2020 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus
Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan FEP Blue Focus – 2020

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

You can 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 $500 per person ($1,000 per Self Plus One or Self and Family enrollment) calendar year deductible. If you use a Non-PPO physician, benefits are not provided.

Medical services provided by physicians, specialists and other health care professionals:

- **Preventive, adult** (pages 41-46)

  You pay:

  Preferred provider: Nothing

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

- **Preventive, child** (pages 46-47)

  You pay:

  Preferred provider: Nothing

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

- **Professional Visits** (page 39)

  You pay:

  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

- **Diagnostic and treatment services provided in the office** (pages 39-40)

  You pay:

  Preferred provider: 30%* of the Plan allowance (deductible applies)

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

- **Telehealth services** (pages 39, 88)

  You pay:

  Preferred Telehealth Provider: Nothing for the first 2 visits per calendar year

  After the 2nd visit: $10 copayment per visit

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

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Services provided by a hospital:

- **Inpatient** (pages 73-74)

  You pay:

  Preferred: 30%* of the Plan allowance (deductible applies)

  Non-preferred (Member/Non-member): You pay all charges

- **Outpatient** (pages 76-79)

  You pay:

  Preferred: 30%* of the Plan allowance (deductible applies)

  Non-preferred (Member/Non-member): You pay all charges

Emergency benefits:

- **Accidental injury** (page 85)

You pay:

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)
- 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

- **Medical emergency** (page 86)

Professional, outpatient hospital

You pay:

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

You pay:

Ambulance transport services: 30%* of our allowance (deductible applies)

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

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- **Mental health visits** (page 88)

You pay:

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

- **Mental health and substance use disorder treatment** (inpatient and outpatient) (pages 88-90)

You pay:

Preferred provider: 30%* of the Plan allowance (deductible applies)

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

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Prescription drugs:

- **Retail Pharmacy Program** (page 95)

You pay:

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

- **Specialty Drug Pharmacy Program** (page 100)

You pay:

Preferred specialty pharmacy

Tier 2: 40% coinsurance of the Plan allowance (up to a $350 maximum) for up to a 30-day supply

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Dental care (page 103)
Treatment of an accidental dental injury within 72 hours (regular benefits apply thereafter)

You pay:

Preferred: Nothing

Non-Preferred:

- Participating: Nothing (no deductible)
- Non-participating: Any difference between our allowance and the billed amount (no deductible)

Wellness and Other Special Features (page 105)

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

Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) (page 30)

You pay:

- Self Only: Nothing after $6,500 per contract per year
- Self Plus One: Nothing after $13,000 (PPO) per contract per year
- Self and Family: Nothing after $13,000 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.

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