom* • *Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above* • *LASIK, INTACS, radial keratotomy, and other refractive surgical services* • *Refractions, including those performed during an eye examination related to a specific medical condition, except as described above*	*All charges*

Benefit Description	You Pay
Foot Care	**FEP Blue Focus**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes Notes: • For corresponding office visits, see the beginning of Section 5(a). • See below, *Orthopedic and Prosthetic Devices*, for information on podiatric shoe inserts. • See Section 5(b) for our coverage for surgical procedures.	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Not covered: • *Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above*	*All charges*
Orthopedic and Prosthetic Devices	**FEP Blue Focus**
Orthopedic braces and prosthetic appliances such as: • Artificial limbs and eyes • Functional foot orthotics when prescribed by a physician • Rigid devices attached to the foot or a brace, or placed in a shoe • Replacement, repair, and adjustment of covered devices • Following a mastectomy, breast prostheses and surgical bras, including necessary replacements • Surgically implanted penile prostheses limited to treatment of erectile dysfunction • Surgical implants Note: **A prosthetic appliance** is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. We provide hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(*c*) for payment information. Insertion of the device is paid as surgery; see Section 5(b).	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Not covered: • *Shoes (including diabetic shoes)* • *Over-the-counter orthotics* • *Arch supports* • *Heel pads and heel cups* • *Wigs (including cranial prostheses)* • *Hearing aids, including bone anchored hearing aids, accessories or supplies (including remote controls and warranty packages) and all associated services*	*All charges*

Benefit Description	You Pay
Durable Medical Equipment (DME)	**FEP Blue Focus**

Durable medical equipment (DME) is equipment and supplies that are:
1. Prescribed by your attending physician (i.e., the physician who is treating your illness or injury);
2. Medically necessary;
3. Primarily and customarily used only for a medical purpose;
4. Generally useful only to a person with an illness or injury;
5. Designed for prolonged use; and
6. Used to serve a specific therapeutic purpose in the treatment of an illness or injury.
 	
We cover rental or purchase of prescribed durable medical equipment, at our option, including repair and adjustment. Covered items include:
• Home dialysis equipment
• Oxygen equipment
• Hospital beds
• Wheelchairs
• Crutches
• Walkers
• Continuous passive motion (CPM) devices
• Dynamic orthotic cranioplasty (DOC) devices
• Insulin pumps
• Other items that we determine to be DME, such as compression stockings
• **Specialty DME*** to include**:**
  - Specialty hospital beds
  - Deluxe wheelchairs, power wheelchairs and mobility devices including scooters and related supplies.
 	
Note: We cover DME at Preferred benefit levels only when you use a Preferred DME provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred DME providers.
 	
***Prior approval required**
	Preferred: 30% of the Plan allowance (deductible applies)
	
	Non-preferred (Participating/Non-participating): You pay all charges

• Speech-generating devices, limited to $625 per calendar year	Any amount over $625 per year (no deductible)
Not covered: • *Exercise and bathroom equipment* • *Vehicle modifications, replacements, or upgrades* • *Home modifications, upgrades, or additions* • *Lifts, such as seat, chair, or van lifts* • *Car seats* • *Diabetic supplies, except as described in Section 5(f), or 5(f)(a) if applicable, or when Medicare Part B is primary* • *Air conditioners, humidifiers, dehumidifiers, and purifiers* • *Breast pumps, except as previously described*	*All charges*

Durable Medical Equipment (DME) - continued on next page

Benefit Description	You Pay
Durable Medical Equipment (DME) (cont.)	**FEP Blue Focus**
• *Communications equipment, devices, and aids (including computer equipment) such as "story boards" or other communication aids to assist communication-impaired individuals (except for speech-generating devices as listed above)* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)* • *Charges associated with separate or extended warranties*	*All charges*
Medical Supplies	**FEP Blue Focus**
Covered medical supplies include: • Medical foods and nutritional supplements when administered by catheter or nasogastric tubes Note: See Section 10 for the definition of medical foods. • Ostomy and catheter supplies • Oxygen Note: When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for oxygen, according to the contracting status of the facility. See Section 5(c) for outpatient services received while in a skilled nursing facility. • Blood and blood plasma, except when donated or replaced, and blood plasma expanders Note: We cover medical supplies at Preferred benefit levels only when you use a Preferred medical supply provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred medical supply providers.	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Not covered: • *Infant formulas used as a substitute for breastfeeding* • *Diabetic supplies, except as described in Section 5(f), or 5(f)(a) if applicable, or when Medicare Part B is primary, or you are enrolled in the FEP Medicare Prescription Drug Program* • *Medical foods administered orally, except as described in Section 5(f), or 5 (f)(a) if applicable*	*All charges*
Home Health Services	**FEP Blue Focus**
Home nursing care (skilled) for two hours per day limited to 10 visits when: • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and • A physician orders the care.	Preferred: $25 copayment per visit (no deductible) Non-preferred (Participating/Non-participating): You pay all charges Note: You pay 30% of the Plan allowance (deductible applies) for agents, drugs, and/or supplies administered or obtained in connection with your care.
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter*	*All charges*

Home Health Services - continued on next page

Benefit Description	You Pay
Home Health Services (cont.)	**FEP Blue Focus**
• *Services provided by a nurse, nursing assistant, health aide, or other similarly licensed or unlicensed person that are billed by a skilled nursing facility, extended care facility, or nursing home* • *Private duty nursing*	*All charges*
Alternative/Manipulative Treatments	**FEP Blue Focus**
Benefits for manipulative treatment and acupuncture are subject to a combined limit of 10 visits per person per calendar year • Acupuncture is covered when performed and billed by a healthcare provider who is licensed or certified to perform acupuncture by the state where the services are provided, and who is acting within the scope of that license or certification. See Section 3 for more information. Note: See Section 5(b) for our coverage of acupuncture when provided as anesthesia for covered surgery. Note: See earlier in this section for our coverage of acupuncture when provided as anesthesia for covered maternity care. • Manipulative treatment limited to: - Osteopathic manipulative treatment to any body region - Chiropractic spinal and/or extraspinal manipulative treatment See Section 5(c) for facility benefits.	Preferred: $25 copayment per visit (no deductible) Non-preferred (Participating/Non-participating): You pay all charges Note: You pay 30% of the Plan allowance (deductible applies) for agents, drugs, and/or supplies administered or obtained in connection with your care.
Not covered: • *Biofeedback* • *Self-care or self-help training*	*All charges*
Educational Classes and Programs	**FEP Blue Focus**
• Smoking and tobacco cessation treatment including: - Counseling for smoking and tobacco use cessation - Smoking and tobacco cessation classes Note: See Section 5(f) for our coverage of smoking and tobacco cessation drugs.	Preferred: Nothing (no deductible) Non-preferred (Participating/Non-participating): You pay all charges
• Diabetic education Note: See previous information in this section for our coverage of nutritional counseling services that are not part of a diabetic education program.	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Not covered: • *Educational or other counseling or training services, or applied behavior analysis (ABA), when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation, headache, eating disorder, and other educational clinics unless described earlier in this section as being covered* • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Services performed or billed by a school or halfway house or a member of its staff*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

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.).
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drugs when obtained from a covered provider other than a pharmacy under the pharmacy benefit. You must use a Preferred pharmacy thereafter. 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), or 5(f)(a) if applicable, for information about specialty drug fills from a Preferred pharmacy. Medications restricted under this benefit are available on our FEP Blue Focus Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731.
- **YOU MUST GET PRIOR APPROVAL for services such as the following: surgery for severe obesity and oral maxillofacial surgeries/surgery on the jaw, cheeks, lips, tongue, roof and floor of the mouth, and related procedures.**
- **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 CERTAIN PROCEDURES; FAILURE TO DO SO WILL RESULT IN A $100 PENALTY.** Please refer to Section 3 for the complete list of services which require prior approval.
- When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple, bilateral, or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure.
- We do not pay extra for "incidental" procedures (those that do not add time or complexity to patient care).
- **When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them,** the Local Plan may determine that a separate allowance is payable.
- The calendar year deductible is $750 per person ($1,500 per Self Plus One or Self and Family enrollment). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- **You must use Preferred providers in order to receive benefits. See below and Section 3 for the exceptions to this requirement**.
- We provide benefits at Preferred benefit levels 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.

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this section.	
Surgical Procedures	**FEP Blue Focus**
A comprehensive range of services, such as: • Operative procedures • Assistant surgeons/surgical assistance if required because of the complexity of the surgical procedures • Treatment of fractures and dislocations, including casting • Routine pre- and post-operative care by the surgeon • Corneal transplant • Correction of amblyopia and strabismus • Colonoscopy, with or without biopsy Note: Preventive care benefits apply to the professional charges for your first covered colonoscopy of the calendar year (see Section 5(a)). We provide benefits as described here for subsequent colonoscopy procedures performed by a professional provider in the same year. • Endoscopic procedures • Injections • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies • Treatment of burns • Male circumcision • Insertion of internal prosthetic devices. See Section 5(a), *Orthopedic and Prosthetic Devices*, and "Other hospital services and supplies" in Section 5(c), *Inpatient Hospital*, for our coverage for the device. • **Procedures to treat severe obesity** when you meet the clinical criteria listed in our *Bariatric* medical policy at www.fepblue.org/legal/policies-guidelines for any initial and subsequent surgery (prior approval required). Contact the number on the back of your ID card if you need assistance. Notes: • Surgical services to treat severe obesity must be performed in a Blue Distinction Center for Comprehensive Bariatric Surgery. • When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure. • We do not pay extra for "incidental" procedures (those that do not add time or complexity to patient care). • When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable • For surgical family planning procedures, see *Family Planning* in Section 5(a).	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Not covered: • *Reversal of voluntary sterilization*	*All charges*

Surgical Procedures - continued on next page

Benefit Description	You Pay
Surgical Procedures (cont.)	**FEP Blue Focus**
• *Services of a standby physician* • *Routine surgical treatment of conditions of the foot (See Section 5(a),* Foot care.*)* • *Cosmetic surgery* • *LASIK, INTACS, radial keratotomy, and other refractive surgery* • *Surgeries related to sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction)* • *Surgeries related to sex transformations* • *Surgical procedures for the treatment of severe obesity when performed outside a Blue Distinction Center*	*All charges*
Reconstructive Surgery	**FEP Blue Focus**
Reconstructive surgical procedures, limited to: • Surgery to correct a functional defect • Surgery to correct a congenital anomaly (See Section 10 for definition.) • Treatment to restore the mouth to a pre-cancer state • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of the patient's breasts - Treatment of any physical complications, such as lymphedemas Notes: • Internal breast prostheses are paid as orthopedic and prosthetic devices; see Section 5(a). See Section 5(c) when billed by a facility. • If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. • Surgery for placement of penile prostheses to treat erectile dysfunction	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Not covered: • *Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth) (See Section 5(d) for Accidental Injury benefits)* • *Surgeries related to sexual dysfunction or sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction)* • *Surgery for Sex-Trait Modification to treat gender dysphoria - If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. If you have questions about the exception process, contact us using the customer service phone number listed on the back of your ID card. If you disagree with our decision, please see Section 8 of this brochure for the disputed claims process. Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*

Benefit Description	You Pay
Oral and Maxillofacial Surgery	**FEP Blue Focus**
Oral surgical procedures when **prior approved** are limited to: • Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary • Surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth • Excision of exostoses of jaws and hard palate • Incision and drainage of abscesses and cellulitis • Incision and surgical treatment of accessory sinuses, salivary glands, or ducts • Reduction of dislocations and excision of temporomandibular joints • Removal of impacted teeth Notes: • See Section 3 for information regarding prior approval. • **Prior approval is required for oral/maxillofacial surgery**, except when related to an accidental injury and provided within 72 hours of the accident. For more information regarding the **prior approval** see Section 3. • 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., oral surgery) you are scheduled to receive.	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Not covered: • *Oral implants and transplants except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Surgical procedures involving dental implants or preparation of the mouth for the fitting or the continued use of dentures, except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Orthodontic care before, during, or after surgery, except for orthodontia associated with surgery to correct accidental injuries as specifically described above and in Section 5(g)*	*All charges*

Organ/Tissue Transplants

Covered solid organ/tissue transplants listed below are subject to medical necessity and experimental/investigational review, and to the prior approval requirements shown below.

Prior approval requirements:

You must obtain prior approval from the Local Plan for the procedure and precertification for the facility admission (see Section 3).

In addition, benefits are only available for some transplants (and covered related services) when performed in a Blue Distinction Center or Medicare-Approved Transplant Program as described in this section. Benefits for implantation of an artificial heart as a bridge to transplant or destination therapy are only available when the facility is designated as a Blue Distinction Center for heart transplants.

Notes:

- **Organ transplants** that are not available in a Blue Distinction Center for Transplants must be performed in a facility with a Medicare-Approved Transplant Program for the type of transplant anticipated. Transplants involving more than one organ must be performed in a facility that offers a Medicare-Approved Transplant Program for each organ transplanted. Contact your local Plan for Medicare's approved transplant programs.
- If Medicare does not offer an approved program for a certain type of organ transplant procedure, this requirement does not apply and you may use any Preferred facility that performs the procedure. If Medicare offers an approved program for an anticipated organ transplant, but your facility is not approved by Medicare for the procedure, please contact your Local Plan at the customer service phone number appearing on the back of your ID card.

Benefit Description	You Pay
Organ/Tissue Transplants	**FEP Blue Focus**
The following transplants **must** be performed at a **Blue Distinction Centers for Transplants** (see Section 3 for more information): • Heart transplant (adult and pediatric) - Implantation of an artificial heart as a bridge to transplant or destination therapy (when performed in a Blue Distinction Center for Heart Transplants) • Liver transplant (adult and pediatric) • Lung (adult) (single, double, or lobar) transplant - benefits are limited to double lung transplants for members with end-stage cystic fibrosis • Combination liver-kidney transplant (adult) Note: See the end of this section for covered related transplant services.	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
The following transplants may not be available in a Blue Distinction Centers for Transplants® and **must** be performed at a Preferred facility with a Medicare-Approved transplant program, if one is available (see below): • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Heart-lung transplant • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney transplant • Pancreas transplant • Combination liver-kidney transplant (pediatric) • Combination pancreas-kidney transplant • Single, double, or lobar lung transplant (pediatric)	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges

Organ/Tissue Transplants - continued on next page

Benefit Description	You Pay
Organ/Tissue Transplants (cont.)	**FEP Blue Focus**
The blood or marrow stem cell transplants (adult and pediatric) listed below and on the following pages **must** be performed at a **Blue Distinction Center for Transplants**. You must obtain prior approval from the Local Plan for the procedure and precertification for the facility admission. See Section 3 (*How You Get Care*). Benefits are limited to the diagnoses and stages listed.	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges

Benefits for Allogeneic blood or marrow stem cell transplants are only available for the diagnoses indicated below:

- Acute lymphocytic or myeloid (e.g., AML promyelocytic) leukemia
- Blastic plasmacytoid dendritic cell neoplasm
- Chronic lymphocytic leukemia (e.g., T cell prolymphocytic leukemia, B cell prolymphocytic leukemia, hairy cell leukemia)
- Chronic myeloid leukemia
- Hemoglobinopathy (e.g., sickle cell anemia, thalassemia)
- Hodgkin lymphoma
- Inherited metabolic disorders: Adrenoleukodystrophy, Globoid cell leukodystrophy (Krabbe's leukodystrophy), Metachromatic leukodystrophy, and Mucopolysaccharidosis type I (Hurler syndrome)
- IPEX - immune dysregulation, polyendocrinopathy, enteropathy, X-linked syndrome
- Marrow failure (e.g., severe aplastic anemia, Fanconi’s anemia, paroxysmal nocturnal hemoglobinuria (PNH), pure red cell aplasia, congenital thrombocytopenia, Dyskeratosis congenita)
- MDS/MPN (e.g., chronic myelomonocytic leukemia (CMML))
- Myelodysplastic syndromes (MDS)
- Myeloproliferative neoplasms (MPN) (e.g., polycythemia vera, essential thrombocythemia, primary myelofibrosis, Hypereosinophilic syndromes)
- Non-Hodgkin lymphoma (e.g., Waldenstrom’s macroglobulinemia, B-cell lymphoma, Burkitt lymphoma)
- Osteopetrosis
- Plasma cell disorders (e.g., multiple myeloma, amyloidosis, plasma cell leukemia, POEMS – (polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes syndrome)
- Primary immunodeficiencies (e.g., severe combined immunodeficiency, Wiskott-Aldrich syndrome, hemophagocytic disorders, X-linked lymphoproliferative syndrome, severe congenital neutropenia, leukocyte adhesion deficiencies, common variable immunodeficiency, chronic granulomatous disease/phagocytic cell disorders)
- Systemic mastocytosis, aggressive

Benefits for Autologous blood or marrow stem cell transplants are only available for the diagnoses indicated below:

- Acute myeloid leukemia
- Autoimmune - limited to: Idiopathic (juvenile) rheumatoid arthritis, multiple sclerosis (treatment-refractory relapsing with high risk of future disability) and Scleroderma/systemic sclerosis
- Central nervous system (CNS) embryonal tumors (e.g., atypical teratoid/rhabdoid tumor, primitive neuroectodermal tumors (PNETs), medulloblastoma, pineoblastoma, ependymoblastoma)
- Chronic lymphocytic leukemia (e.g., T cell prolymphocytic leukemia, B cell prolymphocytic leukemia, hairy cell leukemia)
- Ewing sarcoma
- Germ cell tumors (e.g., testicular germ cell tumors)
- High-risk or relapsed neuroblastoma

- Hodgkin lymphoma
- Non-Hodgkin lymphoma (e.g., Waldenstrom’s macroglobulinemia, B-cell lymphoma, Burkitt lymphoma)
- Osteosarcoma
- Plasma cell disorders (e.g., multiple myeloma, amyloidosis, plasma cell leukemia, POEMS - polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes syndrome)
- Wilms Tumor

Benefits for Blood or marrow stem cell transplants are available for the diagnoses below, **only** when performed as part of a **clinical trial** when a clinical trial for the diagnosis below is available in a Blue Distinction Center; and you meet the criteria for inclusion in the clinical trial and the requirements below.

- Allogeneic blood or marrow stem cell transplants for:
  - Autoimmune - limited to: scleroderma/systemic sclerosis, systemic lupus erythematosus, CIDP – (chronic inflammatory demyelinating polyneuropathy), and Idiopathic (Juvenile) rheumatoid arthritis
  - Breast cancer
  - Germ Cell Tumors
  - High-risk or relapsed neuroblastoma
  - Lysosomal metabolic diseases: e.g., Mucopolysaccharidosis type II (Hunter syndrome); Mucopolysaccharidosis type IV (Morquio syndrome); Mucopolysaccharidosis type VI (Maroteaux-Lamy syndrome), Fabry disease, Gaucher disease
  - Renal cell carcinoma
  - Sarcoma – Ewing sarcoma, rhabdomyosarcoma, soft tissue sarcoma
- Autologous blood or marrow stem cell transplants for:
  - Autoimmune disease - e.g., systemic lupus erythematosus, CIDP (chronic inflammatory demyelinating polyneuropathy), Crohn's disease, Polymyositis-dermatomyositis, rheumatoid arthritis
  - Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme)
  - Sarcoma (e.g., rhabdomyosarcoma, soft tissue sarcoma
- You must contact us at the customer service phone number listed on the back of your ID card to obtain prior approval (see Section 3); and
- The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial; and
- For the transplant procedures listed above, the clinical trial must be reviewed and approved by the Institutional Review Board for the Blue Distinction Center for Transplant program where the procedure is to be performed.

Clinical trials are research studies in which physicians and other researchers work to find ways to improve care. Each study tries to answer scientific questions and to find better ways to prevent, diagnose, or treat patients. A clinical trial has possible benefits as well as risks. Each trial has a protocol which explains the purpose of the trial, how the trial will be performed, who may participate in the trial, and the beginning and end points of the trial. Information regarding clinical trials is available at www.cancer.gov/about-cancer/treatment/clinical-trials.

A transplant clinical trial may not be available for your condition, or you may not be eligible for inclusion in these trials or there may not be any trials available in a Blue Distinction Center for Transplants to treat your condition at the time you seek to be included in a clinical trial. If your physician has recommended you participate in a clinical trial, we encourage you to contact the contact us at the phone number on the back of your ID card for assistance in determining if a covered clinical trial is available in a covered facility.

