Blue Cross® and Blue Shield® Service Benefit Plan

www.fepblue.org

2022

A Fee-For-Service Plan (FEP Blue Standard and FEP Blue Basic Options) 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 page 9 for details. This Plan is accredited. See page 13.

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

Who may enroll in this Plan: All Federal employees, Tribal employees, and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program

Enrollment codes for this Plan:

104 Standard Option - Self Only
106 Standard Option - Self Plus One
105 Standard Option - Self and Family
111 Basic Option - Self Only
113 Basic Option - Self Plus One
112 Basic Option - Self and Family

IMPORTANT

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice 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 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 you do not need to enroll in Medicare Part D 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 FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB 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 percent 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: 800-325-0778.

You can get more information about 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 877-486-2048.

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Standard and FEP Blue Basic Options** under contract (CS 1039) between the Blue Cross and Blue Shield Association and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan in their individual localities. For customer service assistance, visit our website, www.fepblue.org, or contact your Local Plan at the phone number appearing on the back of your ID card.

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

Blue Cross and Blue Shield Service Benefit Plan
1310 G Street NW, Suite 900
Washington, DC 20005

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 healthcare 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. You do not have a right to benefits that were available before January 1, 2022, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2022, and changes are summarized on pages 15-16. Rates are shown on the back cover of this brochure.

Plain Language

All FEHB 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. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Healthcare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB 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)
  - 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 FEHB enrollment.
- If you have any questions about the eligibility of a dependent, 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 FEHB 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

The Blue Cross and Blue Shield Service Benefit Plan complies with all applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

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, or sex, 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 of Civil Rights, OPM, or FEHB Program Carriers.

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director, FEIO
1900 E Street NW, Suite 3400-S
Washington, D.C. 20415-3610

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 member 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 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 medications or give your doctor and pharmacist a list of all the medications and dosages 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 to 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.

- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from 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?
- Do not 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/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- 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.
- 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 FEHB 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 or Member 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.

FEHB Facts

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 FEHB Program**

  See www.opm.gov/healthcare-insurance/healthcare for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you brochures for other plans and other materials you need to make an informed decision about your FEHB 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 and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

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

- **Types of coverage 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 dependent 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. 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 form. 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 FEHB enrollment.

Contact your carrier to obtain a Certificate of Creditable Coverage (COCC) or to add a dependent when there is already family Coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a newborn if you currently have a Self Only plan.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB 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 FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, 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 has implemented 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 FEHB 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 FEHB 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 FEHB 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 FEHB coverage, you must continue your FEHB 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.

- **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 begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or Plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2022 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2021 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing 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 FEHB Program. Generally, you must have been enrolled in the FEHB 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 FEHB 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.

You may be eligible for spouse equity coverage or assistance with enrolling in a conversion policy (non-FEHB individual policy). FEP helps members with Temporary Continuation of Coverage (TCC) and with finding replacement coverage.

- **Upon divorce**

If you are divorced from a Federal employee or annuitant you may not continue to get benefits 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 FEHB coverage under either the spouse equity law or 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/healthcare/plan-information/guides. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn age 26, regardless of marital status, etc.

You may not elect TCC if you are fired from your Federal or Tribal 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/healthcare/plan-information/guides. 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 new kind of 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 FEHB 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 ACA'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 ACA's Health Insurance Marketplace. These rules are established by the Federal Government agencies that have responsibility for implementing the ACA 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. You can choose your own physicians, hospitals, and other healthcare providers. We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

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

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

General features of our Standard and Basic Options

We have a Preferred Provider Organization (PPO)

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

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

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

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service phone number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

How we pay professional and facility providers

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

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

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

- **Non-participating providers.** Providers who are not Preferred or Participating providers do not have contracts with us, and may or may not accept our allowance. **We refer to them as "Non-participating providers" generally, although if they are facilities we refer to them as "Non-member facilities."** When you use Non-participating providers, you may have to file your claims with us. We will then pay our benefits to you, and you must pay the provider.

  You must pay any difference between the amount Non-participating providers charge and our allowance (except in certain circumstances – see pages 156-157). In addition, you must pay any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Under Standard Option, your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use Preferred or Participating providers.** Under Basic Option, you must use Preferred providers to receive benefits. See page 20 for the exceptions to this requirement.

  Note: In Local Plan areas, Preferred providers and Participating 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 coinsurance or copayments (and, under **Standard Option** only, the applicable deductible), for covered services, and any charges for noncovered services.

- **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. For example, certain pilot programs may revise the Plan Allowance for Non-participating providers described in Section 10 of this brochure.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB 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 Service Benefit Plan 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.

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 2022

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 Standard Option only

- The member cost-share associated with care you receive from Non-participating providers who cannot balance bill you under the No Surprises Act (NSA), will now be applied to your Preferred Provider catastrophic out-of-pocket maximum. Previously, these amounts only counted toward the Non-preferred Provider out-of-pocket maximum. (See page 33.)
- For Self Only contracts, your Preferred Provider catastrophic out-of-pocket maximum is now $6,000. For Self Plus One and Self and Family contracts, your Preferred Provider catastrophic out-of-pocket maximum is now $12,000. Previously, the Preferred Provider out-of-pocket maximum for Self Only contracts was $5,000; for Self Plus One and Self and Family Contracts, the Preferred Provider out-of-pocket maximum was $10,000. (See page 33.)
- For Self Only contracts, your Non-preferred Provider catastrophic out-of-pocket maximum is now $8,000. For Self Plus One and Self and Family contracts, your Non-preferred Provider catastrophic out-of-pocket maximum is now $16,000. Previously, the Non-preferred Provider out-of-pocket maximum for Self Only contracts was $7,000; for Self Plus One and Self and Family Contracts, the Non-preferred Provider out-of-pocket maximum was $14,000. (See page 33.)
- We now provide only medical benefits for EKGs. Previously, one EKG per calendar year was covered under the preventive care adult benefit with no member cost-share. (See page 40.)
- If you are admitted to a Member or Non-member facility due to a medical emergency or accidental injury, you now will pay a $350 per admission copayment for unlimited days and we will then provide benefits at 100% of the Plan allowance. Previously, you paid a $450 per admission copayment. (See page 79.)

