2020 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals
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Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.

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 page 18 for exceptions to this requirement.

Benefit Description

Diagnostic and Treatment Services

Outpatient professional services of physicians and other healthcare professionals:

- Consultations
- Second surgical opinions
- Clinic visits
- Office visits
- Home visits
- 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(f) for prescription drug coverage)

Note: Please refer to pages 40-41 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a healthcare professional, and to page 77 for our coverage of these services when billed for by a facility, such as the outpatient department of a hospital.

You Pay
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) page 88)

Preferred provider, visits after the 10th visit: 30% of the Plan allowance

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

Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 131 for more information about "agents.")

Benefit Description
Telehealth professional services for:

- Minor acute conditions (see page 134 for definition)
- Dermatology care (see 138 for definition)

Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access a provider.

You Pay
Preferred Telehealth Provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service (benefits are combined with telehealth services listed in Section 5(e) page 88)

$10 copayment per visit (no deductible) after the 2nd visit

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

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Benefit Description
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

You Pay
Preferred: 30% of the Plan allowance

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

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Diagnostic and Treatment Services - continued on next page