Benefit Description	You Pay
Organ/Tissue Transplants	**FEP Blue Focus**
Related transplant services: • Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous transplant • Harvesting, immediate preservation, and storage of stem cells when the autologous blood or marrow stem cell transplant has been scheduled or is anticipated to be scheduled within an appropriate time frame for patients diagnosed at the time of harvesting with one of the conditions previously listed Note: Benefits are available for charges related to fees for storage of harvested autologous blood or marrow stem cells related to a covered autologous stem cell transplant that has been scheduled or is anticipated to be scheduled within an appropriate time frame. No benefits are available for any charges related to fees for long-term storage of stem cells. • Collection, processing, storage and distribution of cord blood only when provided as part of a blood or marrow stem cell transplant scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed with one of the conditions previously listed • Covered medical and hospital expenses of the donor, when we cover the recipient • Covered services or supplies provided to the recipient • Donor screening tests for non-full sibling (such as unrelated) potential donors, for any full sibling potential donors, and for the actual donor used for transplant Note: See Section 5(a) for coverage for related services, such as chemotherapy and/or radiation therapy and drugs administered to stimulate or mobilize stem cells for covered transplant procedures.	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Travel benefits: Members who receive covered care at a **Blue Distinction Center for Transplants** for one of the transplants listed can be reimbursed for incurred travel costs related to the transplant, subject to the criteria and limitations described here. **You must obtain prior approval for travel benefits** (see Section 3).	We reimburse costs for transportation (air, rail, bus, and/or taxi) and lodging if you live 50 miles or more from the facility, up to a maximum of $5,000 per transplant for the member and companions. Reimbursement is subject to IRS regulations.
Not covered: • *Any transplant not listed as covered and transplants for any diagnosis not listed as covered* • *Transplants performed in a facility other than the type of facility required for the particular transplant* • *Donor screening tests and donor search expenses, including associated travel expenses, except as defined above* • *Implants of artificial organs, including those implanted as a bridge to transplant and/or as destination therapy, other than medically necessary implantation of an artificial heart as previously described* • *Implantation of an artificial heart in a facility not designated as a Blue Distinction Center for Heart Transplant* • *Allogeneic pancreas islet cell transplantation* • *Travel costs related to covered transplants performed at facilities other than Blue Distinction Centers for Transplants; travel costs incurred when prior approval has not been obtained; travel costs outside those allowed by IRS regulations, such as food-related expenses*	*All charges*

Benefit Description	You Pay
Anesthesia	**FEP Blue Focus**
Anesthesia services consist of administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness. Anesthesia (including acupuncture) for covered medical or surgical services when requested by the attending physician and performed by: • A certified registered nurse anesthetist (CRNA), or • A physician other than the physician (or the assistant) performing the covered medical or surgical procedure Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Residential treatment center • Office Notes: • Anesthesia acupuncture services do not accumulate toward the member's annual maximum. • See Section 5(c) for our payment levels for anesthesia services billed by a facility.	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

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.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- Note: **Observation services** are billed as outpatient facility care. Benefits for observation services are provided at the outpatient facility benefit levels described in this section. See Section 10, *Definitions*, for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for services such as the following: surgery for severe obesity and oral maxillofacial surgeries/surgery on the jaw, cheeks, lips, tongue, roof and floor of the mouth, and related procedures.**
- When **PRIOR APPROVAL IS REQUIRED** for a surgical procedure and the surgery is performed on an inpatient basis, **YOU MUST ALSO GET PRECERTIFICATION** for the inpatient admission.
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- **You must use Preferred providers in order to receive benefits**. See Section 3 for the exceptions to this requirement.
  - You are responsible for the applicable cost-sharing amounts for care performed and billed by Preferred professional providers in the outpatient department of a Preferred hospital.
- 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 or facility bills for the service.
- The services listed in this Section are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service, for your inpatient or outpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Sections 5(a) or 5(b).
- The calendar year deductible is $750 per person ($1,500 per Self Plus One or Self and Family enrollment). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drugs when obtained from a covered provider other than a pharmacy under the pharmacy benefit. You must use a Preferred pharmacy, thereafter. 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), or 5(f)(a) if applicable, for information about specialty drug fills from a Preferred pharmacy. Medications restricted under this benefit are available on our FEP Blue Focus Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731.

Benefit Description	You Pay
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Inpatient Hospital	**FEP Blue Focus**
Room and board, such as: • Semiprivate or intensive care accommodations • General nursing care • Meals and special diets Note: We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a hospital only has private rooms. Other inpatient hospital services and supplies, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic studies, radiology services, laboratory tests, and pathology services • Administration of blood or blood plasma • Dressings, splints, casts, and sterile tray services • Internal prosthetic devices • Other medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take-home items • Pre-admission testing recognized as part of the hospital admissions process • Nutritional counseling • Acute inpatient rehabilitation Note: **Observation services** are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described in this section. See Section 10, *Definitions*, for more information about these types of services. **Here are some things to keep in mind:** • If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days. • We pay inpatient hospital benefits for an admission in connection with the treatment of children up to age 22 with severe dental caries. We cover hospitalization for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(g). Notes: • See later in this section and Section 5(e) for inpatient residential treatment center. • For inpatient care received overseas, refer to Section 5(i).	Preferred facilities: 30% of the Plan allowance (deductible applies) Non-preferred facilities (Member/Non-member): You pay all charges

Inpatient Hospital - continued on next page

Benefit Description	You Pay
Inpatient Hospital (cont.)	**FEP Blue Focus**
Not covered: • *Admission to noncovered facilities, such as nursing homes, extended care/ skilled nursing facilities, schools, or residential treatment centers (except as described on later in this section and Section 5(e))* • *Personal comfort items, such as guest meals and beds, phone, television, beauty and barber services* • *Private duty nursing* • *Facility room and board expenses when, in our judgment, an admission or portion of an admission is:* - *Custodial or long-term care (see* Definitions*)* - *Convalescent care or a rest cure* - *Domiciliary care provided because care in the home is not available or is unsuitable* • *Care that is not medically necessary, such as:* - *When services did not require the acute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive.* - *Admissions for, or consisting primarily of, observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician's office)* - *Admissions primarily for diagnostic studies, radiology services, laboratory tests, or pathology services that could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician's office)* *Note: If we determine that an inpatient admission is one of the types listed above, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting. Benefits are limited to care provided by covered facility providers described in Section 3.*	*All charges*
Maternity - Facility	**FEP Blue Focus**
We encourage you to notify us of your pregnancy during the first trimester, see Section 3. Maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage, such as: • Inpatient facility care, • Care at birthing facilities, • Services you receive on an outpatient basis, and • Tocolytic therapy and related services when provided on an inpatient basis during a covered hospital admission or during a covered observation stay	Preferred facilities: $3,500 copayment per pregnancy (no deductible) Non-preferred facilities (Member/Non-member): You pay all charges

Maternity - Facility - continued on next page

Benefit Description	You Pay
Maternity - Facility (cont.)	**FEP Blue Focus**
Notes: • We cover up to 8 visits per year in full to treat depression associated with pregnancy (i.e., depression during pregnancy, postpartum depression, or both) when you use a Preferred provider. See Section 5(a). • Preventive care benefits apply to the screening of pregnant members for HIV, syphilis and unhealthy alcohol use/substance use when billed by a facility. Room and board, such as: • Semiprivate or intensive care accommodations • General nursing care • Meals and special diets Other inpatient hospital services and supplies, such as: • Administration of blood or blood plasma • Anesthetics and anesthesia services • Breastfeeding education • Covered medical supplies and equipment, including oxygen • Delivery, operating, recovery, and other treatment rooms • Diagnostic studies, radiology services, laboratory tests, and pathology services • Dressings and sterile tray services • Nutritional counseling • Prescribed drugs and medications • Take-home items Here are some things to keep in mind: • You do not need to precertify your delivery; see Section 3 for other circumstances, such as extended stays for you or your newborn. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary. • We cover routine nursery care of the newborn when performed during the covered portion of the mother's maternity stay and billed by the facility. We cover other care of a newborn who requires professional services or non-routine treatment, only if we cover the newborn under a Self Plus One or Self and Family enrollment. Surgical benefits apply to circumcision if billed by a professional provider for a male newborn. • When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in his or her own right. Regular medical or surgical benefits apply rather than maternity benefits. • See Section 5(b) for our payment levels for circumcision. • For inpatient care received overseas, refer to Section 5(i).	Preferred facilities: $3,500 copayment per pregnancy (no deductible) Non-preferred facilities (Member/Non-member): You pay all charges

Maternity - Facility - continued on next page

Benefit Description	You Pay
Maternity - Facility (cont.)	**FEP Blue Focus**
Not covered: • *Breast pumps and milk storage bags except as stated in Section 5(a)* • *Breastfeeding supplies other than those contained in the breast pump kit described in Section 5(a) including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or convenience (e.g., nursing pads)* • *Childbirth preparation, Lamaze, and other birthing/parenting classes* • *Doula, birth companion, and similar supporter* • *Maternity care for members not enrolled in this Plan* • *Personal comfort items, such as guest meals and beds, phone, television, beauty and barber services* • *Private duty nursing* • *Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest* • *Tocolytic therapy and related services except as previously described*	*All charges*
Outpatient Hospital or Ambulatory Surgical Center	**FEP Blue Focus**
Outpatient **surgical and treatment services** performed and billed by a facility, such as: • Operating, recovery, and other treatment rooms • Anesthetics and anesthesia services • Pre-surgical testing performed within one business day of the covered surgical services • Chemotherapy and radiation therapy • Colonoscopy, with or without biopsy Note: Preventive care benefits apply to the facility charges for your first covered colonoscopy of the calendar year. We provide diagnostic benefits for services related to subsequent colonoscopy procedures in the same year. • Intravenous (IV)/infusion therapy • Renal dialysis • Visits to the outpatient department of a hospital for non-emergency treatment services • Diabetic education • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Facility supplies for hemophilia home care • Other medical supplies, including oxygen • Surgical implants • Cardiac rehabilitation	Preferred facilities: 30% of the Plan allowance (deductible applies) Non-preferred facilities (Member/Non-member): You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**FEP Blue Focus**
• Observation services Note: All outpatient services billed by the facility during the time you are receiving observation services are included in the cost-share amounts shown here. Please refer to Section 5(a) for services billed by professional providers during an observation stay and earlier in this section for information about benefits for inpatient admissions. • Pulmonary rehabilitation • Hospital-based clinic visits • Outpatient hospital services and supplies related to: - Treatment of children up to age 22 with severe dental caries. - Dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section 5(g), *Dental Benefits*. Notes: • See Section 5(d) for our payment levels for care related to a medical emergency or accidental injury. • See Section 5(a) for our coverage of family planning services. • See later in this section for outpatient drugs, medical devices, and durable medical equipment billed for by a facility. • See earlier in this section for maternity care provided in an outpatient facility.	Preferred facilities: 30% of the Plan allowance (deductible applies) Non-preferred facilities (Member/Non-member): You pay all charges
Outpatient **diagnostic testing** performed and billed by a facility, such as: • Angiographies • Bone density tests • CT scans*/MRIs*/PET scans* • Genetic testing - prior approval is required for genetic testing performed in the absence of signs, symptoms, or diagnosis of an active disease, or to assess the risk of passing genetic conditions to a child. • Nuclear medicine • Sleep studies • Cardiovascular monitoring • EEGs • Ultrasounds • Neurological testing • X-rays (including set-up of portable X-ray equipment) • EKGs • Laboratory tests and pathology services Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, see *Maternity – Facility*, earlier in this section. ***Prior approval is required.**	Preferred facilities: 30% of the Plan allowance (deductible applies) Non-preferred facilities (Member/Non-member): • Member: 30% of the Plan allowance (deductible applies) • Non-member: 30% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**FEP Blue Focus**
Outpatient **treatment and therapy services** performed and billed by a facility, limited to: • Cognitive rehabilitation therapy limited to 25 visits per person per calendar year • Physical therapy, occupational therapy, and speech therapy limited to 25 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. • Manipulative treatment and acupuncture services, limited to a combined 10 visits per person. Notes: • We provide benefits for manipulative treatment and acupuncture services as described in Section 5(a). • See Section 5(b) for our coverage of acupuncture when provided as anesthesia for covered surgery. • See earlier in this section for our coverage of acupuncture when provided as anesthesia for covered maternity care. Note: The limitations listed above are a combined total regardless of the type of covered provider or facility billing for the services.	Preferred facilities: $25 copayment per visit (no deductible) Non-preferred facilities (Member/Non-member): You pay all charges Note: You pay 30% of the Plan allowance (deductible applies) for supplies or drugs administered or obtained in connection with your care.
Outpatient **treatment services** performed and billed by a facility, are limited to: • Outpatient applied behavior analysis* (ABA) for an autism spectrum disorder performed and billed by a facility limited to 200 hours per person, per calendar year. Note: The limitations listed is a combined total regardless of the type of covered provider or facility billing for the services. ***Prior approval is required,** see Section 3 for prior approval requirements.	Preferred facilities: 30% of the Plan allowance (deductible applies) Non-preferred facilities (Member/Non-member): You pay all charges
Outpatient **adult preventive care** performed and billed by a facility, limited to: • Visits/exams for preventive care, screening procedures, and routine immunizations described in Section 5(a) • Cancer screenings listed Section 5(a) and ultrasound screening for abdominal aortic aneurysm Note: • See Section 5(a) for our payment levels for covered preventive care services for children billed for by facilities and performed on an outpatient basis.	Preferred facilities: Nothing (no deductible) Non-preferred facilities (Member/Non-Member): Nothing (no deductible) for cancer screenings and ultrasound screening for abdominal aortic aneurysm Note: Benefits are not available for routine adult physical examinations, associated laboratory tests, colonoscopies, or routine immunizations performed at Non-preferred (Member/Non-member) facilities.

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**FEP Blue Focus**
Outpatient **drugs, medical devices, and durable medical equipment** billed for by a facility, such as: • Prescribed drugs and medications Note: Certain self-injectable drugs are covered only when dispensed by a pharmacy under the pharmacy benefit. These drugs will be covered once per lifetime per therapeutic category of drugs when dispensed by a non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage, or you are enrolled in the FEP Medicare Prescription Drug Program. See Section 5(f), or 5(f)(a) if applicable, for information about specialty drug fills from a Preferred pharmacy. • Orthopedic and prosthetic devices • Durable medical equipment • Surgical implants • Oral and transdermal contraceptives Note: We waive your cost-share for generic oral and transdermal contraceptives when you purchase them at a Preferred retail pharmacy; see Section 5(f), or 5(f)(a) if applicable.	Preferred facilities: 30% of the Plan allowance (deductible applies) Non-preferred facilities (Member/Non-member): You pay all charges
Residential Treatment Center	**FEP Blue Focus**
Inpatient Residential Treatment Center: **Precertification prior to admission is required.** We cover inpatient care provided and billed by an RTC when the care is medically necessary for the treatment of a medical, mental health, and/or substance use disorder: • Room and board, such as semiprivate room, nursing care, meals, special diets, ancillary charges, and covered therapy services when billed by the facility. Notes: • For inpatient care received overseas, refer to Section 5(i). • For outpatient residential treatment center services, see Section 5(c).	Preferred facilities: 30% of the Plan allowance (deductible applies) Non-preferred facilities (Member/Non-member): You pay all charges
Not covered services, such as: • *Biofeedback* • *Custodial or long term-care (see* Definitions*)* • *Domiciliary care provided because care in the home is not available or is unsuitable* • *Educational therapy or educational classes* • *Equine/hippotherapy provided during the approved stay* • *Recreational therapy* • *Respite care* • *Outdoor residential programs* • *Outward Bound programs* • *Personal comfort items, such as guest meals and beds, phone, television, beauty and barber service*	*All charges*

Residential Treatment Center - continued on next page

Benefit Description	You Pay
Residential Treatment Center (cont.)	**FEP Blue Focus**
• *Services provided outside of the provider's licensure/scope of practice* *Note: Residential treatment center benefits are not available for facilities licensed as skilled nursing facilities, group home, halfway house or similar type facilities.*	*All charges*
Extended Care Benefits/Skilled Nursing Care Facility Benefits	**FEP Blue Focus**
There are no benefits for admissions to an extended care or skilled nursing facility.	*All charges*
Benefits are available for the following covered services when provided as outpatient services and billed by a skilled nursing facility: • Oxygen Note: See Section 5(f), or 5(f)(a) if applicable, for benefits for prescription drugs.	Preferred facilities: 30% of the Plan allowance (deductible applies) Non-preferred facilities (Member/Non-member): You pay all charges
Benefits are available for the following covered professional services when provided as outpatient services and billed by a skilled nursing facility: • Cognitive rehabilitation therapy, limited to 25 visits per calendar year, regardless of the provider billing the service • Physical therapy, occupational therapy, or speech therapy or a combination of all three (regardless of the provider or facility billing for the services) limited to 25 visits per person, per calendar year	Preferred: $25 copayment per visit (no deductible) Non-preferred (Member/Non-member): You pay all charges Note: You pay 30% of the Plan allowance (deductible applies) for agents, drugs, and/or supplies administered or obtained in connection with your care.
Not covered: • *Inpatient room and board billed by a skilled nursing facility* • *Phone; television; personal comfort items, such as guest meals and beds, beauty and barber services, recreational outings/trips, stretcher or wheelchair transportation; non-emergent ambulance transport that is requested beyond the nearest facility adequately equipped to treat the member's condition, by patient or physician for continuity of care or other reason; custodial or long-term care (see* Definitions*), and domiciliary care provided because care in the home is not available or is unsuitable.*	*All charges*
Hospice Care	**FEP Blue Focus**
Hospice care is an integrated set of services and supplies designed to provide palliative and supportive care to members with a projected life expectancy of six months or less due to a terminal medical condition, as certified by the member's primary care provider or specialist.	See the following
Pre-Hospice Enrollment Benefits **Prior approval is not required**. Before home hospice care begins, members may be evaluated by a physician to determine if home hospice care is appropriate. We provide benefits for pre-enrollment visits when provided by a physician who is employed by the home hospice agency and when billed by the agency employing the physician. The pre-enrollment visit includes services such as: • Evaluating the member's need for pain and/or symptom management; and • Counseling regarding hospice and other care options	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges

Hospice Care - continued on next page

Benefit Description	You Pay
Hospice Care (cont.)	**FEP Blue Focus**
Please check with your Local Plan, and/or visit www.fepblue.org/provider to use our National Doctor & Hospital Finder, for listings of Preferred hospice providers. Note: If Medicare Part A is the primary payor for the member's hospice care, our benefits will be limited to those services listed in this Section. **Members with a terminal medical condition (or those acting on behalf of the member) are encouraged to contact the Case Management Department at their Local Plan for information about inpatient hospice services and Preferred hospice providers.**	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Covered services: We provide benefits for the hospice services listed below: • Advanced care planning • Dietary counseling • Durable medical equipment rental • Medical social services • Medical supplies • Nursing care • Oxygen therapy • Periodic physician visits • Physical therapy, occupational therapy, and speech therapy related to the terminal medical condition • Prescription drugs and medications • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency)	See the following
Traditional Home Hospice Care Periodic visits to the member's home for the management of the terminal medical condition and to provide limited patient care in the home.	Preferred facilities: Nothing (no deductible) Non-preferred facilities (Member/Non-member): You pay all charges

Hospice Care - continued on next page

Benefit Description	You Pay
Hospice Care (cont.)	**FEP Blue Focus**
Continuous Home Hospice Care Services provided in the home to members enrolled in home hospice during a period of crisis, such as frequent medication adjustments to control symptoms or to manage a significant change in the member's condition, requiring a minimum of 8 hours of care during each 24-hour period by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).	Preferred facilities: Nothing (no deductible) Non-preferred facilities (Member/Non-member): You pay all charges
Inpatient Hospice Care* Benefits are available for inpatient hospice care when provided by a facility that is licensed as an inpatient hospice facility and when: • Inpatient services are necessary to control pain and/or manage the member's symptoms; • Death is imminent; or • Inpatient services are necessary to provide an interval of relief (respite) to the caregiver Note: Benefits are provided for up to 30 consecutive days in a facility licensed as an inpatient hospice facility. ***Precertification is required**	Preferred facilities: 30% of the Plan allowance (deductible applies) Non-preferred facilities (Member/Non-member): You pay all charges
Not covered: • *Advanced care planning, except when provided as part of a covered hospice care treatment plan as previously noted* • *Homemaker services*	*All charges*

Benefit Description	You Pay
Ambulance	**FEP Blue Focus**
Professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically necessary, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care Notes: • We also cover medically necessary emergency care provided at the scene when transport services are not required. • **Prior approval is required for all non-emergent air ambulance transport.**	30% of the Plan allowance (deductible applies)
Professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically necessary, and when related to accidental injury care for your accidental injury. Notes: • We also cover medically necessary emergency care provided at the scene when transport services are not required. • Prior approval is required for all non-emergent air ambulance transport.	Nothing (no deductible) Note: These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.
Medically necessary emergency ground, air and sea ambulance transport services to the nearest hospital equipped to adequately treat your condition if you travel outside the United States, Puerto Rico and the U.S. Virgin Islands Note: If you are traveling overseas and need assistance with emergency evacuation services to the nearest facility equipped to adequately treat your condition, please contact the Overseas Assistance Center (provided by GeoBlue) by calling 804-673-1678. See Section 5(i) for more information.	30% of the Plan allowance (deductible applies)
Not covered: • *Wheelchair van services and gurney van services* • *Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care* • *Ambulance transport that is requested, beyond the nearest facility adequately equipped to treat the member's condition, by patient or physician for continuity of care or other reason* • *Commercial air flights* • *Repatriation from an international location back to the United States. See definition of repatriation in Section 10. Members traveling overseas should consider purchasing a travel insurance policy that covers repatriation to your home country.* • *Costs associated with overseas air or sea transportation to other than the closest hospital equipped to adequately treat your condition*	*All charges*

Section 5(d). Emergency Services/Accidents

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.
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- **You must use Preferred providers in order to receive benefits, except in cases of medical emergency or accidental injury.** Refer to the guidelines appearing below for additional information.
- We provide benefits at Preferred benefit levels for emergency department services performed by both PPO and non-PPO providers when their services are related to an accidental injury or medical emergency. The Plan allowance for these services is determined by the contracting status of the provider. Note: For information regarding the Plan allowance, see Section 10, *Definitions*. If services are performed by non-PPO professional providers in a PPO facility, you will be responsible for your cost-share for those services. For more information, see Section 4, NSA.
- The calendar year deductible is $750 per person ($1,500 per Self Plus One or Self and Family enrollment). We state whether or not the calendar year deductible applies for each benefit listed in this section.