Changes to our Basic Option only

- For Self Only contracts, your Preferred Provider catastrophic out-of-pocket maximum is now $6,500. For Self Plus One and Self and Family contracts, your Preferred Provider catastrophic out-of-pocket maximum is now $13,000. Previously, the Preferred Provider out-of-pocket maximum for Self Only contracts was $5,500; for Self Plus One and Self and Family Contracts, the Preferred Provider out-of-pocket maximum was $11,000. (See page 33.)
- We now provide only medical benefits for EKGs. Previously, one EKG per calendar year was covered under the preventive care adult benefit with no member cost-share. (See page 40.)
- The member cost-share for a Tier 4 preferred specialty drug is now an $85 copayment, limited to one purchase of up to a 30-day supply when obtained at a Preferred retail pharmacy. The member cost-share for a Tier 5 non-preferred specialty drug is now a $110 copayment, limited to one purchase of up to a 30-day supply when obtained at a Preferred retail pharmacy. Previously, the member cost-share for a Tier 4 preferred specialty drug was a $65 copayment and the member cost-share for a Tier 5 non-preferred specialty drug was $90; each was also limited to one purchase of up to a 30-day supply at a Preferred retail pharmacy. (See page 114.)
- For members with Medicare Part B primary, the member cost-share for a Tier 4 preferred specialty drug is now an $80 copayment, limited to one purchase of up to a 30-day supply when obtained at a Preferred retail pharmacy. The member cost-share for a Tier 5 non-preferred specialty drug is now a $100 copayment, limited to one purchase of up to a 30-day supply when obtained at a Preferred retail pharmacy. Previously, the member cost-share for a Tier 4 preferred specialty drug was a $60 copayment and the member cost-share for a Tier 5 non-preferred specialty drug was $80; each was also limited to one purchase of up to a 30-day supply at a Preferred retail pharmacy. (See page 115.)
- Your member cost-share for some services to treat a covered accidental dental injury is now subject to a 30% coinsurance. Previously, you paid a $30 copayment per visit to treat an accidental dental injury. (See page 121.)

Changes to both our Standard and Basic Options

- You will no longer need to obtain prior approval for surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth, for care provided within 72 hours of the accidental injury. Previously, prior approval was required for all surgeries needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth regardless of when the care was performed. (See pages 22, 62, 68 and 78.)
- You are no longer responsible for the difference between our allowance and a Non-participating provider's billed charges in certain situations described under the No Surprises ACT (NSA) federal legislation. Previously, you were responsible for these differences. (See page 32.)
- We now cover group counseling on prevention and reducing health risks, and group nutritional counseling under the preventive benefit. Previously, only individual counseling was covered. (See pages 42, 46 and 61.)
- Under our maternity benefit, we now offer a breast pump and milk storage bags for members who are pregnant and/or nursing when ordered through our fulfillment vendor. Previously, these items were covered when ordered through CVS Caremark. (See page 48.)
- We now offer kidney transplants as part of the Blue Distinction Centers for Transplants® Program. Previously, kidney transplants were not a part of this program. (See page 76.)
- Kidney transplants will now require prior approval. Previously, kidney transplants did not require prior approval. (See pages 62, 69 and 76.)
- We now cover nipple reconstruction after a mastectomy for female to male gender reassignment surgery. Previously, there was no benefit for this procedure. (See page 66.)
- We no longer offer pancreas transplants as part of the Blue Distinction Centers for Transplants® Program. (See page 76.)
- We now provide coverage for tubeless insulin delivery systems under the Tier 2 and Tier 3 pharmacy benefit. Previously, all types of insulin delivery systems were covered only under the durable medical equipment benefit. (See pages 110 and 114.)
- For inpatient stays at Non-member facilities resulting from medical emergencies or accidental injuries, or for emergency deliveries, our allowance is now the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations. Previously, our allowance for these services was the billed amount. (See page 156.)
- For outpatient services resulting from a medical emergency or accidental injury and billed by a Non-member facility, our allowance is now the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations. Previously, our allowance for these services was the billed amount. (See page 157.)
- For non-emergency medical services performed in Preferred hospitals provided by physicians and other covered healthcare professionals identified under the NSA that do not contract with your local Blue Cross and Blue Shield Plans and cannot balance bill you under this regulation, our allowance is now equal to the lesser of the billed amount or the qualifying payment amount (QPA). Previously, our allowance was equal to the greater of the Medicare participating fee schedule amount or 100% of the local Plan allowance. (See page 157.)
- For emergency medical services performed in the emergency department of a hospital provided by physicians and other covered healthcare professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is now equal to the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations. Previously, the Plan allowance was equal to the greatest 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 Allowance for the service or supply in the geographic area in which it was performed or obtained; or (3) an allowance based on equivalent Preferred provider services that is calculated in compliance with the Affordable Care Act. (See page 157.)
- We no longer limit the difference between the Non-participating Provider Allowance (NPA) and the amount billed to $5,000 when care is received in a Preferred facility from certain non-participating professional providers. Federal regulations now limit what you can be billed in these situations. (See pages 32 and 157.)