What is an accidental injury?

An accidental injury is an injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites, and poisonings. (See Section 5(g) for dental care for accidental injury.)

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

You are encouraged to seek care from Preferred providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Preferred provider, we will provide benefits for the initial treatment provided in the emergency room of any hospital – even if the hospital is not a Preferred facility. We will also provide benefits if you are admitted directly to the hospital from the emergency room until your condition has been stabilized. In addition, we will provide benefits for emergency ambulance transportation provided by Preferred or Non-preferred ambulance providers if the transport is due to a medical emergency or accidental injury.

We provide emergency benefits when you have acute symptoms of sufficient severity – including severe pain – such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant member, the health of the member and the unborn child.

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this section.	
Accidental injury	**FEP Blue Focus**
When you receive care for your accidental injury within 72 hours of the injury, we cover: • **Professional provider** services in the emergency room, hospital outpatient department, including professional care, diagnostic studies, radiology services, laboratory tests, and pathology services, when billed by a professional provider • **Outpatient hospital** services and supplies, including professional provider services, diagnostic studies, radiology services, laboratory tests, and pathology services, when billed by the hospital • **Urgent care centers** licensed as and permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the urgent care center provider Notes: • All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits. • The urgent care center must be licensed and permitted to provide emergency services in order to receive protections under the NSA. See Section 4. • See Section 5(g) for dental benefits for accidental injury.	Preferred: Nothing (no deductible) Participating: Nothing (no deductible) Non-participating: Nothing (no deductible) Non-preferred facilities (Member/Non-member): • Member: Nothing (no deductible) • Non-member: Nothing (no deductible) Note: The benefits described above apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular benefits apply. See Sections 5(a), 5(b), and 5(c) for the benefits we provide.
Professional provider *services* in the provider's office, including, diagnostic studies, radiology services, laboratory tests, and pathology services, when billed by a professional provider.	Preferred: Nothing (no deductible) Participating: Nothing (no deductible) Non-participating: Any difference between our allowance and the billed amount (no deductible) Note: The benefits described above apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular benefits apply. See Sections 5(a), 5(b), and 5(c) for the benefits we provide.
When you are admitted to the hospital within 72 hours of an accidental injury, your inpatient admission and inpatient professional care you receive is covered regardless of the hospital's or professional provider's network status. Notes: • See Section 5(a) for inpatient professional services. • See Section 5(c) for services associated with an inpatient admission. • All follow-up care must be performed and billed for by Preferred providers to be eligible for coverage. • See Section 4 for your protections against balance billing from Non-participating providers. • For more information regarding non-participating provider exceptions, see Section 3.	30% of the Plan allowance (deductible applies) Note: In certain circumstance you may be responsible for any difference between our allowance and the billed amount for care you receive from Non-member facilities. See Section 4 for more information on your protections against balance billing from Non-participating providers.

Accidental injury - continued on next page

Benefit Description	You Pay
Accidental injury (cont.)	**FEP Blue Focus**
Urgent care centers, not licensed as or permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider.	Preferred urgent care center: Nothing (no deductible) Non-preferred (Participating and Non-participating): You pay all charges
Not covered: • *Oral surgery except as shown in Section 5(b)* • *Injury to the teeth while eating* • *Emergency room professional charges for shift differentials*	*All charges*
Medical Emergency	**FEP Blue Focus**
Outpatient medical or surgical services and supplies related to a medical emergency to include: • **Professional provider services in the emergency room**, including professional care, diagnostic studies, radiology services, laboratory tests, and pathology services, when billed by a professional provider • Outpatient **hospital emergency room** services and supplies, including professional provider services, diagnostic studies, radiology services, laboratory tests, and pathology services, when billed by the hospital Notes: • All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits. • If you are treated by a non-PPO professional provider in a PPO facility your liability for the difference between our allowance and the billed amount may be limited under the NSA. See Section 4 for more information. • We pay inpatient benefits if you are admitted as a result of a medical emergency. See Section 5(c). • Regular benefit levels apply to covered services provided in settings other than the emergency room. See Section 5(c) for those benefits.	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred professional providers (Participating and Non-participating): • Participating: 30% of the Plan allowance (deductible applies) • Non-participating: 30% of the Plan allowance (deductible applies) Non-preferred facilities (Member/Non-member): • Member: 30% of the Plan allowance (deductible applies) • Non-member: 30% of the Plan allowance (deductible applies)
• Urgent care centers, licensed as and permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider regardless of the providers network status Notes: • The urgent care center must be licensed as and permitted to provide emergency services in order to receive protections under the NSA. See Section 4 for more information. • Benefits for crutches, splints, braces, etc. when billed by a provider other than the urgent care center are stated in Section 5(a), *DME.*	$25 copayment per visit (no deductible)
• Urgent care centers, not licensed as or permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider Note: Benefits for crutches, splints, braces, etc. when billed by a provider other than the urgent care center are stated in Section 5(a), *DME.*	Preferred urgent care center: $25 copayment per visit (no deductible) Non-preferred (Participating/Non-participating): You pay all charges

Medical Emergency - continued on next page

Benefit Description	You Pay
Medical Emergency (cont.)	**FEP Blue Focus**
Not covered: Emergency room professional charges for shift differentials	*All charges*
Ambulance	**FEP Blue Focus**
See Section 5(c) for complete ambulance benefit and coverage information.	See Section 5(c)

Section 5(e). Mental Health and Substance Use Disorder Benefits

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.
- If you have an acute chronic and/or complex condition, you may be eligible to receive the services of a professional case manager to assist in assessing, planning, and facilitating individualized treatment options and care. For more information about our Case Management process, please refer to Section 5(h). Contact us at the phone number listed on the back of your ID card if you have any questions or would like to discuss your healthcare needs.
- 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.
- Every year, we conduct an analysis of the financial requirements and treatment limitations which apply to this Plan's mental health and substance use disorder benefits in compliance with the federal Mental Health Parity and Addiction Equity Act (the Act), and the Act's implementing regulations. Based on the results of this analysis, we may suggest changes to program benefits to OPM. More information on the Act is available on the following Federal Government websites:
  https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html
  https://www.dol.gov/ebsa/
  https://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL OR RESIDENTIAL TREATMENT CENTER STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY**. Please refer to the precertification information listed in Section 3.
- The calendar year deductible is $750 per person ($1,500 per Self Plus One or Self and Family enrollment). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- **You must use Preferred providers in order to receive benefits. See Section 3 for the exceptions to this requirement.**
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- There is a $10 visit copayment for each of the first 10 visits to a professional provider per calendar year. This applies to a combined total for medical and mental health and substance use disorder conditions.

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this section.	
Professional Services	**FEP Blue Focus**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.

Professional Services - continued on next page

Benefit Description	You Pay
Professional Services (cont.)	**FEP Blue Focus**
Services provided by licensed professional mental health and substance use disorder practitioners when acting within the scope of their license Outpatient professional services including: • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Office visits • Clinic visits • Home visits • Phone consultations and online medical evaluation and management services (telemedicine) Notes: • We cover up to 8 visits per year in full to treat depression associated with pregnancy under maternity benefits (i.e., depression during pregnancy, postpartum depression, or both) when you use a Preferred provider. See Section 5(a). • To locate a Preferred provider, visit www.fepblue.org/provider to use our National Doctor & Hospital Finder, or contact your Local Plan at the mental health and substance use disorder phone number on the back of your ID card. • See Sections 5(a) and 5(f), or 5(f)(a) if applicable, for our coverage of smoking and tobacco cessation treatment. We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here. **Prior approval is required.**	Preferred: $10 copayment (no deductible) per visit up to a combined total of 10 visits per calendar year (benefits combined with visits in Section 5(a)) Preferred provider, visits after the 10th visit: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges
Telehealth professional services for: • Behavioral health counseling • Substance use disorder counseling Notes: • Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access our telehealth provider network. • Copayments are waived for members with Medicare Part B primary.	Preferred Telehealth Provider: Nothing (no deductible) Non-preferred (Participating/Non-participating): You pay all charges
Services provided by licensed professional mental health and substance use disorder practitioners when acting within the scope of their license: • Inpatient professional services • Professional charges for facility-based intensive outpatient treatment • Professional charges for outpatient diagnostic tests to include psychological testing	Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges

Benefit Description	You Pay
Inpatient Hospital or Other Covered Facility	**FEP Blue Focus**
Inpatient services to treat mental health and/or substance use disorders provided and billed by a hospital or other covered facility (see below for residential treatment center care) includes: • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Diagnostic tests Notes: • Inpatient care to treat substance use disorders includes room and board and ancillary charges for confinements in a hospital/treatment facility for rehabilitative treatment of alcoholism or substance use disorder. • You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	Preferred facilities: 30% of the Plan allowance (deductible applies) Non-preferred (Member/Non-member) facilities: You pay all charges
Residential Treatment Center	**FEP Blue Focus**
Precertification prior to admission is required. We cover inpatient care provided and billed by an RTC when the care is medically necessary for the treatment of a medical, mental health, and/or substance use disorder: • Room and board, such as semiprivate room, nursing care, meals, special diets, ancillary charges, and covered therapy services when billed by the facility Notes: • RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, halfway house, or similar type facility. • Benefits are not available for noncovered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; biofeedback; Outward Bound programs; hippotherapy/equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, television, beauty and barber services; custodial or long-term care (see *Definitions*); and domiciliary care provided because care in the home is not available or is unsuitable. • For outpatient residential treatment center services, see next page.	Preferred facilities: 30% of the Plan allowance (deductible applies) Non-preferred (Member/Non-member) facilities: You pay all charges
Outpatient Hospital or Other Covered Facility	**FEP Blue Focus**
Outpatient services provided and billed by a covered facility • Diagnostic tests • Group psychotherapy • Individual psychotherapy • Intensive outpatient treatment • Partial hospitalization • Pharmacologic (medication) management • Psychological testing	Preferred facilities: 30% of the Plan allowance (deductible applies) Non-preferred (Member/Non-member) facilities: You pay all charges

Outpatient Hospital or Other Covered Facility - continued on next page

Benefit Description	You Pay
Outpatient Hospital or Other Covered Facility (cont.)	**FEP Blue Focus**
Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here. **Prior approval is required.** Failure to obtain prior approval will result in a $100.00 penalty. See Section 3.	Preferred facilities: 30% of the Plan allowance (deductible applies) Non-preferred (Member/Non-member) facilities: You pay all charges
Not covered: • *Educational or other counseling or training services* • *Services performed by a noncovered provider* • *Testing for and treatment of learning disabilities and intellectual disability* • *Inpatient services performed or billed by residential treatment centers, except as described earlier in this section and in Section* 5(*c*) • *Services performed or billed by schools, halfway houses, group homes or members of their staffs* *Note: We cover professional services as described in Section* 5(*c*) *when they are provided and billed by a covered professional provider acting within the scope of their license.* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present* • *Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.)* • *Light boxes* • *Custodial or long-term care (see* Definitions*)* • *Costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies, non-interactive telecommunication such as email communications, or asynchronous store-and-forward telehealth services*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits for members enrolled in our regular pharmacy program:

- We cover prescription drugs and supplies, as described below and on the following pages for members enrolled in our regular pharmacy drug program.
- If there is no generic drug available, you must pay the brand-name cost-sharing amount when you receive a brand-name drug.
- If there is a generic substitution available and you or your provider requests a brand-name drug, you will be responsible for the applicable cost-share plus the difference in the costs of the brand-name and generic drugs.
- If the cost of your prescription is less than your cost-sharing amount, you pay only the cost of your prescription.
- 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.
- Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit.
- Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained from a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this section for more information.
- 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.
- Medication prices vary among different retail pharmacies and the Specialty Drug Pharmacy Program. **Review purchasing options for your prescriptions to get the best price**. A drug cost tool is available at www.fepblue.org or call:
  - **Retail Pharmacy Program: 800-624-5060, TTY: 711**
  - **Specialty Drug Pharmacy Program: 888-346-3731, TTY: 711**
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS AND SUPPLIES, and prior approval must be renewed periodically**. Prior approval is part of our Patient Safety and Quality Monitoring (PSQM) program. Please keep reading for more information about the PSQM program and refer to Section 3 for more information about prior approval. Our prior approval process may include step therapy, which requires you to use a generic and/or preferred medication(s) before a non-preferred medication is covered.
- During the course of the year, we may move a brand-name drug from Tier 2 (preferred brand-name, preferred generic specialty and preferred brand-name specialty drugs) to noncovered if a generic equivalent or biosimilar becomes available or if new safety concerns arise. If your drug is moved to noncovered, you pay the full cost of the medication. Tier reassignments during the year are not considered benefit changes.
- A pharmacy restriction may be applied for clinically inappropriate use of prescription drugs and supplies.
- **You must use Preferred FEP Blue Focus retail pharmacies or the Specialty Drug Pharmacy Program in order to receive benefits.** Our specialty drug pharmacy is a Preferred pharmacy.
- There is no calendar year deductible for the Retail Pharmacy Program or the Specialty Drug Pharmacy Program.
- The FEP Blue Focus formulary contains a comprehensive list of drugs under all therapeutic categories with two exceptions: some drugs, nutritional supplements and supplies are noncovered; we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available.
- **The Blue Cross and Blue Shield Service Benefit Plan's FEP Blue Focus uses a closed formulary.** Please see our online formulary and drug pricing search tools at www.fepblue.org or call 800-624-5060, TTY: 711.

- **The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria** only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). **We do not exclude coverage for entire classes of pharmaceuticals**, e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/ tumor growth prevention.

We will send each new enrollee an FEP Blue Focus identification card, which covers pharmacy and medical benefits.

There are important features you should be aware of. These include:

- **Who can write your prescriptions.** A physician or dentist licensed in the United States, Puerto Rico, or the U.S. Virgin Islands, or, in states that permit it, a licensed/certified provider with prescriptive authority prescribing within their scope of practice must write your prescriptions. See Section 5(i) for drugs purchased overseas.

- **Where you can obtain them.**
  You must fill prescriptions only at a Preferred retail pharmacy or through the Specialty Drug Pharmacy Program, in order to receive benefits. See Section 10 for the definition of "specialty drugs." For information about prescriptions obtained from an overseas retail pharmacy, see Section 5(i).

  The Retail Pharmacy Program is administered by CVS Caremark. For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 800-624-5060, TTY: 711, or visit our website, www.fepblue.org.

  Note: If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.

  The Specialty Drug Pharmacy Program is administered by CVS Caremark.

  Notes:

  - The Specialty Drug Pharmacy Program will not fill your prescription until you have obtained prior approval. CVS Caremark, the program administrator, will hold your prescription for up to 30 days. If prior approval is not obtained within 30 days, your prescription will be returned to you along with a letter explaining the prior approval procedures.
  - Preferred retail pharmacies may offer options for ordering prescription drugs online. Drugs ordered online may be delivered to your home and these online orders are a part of the Retail Prescription Drug Program.
  - Due to manufacturer restrictions, a small number of specialty drugs used to treat rare or uncommon conditions may be available only through a Preferred retail pharmacy. See Specialty Drug Pharmacy Program in this section for information about your cost-share for specialty drugs purchased at a Preferred retail pharmacy that are affected by these restrictions.

- **What is covered.**
  We use a closed formulary. Please see our online formulary and drug pricing search tools at www.fepblue.org or call 800-624-5060, TTY: 711.

  If you purchase a drug that is not on the formulary, you will pay the full cost of that drug.

  The FEP Blue Focus Formulary includes a list of preferred drugs that are safe, effective and appropriate for our members and are available at lower costs than other drugs.

  Some drugs, nutritional supplements, and supplies are not covered; we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. If you purchase a drug, nutritional supplement, or supply that is not covered, you will be responsible for the full cost of the item.

  Notes:

  - **Before filling your prescription, please check the FEP Blue Focus Formulary drug list and tier assignment of the drug. Other than changes resulting from new drugs or safety issues, the preferred drug list is updated periodically during the year and not considered a benefit change.**

- Member cost-share for prescription drugs is determined by the tier to which a drug has been assigned. To determine the tier assignments for formulary drugs, we work with our Pharmacy and Medical Policy Committee, a group of physicians and pharmacists who are not employees or agents of, nor have financial interest in, the Blue Cross and Blue Shield Service Benefit Plan. The Committee meets quarterly to review new and existing drugs to assist us in our assessment. Drugs determined to be of equal therapeutic value and similar safety and efficacy are then evaluated on the basis of cost. The Committee's recommendations, together with our evaluation of the relative cost of the drugs, determine the placement of formulary drugs on a specific tier. Using lower cost preferred generic drugs will provide you with a high-quality, cost-effective prescription drug benefit.

Your cooperation with our cost-saving efforts helps keep your premium affordable. Our payment levels are generally categorized as:

Tier 1: Preferred generic drugs obtained at a Preferred retail pharmacy
Tier 2: Preferred brand-name drugs, preferred generic specialty drugs, and preferred brand-name specialty drugs obtained at a Preferred retail pharmacy or through the Specialty Drug Pharmacy Program.

You can view the formulary on our website at www.fepblue.org or call 800-624-5060, TTY: 711, for assistance. If you do not find your drug on the formulary, or the preferred drug list, please call 800-624-5060. Changes to the formulary are not considered benefit changes.

Any savings we receive on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

- **Generic equivalents**
  Generic equivalent drugs have the same active ingredients as their brand-name equivalents. By filling your prescriptions (or those of family members covered by the Plan) at a Preferred retail pharmacy or through the Specialty Drug Pharmacy Program, you authorize the pharmacist to substitute any available U.S. FDA-approved generic equivalent, unless you or your physician specifically request a brand-name drug. However, if there is a generic substitution available and you or your provider requests a brand-name drug, you will be responsible for the applicable cost-share plus the difference in the costs of the brand-name and generic drugs. Keep in mind that FEP Blue Focus members **must use Preferred pharmacies in order to receive benefits.** See Section 10 for our definition of generic alternatives and generic equivalents.

- **Disclosure of information.** As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.