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 Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

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

Under Standard Option, you can get care from any "covered professional provider" or "covered facility provider." How much we pay – and you pay – depends on the type of covered provider you use. If you use our Preferred, Participating, or Member providers, you will pay less.

Under Basic Option, you **must** use those "covered professional providers" or "covered facility providers" that are **Preferred providers** for Basic Option in order to receive benefits. Please refer to page 20 for the exceptions to this requirement. Refer to page 13 for more information about Preferred providers.

Under both Standard and Basic Option, you can also get care for the treatment of minor acute conditions (see page 155 for definition), dermatology care (see page 39), counseling for behavioral health and substance use disorder (see page 99), and nutritional counseling (see pages 42 and 46), using teleconsultation services delivered via phone by calling 855-636-1579, TTY: 855-636-1578, or via secure online video/messaging at www.fepblue.org/telehealth.

The term "primary care provider" includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants. Physician assistants working for a specialist may also be considered specialists.

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) providers 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, co-insurance) 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.

This plan recognizes that transsexual, transgender, and gender-nonconforming members require healthcare delivered by healthcare providers experienced in transgender health. While gender reassignment surgeons (benefit details found in Section 5(b)) and hormone therapy providers (benefit details found in Section 5(f)) play important roles in preventive care, you should see a primary care provider familiar with your overall healthcare needs. Benefits described in this brochure are available to all members meeting medical necessity guidelines.

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

- **Covered facility providers**

Covered 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, drug addicts, or alcoholics; or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

Note: 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-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 accredited by a nationally recognized organization and licensed by the state, district, or territory 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. Benefits are available for services performed and billed by RTCs, as described on pages 87-88 and 100-101. If you have questions about treatment at an RTC, 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), Gene Therapy, 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.

We cover specialty care at designated Blue Distinction Centers at Preferred benefit levels. See pages 86-87 for information regarding enhanced inpatient and outpatient benefits for bariatric, spine, knee and hip surgeries performed at a Blue Distinction Center. We also provide enhanced benefits for covered transplant services performed at the Blue Distinction Centers for Transplant designated centers as described on page 76.

For listings of Blue Distinction Centers, visit https://www.bcbs.com/blue-distinction-center/facility; 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.

Cancer Research Facility – A facility that is:

1. A National Cooperative Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a blood or marrow stem cell transplant center;
2. An NCI-designated Cancer Center; or
3. An institution that has a peer-reviewed grant funded by the National Cancer Institute (NCI) or National Institutes of Health (NIH) to study allogeneic or autologous blood or marrow stem cell transplants.

FACT-Accredited Facility

A facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT). FACT-accredited cellular therapy programs meet rigorous standards. Information regarding FACT transplant programs can be obtained by contacting the transplant coordinator at the customer service phone number listed on the back of your ID card or by visiting www.factwebsite.org.

Note: Certain stem cell transplants must be performed at a FACT-accredited facility (see page 70).

Skilled Nursing Facility (SNF)

A SNF is a freestanding institution or a distinct part of a hospital which customarily bills insurance as a skilled nursing facility and meets the following criteria:

- Is Medicare-certified as a skilled nursing facility;
- Is licensed in accordance with state or local law or is approved by the state or local licensing agency as meeting the licensing standards (where state or local law provides for the licensing of such facilities);
- Has a transfer agreement in effect with one or more Preferred hospitals; and
- Is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

To be covered, skilled nursing facility care cannot be maintenance or custodial care. The term skilled nursing facility does not include any institution that is primarily for the care and treatment of mental diseases.

Note: Additional criteria apply when Medicare Part A is not the primary payor (see page 88).

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

What you must do to get covered care

Under **Standard Option**, you can go to any covered provider you want, but in some circumstances, we must approve your care in advance.

Under **Basic Option**, **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, 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 U.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 under Basic Option exceptions 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: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your Preferred specialist because 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 or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy 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.

- **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 Service Benefit Plan ID card, you can contact your Local Plan at the phone number listed in your local phone directory. If you already have your new Service Benefit Plan ID card, call us at the phone number on the back of the card. If you are new to the FEHB 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 FEHB 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 FEHB 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, there may be a reduction or denial of benefits. Be sure to read all of the precertification and prior approval information below and on pages 22-26. Our FEP medical policies may be found by visiting www.fepblue.org/policies.

- **Inpatient hospital admission, inpatient residential treatment center admission, or skilled nursing facility 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, inpatient residential treatment center, or skilled nursing facility whether or not they have contacted us and provided all necessary information. You may contact us at the phone number on the back of your ID card to ask if we have received the request for precertification. You are also responsible for enrolling in case management and working with your case manager if your care involves residential treatment or a skilled nursing facility. For information about precertification of an emergency inpatient hospital admission, please see page 26.

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.

Note: If precertification was not obtained prior to admission, inpatient benefits (such as room and board) are not available for inpatient care at a residential treatment center, or, when Medicare Part A is not the primary payor, at a skilled nursing facility. We will pay only for covered medical services and supplies that are otherwise payable on an outpatient basis.

Exceptions: You do not need precertification in these cases:

- You are admitted to a hospital outside the United States; with the exception of admissions for gender reassignment surgery and admissions to residential treatment centers, and skilled nursing facilities.
- You have another group health insurance policy that is the primary payor for the hospital stay; with the exception of admissions for gender reassignment surgery. (See page 76 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payor for the hospital or skilled nursing facility stay; with the exception of admissions for gender reassignment surgery. (See page 76 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)

  Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then you **do** need precertification.

  Note: Morbid obesity surgery performed during an inpatient stay (even when Medicare Part A is your primary payor) must meet the surgical requirements described on pages 64-65 in order for benefits to be provided for the admission and surgical procedure.

- **Other services**

You must obtain prior approval for these services under both Standard and Basic Option in all outpatient and inpatient settings unless otherwise noted. Precertification is also required if the service or procedure requires an inpatient hospital admission. 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, for example CAR-T and T-Cell receptor therapy**
- **Air Ambulance Transport (non-emergent)** – Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval; see Section 5 (c), page 92, for more information.
- **Outpatient facility-based sleep studies** – Prior approval is required for sleep studies performed in a provider's office, sleep center, clinic, any type of outpatient center, or any location other than your home.
- **Applied behavior analysis (ABA)** – Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
- **Gender reassignment surgery –** Prior to surgical treatment of gender dysphoria, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan.
- **BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes** – Prior approval is required for BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes whether performed for preventive or diagnostic reasons.
  Note: You must receive genetic counseling and evaluation services before preventive BRCA testing is performed. See page 44.
- **Surgical services** – The surgical services on the following list require prior approval for care performed by Preferred, Participating/Member, and Non-participating/Non-member professional and facility providers:
  - Surgery for morbid obesity;
    Note: Benefits for the surgical treatment of morbid obesity – performed on an inpatient or outpatient basis – are subject to the pre-surgical requirements listed on page 64-65.
  - Surgical correction of congenital anomalies (see definition on page 152);
  - Surgery needed to correct accidental injuries (see definition on page 152) to jaws, cheeks, lips, tongue, roof and floor of mouth except when care is provided within 72 hours of the accidental injury; and
  - Gender reassignment surgery.
- **Intensity-modulated radiation therapy (IMRT)** – Prior approval is required for all IMRT services except IMRT related to the treatment of head, neck, breast, prostate or anal cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer.
- **Hospice care** – Prior approval is required for home hospice, continuous home hospice, or inpatient hospice care services. We will advise you which home hospice care agencies we have approved. See page 90 for information about the exception to this requirement.

- **Organ/tissue transplants** – See page 69 for the list of covered organ/tissue transplants. **Prior approval is required** for both the procedure and the facility. 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. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.

  The **organ transplant procedures** listed on pages 70-71 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 covered 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 listed on the back of your ID card.

  The blood or marrow stem cell transplants listed on pages 71-73 must be performed in a facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT), or in a facility designated as a Blue Distinction Center for Transplants or as a Cancer Research Facility. The **transplant procedures listed on page 74** must be performed at a FACT-accredited facility. See page 19 for more information about these types of facilities.

  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 facility is specifically designated or accredited to perform that procedure. Before scheduling a transplant, call your Local Plan at the customer service phone number listed 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** – See pages 73-74 for the 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 FACT-accredited facility, Blue Distinction Center for Transplants, or Cancer Research Facility (see page 73) where the procedure is to be performed.
- **Transplant travel –** 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. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. Reimbursement is subject to IRS regulations.

- **Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.** Contact CVS Caremark, our Pharmacy Program administrator, at 800-624-5060, TTY: 800-624-5077, 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 pages 106-107 for more information about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

  Please note that 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.

  Note: 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.

  Standard Option members may use our Mail Service Prescription Drug Program to fill their prescriptions. **Basic Option** members with primary Medicare Part B coverage also may use this program once prior approval is obtained.

  Note: The Mail Service Prescription Drug Program will not fill your prescription for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

  Note: The Specialty Drug Pharmacy Program will not fill your prescription for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.
- **Medical foods covered under the pharmacy benefit require prior approval.** See Section 5 (f), page 109, for more information.

- **Surgery by Non-participating providers under Standard Option**

You may request prior approval and receive specific benefit information in advance for non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery **will be $5,000 or more**. When you contact your local Blue Cross and Blue Shield Plan before your surgery, the Local Plan will review your planned surgery to determine your coverage, the medical necessity of the procedure(s), and the Plan allowance for the services. You can call your Local Plan at the customer service phone number on the back of your ID card.

Note: Standard Option members are not required to obtain prior approval for surgeries performed by Non-participating providers (unless the surgery is listed on page 22 or is one of the transplant procedures listed on pages 70-74) – even if the charge will be $5,000 or more. If you do not call your Local Plan in advance of the surgery, we will review your claim to provide benefits for the services in accordance with the terms of your coverage.

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

First, 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 Service Benefit Plan ID card any time prior to admission or before receiving services that require prior approval.

Next, provide 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; and
- If the admission is to a residential treatment center, a preliminary treatment and discharge plan agreed to by the member, provider and case manager at the Local Plan, and the RTC.

  Note: You must enroll and participate in case management with your Local Plan prior to, during, and following an inpatient RTC stay. See pages 87-88 and 100-101 for additional information.

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* on page 27.) 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 Service Benefit Plan ID card. You may also call OPM's FEHB 1 at 202-606-0727 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 a period of 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* below.

Admissions to residential treatment centers do not qualify as emergencies.

- **Maternity care**

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 confinement, 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 facility stay needs to be extended**

If your **hospital** stay – including for maternity 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 **residential treatment center** stay needs to be extended, you, your representative, your physician or the residential treatment center must ask us to approve the additional days. If you remain in the residential treatment center beyond the number of days approved and did not get the additional days precertified, we will provide benefits for medically necessary covered services, other than room and board and inpatient physician care, at the level we would have paid if they had been provided on an outpatient basis.

- **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 (see page 152 for definition). (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.

- **The Federal Flexible Spending Account Program – FSAFEDS**

Healthcare FSA (HCFSA) – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

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: If you have Standard Option when you see your Preferred physician, you pay a copayment of $25 for the office visit, and we then pay the remainder of the amount we allow for the office visit. (You may have to pay separately for other services you receive while in the physician's office.) When you go into a Preferred hospital, you pay a copayment of $350 per admission. We then pay the remainder of the amount we allow for the covered services you receive.