- **These are the dispensing limitations.**
  Subject to manufacturer packaging and your prescriber's instructions, you may purchase either up to a 30-day supply or a 31 to 90 day supply of covered drugs and supplies through the Retail Pharmacy Program or up to a 30-day supply through the Specialty Drug Pharmacy Program.

  Notes:

  - Certain drugs such as narcotics may have additional limits or requirements as established by the U.S. FDA or by national scientific or medical practice guidelines (such as Centers for Disease Control, American Medical Association, etc.) on the quantities that a pharmacy may dispense. In addition, pharmacy dispensing practices are regulated by the state where they are located and may also be determined by individual pharmacies. Due to safety requirements, some medications are dispensed as originally packaged by the manufacturer and we cannot make adjustments to the packaged quantity or otherwise open or split packages to create 30, and 90-day supplies of those medications. **In most cases, refills cannot be obtained until 75% of the prescription has been used. Controlled substances cannot be refilled until 80% of the prescription has been used.** Controlled substances are medications that can cause physical and mental dependence, and have restrictions on how they can be filled and refilled. They are regulated and classified by the DEA (Drug Enforcement Administration) based on how likely they are to cause dependence. Call us or visit our website if you have any questions about dispensing limits. Please note that in the event of a national or other emergency, or if you are a reservist or National Guard member who is called to active military duty, you should contact us regarding your prescription drug needs.

- Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. Medical benefits will be provided for a once-per-lifetime dose per therapeutic category of drugs dispensed by your provider or any non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage.
- Benefits for certain auto-immune infusion medications (Remicade, Renflexis and Inflectra) are provided only when they are obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this section for more information.

Patient Safety and Quality Monitoring (PSQM)

We have a special program to promote patient safety and monitor healthcare quality. Our Patient Safety and Quality Monitoring (PSQM) program features a set of closely aligned programs that are designed to promote the safe and appropriate use of medications. Examples of these programs include:

- Prior approval – As described below, this program requires that approval be obtained for certain prescription drugs and supplies before we provide benefits for them.
- Safety checks – Before your prescription is filled, we perform quality and safety checks for usage precautions, drug interactions, drug duplication, excessive use, and frequency of refills.
- Quantity allowances – Specific allowances for several medications are based on U.S. FDA-approved recommendations, national scientific and generally accepted standards of medical practice guidelines (such as Centers for Disease Control, American Medical Association, etc.), and manufacturer guidelines.

For more information about our PSQM program, including listings of drugs subject to prior approval or quantity allowances, visit our website at www.fepblue.org or call the Retail Pharmacy Program at 800-624-5060, TTY: 711.

Prior Approval

As part of our Patient Safety and Quality Monitoring (PSQM) program (see above), **you must make sure your physician obtains prior approval for certain prescription drugs and supplies in order to use your prescription drug coverage.** In providing prior approval, we may limit benefits to quantities prescribed in accordance with generally accepted standards of medical, dental, or psychiatric practice in the United States. Our prior approval process may include step therapy, which requires you to use a generic and/or preferred medication(s) before a non-preferred medication is covered. **Prior approval must be renewed periodically.** To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the Retail Pharmacy Program at 800-624-5060, TTY: 711. You can also obtain the list and forms through our website at www.fepblue.org. Please read Section 3 for more information about prior approval.

Notes:

- Updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change. Changes to the prior approval list or to prior approval criteria are not considered benefit changes.
- If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.
- It is your responsibility to know the prior approval authorization expiration date for your medication. We encourage you to work with your physician to obtain prior approval renewal in advance of the expiration date.

Medical Foods

Medical foods, as defined by the U.S. Food and Drug Administration, that are consumed or administered enterally and are intended for the specific dietary management of a disease or condition for which there are distinctive nutritional requirements.

The Plan covers medical food formulas and enteral nutrition products that are ordered by a healthcare provider and are medically necessary to prevent clinical deterioration in members at nutritional risk.

Must meet the definition of medical food described in Section 10.

Must be receiving active, regular, and ongoing medical supervision and must be unable to manage the condition by modification of diet alone.

Coverage is provided as follows:

- Inborn errors of amino acid metabolism
- Food allergy with atopic dermatitis, gastrointestinal symptoms, IgE mediation, malabsorption disorder, seizure disorder, failure to thrive, or prematurity, when administered orally and is the sole source (100%) of nutrition. This once per lifetime benefit is limited to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate, in a formula form or powders mixed to become formulas)
- Medical foods and nutritional supplements when administered by catheter or nasogastric tubes

Notes:

- A prescription and prior approval are required for medical foods provided under the pharmacy benefit. Renewals of the prior authorization are required every benefit year for inborn errors of metabolism and tube feeding.
- See Section 5(a) for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube under the medical benefit.

Here is how to obtain your prescription drugs and supplies:

- Make sure you have your ID card when you are ready to purchase your prescription.
- Go to any Preferred retail pharmacy, or
- Visit the website of your Preferred retail pharmacy to request your prescriptions online and delivery, if available.

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this section.	
Covered Medications and Supplies	**FEP Blue Focus**
Preferred retail pharmacies **Covered drug and supplies, such as:** • Drugs, vitamins and minerals, and nutritional supplements that by federal law of the United States require a prescription for their purchase. • Drugs for the diagnosis and treatment of infertility • Drugs for IVF - limited to 3 cycles annually (prior approval required) Note: Drugs for the treatment of IVF must be purchased through the pharmacy drug program and you must meet our definition of infertility • Drugs associated with covered artificial insemination procedures • Drugs prescribed to treat obesity (prior approval required) • Medical foods • Insulin, diabetic test strips, lancets, and tubeless insulin delivery systems (See Section 5(a) for our coverage of insulin pumps with tubes.) • Needles and disposable syringes for the administration of covered medications • Clotting factors and anti-inhibitor complexes for the treatment of hemophilia	**Tier 1 Preferred Generic Drugs** obtained at Preferred retail pharmacies: • $5 copayment for each purchase of up to a 30-day supply (no deductible) • $15 copayment for each purchase of a 31 to 90-day supply (no deductible) Non-preferred pharmacy: You pay all charges **Tier 2 Preferred Brand-Name Drugs** obtained at Preferred retail pharmacies: • 40% of the Plan allowance (up to the maximum of $550) for each purchase of up to a 30-day supply (no deductible) • 40% of the Plan allowance (up to the maximum of $1,650) for each purchase of up to a 90-day supply (no deductible) Non-preferred pharmacy: You pay all charges

Covered Medications and Supplies - continued on next page

Benefit Description	You Pay
Covered Medications and Supplies (cont.)	**FEP Blue Focus**
• Contraceptive drugs and devices, limited to: - Diaphragms and contraceptive rings - Injectable contraceptives - Intrauterine devices (IUDs) - Implantable contraceptives - Oral and transdermal contraceptives Notes: • We waive your cost-share for generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative, as listed in each therapeutic class under the HRSA guidelines, when purchased from a Preferred retail pharmacy. You may seek an exception for any contraceptive that is not available with zero-member cost-share. Your provider will need to complete the Contraceptive Exception Form under Pharmacy Forms found on our website at www.fepblue.org/claim-forms. If you have questions about the exception process, call 800-624-5060. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. • Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. • For additional Family Planning benefits, see Section 5(a). • Benefits for Tier 2 specialty drugs purchased at a Preferred retail pharmacy are limited to one purchase of up to a 30-day supply for each prescription dispensed. • All refills must be obtained through the Specialty Drug Pharmacy Program. • Each time you order a new specialty drug or refill, a Specialty Drug pharmacy representative will work with you to arrange a delivery time and location that are most convenient for you, as well as ask you about any side effects you may be experiencing. See Section 7 for more details about the Program. • We cover specialty drugs that are listed on the FEP Blue Focus Specialty Drug List. This list is subject to change. For the most up-to-date list, call the phone number below or visit our website, www.fepblue.org. (See Section 10 for the definition of "specialty drugs."	Continued from previous page: **Preferred Specialty Drugs (generic and brand-name)** obtained at Preferred retail pharmacies and through the Specialty Drug Pharmacy Program: • 40% of the Plan allowance (up to the maximum of $550) for each purchase of up to a 30-day supply (no deductible) • If a 31 to 90-day supply of a specialty drug has to be dispensed due to manufacturer packaging, you pay 40% of the Plan allowance (up to the maximum of $1,650) for each purchase (no deductible) Non-preferred pharmacy: You pay all charges

See page 94 and on for additional pharmacy benefits for all eligible members.

Section 5(f)(a). FEP Medicare Prescription Drug Program

Important things you should keep in mind about these benefits:

- These prescription drug benefits are for members enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- Members with Medicare Part A and/or Part B primary are eligible for the benefits under the FEP Medicare Prescription Drug Program.
- For additional information about who is eligible for this program and when, or to dispute your claim, please visit us at www.fepblue.org/medicarerx
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at 888-338-7737.

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our FEP Prescription Drug Plan will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our FEP Medicare Prescription Drug Plan:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- We may provide additional coverage for prescription drugs not included in your Medicare Part D For more information about your share of the cost or which prescription drugs may or may not be covered, please call 888-338-7737, TTY 711.
- There is no calendar year deductible for drugs purchased under this program.
- Certain medications may be covered under Medicare Part B or Medicare Part D, depending on the condition being treated.
- If the cost of your prescription is less than your cost-sharing amount, you pay only the cost of your prescription.
- In our FEP Medicare Prescription Drug Plan, you have a pharmacy network. You must go to a network pharmacy to obtain your prescriptions to be covered. If you are unable to get to a network pharmacy in certain situations such as during an emergency, you may pay for your prescriptions and request a reimbursement.
- Medication prices vary among different pharmacies in our network. **Review purchasing options for your prescriptions to get the best price.** A drug cost tool is available at www.fepblue.org/medicarerx or call 888-338-7737, TTY: 711.

We cover prescription drugs, medications, and supplies as described below and on the following pages.

- 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.
- The FEP Blue Focus formulary contains a comprehensive list of drugs under all therapeutic categories with two exceptions: some drugs, nutritional supplements and supplies are noncovered; we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available.
- **The Blue Cross and Blue Shield Service Benefit Plan's FEP Blue Focus uses a closed formulary.** Please see our online formulary and drug pricing search tools at www.fepblue.org or call 800-624-5060, TTY: 711.
- During the course of the year, we may move a brand-name drug from Tier 2 (preferred brand-name) to Tier 3 (non-preferred brand-name) if a generic equivalent becomes available or if new safety concerns If your drug is moved to a higher tier, your cost-share will increase. If your drug is moved to noncovered, you pay the full cost of the medication. Tier reassignments during the year are not considered benefit changes.

- If there is no generic drug available, you must pay the brand-name cost-sharing amount when you receive a brand-name drug.
- **YOU OR YOUR PRESCRIBER MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS AND SUPPLIES, and prior approval must be renewed periodically.** Our prior approval process may include step therapy, which requires you to use a generic and/or preferred medication(s) before a non-preferred medication is covered.
- 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.
- If you choose to opt out of or disenroll from our FEP Medicare Prescription Drug Plan, see Section 9 for additional FEP Medicare Prescription Drug Plan information and for our opt-out and disenrollment process. Contact us for assistance with the FEP Medicare Prescription Drug Plan opt out and disenrollment process at (888) 338-7737.
- A restriction may be applied to prescriptions for drugs and supplies when there is misuse.
- Members enrolled in the FEP Medicare Prescription Drug Program have no coverage for drugs obtained and/or purchased overseas.
- Federal law prevents the pharmacy from accepting unused drugs, medications, and supplies.

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance with the PDP EGWP opt out disenrollment process.

We will send each new enrollee a Plan identification card, which covers pharmacy and medical benefits. Each new enrollee has access to our FEP Medicare Prescription Drug Program Evidence of Coverage, Summary of Benefits, Annual Notice of Change, and other resources at www.fepblue.org/medicarerx/resources.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist in the United States, Puerto Rico, or the U.S. Virgin Islands, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain prescription drugs.**

  You may fill prescriptions at a pharmacy that participates in our nationwide network. The network includes retail pharmacies and Specialty pharmacies. You may also receive your medication from a long-term care pharmacy when your care is handled in or by a long-term care facility. You will receive information on how to obtain a copy of the pharmacy directory, which lists all pharmacies participating in our network, in your enrollment package. You may also go online to our webpage, www.fepblue.org/medicarerx/resources for a complete listing.

  Network retail pharmacies may offer options for ordering prescription drugs online. Drugs ordered online may be delivered to your home and these online orders are part of the Retail Prescription Drug Program described in this section.

- **We have a managed formulary.** Your provider may prescribe drugs that are subject to additional review to determine they are medically necessary. You may view our FEP Blue Focus formulary on our website at www.fepblue.org, or call us at 800-624-5060, TTY: 711, for assistance.

We use a closed formulary.

If you purchase a drug that is not on the formulary, you will pay the full cost of that drug.

The FEP Blue Focus Formulary includes a list of preferred drugs that are safe, effective and appropriate for our members and are available at lower costs than other drugs.

Some drugs, nutritional supplements, and supplies are not covered; we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. If you purchase a drug, nutritional supplement, or supply that is not covered, you will be responsible for the full cost of the item.

Notes:

- **Before filling your prescription, please check the FEP Blue Focus Formulary drug list and tier assignment of the drug. Other than changes resulting from new drugs or safety issues, the preferred drug list is updated periodically during the year and not considered a benefit change.**
- Member cost-share for prescription drugs is determined by the tier to which a drug has been assigned. To determine the tier assignments for formulary drugs, we work with the CVS Caremark National Pharmacy and Therapeutics Committee, a group of physicians and pharmacists who are not employees or agents of, nor have financial interest in, the Blue Cross and Blue Shield Service Benefit Plan. The Committee meets quarterly to review new and existing drugs to assist us in our assessment. Drugs determined to be of equal therapeutic value and similar safety and efficacy are then evaluated on the basis of cost. The Committee's recommendations, together with our evaluation of the relative cost of the drugs, determine the placement of formulary drugs on a specific tier. Using lower cost preferred generic drugs will provide you with a high-quality, cost-effective prescription drug benefit.

Your cooperation with our cost-saving efforts helps keep your premium affordable. Our payment levels are generally categorized as:

Tier 1: Includes generic drugs
Tier 2: Includes preferred brand-name drugs
Tier 3: Includes non-preferred brand-name drugs
Tier 4: Includes preferred specialty drugs

Changes to the formulary are not considered benefit changes.

Any savings we receive on the costs of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

- **These are the dispensing limitations.**

Subject to manufacturer packaging and your prescriber's instructions, you may purchase up to a 90-day supply of covered drugs and supplies through the pharmacy network.

Notes:

- Certain drugs such as narcotics may have additional limits or requirements as established by the U.S. FDA or by national scientific or medical practice guidelines (such as Centers for Disease Control, American Medical Association, etc.) on the quantities that a pharmacy may dispense. In addition, pharmacy dispensing practices are regulated by the state where they are located and may also be determined by individual pharmacies. Due to safety requirements, some medications are dispensed as originally packaged by the manufacturer and we cannot make adjustments to the packaged quantity or otherwise open or split packages to create 30, and 90-day supplies of those medications. **In most cases, refills cannot be obtained until 75% of the prescription has been used.** Controlled substances cannot be refilled until 80% of the prescription has been used. Controlled substances are medications that can cause physical and mental dependence, and have restrictions on how they can be filled and refilled. They are regulated and classified by the DEA (Drug Enforcement Administration) based on how likely they are to cause dependence. Call us or visit our website if you have any questions about dispensing limits. Please note that in the event of a national or other emergency, or if you are a reservist or National Guard member who is called to active military duty, you should contact us regarding your prescription drug needs.

- **We may require Prior Approval for Drug on the Formulary (or when you need a drug that is not listed on the Formulary)**

You must make sure that your physician obtains prior approval for certain prescription drugs and supplies in order to use your prescription drug coverage. In providing prior approval, we may limit benefits to quantities prescribed in accordance with generally accepted standards of medical, dental, or psychiatric practice in the United States. Our prior approval process may include step therapy, which requires you to use a generic and/or preferred medication(s) before a non-preferred medication is covered. **Prior approval must be renewed periodically.** To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the FEP Medicare Prescription Drug Program at 888-338-7737, TTY: 711. You can also obtain the list of forms through our website at www.fepblue.org. Please read Section 3 for more information about prior approval.

Notes:

- Updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change. Changes to the prior approval list or to prior approval criteria are not considered benefit changes.
- If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.
- It is your responsibility to know the prior approval authorization expiration date for your medication. We encourage you to work with your physician to obtain prior approval renewal in advance of the expiration date.

- **A generic equivalent will be dispensed if it is available** unless your physician specifically requires a brand name drug. If you receive a brand name drug when an FDA approved generic drug is available, and your physician has not specified Dispense as Written for the brand name drug, you have to pay the difference in cost between the brand name drug and the generic.
- **Why use generic drugs.** Generic equivalent drugs have the same active ingredients as their brand-name equivalents. By filling your prescriptions (or those of family members covered by the Plan) at a Preferred retail pharmacy or through the Specialty Drug Pharmacy Program, you authorize the pharmacist to substitute any available U.S. FDA-approved generic equivalent, unless you or your physician specifically request a brand-name drug. Keep in mind that FEP Blue Focus members **must use network pharmacies in order to receive benefits**. See Section 10 for our definitions of generic alternatives and generic equivalents.

- **How to obtain your prescription drugs and supplies:**
  - Make sure you have your ID card when you are ready to purchase your prescription.
  - Go to any network pharmacy, or
  - Visit the website of your retail pharmacy to request your prescriptions online and delivery, if available.

Medical Foods

Medical foods, as defined by the U.S. Food and Drug Administration, that are consumed or administered enterally and are intended for the specific dietary management of a disease or condition for which there are distinctive nutritional requirements.

The Plan covers medical food formulas and enteral nutrition products that are ordered by a healthcare provider and are medically necessary to prevent clinical deterioration in members at nutritional risk.

Must meet the definition of medical food described in Section 10.

Must be receiving active, regular, and ongoing medical supervision and must be unable to manage the condition by modification of diet alone.

Coverage is provided as follows:

- Inborn errors of amino acid metabolism
- Food allergy with atopic dermatitis, gastrointestinal symptoms, IgE mediation, malabsorption disorder, seizure disorder, failure to thrive, or prematurity, when administered orally and is the sole source (100%) of nutrition. This once per lifetime benefit is limited to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate, in a formula form or powders mixed to become formulas)
- Medical foods and nutritional supplements when administered by catheter or nasogastric tubes

Notes:

- A prescription is required for medical foods provided under the pharmacy benefit.
- See Section 5(a) for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube under the medical benefit.

- **Disclosure of information.** As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.

- **Important contact information**

  FEP Medicare Prescription Drug Program: 888-338-7737, TTY 711

- **PDP EGWP Catastrophic Maximums**

Each individual enrolled in the FEP Medicare Prescription Drug Program has a separate and lower out-of-pocket catastrophic protection maximum for the drugs purchased while covered under this Program.

This separate catastrophic maximum is $2,100 true out-of-pocket cost (TrOOP).

This amount accumulates toward the out-of-pocket catastrophic protection maximum described in Section 4.