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.

Note: When multiple copayment services are performed by the same professional or facility provider on the same day, only one copayment applies per provider per day. When the copayment amounts are different, the highest copayment is applicable. You may be responsible for a separate copayment for some services.

Example: If you have Basic Option when you visit the outpatient department of a Preferred hospital for non-emergency treatment services, your copayment is $100 (see page 81). If you also receive an ultrasound in the outpatient department of the same hospital on the same day, you will not be responsible for the $40 copayment for the ultrasound (shown on page 83).

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.

Under Standard Option, the calendar year deductible is $350 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 $700.

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 Standard Option 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 Standard Option calendar year deductible ($270) has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Under Basic Option, there is **no calendar year deductible**.

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. **Under Standard Option only**, coinsurance does not begin until you have met your calendar year deductible. See Section 5(i) for information about the deductible and overseas benefits.

Example: You pay 15% of the Plan allowance under Standard Option for durable medical equipment obtained from a Preferred provider, after meeting your $350 calendar year deductible.

If your provider routinely waives your cost

Note: **If your provider routinely waives** (does not require you to pay) your applicable deductible (under Standard Option only), coinsurance, or copayments, 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 35% Standard Option coinsurance, the actual charge is $65. We will pay $42.25 (65% of the actual charge of $65).

Waivers

In some instances, a Preferred, Participating, or Member 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 or Participating 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 providers**. 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.

  Under Standard Option, your share consists only of your deductible and coinsurance 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, under Standard Option, you pay just 15% of our $100 allowance ($15). Because of the agreement, your Preferred physician will not bill you for the $150 difference between our allowance and the bill.

  Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges $250 for covered services subject to a $30 copayment. Even though our allowance may be $100, you still pay just the $30 copayment. Because of the agreement, your Preferred physician will not bill you for the $220 difference between your copayment and the bill.

  Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 20 for the exceptions to this requirement.

- **Participating providers.** These types of **Non-preferred** providers have agreements with the Local Plan to limit what they bill our members.

  Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges $250, but the Plan allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 35% of our $100 allowance ($35). Because of the agreement, your Participating physician will not bill you for the $150 difference between our allowance and the bill.

  Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 20 for the exceptions to this requirement.

- **Non-participating providers.** These **Non-preferred providers** have no agreement to limit what they will bill you. As a result, your share of the provider's bill could be significantly more than what you would pay for covered care from a Preferred provider. If you plan to use a Non-participating provider for your care, we encourage you to ask the provider about the expected costs and visit our website, www.fepblue.org, or call us at the customer service phone number on the back of your ID card for assistance in estimating your total out-of-pocket expenses.

  Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and the charges on the bill (except in certain circumstances – see pages 156-158). For example, you see a Non-participating physician who charges $250. The Plan allowance is again $100, and you have met your deductible. You are responsible for your coinsurance, so you pay 35% of the $100 Plan allowance or $35. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the $150 difference between our allowance and the bill. This means you would pay a total of $185 ($35 + $150) for the Non-participating physician's services, rather than $15 for the same services when performed by a Preferred physician. We encourage you to **always visit Preferred providers for your care. Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.**

  Under Basic Option, there are no benefits for care performed by Non-participating providers; you pay all charges. See page 20 for the exceptions to this requirement.

The following tables illustrate how much **Standard Option** members have to pay out-of-pocket for services performed by Preferred providers, Participating/Member providers, and Non-participating/Non-member providers. The first example shows services provided by a physician and the second example shows facility care billed by an ambulatory surgical facility. In both examples, your calendar year deductible has already been met. **Use this information for illustrative purposes only**.

Basic Option benefit levels for physician care begin on page 39; see page 81 for Basic Option benefit levels that apply to outpatient hospital or ambulatory surgical facility care.

In the following example, we compare how much you have to pay out-of-pocket for services provided by a Preferred physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges $250 and the Plan allowance is $100.

EXAMPLE

Preferred Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 85% of our allowance: 85
You owe: Coinsurance: 15% of our allowance: 15
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $15

Participating Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 65% of our allowance: 65
You owe: Coinsurance: 35% of our allowance: 35
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $35

Non-participating Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 65% of our allowance: 65
You owe: Coinsurance: 35% of our allowance: 35
You owe: Copayment: Not applicable
+Difference up to charge?: Yes: 150
TOTAL YOU PAY: $185

Note: If you had not met any of your **Standard Option** deductible in the above example, only our allowance ($100), which you would pay in full, would count toward your deductible.

You should also see section *Important Notice About Surprise Billing – Know Your Rights* on page 32 that describes your protections against surprise billing under the No Surprises Act.

In the following example, we compare how much you have to pay out-of-pocket for services billed by a Preferred, Member, and Non-member ambulatory surgical facility for facility care associated with an outpatient surgical procedure. The table uses an example of services for which the ambulatory surgical facility charges $5,000. The Plan allowance is $2,900 when the services are provided at a Preferred or Member facility, and the Plan allowance is $2,500 when the services are provided at a Non-member facility.

EXAMPLE

Preferred Ambulatory Surgical Facility Standard Option
Facility's charge: $5,000
Our allowance: We set it at: 2,900
We pay: 85% of our allowance: 2,465
You owe: Coinsurance: 15% of our allowance: 435
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $435

Member Ambulatory Surgical Facility Standard Option
Facility's charge: $5,000
Our allowance: We set it at: 2,900
We pay: 65% of our allowance: 1,885
You owe: Coinsurance: 35% of our allowance: 1,015
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $1,015

Non-member Ambulatory Surgical Facility* Standard Option
Facility's charge: $5,000
Our allowance: We set it at: 2,500
We pay: 65% of our allowance: 1,625
You owe: Coinsurance: 35% of our allowance: 875
You owe: Copayment: Not applicable
+Difference up to charge?: Yes: 2,500
TOTAL YOU PAY: $3,375

Note: If you had not met any of your **Standard Option** deductible in the above example, $350 of our allowed amount would be applied to your deductible before your coinsurance amount was calculated.

***A Non-member facility may bill you any amount for the services it provides. You are responsible for paying all expenses over our allowance, regardless of the total amount billed, in addition to your calendar year deductible and coinsurance. For example, if you use a Non-member facility that charges $60,000 for facility care related to outpatient bariatric surgery, and we pay the $1,625 amount illustrated above, you would owe $58,375 ($60,000 - $1,625 = $58,375). This example assumes your calendar year deductible has been met.**

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" under certain circumstances. A surprise bill is an unexpected bill you receive from a Non-participating healthcare provider, facility, or air ambulance service for healthcare. Surprise bills can happen when you receive emergency care – when you have little or no say in the facility or provider from whom you receive care. They can also happen when you received non-emergency services at participating facilities, but you receive some care from Non-participating 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 unexpected 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. **Under Standard and Basic Options**, we pay overseas claims at Preferred benefit levels. Therefore, the Basic Option requirement to use Preferred providers in order to receive benefits does not apply. See Section 5(i) for specific information about our overseas benefits.

Dental care. Under Standard Option, we pay scheduled amounts for covered dental services and you pay balances as described in Section 5(g). **Under Basic Option**, you pay $30 for any covered evaluation and we pay the balance for covered services. **Basic Option members** must use **Preferred** dentists in order to receive benefits. See Section 5(g) for a listing of covered dental services and additional payment information.

Inpatient facility care. Under Standard and Basic Options, you pay the coinsurance or copayment amounts listed in Section 5(c). **Under Standard Option**, you must meet your deductible before we begin providing benefits for certain facility-billed services. **Under Basic Option**, you must use **Preferred** facilities in order to receive benefits. See page 20 for the exceptions to this requirement.

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

Under Standard and Basic Options, 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.

Standard Option maximums:

Preferred Provider maximum – For a Self Only enrollment, your out-of-pocket maximum for your deductible, and for eligible coinsurance and copayment amounts, is $6,000 when you use Preferred providers. For a Self Plus One or Self and Family enrollment, your out-of-pocket maximum for these types of expenses is $12,000 for Preferred provider services. Only eligible expenses for Preferred provider services, and the cost-shares associated with care from Non-participating providers under the NSA (see page 32), count toward these limits.

Non-preferred Provider maximum – For a Self Only enrollment, your out-of-pocket maximum for your deductible, and for eligible coinsurance and copayment amounts, is $8,000 when you use Non-preferred providers. For a Self Plus One or Self and Family enrollment, your out-of-pocket maximum for these types of expenses is $16,000 for Non-preferred provider services. For either enrollment type, eligible expenses for the services of Preferred providers also count toward these limits.

Basic Option maximum:

Preferred Provider maximum – For a Self Only enrollment, your out-of-pocket maximum for eligible coinsurance and copayment amounts is $6,500 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 $13,000 when you use Preferred providers. Only eligible expenses for Preferred provider services count toward these limits.

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. See pages 29-30;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;
- Under Standard Option, your 35% coinsurance for inpatient care in a Non-member facility;
- Under Standard Option, your 35% coinsurance for outpatient care by a Non-member facility;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(g);
- 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; and
- Under Basic Option, your expenses for care received from Participating/Non-participating professional providers or Member/Non-member facilities, except for coinsurance and copayments you pay in those situations where we do pay for care provided by Non-preferred providers. Please see page 20 for the exceptions to the requirement to use Preferred providers.

If your provider's prescription allows for generic substitution and you select a brand-name drug, your expenses for the difference in cost-share do not count toward your catastrophic protection out-of-pocket maximum (see page 103 for additional information).

Carryover

If you change to another plan during Open Season, we will continue to provide benefits between January 1 and the effective date of your new plan.

- If you had already paid the out-of-pocket maximum, we will continue to provide benefits as described on page 32 and on this page until the effective date of your new plan.
- If you had not yet paid the out-of-pocket maximum, we will apply any expenses you incur in January (before the effective date of your new plan) to our prior year's out-of-pocket maximum. Once you reach the maximum, you do not need to pay our deductibles, copayments, or coinsurance amounts (except as shown on page above) from that point until the effective date of 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 Plan during the year, we will credit the amounts already accumulated toward the catastrophic protection out-of-pocket limit of your prior 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. Benefits

See page 15 for how our benefits changed this year. Pages 163-166 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. Standard and Basic Option Overview

The benefit package for Standard and Basic Options are described in Section 5, which is divided into subsections 5(a) through 5(i). Make sure that you review the benefits that are available under the option in which you are enrolled.

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 Standard and Basic Option benefits, contact us at the customer service phone number on the back of your Service Benefit Plan ID card or on our website at www.fepblue.org. Each option offers unique features. Members do not need to have referrals to see specialists.

Standard Option

When you have Standard Option, you can use both Preferred and Non-preferred providers. However, your out-of-pocket expenses are lower when you use Preferred providers and Preferred providers will submit claims to us on your behalf. Standard Option has a calendar year deductible for some services and a $25 copayment for office visits to primary care providers ($35 for specialists). Standard Option also features a Retail Pharmacy Program, a Mail Service Prescription Drug Program, and a Specialty Drug Pharmacy Program.