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this section.	
Covered Medications and Supplies	**FEP Blue Focus**
Covered drug and supplies, such as: • Drugs, vitamins and minerals, and nutritional supplements that by federal law of the United States require a prescription for their purchase. • Drugs for the diagnosis and treatment of infertility • Drugs for IVF - limited to 3 cycles annually Note: Drugs for the treatment of IVF must be purchased through the pharmacy drug program and you must meet our definition of infertility • Drugs associated with covered artificial insemination procedures • Drugs prescribed to treat obesity (prior approval required) • Medical foods • Insulin, diabetic test strips, lancets, and tubeless insulin delivery systems (See Section 5(a) for our coverage of insulin pumps with tubes.) • Needles and disposable syringes for the administration of covered medications • Clotting factors and anti-inhibitor complexes for the treatment of hemophilia • Contraceptive drugs and devices, limited to: - Diaphragms and contraceptive rings - Injectable contraceptives - Intrauterine devices (IUDs) - Implantable contraceptives - Oral and transdermal contraceptives	Tier 1: Preferred Generic Drugs obtained at a Retail Pharmacy • $5 copayment for each purchase of up to a 30-day supply (no deductible) • $15 copayment for each purchase of a 31 to 90-day supply (no deductible) Tier 2: Preferred Brand-name Drugs obtained at a Retail Pharmacy • 40% of the Plan allowance (up to a $350 maximum) for each purchase of up to a 30-day supply (no deductible) • 40% of the Plan allowance (up to a $1,050 maximum) for each purchase of a 31 to 90-day supply (no deductible) Tier 3: Non-preferred Brand-name Drugs obtained at a Retail Pharmacy • 40% of the Plan allowance (up to a $350 maximum) for each purchase of up to a 30-day supply (no deductible) • 40% of the Plan allowance (up to a $1,050 maximum) for each purchase of a 31 to 90-day supply (no deductible) Tier 4: Preferred Specialty Drugs obtained at a Retail Pharmacy • 40% of the Plan allowance (up to a $350 maximum) for each purchase of up to a 30-day supply (no deductible) • 40% of the Plan allowance (up to a $1,050 maximum) for each purchase of a 31 to 90-day supply (no deductible)

Covered Medications and Supplies - continued on next page

Benefit Description	You Pay
Covered Medications and Supplies (cont.)	**FEP Blue Focus**
Note: We waive your cost-share for available forms of generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative, as listed in each therapeutic class under the HRSA guidelines, when purchased from a Preferred retail pharmacy. You may seek an exception for any contraceptive that is not available with zero-member cost-share. Your provider will need to complete the Contraceptive Exception Form under Pharmacy Forms found on our website at www.fepblue.org/claim-forms. If you have questions about the exception process, call 800-624-5060. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits, see Section 5(a).	Tier 1: Preferred Generic Drugs obtained at a Retail Pharmacy • $5 copayment for each purchase of up to a 30-day supply (no deductible) • $15 copayment for each purchase of a 31 to 90-day supply (no deductible) Tier 2: Preferred Brand-name Drugs obtained at a Retail Pharmacy • 40% of the Plan allowance (up to a $350 maximum) for each purchase of up to a 30-day supply (no deductible) • 40% of the Plan allowance (up to a $1,050 maximum) for each purchase of a 31 to 90-day supply (no deductible) Tier 3: Non-preferred Brand-name Drugs obtained at a Retail Pharmacy • 40% of the Plan allowance (up to a $350 maximum) for each purchase of up to a 30-day supply (no deductible) • 40% of the Plan allowance (up to a $1,050 maximum) for each purchase of a 31 to 90-day supply (no deductible) Tier 4: Preferred Specialty Drugs obtained at a Retail Pharmacy • 40% of the Plan allowance (up to a $350 maximum) for each purchase of up to a 30-day supply (no deductible) • 40% of the Plan allowance (up to a $1,050 maximum) for each purchase of a 31 to 90-day supply (no deductible)

The pharmacy benefits starting here to the end of the section apply to all covered members, unless otherwise noted.

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this section.	
Covered Medications and Supplies	**FEP Blue Focus**
Over-the-counter (OTC) contraceptive drugs and devices, limited to: • Emergency contraceptive pills • Condoms • Spermicides • Sponges Note: We provide benefits in full for OTC contraceptive drugs and devices when the contraceptives meet U.S FDA standards for OTC products. To receive benefits, you must use a Preferred retail pharmacy and present the pharmacist with a written prescription from your physician.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges
Immunizations when provided by a Preferred retail pharmacy that participates in our vaccine network (see below) and administered in compliance with applicable state law and pharmacy certification requirements. Note: Our vaccine network is a network of Preferred retail pharmacies that have agreements with us to administer one or more routine immunizations. Check with your pharmacy or call our Retail Pharmacy Program at 800-624-5060, TTY: 711, to find out which vaccines your pharmacy can provide.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges Notes: • You pay nothing for influenza (flu) vaccines obtained at Non-preferred retail pharmacies.
Diabetic Meter Program - Not available for those enrolled in the FEP Medicare Prescription Drug Program Members with diabetes may obtain one glucose meter kit every 365 days at no cost through our Diabetic Meter Program. To use this program, you must call the phone number listed below and request one of the eligible types of meters. The types of glucose meter kits available through our program are subject to change. To order your free glucose meter kit, call us toll-free at 855-582-2024, Monday through Friday, from 9 a.m. to 7 p.m., Eastern Time, or visit our website at www.fepblue.org. The selected meter kit will be sent to you within 7 to 10 days of your request. Note: Contact your physician to obtain a new prescription for the test strips and lancets to use with the new meter. Benefits will be provided for the test strips at Tier 2 (preferred brand-name) benefit payment levels if you purchase brand-name strips at a Preferred retail pharmacy.	Nothing for a glucose meter kit ordered through our Diabetic Meter Program When obtained from any other source: You pay all charges
Medications to promote better health as recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act"), limited to: • Iron supplements for children from age 6 months through 12 months • Oral fluoride supplements for children from age 6 months through 5 years • Folic acid supplements, 4 mg to 0.8 mg, for individuals capable of pregnancy • Low-dose aspirin (81 mg per day) for pregnant members at risk for preeclampsia • Aspirin for men age 45 through 79 and women age 50 through 79 • Generic cholesterol-lowering statin drugs	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges

Covered Medications and Supplies - continued on next page

Benefit Description	You Pay
Covered Medications and Supplies (cont.)	**FEP Blue Focus**
Notes: • Benefits are not available for acetaminophen, ibuprofen, naproxen, etc. • Benefits for these medications listed above are subject to the dispensing limitations described earlier and are limited to recommended prescribed limits. • To receive benefits, you must use a Preferred retail pharmacy and present a written prescription from your physician to the pharmacist. • A complete list of USPSTF-recommended preventive care services is available online at: www.healthcare.gov/preventive-care-benefits. See Sections 5(a) and 5(c) for information about other covered preventive care services.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges
Generic medications to reduce breast cancer risk for women, age 35 or over, who have not been diagnosed with any form of breast cancer Note: Your physician must send a completed Coverage Request Form to CVS Caremark before you fill the prescription. Call CVS Caremark at 800-624-5060, TTY: 711, to request this form. You can also obtain the Coverage Request Form through our website at www.fepblue.org. This not required if you are covered under our FEP Medicare Prescription Drug Program.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges
We cover the first prescription filled for certain bowel preparation medications for colorectal cancer screenings with no member cost-share. We also cover certain antiretroviral therapy medications for HIV for those at risk but who do not have HIV. You can view the list of covered medications on our website at www.fepblue.org or call 800-624-5060, TTY: 711, for assistance.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges
Opioid rescue agents are covered under this Plan with no cost-sharing when obtained with a prescription from a pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information, consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	Preferred retail pharmacy: Nothing for the purchase of one 90-day supply per calendar year (no deductible) Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share. Non-preferred retail pharmacy: You pay all charges

Covered Medications and Supplies - continued on next page

Benefit Description	You Pay
Covered Medications and Supplies (cont.)	**FEP Blue Focus**
Smoking and Tobacco Cessation Medications If you are a covered member, you may be eligible to obtain specific prescription generic and brand-name smoking and tobacco cessation medications at no charge. Additionally, you may be eligible to obtain over-the-counter (OTC) smoking and tobacco cessation medications, prescribed by your physician, at no charge. These benefits are only available when you use a Preferred retail pharmacy. The Quit Plan is not required for those covered under the FEP Medicare Prescription Drug Program. Note: There may be age restrictions based on U.S. FDA guidelines for these medications. The following medications are covered through this program: • Generic medications available by prescription: - Bupropion ER 150 mg tablet - Bupropion SR 150 mg tablet - Varenicline 0.5 mg tablets - Varenicline 1 mg tablets - Varenicline starting pack • Brand-name medications available by prescription: - Nicotrol cartridge inhaler - Nicotrol NS spray 10 mg/ml • Over-the-counter (OTC) medications Notes: • To receive benefits for over-the-counter (OTC) smoking and tobacco cessation medications, you must have a physician's prescription for each OTC medication that must be filled by a pharmacist at a Preferred retail pharmacy. • Regular prescription drug benefits will apply to purchases of smoking and tobacco cessation medications not meeting these criteria. Benefits are not available for over-the-counter (OTC) smoking and tobacco cessation medications except as described above. • See Section 5(a) for our coverage of smoking and tobacco cessation treatment, counseling, and classes.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges
Not covered: • *Drugs and supplies purchased from a Non-preferred pharmacy* • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Supplies for weight loss* • *Drugs for orthodontic care, dental implants, and periodontal disease* • *Drugs used in conjunction with non-covered assisted reproductive technology (ART) and assisted insemination procedures* • *Drugs used in conjunction with IVF that exceed the covered 3 per year annual cycle limitation described in this section*	*All charges*

Covered Medications and Supplies - continued on next page

Benefit Description	You Pay
Covered Medications and Supplies (cont.)	**FEP Blue Focus**
• *Insulin and diabetic supplies except when obtained from a Preferred retail pharmacy or except when Medicare Part B is primary, or you are enrolled in the FEP Medicare Prescription Drug Program. See Section 5(a).* • *Medications and orally taken nutritional supplements that do not require a prescription under Federal law even if your doctor prescribes them or if a prescription is required under your state law* *Note: See previous benefits in this section for our coverage of medications recommended under the Affordable Care Act and for smoking and tobacco cessation medications.* • *Medical foods administered orally are not covered if not obtained at a Preferred retail pharmacy* *Note: See Section 5(a) for our coverage of medical foods when administered by catheter or nasogastric tube.* • *Products and foods other than liquid formulas or powders mixed to become formulas; foods and formulas readily available in a retail environment and marketed for persons without medical conditions; low-protein modified foods (e.g., pastas, breads, rice, sauces and baking mixes); nutritional supplements, energy products; and similar items* *Note: See Section 5(a) for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.* • *Infant formula other than previously described in this section and in Section 5(a)* • *Drugs not listed on the formulary or preferred drug list* • *Brand name opioids* • *Remicade, Renflexis, and Inflectra are not covered for prescriptions obtained from a Preferred retail pharmacy, or through the Specialty Drug Pharmacy Program* • *Drugs for which prior approval has been denied or not obtained* • *Drugs and supplies related to sexual dysfunction or sexual inadequacy* • *For members enrolled in our regular pharmacy drug program (Section 5(f) only), drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria* *If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. If you have questions about the exception process, contact us using the customer service number listed on the back of your ID card. If you disagree with our decision, please see Section 8 of this brochure for the disputed claims process.* *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.* • *Drugs purchased through the mail or internet from pharmacies inside or outside the United States by members located in the United States* • *Over-the-counter (OTC) contraceptive drugs and devices, except as previously described in this section*	*All charges*

Covered Medications and Supplies - continued on next page

Benefit Description	You Pay
Covered Medications and Supplies (cont.)	**FEP Blue Focus**
• *Drugs used to terminate pregnancy* • *Sublingual allergy desensitization drugs, except as described in Section 5 (a)*	*All charges*
Drugs From Other Sources	**FEP Blue Focus**
Covered prescription drugs and supplies not obtained at a retail pharmacy or through the Specialty Drug Pharmacy Program to include, but not limited to: • Physician's office – for more information refer to Section 5(a) • Facility (inpatient or outpatient) – for more information refer to Section 5 (c) • Hospice agency – for more information refer to Section 5(c) • Drugs obtained at a physician's office, inpatient or outpatient facility or hospice agency while overseas, see Section 5(i) • Drugs and supplies covered only under the medical benefit, see auto-immune infusions below • Prescription drugs obtained from a Preferred retail pharmacy, that are billed by a skilled nursing facility, nursing home, or extended care facility previously described in this section Note: Prior approval is required for certain medical benefit drugs that will be submitted on a medical claim for reimbursement. Contact the customer service number on the back of your ID card or visit us at www.fepblue.org/medicalbenefitdrugs for a list of these drugs. See Section 3 for more information on prior approval.	Preferred professional providers and facilities: 30% of the Plan allowance (deductible applies) Non-preferred professional providers (Participating/Non-participating) and Non-preferred facilities (Member/Non-member): You pay all charges
For members covered under our traditional pharmacy drug program Auto-immune infusion medications: Remicade, Renflexis and Inflectra Notes: • Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). • Members covered under the FEP Medicare Prescription Drug Program may obtain these drugs under their pharmacy benefits.	Preferred professional providers and facilities: 30% of the Plan allowance (deductible applies) Non-preferred professional providers (Participating/Non-participating) and Non-preferred facilities (Member/Non-member): You pay all charges

Section 5(g). Dental Benefits

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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be the primary payor for any covered services and your FEDVIP Plan will be secondary to your PSHB Plan. See Section 9, *Coordinating Benefits with Medicare and Other Coverage*, for additional information.
- 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.
- The calendar year deductible is $750 per person ($1,500 per Self Plus One or Self and Family enrollment). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- **You must use Preferred providers in order to receive accidental dental injury benefits** for treatment after 72 hours of the accident. Covered services provided more than 72 hours after an accident are subject to the deductible and coinsurance.

Benefit Description	You Pay
Note: We state whether or not the calendar year deductible applies for each benefit listed in this section.	
Accidental Injury Benefit	**FEP Blue Focus**
We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury. To determine benefit coverage, we may require documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses. Notes: • An **accidental injury** is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries. • A **sound natural tooth** is a tooth that is whole or properly restored (restoration with amalgams or resin-based composite fillings only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth. • **We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers.** See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable cost-share as shown here. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. • **All follow-up** care must be performed and billed for by Preferred providers to be eligible for benefits.	**Treatment of an accidental dental injury within 72 hours:** Preferred: Nothing (no deductible) Non-preferred professional providers (Participating and Non-participating): • Participating: Nothing (no deductible) • Non-participating: Any difference between our allowance and the billed amount (no deductible) **Treatment after the initial 72 hours:** Preferred: 30% of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges

Benefit Description	You Pay
Inpatient and Outpatient Facility Care	**FEP Blue Focus**
We cover inpatient and outpatient hospital care, as well as anesthesia administered at the facility, • To treat children up to age 22 with severe dental caries, or • When a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient (even if the dental procedure itself is not covered).	See Section 5(c) for inpatient and outpatient hospital benefits.
Not covered: Routine dental care	*All charges*

Section 5(h). Wellness and Other Special Features

Special Feature	Description
Health Tools	Stay connected to your health and get the answers you need when you need them by using Health Tools 24 hours a day, 365 days a year. Go to www.fepblue.org or call 888-258-3432 toll-free to check out these valuable easy-to-use services: • Talk directly with a **Registered Nurse** any time of the day or night via phone, secure email, or live chat. Ask questions and get medical advice. Please keep in mind that benefits for any healthcare services you may seek after using Health Tools are subject to the terms of your coverage under this Plan. • **Personal Health Record** – Access your secure online personal health record for information such as the medications you're taking, recent test results, and medical appointments. Update, store, and track health-related information at any time. • **Blue Health Assessment** – An online health and lifestyle questionnaire (see below). • **Daily Habits** – Manage your health proactively by setting and managing health goals, create a plan of care, track your progress, and pursue healthy activities. Daily Habits offers members a combination of guidance, support, and resources. • **Health Topics and WebMD Videos** offer an extensive variety of educational tools using videos, recorded messages, and colorful online materials that provide up-to-date information about a wide range of health-related topics.
Services for the Deaf and Hearing Impaired	All Blue Cross and Blue Shield Plans provide TTY access for the hearing impaired to access information and receive answers to their questions.
Web Accessibility for the Visually Impaired	Our website, www.fepblue.org, adheres to the most current Section 508 Web accessibility standards to ensure that visitors with visual impairments can use the site with ease.
Travel Benefit/Services Overseas	Please refer to Section 5(i) for benefit and claims information for care you receive outside the United States, Puerto Rico, and the U.S. Virgin Islands.
Healthy Families	Our Healthy Families suite of resources is for families with children and teens, ages 2 to 19. Healthy Families provides activities and tools to help parents teach their children about weight management, nutrition, physical activity, and personal well-being. For more information, go to www.fepblue.org.
Blue Health Assessment	The **Blue Health Assessment (BHA**) questionnaire is an easy and engaging online health evaluation program which can be completed in 10-20 minutes. Your BHA answers are evaluated to create a unique health action plan. Based on the results of your BHA, you can select personalized goals, receive supportive advice, and easily track your progress through our online coaching tool, Daily Habits. Visit our website, www.fepblue.org, for more information and to complete the BHA so you can receive your individualized results and begin working toward achieving your goals. **You may also request a printed BHA** by calling 888-258-3432 toll-free.
Hypertension Management Program	The **Hypertension Management Program** gives members with hypertension (otherwise known as high blood pressure) access to a free blood pressure monitor (BPM) to encourage members to make healthier choices to reduce the potential for complications from cardiac disease.

	To qualify, you must be the contract holder or covered spouse (age 18 and over) and have at least one medical claim processed during the past 12 months reporting a diagnosis of hypertension or high blood pressure. If you qualify, you will receive a letter and a notice will be sent to your MyBlue account (visit www.fepblue.org to set up your account) with instructions on how you may receive a blood pressure monitor from us at no cost if your healthcare provider's treatment plan includes home blood pressure monitoring for your diagnosis. You may receive this benefit once every two years. If you have questions, please call the customer service phone number listed on the back of your ID card. The BPM must be received through this program. Benefits are not available for BPMs for members who do not meet the criteria or for those who obtain a BPM outside of this program. For more information, call us at the phone number on the back of your ID card.
MyBlue® Customer eService	Visit **MyBlue Customer eService** at www.fepblue.org/myblue or use the fepblue mobile app to check the status of your claims, change your address of record, request claim forms, request an ID card, and track how you use your benefits. Additional features include: • **Online EOBs** – **You will automatically be enrolled in online EOBs**. This will allow you to view, download, and print your explanation of benefits (EOB) forms. Simply log on to MyBlue via www.fepblue.org/myblue and click on "View My Claims"; from there you can search claims and select the "EOB" link next to each claim to access your EOB. Though your EOBs typically will be available online, there are some instances where you will receive a paper EOB and a form to complete. You can also access EOBs via the fepblue mobile app. Simply link to MyBlue, and click on "Claims." • **Opt in to Paper EOBs** – If you wish to receive paper EOBs, you may log on to MyBlue home page, click on "Member Preferences" from the navigation bar and opt in by selecting "paper EOBs." • **Personalized Messages** – Our EOBs provide a wide range of messages just for you and your family, ranging from preventive care opportunities to enhancements to our online services. • **Financial Dashboard** – Log in to MyBlue to access important information in real time, including deductibles, out-of-pocket costs, remaining covered provider visits, medical claims, and pharmacy claims. You also can review your year-to-date summary of completed claims, and pharmacy spending throughout the year.
National Doctor & Hospital Finder	Visit www.fepblue.org/provider to access our National Doctor & Hospital Finder and other nationwide listings of Preferred providers.
Care Management Programs	If you have a rare or chronic disease or have complex healthcare needs, the Service Benefit Plan offers two types of Care Management Programs that provide assistance with the coordination of your care, provide member education and clinical support. • Case Management provides members who have acute or chronic complex healthcare needs with the services and assistance of a licensed healthcare professional with a nationally recognized case management certification. Case managers may be a registered nurse, licensed social worker, or other licensed healthcare professional practicing within the scope of their license, who may work with you and your providers to assess your healthcare needs, coordinate needed care and available resources, evaluate the outcomes of your care, and support and monitor the progress of the member's treatment plan and healthcare needs. Some members may receive guidance and clinical support for an acute healthcare need while others may benefit from a short term case management enrollment. Enrollment in case management requires your consent. Members in case management are asked to provide verbal consent prior to enrollment in case management and must provide written consent for case management. • Disease Management supports members who have diabetes, asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease, or congestive heart failure by helping them adopt effective self-care habits to improve the self-management of their condition. If you have been diagnosed with any of these conditions, we may send you information about the programs available to you in your area.

	If you have any questions regarding these programs, including if you are eligible for enrollment and assistance with enrollment, please contact us at the customer service phone number on the back of your ID card.
Flexible Benefits Option	Under the Blue Cross and Blue Shield Service Benefit Plan's FEP Blue Focus, our Case Management process may include a **flexible benefits option**. This option allows professional case managers at Local Plans to assist members with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans. Through the flexible benefits option, case managers will review the member's healthcare needs and may at our sole discretion, identify a less costly alternative treatment plan for the member. The member (or their healthcare proxy) and provider(s) must cooperate in the process. Case Management Program enrollment is required for eligibility. Prior to the starting date of the alternative treatment plan, members who are eligible to receive services through the flexible benefits option are required to sign and return a written consent for case management and the alternative plan. If you and your provider agree with the plan, alternative benefits will begin immediately and you will be asked to sign an **alternative benefits agreement** that includes the terms listed below, in addition to any other terms specified in the agreement. **We must receive the consent for case management and the alternative benefits agreement signed by the member/healthcare proxy before you receive any services included in the alternative benefits agreement.** • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with and participate in the review process. Your provider (s) must submit the information necessary for our reviews. You and/or your healthcare proxy must participate in care conferences and caregiver training as requested by your provider(s) or by us. • We may revoke the alternative benefits agreement immediately at any time, if we discover we were misled by the information given to us by you, your provider, or anyone else involved in your care, or that you are not meeting the terms of the agreement. • If we approve alternative benefits, we do not guarantee that they will be extended beyond the limited time period and/or scope of the alternative benefits agreement or that they will be approved in the future. • The decision to offer alternative benefits is solely ours, and unless otherwise specified in the **alternative benefits agreement**, we may at our sole discretion, withdraw those benefits at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. If you sign the **alternative benefits agreement**, we will provide the agreed-upon alternative benefits for the stated time period, unless we are misled by the information given to us or circumstances change. Benefits as stated in this brochure will apply to all services and dates of care not included in the alternative benefits agreement. You or your provider may request an extension of the time period initially approved for alternative benefits, no later than five business days prior to the end of the alternative benefits agreement. We will review the request, including the services proposed as an alternative and the cost of those services, but benefits as stated in this brochure will apply if we do not approve your request. Note: If we deny a request for precertification or prior approval of regular contract benefits, as stated in this brochure, or if we deny regular contract benefits for services you have already received, you may dispute our denial of regular contract benefits under the OPM disputed claims process (see Section 8).
Telehealth Services	Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 711, toll free to access on-demand, affordable, high-quality care for adults and children experiencing non-emergency medical issues, including treatment of minor acute conditions, dermatology care, counseling for mental health and substance use disorder, and nutritional counseling. Note: This benefit is available only through the contracted telehealth provider network.

Special Feature	Description
Routine Annual Physical Incentive Program	The Routine Annual Physical Incentive Program rewards members for receiving a routine annual physical exam. This incentive enables you to receive, at no cost, an incentive reward from our “shopping mall.” To qualify, you must be the contract holder or covered spouse (over age 18), receive an annual routine physical exam from a Preferred provider, and have an active MyBlue account (visit www.fepblue.org to set up your account). Qualifying members will receive notification through their MyBlue account with instructions on how to redeem this incentive. Additional details are available on our website, www.fepblue.org/fepbluefocus. FEP Blue Focus members may also call 800-411-BLUE (2583) for inquiries related to this incentive program. Note: In order to receive your incentive, you must have received your annual physical no later than December 31, 2025, and you must request your incentive before December 31, 2026. Please allow ample time to complete all activities by this date. If these activities are not completed by the dates listed above, the incentive will be forfeited. Product availability and shipping limitations may apply. International shipping is not available.
The fepblue Mobile Application	Blue Cross and Blue Shield’s fepblue mobile application is available for download for both iOS and Android mobile phones. The application provides members with 24/7 access to helpful features, tools and information related to Blue Cross and Blue Shield Service Benefit Plan’s FEP Blue Focus benefits. Members can log in with their MyBlue® username and password to access personal healthcare information such as benefits, out-of-pocket costs, deductibles (if applicable) and physician visit limits. They can also view claims and approval status, view/share Explanation of Benefits (EOBs), view/share member ID cards, locate Preferred providers, and connect with our telehealth services.
Weight Loss Management Program	The Weight Management Program is designed to assist members in managing their weight. This program positively influences members' cardiometabolic health, including diet, activity, sleep, and stress management. All members and dependents aged 13 and older with a qualifying BMI are eligible for participation. Participants will receive a complimentary cellular-enabled weight scale, which will be delivered directly to them. Upon receipt, members should activate the scale by completing their first weigh-in and synchronizing it with their smart device. The program includes personalized health coaching, provider access, medication management, and on-demand support. Additionally, members have unlimited access to goal setting, action planning, and a dashboard for daily progress tracking via the mobile app. Member support is available 24/7/365. For further details, please visit www.fepblue.org/manage-your-health/managing-specific-conditions/weight.

Section 5(i) Services, Drugs, and Supplies Provided Overseas

If you travel or live outside the United States, Puerto Rico, and the U.S. Virgin Islands, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this Section, the same definitions, limitations, and exclusions also apply. Costs associated with repatriation from an international location back to the United States are not covered. See Section 10 for a definition of repatriation. See later in this section for the claims information we need to process overseas claims. We may request that you provide complete medical records from your provider to support your claim. If you plan to receive healthcare services in a country sanctioned by the Office of Foreign Assets Control (OFAC) of the U.S. Department of the Treasury, your claim must include documentation of a government exemption under OFAC authorizing care in that country.

Please note that the requirements to obtain precertification for inpatient care and prior approval for those services listed in Section 3 do not apply when you receive care overseas, with the exception of admissions to residential treatment centers. Prior approval is required for all non-emergent air ambulance transport services for overseas members (refer to Section 5(c) for more information). Protections offered under the NSA (see Section 4) do not apply to overseas claims. Please visit www.fepblue.org/overseas-coverage for additional information.

Overseas Assistance Center	We have a network of participating hospitals overseas that will file your claims for inpatient facility care for you – without an advance payment for the covered services you receive. We also have a network of professional providers who have agreed to accept a negotiated amount as payment in full for their services. The Overseas Assistance Center can help you locate a hospital or physician in our network near where you are staying. You may also view a list of our network providers on our website, www.fepblue.org. You will have to file a claim to us for reimbursement for professional services unless you or your provider contacts the Overseas Assistance Center in advance to arrange direct billing and payment to the provider. If you are overseas and need assistance locating providers (whether in or out of our network), contact the Overseas Assistance Center (provided by GeoBlue), by calling 804-673-1678. Members in the United States, Puerto Rico, or the U.S. Virgin Islands should call 800-699-4337 or email the Overseas Assistance Center at fepoverseas@geo-blue.com. GeoBlue also offers emergency evacuation services to the nearest facility equipped to adequately treat your condition, translation services, and conversion of foreign medical bills to U.S. currency. You may contact one of their multilingual operators 24 hours a day, 365 days a year.
Hospital and professional provider benefits	For **professional care** you receive overseas, we provide benefits at Preferred benefit levels using either our Overseas Fee Schedule, a customary percentage of the billed charge, or a provider-negotiated discount as our Plan allowance. **The requirement to use Preferred providers in order to receive benefits does not apply when you receive overseas care.** We also waive the $10 office visit copayments described in Sections 5(a) and 5(e) for care received overseas. When the Plan allowance is based on the Overseas Fee Schedule, you pay any difference between our payment and the amount billed, in addition to any applicable coinsurance and/or copayment amounts. When the Plan allowance is a provider-negotiated discount, you are only responsible for any applicable coinsurance and/or copayment. You must also pay any charges for noncovered services. For **inpatient facility care** you receive overseas, we provide benefits at the Preferred level **without member cost-share,** for admissions to a DoD facility, or when the Overseas Assistance Center (provided by GeoBlue) has arranged direct billing or acceptance of a guarantee of benefits with the facility. For all other inpatient facility care, you are responsible for any applicable coinsurance. For **outpatient facility care** you receive overseas, we provide benefits at the Preferred level after you pay the applicable copayment and/or coinsurance. We waive the facility and professional cost-shares associated with the emergency services provided in an emergency room as described in Section 5(d). For **transport services** you receive overseas, we provide benefits for transport services to the nearest hospital equipped to adequately treat your condition when the transport services are medically necessary. We provide benefits as described in Section 5(c) and Section 5(d). Benefits are not available for costs associated with transportation to other than the closest hospital equipped to treat your condition. You are responsible for any coinsurance and/or copayments. You must also pay any charges for noncovered services.

Pharmacy benefits

For **prescription drugs purchased at overseas pharmacies,** we provide benefits at Preferred benefit levels, using the billed charge as our Plan allowance. You pay the applicable copayment or coinsurance. The calendar year deductible is not applicable when purchasing drugs at pharmacies located overseas. See Section 5(f) for more information.

Overseas claims payment

Most overseas providers are under no obligation to file claims on behalf of our members. Follow the procedures listed below to file claims for covered services and drugs you receive outside the United States, Puerto Rico, and the U.S. Virgin Islands. **You may need to pay for the services at the time you receive them and then send a claim to us for reimbursement.** We will provide translation and currency conversion services for your overseas claims.

Filing overseas claims

To file a claim for covered hospital and professional provider services received outside the United States, Puerto Rico, and the U.S. Virgin Islands, send us a completed FEP Overseas Medical Claim Form, by mail, fax, or internet, along with itemized bills from the provider. In completing the claim form, indicate whether you want to be paid in U.S. dollars or in the currency reflected on the itemized bills, and if you want to receive payment by check or bank wire. Use the following information to mail, fax, or submit your claim electronically:

1. Mail: Federal Employee Program, Overseas Claims, P.O. Box 1568, Southeastern, PA 19399.
2. Fax: 001-610-293-3529. Be sure to first dial the AT&T Direct Access Code of the country from which you are faxing the claim.
3. Internet: Go to the MyBlue portal on www.fepblue.org. If you are already a registered MyBlue portal user, click on the "Health Tools" menu and, in the "Get Care" section, select "Submit Overseas Claim" and follow the instructions for submitting a medical claim. If you are not yet a registered user, go to MyBlue, click on the "Sign Up" link, and register to use the online filing process.

If you have questions about your medical claims, call us at 888-999-9862, using the AT&T Direct Access Code of the country from which you are calling, or email us through our website (www.fepblue.org) via the MyBlue portal. You may also write to us at: Mailroom Administrator, FEP Overseas Claims, P.O. Box 14112, Lexington, KY 40512-4112. You may obtain Overseas Medical Claim Forms from our website, by email at fepoverseas@geo-blue.com or from your Local Plan.

Filing a claim for pharmacy benefits

Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. To file a claim for covered drugs and supplies you purchase from pharmacies outside the United States, Puerto Rico, and the U.S. Virgin Islands, send us a completed FEP Retail Prescription Drug Overseas Claim Form, along with itemized pharmacy receipts or bills. The timely filing deadline for overseas pharmacy claims is limited to one year from the prescription fill date. Use the following information to mail, fax, or submit your claim electronically:

1. Mail: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.
2. Fax: 001-480-614-7674. Be sure to first dial the AT&T Direct Access Code of the country from which you are faxing the claim.
3. Internet: Go to the MyBlue portal on www.fepblue.org. If you are already a registered MyBlue portal user, click on the "Health Tools" menu and, in the "Get Care" section, select "Submit Overseas Claim" and follow the instructions for submitting a pharmacy claim. If you are not yet a registered user, go to MyBlue, click on the "Sign Up" link, and register to use the online filing process.

Send any written inquiries concerning drugs you purchase overseas to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057. You may obtain FEP Retail Prescription Drug Overseas Claim forms for your drug purchases by visiting our website, www.fepblue.org, by writing to the address above, or by calling us at 888-999-9862, using the AT&T Direct Access Code of the country from which you are calling.

While overseas, you may be able to order your prescription drugs through our Specialty Drug Pharmacy Program as long as all of the following conditions are met:

- Your address includes a U.S. ZIP code (such as with APO and FPO addresses and in U.S. territories),

- The prescribing physician is licensed in the United States, Puerto Rico, or the S. Virgin Islands, and has a National Provider Identifier (NPI), and
- Delivery of the prescription is permitted by law and is in accordance with the manufacturer's guidelines.

See Section 5(f) for more information about Preferred retail pharmacies with online ordering and delivery options, and the Specialty Drug Pharmacy Program.

Note: In most cases, temperature-sensitive drugs cannot be sent to APO/FPO addresses due to the special handling they require.

Note: We are unable to ship drugs, through our Specialty Drug Pharmacy Program, to overseas countries that have laws restricting the importation of prescription drugs from any other country. This is the case even when a valid APO or FPO address is available. If you are living in such a country, you may obtain your prescription drugs from a local overseas pharmacy and submit a claim to us for reimbursement by faxing it to 001-480-614-7674 or filing it via our website at www.fepblue.org/myblue.

Non-PSHB Benefits Available to Plan Members

These benefits are not part of the PSHB contract or premium, and you cannot file an PSHB dispute regarding these benefits. Fees paid for these services do not count toward PSHB deductibles or catastrophic protection out-of-pocket maximums. In addition, these services are not eligible for benefits under the PSHB Program. Please do not file a claim for these services. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact us at the phone number on the back of your ID card or visit our website at www.fepblue.org.

Blue365® – The Blue Cross and Blue Shield Service Benefit Plan presents Blue365, a program that provides easy access to premier health and wellness products and services to help members build a path to live a healthy life. With Blue365, members get access to over 90 handpicked discounts from leading brands and there is no limit to how many deals a member can redeem. Many deals are available and new ones are constantly being added, including:

- Fitness – Get the support you need to achieve your fitness goals with deals on wearable devices, apparel, home gym equipment, virtual workout classes and in-person gym access.
- Healthy Eyes and Ears – Between replacing hearing aids and correcting your vision, caring for your eyes and ears can get expensive quickly. Blue365 provides up to 60% off hearing aids, discounts on LASIK surgery and more.
- Home and Family – Your home and family can influence your mental, physical, emotional, and financial well-being. Blue365 offers discounts on premium vitamins and supplements, pet insurance, fertility services, products for new parents, financial offers, family health and more.
- Nutrition – Blue365 offers a variety of deals that help you eat right. Choose from meal kit subscriptions, chef-prepared entrees, weight management plans and more.
- Personal Care – A little self-care can go a long way toward improving your mental health. Blue365 offers exclusive discounts on skin care products, oral care products, tooth-whitening kits, mindfulness subscriptions and much more.
- Travel – Sometimes a vacation is all you need to escape stress and reset. Blue365 makes family getaways more affordable with discounted access to lodging, car rentals and vacation packages.

Each week, Blue365 members can receive great health and wellness deals via email. With Blue365, there is no paperwork to fill out. Just visit http://www.fepblue.org/blue365 and select Get Started to learn more about the various Blue365 vendors and discounts. The Blue Cross and Blue Shield Service Benefit Plan may receive payments from Blue365 vendors. The Plan does not recommend, endorse, warrant, or guarantee any specific Blue365 vendor or item. Vendors and the program are subject to change at any time.

Discount Drug Program – The Discount Drug Program is available to members not enrolled in the FEP Medicare Prescription Drug Program at no additional premium cost. It enables you to purchase, at discounted prices, certain prescription drugs that are not covered by the regular prescription drug benefit. Discounts vary by drug product, but average about 24%. The program permits you to obtain discounts on several drugs related to dental care, weight loss, hair removal and hair growth, and other miscellaneous health conditions. Please refer to www.fepblue.org/ddp for a full list of discounted drugs, including those that may be added to this list as they are approved by the U.S. Food and Drug Administration (U.S. FDA). To use the program, simply present a valid prescription and your ID card at a Preferred retail pharmacy. The pharmacist will ask you for payment in full at the negotiated discount rate. For more information, visit www.fepblue.org/ddp or call 800-624-5060.

Section 6. General Exclusions - Services, Drugs and Supplies We Do Not Cover

The exclusions in this Section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** For information on obtaining prior approval for specific services, such as transplants, see Section 3, *You need prior Plan approval for certain services*.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States.
- Services, drugs, or supplies billed by Preferred and Member facilities for inpatient care related to specific medical errors and hospital-acquired conditions known as Never Events.
- Experimental or investigational procedures, treatments, drugs, or devices (see Section 5(b) regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sexual dysfunction or sexual inadequacy (except for surgical placement of penile prostheses to treat erectile dysfunction).
- Travel expenses except as specifically provided for covered transplants performed in a Blue Distinction Center for Transplant (see Section 5(c)).
- Services, drugs, or supplies you receive from a provider or facility barred or suspended from the PSHB Program.
- Services, drugs, or supplies you receive in a country sanctioned by the Office of Foreign Assets Control (OFAC) of the U.S. Department of the Treasury, from a provider or facility not appropriately licensed to deliver care in that country.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services, drugs, or supplies you receive without charge while in active military service.
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B, doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare, or state premium taxes however applied. See Section 9.
- Prescriptions, services or supplies ordered, performed, or furnished by you or your immediate relatives or household members, such as spouse, parents, children, brothers, or sisters by blood, marriage, or adoption.
- Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs; oxygen; and physical, speech, and occupational therapy provided by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- Services, drugs, or supplies you receive from noncovered providers.
- Services, drugs, or supplies you receive for cosmetic purposes.
- Services or supplies for the treatment of obesity, weight reduction, or dietary control, that are not specifically listed as covered, such as but not limited to: specialized foods for weight loss, exercise equipment, or mobile weight loss apps.
- Services you receive from a provider that are outside the scope of the provider's licensure or certification.
- Any dental or oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically described in Section 5(g), *Dental Benefits*, and Section 5(b) under *Oral and Maxillofacial Surgery*.
- Dental and orthodontic services, except for treatment of accidental injury as described in Section 5(g), or oral surgery as described in Section 5(b).
- Orthodontic care for malposition of the bones of the jaw or for temporomandibular joint (TMJ) syndrome.

- Services of standby physicians.
- Self-care or self-help training.
- Custodial or long-term care (see *Definitions*).
- Personal comfort items such as beauty and barber services, radio, television, or phone.
- Furniture (other than medically necessary durable medical equipment) such as commercial beds, mattresses, chairs.
- Routine services, such as periodic physical examinations; screening examinations; immunizations; and services or tests not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care, except for those preventive services specifically covered under Preventive Care, Adult and Preventive Care, Child in Sections 5(a) and 5(c); and certain routine services associated with covered clinical trials (see Section 9).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA) and related services for any condition other than an autism spectrum disorder.
- Applied behavior analysis (ABA) services and related services performed as part of an educational program; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system.
- Topical Hyperbaric Oxygen Therapy (THBO).
- Research costs (costs related to conducting a clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes).
- Professional charges for after-hours care, except when associated with services provided in a physician's office.
- Incontinence products such as incontinence garments (including adult or infant diapers, briefs, and underwear), incontinence pads/liners, bed pads, or disposable washcloths.
- Alternative medicine services including, but not limited to, botanical medicine, aromatherapy, herbal/nutritional supplements, meditation techniques, relaxation techniques, movement therapies, and energy therapies.
- Services, drugs, or supplies related to medical marijuana.
- Hearing aids including bone-anchored hearing aids.
- Advanced care planning, except when provided as part of a covered hospice care treatment plan (see Section 5(c)).
- Membership or concierge service fees charged by a healthcare provider.
- Fees associated with copies, forwarding or mailing of records except as specifically described in Section 8.
- Services not specifically listed as covered.
- Services or supplies we are prohibited from covering under the Federal Law.
- Services related to surrogacy, including but not limited to, fertility services to get pregnant, delivery services, and/or routine nursery services for the infant upon delivery. Benefits for non-routine facility services for infants eligible for coverage will be provided once the infant has been added to the policy. See Family member coverage under PSHB Facts at the beginning of this brochure for more information about who is eligible for coverage.
- Services, drugs, or supplies that do not adhere to correct coding definitions, rules, regulations or guidelines.
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include “gender transition” services), other than mid-treatment exceptions, see Section 3. *How You Get Care*.
- Any benefits or services required solely for your employment are not covered by this plan.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs, or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs, or supplies requiring precertification or prior approval), including urgent care claims procedures.

How to claim benefits

To obtain claim forms or other claims filing advice, or answers to your questions about our benefits, contact us at the customer service phone number on the back of your ID card, or at our website at www.fepblue.org.

In most cases, physicians and facilities file HIPAA-compliant electronic claims for you. Just present your ID card when you receive services. In cases where a paper claim must be used, the provider must file on the CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Use a separate claim form for each family member. For long or continuing inpatient stays, or other long-term care, you should submit claims at least every 30 days. Bills and receipts should be itemized and show:

- Patient’s name, date of birth, address, phone number, and relationship to enrollee
- Patient’s Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

Note: Canceled checks, cash register receipts, balance due statements, or bills you prepare yourself are not acceptable substitutes for itemized bills.