Basic Option

Basic Option does not have a calendar year deductible. Most services are subject to copayments ($30 for primary care providers and $40 for specialists). You must use Preferred providers for your care to be eligible for benefits, except in certain circumstances, such as emergency care. Preferred providers will submit claims to us on your behalf. Basic Option also offers a Retail Pharmacy Program and a Specialty Drug Pharmacy Program. Members with primary Medicare Part B coverage have access to the Mail Service Prescription Drug Program.

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.).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 114 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 104).
- We waive the cost-share for the first 2 visits for telehealth per calendar year. This applies to a combined total for treatment of minor acute conditions, dermatology care, and mental health and substance use disorder conditions. (See pages 39 and 99.)
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment).
  - We provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, 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 page 32, NSA, for information on when you are not responsible for this difference.
- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **You must use Preferred providers in order to receive benefits. See below and page 20 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, 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 page 32, NSA, for information on when you are not responsible for this difference.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Diagnostic and Treatment Services	**Standard Option**	**Basic Option**
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 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) • Phone consultations and online medical evaluation and management services (telemedicine) Note: Please refer to pages 40-42 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a healthcare professional, and to page 83 for our coverage of these services when billed for by a facility, such as the outpatient department of a hospital.	Preferred primary care provider or other healthcare professional: $25 copayment per visit (no deductible) Preferred specialist: $35 copayment per visit (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other healthcare professional: $30 copayment per visit Preferred specialist: $40 copayment per visit Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about "agents.") Participating/Non-participating: You pay all charges
Telehealth professional services for: • Minor acute conditions (see page 155 for definition) • Dermatology care (see page 159 for definition) Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access a provider. Note: Benefits are combined with telehealth services listed in Section 5(e), see page 99. Note: Copayments are waived for members with Medicare Part B primary.	Preferred Telehealth Provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service $10 copayment per visit (no deductible) after the 2nd visit Participating/Non-participating: You pay all charges	Preferred Telehealth Provider: Nothing for the first 2 visits per calendar year for any covered telehealth service $15 copayment per visit after the 2nd visit 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	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Diagnostic and Treatment Services - continued on next page

Benefit Description	You Pay	
Diagnostic and Treatment Services (cont.)	**Standard Option**	**Basic Option**
• 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.) • Second surgical opinion • Nutritional counseling when billed by a covered provider	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
Not covered: • *Routine services except for those Preventive care services described on pages 42-46* • *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*	*All charges*
Lab, X-ray and Other Diagnostic Tests	**Standard Option**	**Basic Option**
Diagnostic tests limited to: • Laboratory tests (such as blood tests and urinalysis) • Pathology services • EKGs Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about "agents.")

Lab, X-ray and Other Diagnostic Tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and Other Diagnostic Tests (cont.)	**Standard Option**	**Basic Option**
	Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Diagnostic tests including but not limited to: • Cardiovascular monitoring • EEGs • Home-based/unattended sleep studies • Neurological testing • Ultrasounds • X-rays (including set-up of portable X-ray equipment) Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred: $40 copayment Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about “agents.”) Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.
Diagnostic tests limited to: • Bone density tests • CT scans/MRIs/PET scans • Angiographies • Nuclear medicine • Facility-based sleep studies (prior approval required) • Genetic testing Note: Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient’s existing medical condition. Benefits are not provided for genetic panels when some or all of the tests included in the panel are not covered, are experimental or investigational, or are not medically necessary.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred: $100 copayment Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about “agents.”) Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.

Lab, X-ray and Other Diagnostic Tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and Other Diagnostic Tests (cont.)	**Standard Option**	**Basic Option**
Note: You must obtain prior approval for BRCA testing (see page 22). Diagnostic BRCA testing, including testing for large genomic rearrangements in the BRCA1 and BRCA2 genes: Benefits are available for members with a cancer diagnosis when the requirements in the note above are met, and the member does not meet criteria for Preventive BRCA testing. Benefits are limited to one test of each type per lifetime whether covered as a diagnostic test or paid under *Preventive Care* benefits (see page 44). Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred: $100 copayment Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about "agents.") Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.
Preventive Care, Adult	**Standard Option**	**Basic Option**
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, on page 158 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 the Service Benefit Plan, you have access to the Blue Cross and Blue Shield HRA, called the "Blue Health Assessment" questionnaire. See Section 5(h) for complete information. • Basic or comprehensive metabolic panel test • CBC • Cervical cancer screening tests - Human papillomavirus (HPV) tests of cervix - Pap tests of the cervix • Colorectal cancer tests, including:	Preferred: Nothing (no deductible) Note: 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. Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: 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.	Preferred: Nothing Note: 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. Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. Note: When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers. Note: Benefits are not available for visits/exams for preventive care, associated laboratory tests, colonoscopies, or routine immunizations performed at Member or Non-member facilities.

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
- Colonoscopy, with or without biopsy (see page 63 for our payment levels for diagnostic colonoscopies) - DNA analysis of stool samples - Double contrast barium enema - Fecal occult blood test - Sigmoidoscopy	Preferred: Nothing (no deductible) Note: 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. Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: 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. Note: We waive your deductible and coinsurance amount for services billed by Participating/ Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount.	Preferred: Nothing Note: 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. Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. Note: When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers. Note: Benefits are not available for visits/exams for preventive care, associated laboratory tests, colonoscopies, or routine immunizations performed at Member or Non-member facilities. 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.

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
• Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) • General health panel • Prostate cancer test – Prostate Specific Antigen (PSA) • 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 • Urinalysis The following preventive services are covered at the time intervals recommended at each of the links below as adopted by December 31, 2020. • Immunizations such as COVID-19, Pneumococcal, influenza, shingles, tetanus/DTaP) 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/schedules. 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. • 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 U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • 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.healthcare.gov/preventive-care-women/ • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Continued from previous page: Note: Many Preferred retail pharmacies participate in our vaccine network. See page 111 for our coverage of these vaccines when provided by pharmacies in the vaccine network.	Continued from previous page: Note: We provide benefits for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount. Note: Many Preferred retail pharmacies participate in our vaccine network. See page 111 for our coverage of these vaccines when provided by pharmacies in the vaccine network.