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment, home nursing care, or physical, occupational, speech, or cognitive rehabilitation therapy, you must provide a written statement from the provider specifying the medical necessity for the service or supply and the length of time needed.
- Claims for dental care to repair accidental injury to sound natural teeth should include documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses.

Claims for prescription drugs and supplies that are not received from the Retail Pharmacy Program must include receipts that show the prescription number, name of drug or supply, prescribing provider’s name, date, and charge. (See Section 5(f) for information on how to obtain benefits from the Retail Pharmacy Program and the Specialty Drug Pharmacy Program.)

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

	If we need an extension because we have not received necessary information (e.g., medical records) from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Prescription drug claims	**Preferred Retail Pharmacies** – When you use Preferred retail pharmacies, show your ID card. To find a Preferred retail pharmacy, visit www.fepblue.org/provider. If you use a Preferred retail pharmacy that offers online ordering, have your ID card ready to complete your purchase. Preferred retail pharmacies file your claims for you. We reimburse them for your covered drugs and supplies. You pay the applicable coinsurance or copayment. Note: Even if you use Preferred retail pharmacies, you will have to file a paper claim form to obtain reimbursement if: • You do not have a valid ID card; • You do not use your valid ID card at the time of purchase; or • You did not obtain prior approval when required (see Section 3). See the following paragraphs for claim filing instructions. **Non-Preferred Retail Pharmacies:** There are **no benefits** for drugs or supplies purchased at Non-preferred retail pharmacies. Note: For overseas pharmacy, see Section 5(i). **Specialty Drug Pharmacy Program** If your physician prescribes a specialty drug that appears on our FEP Blue Focus Specialty Drug List, your physician may order the initial prescription by calling our Specialty Drug Pharmacy Program at 888-346-3731, TTY: 711, or you may send your prescription to: BCBS FEP Specialty Drug Pharmacy Program, CVS Specialty, 9310 Southpark Center Loop, Orlando, FL 32819. You will be billed later for the copayment. The Specialty Drug Pharmacy Program will work with you to arrange a delivery time and location that is most convenient for you. To order refills, call the same phone number to arrange your delivery. You may either charge your copayment to your credit card or have it billed to you later. Note: For the most up-to-date listing of covered specialty drugs, call the Specialty Drug Pharmacy Program at 888-346-3731, TTY: 711, or visit our website, www.fepblue.org.
Records	Keep a separate record of the medical expenses of each covered family member, because deductibles and benefit maximums (such as those for outpatient physical therapy) apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.
Deadline for filing your claim	Send us your claim and appropriate documentation as soon as possible. You must submit the claim by December 31 of the following year after you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information (e.g., diagnosis codes, dates of service, etc.), you must resubmit it within 90 days, or before the timely filing period expires, whichever is later. Note: Timely filing for overseas pharmacy claims is limited to one year after the prescription fill date. Note: Once we pay benefits, there is a five-year limitation on the reissuance of uncashed checks.
Overseas claims	Please refer to the claims filing information in Section 5(i).
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to **process** your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this Section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10% of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo, and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your explanation of benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the procedure or treatment code and its corresponding meaning.

Section 8. The Disputed Claims Process

Please follow this Postal Service Health Benefits Program disputed claims process **if you disagree with our decision on your post-service claim** (a claim where services, drugs, or supplies have already been provided). In Section 3, *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, drugs, or supplies that must have precertification (such as inpatient hospital admissions) or prior approval from the Plan.

You may appeal directly to the U.S. Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7, and 8 of this brochure, please call your Plan's customer service representative at the phone number found on your identification card, plan brochure, or plan website (www.fepblue.org). If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) and you disagree with our **pre-service or post-service** decision about your prescription drug benefits, please, follow Medicare's appeals process outlined in Section 8(a), *Medicare PDP EGWP Disputed Claims Process*.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please call us at the customer service phone number on the back of your ID card, or send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program, or the Specialty Drug Pharmacy Program).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program or the Specialty Drug Pharmacy Program); and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in Step 3.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Postal Service Insurance Operations (PSIO), 1900 E Street NW, Room 3443, Washington, DC 20415.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim;
- Your daytime phone number and the best time to call, and;
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies, or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: If you have a serious or life-threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at the customer service phone number on the back of your ID card. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's PSIO at 202-936-0002 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about Plan eligibility issues. For example, we do not determine whether you or a family member is covered under this Plan. You must raise eligibility issues with your agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant, or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D PDP EGWP you may appeal an adverse pre-service or post-service determination through Medicare's appeals process. See Section 8 (a).

Section 8(a). Medicare PDP EGWP Disputed Claims Process

When a claim is denied in whole or in part, you may appeal the denial. To learn more about your rights and how to file a dispute, please follow the instructions found at www.fepblue.org/medicarerx/resources.

Request for Reconsideration of Medicare Prescription Drug Denial

Because your Medicare drug plan has upheld its initial decision to deny coverage of, or payment for, a prescription drug you requested, or upheld its decision regarding an at-risk determination made under its drug management program, you have the right to ask for an independent review of the plan's decision. You need the form to request an independent review of your drug plan's decision. You have 60 days from the date of the plan's Redetermination Notice to ask for an independent review. Please complete the form and mail or fax it as instructed. They will review your request and provide you with a decision and further instructions on next steps if you still disagree with the outcome. For additional assistance, please call us at 888-338-7737, TTY: 711.

Section 9. Coordinating Benefits With Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other group health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For example:

- If you are covered under our Plan as a dependent, any group health insurance you have from your employer will pay primary and we will pay secondary.
- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of healthcare expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payor and we are the secondary payor.

For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.fepblue.org/coordinationofbenefits.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payor's benefits payment and 100% of the Plan allowance, subject to our applicable deductible and coinsurance or copayment amounts, except when Medicare is the primary payor (see Section 9). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan's copayments), subject to our deductible and coinsurance or copayment amounts.

In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Note: Any visit limitations that apply to your care under this Plan are still in effect when we are the secondary payor.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

Please see Section 4, *Your Costs for Covered Services*, for more information about how we pay claims.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended PSHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these programs, eliminating your PSHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended PSHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these state programs, eliminating your PSHB premium. For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we paid benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we paid benefits for that injury, you must agree to the following provisions:

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you, your representatives, and/or healthcare providers on your behalf. For purposes of this provision, "you" includes your covered dependents, and "your representatives" include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.

- We will not reduce our share of any recovery unless, in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.

If you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you sign a reimbursement agreement and/or assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

Our rights of recovery and subrogation as described in this Section may be enforced, at the Carrier's option, by the Carrier, by any of the Local Plans that administered the benefits paid in connection with the injury or illness at issue, or by any combination of these entities. Please be aware that more than one Local Plan may have a right of recovery/subrogation for claims arising from a single incident (e.g., a car accident resulting in claims paid by multiple Local Plans) and that the resolution by one Local Plan of its lien will not eliminate another Local Plan's right of recovery.

Among the other situations covered by this provision, the circumstances in which we may subrogate or assert a right of recovery shall also include:

- When a third party injures you, for example, in an automobile accident or through medical malpractice;
- When you are injured on premises owned by a third party; or
- When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
  - No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to this Plan
  - Uninsured and underinsured motorist coverage
  - Workers' Compensation benefits
  - Medical reimbursement coverage

Contact us if you need more information about subrogation.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some PSHB plans already cover some dental and vision services. When you are covered by more than one dental/vision plan, coverage provided under your PSHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.gov or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your PSHB plan so that your plans can coordinate benefits. Providing your PSHB information may reduce your out-of-pocket cost.

Clinical trials

If you are a participant in an approved clinical trial, this health Plan will provide benefits for covered related care as follows, if it is not provided by the clinical trial:

- **Routine care costs** – costs for medically necessary services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. We provide benefits for these types of costs at the benefit levels described in Section 5 (*Benefits*) when the services are covered under the Plan and we determine that they are medically necessary.
- **Extra care costs** – costs of covered services related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan covers extra care costs related to taking part in an approved clinical trial for a covered stem cell transplant such as additional tests that a patient may need as part of the clinical trial protocol, but not as part of the patient's routine care. For more information about approved clinical trials for covered stem cell transplants, see Section 5(b). **Extra care costs related to taking part in any other type of clinical trial are not covered**. We encourage you to contact us at the customer service phone number on the back of your ID card to discuss specific services if you participate in a clinical trial.
- **Research costs** – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (U.S. FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

When you have Medicare

For more detailed information on "What is Medicare?" and "When do I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

Important Note: Subject to limited exceptions, Postal Service annuitants entitled to Medicare Part A and their eligible family members who are entitled to Medicare Part A are required to enroll in Medicare Part B to maintain eligibility for the PSHB Program in retirement.

If you are required to enroll in Medicare Part B and fail to do so at your first opportunity, you may be disenrolled (annuitants) and/or your family members removed from coverage.

For more information on these requirements, please contact the number on the back of your ID card.

The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see Section 3 for exceptions).

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When the Original Medicare Plan is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for the covered charges. To find out if you need to do something to file your claims, call us at the customer service phone number on the back of your ID card or visit our website at www.fepblue.org.

You will pay what Medicare says you owe for services subject to the calendar year deductible up to $750 per person under a self only or self + one contract, or a combined $1,500 under a self and family contract. Once you have satisfied the deductible, we will provide benefits as follows:

When Medicare Part A is primary –

- Once you have exhausted your Medicare Part A benefits, you must then pay the coinsurance once the calendar year deductible has been satisfied for the inpatient admission.
  Note: Precertification is required.

Note: We do not waive benefit limitations, such as the 10-visit limit for home skilled nursing visits. In addition, we do not waive any coinsurance or copayments for prescription drugs.

You can find more information about how our Plan coordinates benefits with Medicare in our *Medicare and You Guide for Federal Employees* available online at www.fepblue.org.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Private contract with your physician**

If you are enrolled in Medicare Part B, a physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), TTY: 711, or at www.medicare.gov. If you enroll in a Medicare Advantage plan, the following options are available to you.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's non-PSHB Medicare Advantage plan and also remain enrolled in our PSHB Plan. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

We provide benefits for care received from Preferred providers when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. Please remember that you must receive care from Preferred providers in order to receive benefits. See Section 3 for the exceptions to this requirement.

Suspended PSHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your PSHB coverage to enroll in a Medicare Advantage plan, eliminating your PSHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you (as an active employee eligible for Medicare Part D or their covered Medicare Part D-eligible family member) enroll in any open market Medicare Part D plan and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by that Medicare Part D plan and consider them for payment under the PSHB plan.

Note: If you are a Postal Service annuitant or their covered Medicare-eligible family member enrolled in our Medicare Part D PDP EGWP, this does not apply to you because you may not be enrolled in more than one Medicare Part D plan at the same time. If you opt out of or disenroll from our PDP EGWP, you do not have our PSHB Program prescription drug coverage and we are not a secondary payor for prescription drug benefits.

- **Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP)**

If you are enrolled in Medicare Part A and/or Part B, and are not enrolled in a Medicare Advantage Prescription Drug Plan (MAPD), you will be automatically enrolled into our Medicare PDP EGWP. Our PDP EGWP is a prescription drug benefit for Postal Service annuitants and their covered Medicare-eligible family members. This allows you to receive benefits that will never be less than the standard prescription drug coverage that is available to members with non-PDP EGWP prescription drug coverage. But more often you will receive benefits that are better than members with standard non-PDP EGWP prescription drug coverage. **Note: You have the choice to opt out of or disenroll from our PDP EGWP at any time and may obtain prescription drug coverage outside of the PSHB Program.**

When you are enrolled in our Medicare PDP EGWP for your prescription drug benefits, you continue to have our medical coverage.

Members with higher incomes may have a separate premium payment for their Medicare Part D Prescription Drug Plan (PDP) benefit. Please refer to the part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

For people with limited income and resources, Extra Help is a Medicare program to help with Medicare prescription drug plan costs. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, TTY 800-325-0778. You may also contact the number on the back of your ID card.

The PDP EGWP opt out process:

If you were automatically group enrolled into our PDP EGWP and choose to opt out, you may have to wait to re-enroll during Open Season or for a QLE. Contact us at 888.338.7737 for assistance.

The PDP EGWP disenrollment process:

When you are enrolled in our PDP EGWP, you may choose to disenroll at any time. For information about how to disenroll, visit us at www.fepblue.org/medicarerx and look for the disenrollment form under the auto enrollment process and follow the instructions provided.

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll when and if you are eligible. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at 888.338.7737.

- **Medicare prescription drug coverage (Part B)**

This health plan **does not** coordinate its prescription drug benefits with Medicare Part B.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have PSHB coverage on your own as an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have PSHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Postal Service and your position is excluded from the PSHB (your employing office will know if this is the case) and you are not covered under PSHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Postal Service and your position is not excluded from the PSHB (your employing office will know if this is the case) and...		
• You have PSHB coverage on your own or through your spouse who is also an active employee		✓
• You have PSHB coverage through your spouse who is an annuitant	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a Postal employee receiving Workers' Compensation		✓ *
8) Are a Postal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30-month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30-month coordination period)**		✓
• Medicare based on ESRD **(after the 30-month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have PSHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

When you are age 65 or over and do not have Medicare

Under the FEHB law, which includes the PSHB Program, we must limit our payments for **inpatient hospital care** and **physician care** to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the PSHB benefit from these payment limits. Outpatient hospital care and non-physician-based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you:

- are age 65 or over; and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant, **or** as a family member of an annuitant; and
- are not employed in a position that gives PSHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care:

- The law requires us to base our payment on an amount - the "equivalent Medicare amount" - set by Medicare's rules for what Medicare would pay, not on the actual charge.
- You are responsible for your applicable deductibles, coinsurance, or copayments under this Plan.
- You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you.
- The law prohibits a hospital from collecting more than the "equivalent Medicare amount".

And, for your physician care, the law requires us to base our payment and your coinsurance or copayment on:

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician: Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network
Then you are responsible for: your deductibles, coinsurance, and copayments.

If your physician: Participates with Medicare and is **not** in our Preferred network
Then you are responsible for: all charges.

If your physician: Does not participate with Medicare and is in our Preferred network
Then you are responsible for: your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare-approved amount.

Note: In many cases, your payment will be less because of our Preferred agreements. Contact your Local Plan for information about what your specific Preferred provider can collect from you.

If your physician: Does not participate with Medicare and is **not** a member in our Preferred network
Then you are responsible for: all charges.

If your physician: Opts-out of Medicare via private contract and is in our Preferred network
Then you are responsible for: your deductibles, coinsurance, copayments, and any balance your physician charges.

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare-approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

Physicians Who Opt-Out of Medicare	A physician may have opted-out of Medicare and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a Non-participating doctor, and we recommend you ask your physician if they have opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare-approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.
When you have the Original Medicare Plan (Part A, Part B, or both)	We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to a facility provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare. We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the MRA statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility. If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim. You must see Preferred providers in order to receive benefits. See Section 3 for the exceptions to this requirement. • If your physician **accepts** Medicare assignment, you pay nothing for covered charges. • If your physician **does not accept** Medicare assignment, you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment. It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) form that you receive from Medicare will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Please review the following examples illustrating your cost-share liabilities when Medicare is your primary payor **and** your provider is in our network and participates with Medicare compared to what you pay without Medicare. Please do not rely on this chart alone but read all information in this section of the brochure. You can find more information about how our Plan coordinates with Medicare in our *Medicare and You Guide for Federal Employees* available online at www.fepblue.org.

Benefit Description: Deductible
FEP Blue Focus You Pay **Without** Medicare Parts A & B: $750-Self, $1,500-Family
FEP Blue Focus You Pay **With** Medicare Parts A & B: $750-Self, $1,500-Family

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
FEP Blue Focus You Pay **Without** Medicare Parts A & B: $10,000-Self, $20,000-Family
FEP Blue Focus You Pay **With** Medicare Parts A & B: $10,000-Self, $20,000-Family

Benefit Description: Part B Premium Reimbursement
FEP Blue Focus You Pay **Without** Medicare Parts A & B: N/A
FEP Blue Focus You Pay **With** Medicare Parts A & B: N/A

Benefit Description: Primary Care Provider
FEP Blue Focus You Pay **Without** Medicare Parts A & B: $10 or 30%
FEP Blue Focus You Pay **With** Medicare Parts A & B: $0.00

Benefit Description: Specialist
FEP Blue Focus You Pay **Without** Medicare Parts A & B: $10 or 30%
FEP Blue Focus You Pay **With** Medicare Parts A & B: $0.00

Benefit Description: Inpatient Hospital
FEP Blue Focus You Pay **Without** Medicare Parts A & B: 30%
FEP Blue Focus You Pay **With** Medicare Parts A & B: $0.00

Benefit Description: Outpatient Hospital
FEP Blue Focus You Pay **Without** Medicare Parts A & B: 30%
FEP Blue Focus You Pay **With** Medicare Parts A & B: $0.00

Benefit Description: Incentives Offered
FEP Blue Focus You Pay **Without** Medicare Parts A & B: N/A
FEP Blue Focus You Pay **With** Medicare Parts A & B: N/A

Section 10. Definitions of Terms We Use in This Brochure

Accidental injury	An injury caused by an external force or element such as a blow or fall that requires immediate medical attention, including animal bites and poisonings. Note: Injuries to the teeth while eating are **not** considered accidental injuries. Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth.
Admission	The period from entry (admission) as an inpatient into a hospital (or other covered facility) until discharge. In counting days of inpatient care, the date of entry and the date of discharge count as the same day.
Advanced care planning	Receiving information on the types of life-sustaining treatments that are available, completing advance directives and other standard forms, and/or if you are diagnosed with a terminal illness and making decisions about the care you would want to receive if you become unable to speak for yourself.
Agents	Medications and other substances or products given by mouth, inhaled, placed on you, or injected in you to diagnose, evaluate, and/or treat your condition. Agents include medications and other substances or products necessary to perform tests such as bone scans, cardiac stress tests, CT scans, MRIs, PET scans, lung scans, and X-rays, as well as those injected into the joint.
Assignment	An authorization by the enrollee or spouse for us to issue payment of benefits directly to the provider. We reserve the right to pay you, the enrollee, directly for all covered services. Benefits provided under the contract are not assignable by the member to any person without express written approval of the Carrier, and in the absence of such approval, any such assignment shall be void. Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment. OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void. Please visit www.fepblue.org to obtain a valid authorization form.
Assisted reproductive technology (ART)	Reproductive services, testing, and treatments involving manipulation of eggs, sperm, and embryos to achieve pregnancy. In general, assisted reproductive technology (ART) procedures are used to retrieve eggs from an ovulating individual, combine them with sperm in the laboratory, and then implant the embryos or donate them to an individual capable of pregnancy.
Biologic drug	A complex drug or product that is manufactured in a living organism, or its components, that is used as a diagnostic, preventive or therapeutic agent.
Biosimilar drug	A U.S. FDA-approved biologic drug, which is considered highly similar to an original brand-name biologic drug, with no clinically meaningful differences from the original biologic drug in terms of safety, purity and potency.
Biosimilar, interchangeable drug	A U.S. FDA-approved biosimilar drug that may be automatically substituted for the original brand-name biologic drug.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Carrier	The Blue Cross and Blue Shield Association, on behalf of the local Blue Cross and Blue Shield Plans.

Clinical trials An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally funded; conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (U.S. FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

Coinsurance See Section 4.

Concurrent care claims A claim for continuing care or an ongoing course of treatment that is subject to prior approval. See Section 3.

Congenital anomaly A condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities; cleft lip; cleft palate; birth marks; ambiguous genitalia; and webbed fingers and toes. Note: Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth.

Copayment See Section 4.

Core benefits Benefits under FEP Blue Focus that have no or a low copayment. CORE benefits are not subject to deductible or coinsurance. The benefits are most commonly used to receive general care and to maintain your overall health and well-being, but also include coverage for spinal manipulations, acupuncture and accidental injury.

Cosmetic surgery Any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth) (See Section 5(d) for Accidental Injury benefits.)

Cost-sharing See Section 4.

Covered services Services we provide benefits for, as described in this brochure.

Custodial or long-term care Facility-based care that does not require access to the full spectrum of services performed by licensed healthcare professionals that is available 24 hours a day in acute inpatient hospital settings to avoid imminent, serious, medical or psychiatric consequences. By “facility-based,” we mean services provided in a hospital, long-term care facility, extended care facility, skilled nursing facility, residential treatment center, school, halfway house, group home, or any other facility providing skilled or unskilled treatment or services to individuals whose conditions have been stabilized. Custodial or long-term care can also be provided in the patient’s home, however defined.

Custodial or long-term care may include services that a person not medically skilled could perform safely and reasonably with minimal training, or that mainly assist the patient with daily living activities, such as:

1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing;
2. Homemaking, such as preparing meals or special diets;
3. Moving the patient;
4. Acting as companion or sitter;
5. Supervising medication that can usually be self-administered; or
6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature, and respiration; or administration and monitoring of feeding systems.

We do not provide benefits for custodial or long-term care, regardless of who recommends the care or where it is provided. The Carrier, its medical staff, and/or an independent medical review determine which services are custodial or long-term care.

Durable medical equipment Equipment and supplies that are:

1. Prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Medically necessary;
3. Primarily and customarily used only for a medical purpose;
4. Generally useful only to a person with an illness or injury;
5. Designed for prolonged use; and
6. Used to serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services

Experimental or investigational shall mean:

1. A drug, device, or biological product that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (U.S. FDA); and approval for marketing has not been given at the time it is furnished; or
2. Reliable evidence shows that the healthcare service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
3. Reliable evidence shows that the consensus of opinion among experts regarding the healthcare service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
4. Reliable evidence shows that the healthcare service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) does not improve net health outcome, is not as beneficial as any established alternatives, or does not produce improvement outside of the research setting.

Reliable evidence shall mean only evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations, such as:

1. Published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.

Generic alternative

A generic alternative is a U.S. FDA-approved generic drug in the same class or group of drugs as your brand-name drug. The therapeutic effect and safety profile of a generic alternative are similar to your brand-name drug, but it has a different active ingredient.

Generic equivalent

A generic equivalent is a drug whose active ingredients are identical in chemical composition to those of its brand-name counterpart. Inactive ingredients may not be the same. A generic drug is considered “equivalent,” if it has been approved by the U.S. FDA as interchangeable with your brand-name drug.

Group health coverage

Healthcare coverage that you are eligible for based on your employment, or your membership in or connection with a particular organization or group, that provides payment for medical services or supplies, or that pays a specific amount of more than $200 per day for hospitalization (including extension of any of these benefits through COBRA).

Healthcare professional

A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law. See Section 3 for information about how we determine which healthcare professionals are covered under this Plan.

Health Risk Assessment (HRA)

A questionnaire designed to assess your overall health and identify potential health risks. Service Benefit Plan members have access to the Blue Cross and Blue Shield HRA (called the "Blue Health Assessment") which is supported by a computerized program that analyzes your health and lifestyle information and provides you with a personal and confidential health action plan that is protected by HIPAA privacy and security provisions. Results from the Blue Health Assessment include practical suggestions for making healthy changes and important health information you may want to discuss with your healthcare provider. For more information, visit our website, www.fepblue.org.

Iatrogenic infertility

Infertility caused by a medically necessary medical or surgical intervention used to treat a condition or disease.

Infertility

A disease or condition characterized by the failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse, or a person's inability to reproduce either as a single individual or with their partner without medical intervention, or a licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, and/or diagnostic testing.

Inpatient

You are an inpatient when you are formally admitted to a hospital with a doctor's order.

Note: Inpatient care requires precertification. For some services and procedures prior approval must also be obtained. See Section 3.

Intensive outpatient care

A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions designed to assist members with mental health and/or substance use disorders. It is an intermediate setting between traditional outpatient therapy and partial hospitalization, typically performed in an outpatient facility or outpatient professional office setting. Program sessions may occur more than one day per week. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Local Plan

A Blue Cross and/or Blue Shield Plan that serves a specific geographic area.

Medical foods

The term medical food, as defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b)(3)) is "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

Medical necessity

All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine that the criteria for medical necessity are met. Medical necessity shall mean healthcare services that a physician, hospital, or other covered professional or facility provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice in the United States; and
2. Clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, disease, or its symptoms; and
3. Not primarily for the convenience of the patient, physician, or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury, or disease, or its symptoms; and
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, able to be provided safely only in the inpatient setting.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations.

The fact that one of our covered physicians, hospitals, or other professional or facility providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.

Medicare Part A

Part A helps cover inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

Medicare Part B

Part B covers medically necessary services like doctors' services and tests, outpatient care, home health services, durable medical equipment, and other medical services.

Medicare Part C

Part C is a Medicare Advantage plan that combines the coverage of Medicare Part A and Part B. Part C typically also covers additional benefits like, dental, vision, and hearing services. Some Part C plans also include Medicare Part D coverage.

Medicare Part D

Medicare Part D plans provide coverage for prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D plans. Part D can be offered as a standalone Prescription Drug plan (PDP) or as part of a Medicare Advantage Prescription Drug plan (MAPD).

Medicare Part D EGWP

A Medicare Part D Employer Group Waiver Plan (EGWP) is a type of Medicare prescription drug plan that can be offered to employees and retirees of certain companies, unions, or government agencies, which allows for flexibility and enhanced coverage of traditional Medicare pharmacy benefits. Examples of Medicare Part D EGWPs are Medicare Advantage Prescription Drug (MAPD) plan EGWPs that include both health and drug benefits, as well as Prescription Drug Plan (PDP) EGWPs, which only cover the prescription drug benefit.

Minor acute conditions

Under the telehealth benefit, you have on-demand access to care for common, non-emergent conditions. Examples of common conditions include sinus problems, rashes, allergies, cold and flu symptoms, etc.

Never Events

Errors in medical care that are clearly identifiable, preventable, and serious in their consequences, such as surgery performed on a wrong body part, and specific conditions that are acquired during your hospital stay, such as severe bed sores.

Non-Core benefits

Medical services covered under FEP Blue Focus NON-CORE benefits are subject to the deductible and coinsurance. These services include hospitalization, surgery, transplant coverage, etc.

Observation services

Although you may stay overnight in a hospital room and receive meals and other hospital services, some services and overnight stays – including **"observation services"** – are actually outpatient care. Observation care includes care provided to members who require significant treatment or monitoring before a physician can decide whether to admit them on an inpatient basis, or discharge them to home. The provider may need 6 to 24 hours or more to make that decision.

If you are in the hospital more than a few hours, always ask your physician or the hospital staff if your stay is considered inpatient or outpatient.

Outpatient

You are an outpatient if you are getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor has not written an order to admit you to a hospital as an inpatient. In these cases, you are an outpatient even if you are admitted to a room in the hospital for observation and spend the night at the hospital.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your cost-share for covered services. Fee-for-service plans determine their allowances in different ways. Call the number on the back of your ID card for help in obtaining the Plan allowance. If the amount your provider bills for covered services is less than our allowance, we base your share (coinsurance, deductible, and/or copayments), on the billed amount. We determine our allowance as follows:

- **PPO providers** (Preferred provider) – Our allowance (which we may refer to as the "PPA" for "Preferred Provider Allowance") is the negotiated amount that Preferred providers (hospitals and other facilities, physicians, and other covered healthcare professionals that contract with each local Blue Cross and Blue Shield Plan, and retail pharmacies that contract with CVS Caremark) have agreed to accept as payment in full, when we pay primary benefits.

  Our PPO allowance includes any known discounts that can be accurately calculated at the time your claim is processed. For PPO facilities, we sometimes refer to our allowance as the "Preferred rate." The Preferred rate may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost-sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf.
- **Participating providers** (Non-preferred provider) – Our allowance (which we may refer to as the "PAR" for "Participating Provider Allowance"), applied when a service is paid due to an exception listed on page 19, is the negotiated amount that these providers (hospitals and other facilities, physicians, and other covered healthcare professionals that contract with some local Blue Cross and Blue Shield Plans) have agreed to accept as payment in full, when we pay primary benefits. For facilities, we sometimes refer to our allowance as the "Member rate." The Member rate includes any known discounts that can be accurately calculated at the time your claim is processed, and may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost-sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf.
- **Non-participating providers** (Non-preferred provider) – We have no agreements with these providers to limit what they can bill you for their This means that using Non-participating providers for exceptions listed in Section 3 could result in your having to pay significantly greater amounts for the services you receive. We determine our allowance as follows:
  - For inpatient services at hospitals, and other facilities that do not contract with your local Blue Cross and Blue Shield Plan ("Non-member facilities"), our allowance is based on the Local Plan Allowance. The Local Plan Allowance varies by region and is determined by each Plan. If you would like additional information, or to obtain the current allowed amount, please call the customer service phone number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for emergency deliveries, our allowance is the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations;
  - For outpatient services resulting from a medical emergency or accidental injury that are billed by Non-member facilities, our allowance is the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations (minus any amount for noncovered services);
  - For physicians and other covered healthcare professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of (1) the Medicare participating fee schedule amount or the Medicare Part B Drug Average Sale Price (ASP) for the service, drug, or supply in the geographic area in which it was performed or obtained or (2) 100% of the Local Plan In the absence of a Medicare participating fee schedule amount or ASP for any service, drug, or supply, our allowance is the Local Plan Allowance. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the "NPA" (for "Non-participating Provider Allowance");

- For non-emergency medical services performed in Preferred hospitals provided by physicians and other covered healthcare professionals identified under the NSA (see Section 4) that do not contract with your local Blue Cross and Blue Shield Plan and cannot balance bill you under this regulation, our allowance is equal to the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations;
- For emergency medical and mental health and substance use disorders services performed in the emergency department of a hospital provided by physicians and other covered healthcare professionals, and air ambulance providers that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations;
- For services you receive outside of the United States, Puerto Rico, and the U.S. Virgin Islands from providers that do not contract with us or with the Overseas Assistance Center (provided by GeoBlue), we use our Overseas Fee Schedule to determine our allowance. Our fee schedule is based on a percentage of the amounts we allow for Non-participating providers in the Washington, D.C., area, or a customary percent of billed charge, whichever is higher.

Important notice about using Non-participating providers!

(These providers are only covered on an exception basis)

Note: **Using Non-participating or Non-member providers (Non-preferred) when an exception is granted (see Section 3) could result in your having to pay significantly greater amounts for the services you receive.** Non-participating and Non-member providers are under no obligation to accept our allowance as payment in full. If you use Non-participating and/or Non-member providers, you will be responsible for any difference between our payment and the billed amount (except in certain circumstances involving covered Non-participating professional care – see below). In addition, you will be responsible for any applicable deductible, coinsurance, or copayment. You can reduce your out-of-pocket expenses by using Preferred providers whenever possible. To locate a Preferred provider, visit www.fepblue.org/provider to use our National Doctor & Hospital Finder, or call us at the customer service phone number on the back of your ID card. We encourage you to always use Preferred providers for your care.

Note: For **certain** covered services from Non-participating professional providers, your responsibility for the difference between the Non-participating Provider Allowance (NPA) and the billed amount may be limited. See Section 4, *Important Notice About Surprise Billing*.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Precertification

The requirement to contact the local Blue Cross and Blue Shield Plan serving the area where the services will be performed before being admitted for inpatient care. Please refer to the precertification information listed in Section 3.

Preferred provider organization (PPO) arrangement

An arrangement between Local Plans and physicians, hospitals, healthcare institutions, and other covered healthcare professionals (or for retail pharmacies, between pharmacies and CVS Caremark) to provide services to you at a reduced cost. The PPO provides you with an opportunity to reduce your out-of-pocket expenses for care by selecting your facilities and providers from among a specific group. PPO providers are available in most locations; using them whenever possible helps contain healthcare costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Local Plan's (or for pharmacies, CVS Caremark's) responsibility. We cannot guarantee that any specific provider will continue to participate in these PPO arrangements.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Preventive care, adult — Adult preventive care includes the following services: preventive office visits and exams (including health screening services: to measure height, weight, blood pressure, heart rate, and Body Mass Index (BMI)); general health panel; basic or comprehensive metabolic panel; fasting lipoprotein profile; urinalysis; CBC; screening for diabetes mellitus, hepatitis B and hepatitis C, and latent tuberculosis; screening for alcohol/substance use disorders; counseling on reducing health risks; screening for depression; screening for chlamydia, syphilis, gonorrhea, HPV, and HIV; screening for intimate partner violence for women of reproductive age; administration and interpretation of a Health Risk Assessment questionnaire; cancer screenings including low-dose CT screening for lung cancer; screening for abdominal aortic aneurysms; and osteoporosis screening, as specifically stated in this brochure; and immunizations as licensed by the U.S. Food and Drug Administration (U.S. FDA). Note: Anesthesia services and pathology services associated with preventive colorectal surgical screenings are also paid as preventive care.

Prior approval — Written assurance that benefits will be provided by:

1. The Local Plan where the services will be performed; or
2. The Retail Pharmacy Program or the Specialty Drug Pharmacy Program.

For more information, see the benefit descriptions in Section 5 and *Other services* in Section 3, under *You need prior Plan approval for certain services*.

Reimbursement — A Carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the Carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the Carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Repatriation — The act of returning to the country of birth, citizenship or origin.

Routine services — Services that are not related to a specific illness, injury, set of symptoms, or maternity care (other than those routine costs associated with a clinical trial as defined in this section).

Screening service — An examination or test of an individual with no signs or symptoms of the specific disease for which the examination or test is being done, to identify the potential for that disease and prevent its occurrence.

Sound natural tooth — A tooth that is whole or properly restored (restoration with amalgams or resin-based composite fillings only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

Specialty drugs — Pharmaceutical products that are included on the FEP Blue Focus Specialty Drug List that are typically high in cost and have one or more of the following characteristics:

- Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology
- Complex drug therapy for a chronic or complex condition, and/or high potential for drug adverse effects
- Specialized patient training on the administration of the drug (including supplies and devices needed for administration) and coordination of care is required prior to drug therapy initiation and/ or during therapy
- Unique patient compliance and safety monitoring requirements
- Unique requirements for handling, shipping, and storage

Subrogation — A Carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from the Carrier's health benefits plan.

Telehealth dermatology	Under the telehealth benefit, dermatologic conditions seen and treated include but are not limited to acne, dermatitis, eczema, psoriasis, rosacea, seborrheic keratosis, fungal infections, scabies, suspicious moles, and warts. Members capture important digital images, combine those with the comprehensive questionnaire responses, and send those to the dermatology network without requiring a phone or video interaction.
Telehealth services	Non-emergency services provided by phone or secure online video/messaging for minor acute conditions, dermatology care, behavioral health and substance use disorder counseling, and nutritional counseling. Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 711, toll free to access this benefit. After your telehealth visit, please follow up with your primary care provider or specialist.
Telemedicine services	Services provided by phone or secure online video/messaging for evaluation and management services. This does not include the use of fax machine or email; costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies; or fees for asynchronous services —medical information stored and forwarded to be reviewed at a later time by a physician or healthcare practitioner at a distant site without the patient being present. Providers must perform covered services acting within the scope of their license or certification under applicable state law. Please note, your healthcare provider must know when and where they can treat you. You, in turn, are responsible for accurately identifying to your provider where you are physically located for the service you received through telehealth (telemedicine) technologies. You and your physician must be in the same U.S. State, Territory, or foreign country as required by applicable legislation.
Transplant period	A defined number of consecutive days associated with a covered organ/tissue transplant procedure.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our customer service department using the phone number on the back of your ID card and tell us the claim is urgent. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We/Our	"Us," "we," and "our" refer to the Blue Cross and Blue Shield Service Benefit Plan, and the local Blue Cross and Blue Shield Plans that administer it.
Wrap benefits	FEP Blue Focus WRAP benefits are not subject to the deductible and have either a different copayment than the copayment applied under the CORE benefits (i.e., $25 for the combined 25 visits for physical therapy) or a different coinsurance level than the coinsurance applied under the NON-CORE benefits (i.e., brand-name preferred drugs are paid at 40% of the Plan allowance up to $350 per 30-day prescription).
You/Your	"You" and "your" refer to the enrollee (the contract holder eligible for enrollment and coverage under the Postal Service Health Benefits Program and enrolled in the Plan) and each covered family member.

Index

Do not rely only on this page; it is for your convenience and may not show all pages where the terms appear. This Index is not an official statement of benefits.

Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan FEP Blue Focus - 2026

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 final decision, please read this PSHB brochure.

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.

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.

Below, an asterisk (*) means the item is subject to the $750 per person ($1,500 per Self Plus One or Self and Family enrollment) calendar year deductible. If you use a Non-PPO physician, benefits are not provided.

Benefits	You Pay	Page
Medical services provided by physicians, specialists and other healthcare professionals: Preventive, adult	Preferred provider: Nothing Non-preferred (Participating/Non-participating): You pay all charges	38-40
Medical services provided by physicians, specialists and other healthcare professionals: Preventive, child	Preferred provider: Nothing Non-preferred (Participating/Non-participating): You pay all charges	40-42
Medical services provided by physicians, specialists and other healthcare professionals: Professional Visits	Preferred provider: $10 for the first 10 visits per calendar year (combined medical and mental health and substance use disorder) After the 10th visit: 30%* of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges	36
Medical services provided by physicians, specialists and other healthcare professionals: Diagnostic and treatment services provided in the office	Preferred provider: 30%* of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges	37
Medical services provided by physicians, specialists and other healthcare professionals: Telehealth services	Preferred Telehealth Provider: Nothing Non-preferred (Participating/Non-participating): You pay all charges	36, 79
Services provided by a hospital: Inpatient	Preferred: 30%* of the Plan allowance (deductible applies) Non-preferred (Member/Non-member): You pay all charges	63
Services provided by a hospital: Outpatient	Preferred: 30%* of the Plan allowance (deductible applies) Non-preferred (Member/Non-member): You pay all charges	66-69
Emergency benefits: Accidental injury	Preferred: Nothing for outpatient hospital and physician services within 72 hours (regular benefits apply thereafter) Non-preferred: • Participating: Nothing for outpatient hospital and physician services within 72 hours (regular benefits thereafter)	75

	• Non-participating: Any difference between the Plan allowance and billed amount for outpatient hospital and physician services within 72 hours; regular benefits thereafter Ambulance transport services: Nothing	
Emergency benefits: Medical emergency	Professional, outpatient hospital: Preferred urgent care: $25 copayment; PPO and Non-PPO emergency room care: 30%* of our allowance (deductible applies); Regular benefits for physician and hospital care* provided in other than the emergency room/PPO urgent care center Maternity: Ambulance transport services: 30%* of our allowance (deductible applies) Non-preferred (Participating/Non-participating) urgent care center: You pay all charges	76
Mental health visits	Preferred provider: $10 for the first 10 visits per calendar year (combined medical and mental health and substance use disorder) After the 10th visit: 30%* of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges	79
Mental health and substance use disorder treatment (inpatient and outpatient)	Preferred provider: 30%* of the Plan allowance (deductible applies) Non-preferred (Participating/Non-participating): You pay all charges	79-81
Prescription drugs: Retail Pharmacy Program	Preferred retail pharmacy Tier 1 (generic): $5 copayment up to a 30-day supply Preferred retail pharmacy Tier 2 (brand name): 40% coinsurance of the Plan allowance (up to a $350 maximum) for up to a 30-day supply Non-preferred pharmacy: You pay all charges	86
Prescription drugs: Specialty Drug Pharmacy Program	Preferred specialty pharmacy Tier 2: 40% coinsurance of the Plan allowance (up to a $350 maximum) for up to a 30-day supply	87
Dental care	Treatment of an accidental dental injury within 72 hours (regular benefits apply thereafter) Preferred: Nothing Non-Preferred: • Participating: Nothing (no deductible) • Non-participating: Any difference between our allowance and the billed amount (no deductible)	99

Benefits	You Pay	Page
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 Routine Annual Physical Incentive Program	See Section 5(h).	101-104
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $10,000 per contract per year • Self Plus One: Nothing after $20,000 (PPO) per contract per year • Self and Family: Nothing after $20,000 per family per year Notes: • Some costs do not count toward this protection. • 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.	30

2026 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

To compare your PSHB health plan options please go to https://health-benefits.opm.gov/PSHB/.

To review premium rates for all PSHB health plan options, please go to https://www.opm.gov/healthcare-insurance/pshb/premiums/.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
FEP Blue Focus - Self Only	35A	$225.47	$75.15	$488.51	$162.83
FEP Blue Focus - Self Plus One	35C	$484.70	$161.56	$1,050.17	$350.06
FEP Blue Focus - Self and Family	35B	$533.12	$177.70	$1,155.08	$385.03