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
Note: 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 you cost-share for the diagnostic services. Note: See page 112 for our payment levels for medications to promote better health as recommended under the Affordable Care Act. Note: See page 113 for our payment levels for certain bowel preparation medications, and antiretroviral medications for the prevention of HIV. Note: Unless otherwise noted, the benefits listed above and on pages 42-43 do not apply to children up to age 22. (See benefits under *Preventive Care, Child*, this Section.)	See previous page	See previous page
Hereditary Breast and Ovarian Cancer Screening Benefits are available for screening members, age 18 and over (including children ages 18 – 21) limited to one of each type of test per lifetime, to evaluate the risk for developing certain types of hereditary breast or ovarian cancer related to mutations in BRCA1 and BRCA2 genes: • **Genetic counseling and evaluation** for members whose personal and/or family history is associated with an increased risk for harmful mutations in BRCA1 and BRCA2 genes. • **BRCA testing** for members whose personal and/or family history is associated with an increased risk for harmful mutations in BRCA1 or BRCA2 genes. Note: **You must receive genetic counseling and evaluation services and obtain prior approval before you receive preventive BRCA testing.** Preventive care benefits will not be provided for BRCA testing unless you receive genetic counseling and evaluation prior to the test, and scientifically valid screening measures are used for the evaluation, and the results support BRCA testing. See page 22 for information about prior approval and additional BRCA coverage or call the phone number on the back of your ID card for additional policy information. Note: See page 63 for the benefits available for the surgical removal of breast, ovaries, or prostate cancer when screening reveals a BRCA mutation: preventive care benefits are not available.	See page 42	See page 42

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
Note: 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.	See page 42	See page 42
Not covered: • *Genetic testing related to family history of cancer or other disease, except as described on page 44* *Note: See page 41 for our coverage of medically necessary diagnostic genetic testing.* • *Genetic panels when some or all of the tests included in the panel are not covered, are experimental or investigational, or are not medically necessary* • *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.* • *Immunizations, boosters, and 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 on page 42 for nutritional counseling.*	*All charges*	*All charges*
Preventive Care, Child	**Standard Option**	**Basic Option**
Benefits are provided for preventive care services for children up to age 22. This includes: • Well-child visits, examinations, and other preventive services as adopted by December 31, 2020, and 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 • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html Note: U.S. FDA licensure may restrict the use of the immunizations and vaccines listed above to specific age ranges, frequencies, and/or other patient-specific indications, including gender. • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: 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.	Preferred: Nothing Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. Note: We provide benefits for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount.

Preventive Care, Child - continued on next page

Benefit Description	You Pay	
Preventive Care, Child (cont.)	**Standard Option**	**Basic Option**
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 - Pap tests of the cervix - Human papillomavirus (HPV) tests of the cervix Note: See page 44 for covered BRCA testing. • Screening for human immunodeficiency virus (HIV) infection • Screening for syphilis infection • Screening for latent tuberculosis infection for children ages 18 through 21 • Nutritional counseling 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. Note: 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. Note: See page 112 for our payment levels for medications to promote better health as recommended under the Affordable Care Act.	Continued from previous page: Note: We waive the deductible and coinsurance amount for services billed by Participating/ Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount.	Continued from previous page: Note: 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.
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* • *Immunizations, boosters, and medications for travel or work-related exposure. Medical benefits may be available for these services.*	*All charges*	*All charges*

Preventive Care, Child - continued on next page

Benefit Description	You Pay	
Preventive Care, Child (cont.)	**Standard Option**	**Basic Option**
• *Phone consultations and online medical evaluation and management services (telemedicine) for preventive services, except as noted above for nutritional counseling.*	*All charges*	*All charges*
Maternity Care	**Standard Option**	**Basic Option**
Maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage, such as: • Prenatal care (including ultrasound, laboratory, and diagnostic tests) Note: See Section 5(h) for details about our Pregnancy Care Incentive Program. • Delivery • Postpartum care • 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 consultants Note: See page 48 for our coverage of breast pump kits. • Mental health treatment for postpartum depression and depression during pregnancy Note: We provide benefits to cover up to 4 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 of mental health visits to Non-preferred providers and benefits for additional mental health services. Note: See page 42 for our coverage of nutritional counseling. Note: Benefits for home nursing visits (skilled) related to covered maternity care are subject to the visit limitations described on page 59. Note: Maternity care benefits are not provided for prescription drugs required during pregnancy, except as recommended under the Affordable Care Act. See page 112 for more information. See Section 5(f) for other prescription drug coverage.	Preferred: Nothing (no deductible) Note: For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers. Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: You may request prior approval and receive specific benefit information in advance for the delivery itself and any other maternity-related surgical procedures to be provided by a Non-participating physician when the charge for that care will be **$5,000 or more**. Call your Local Plan at the customer service phone number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services.	Preferred: Nothing Note: For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered inpatient services is limited to $175 per admission. For outpatient facility services related to maternity, see the notes on pages 82-85. Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Participating and Non-participating laboratories or radiologists, you are responsible only for any difference between our allowance and the billed amount.

Maternity Care - continued on next page

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 26 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 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). Note: See page 156 for our payment for inpatient stays resulting from an emergency delivery at a hospital or other facility not contracted with your Local Plan. Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. Regular medical or surgical benefits apply rather than maternity benefits. Note: See page 63 for our payment levels for circumcision.	See previous page	See previous page
• Breast pump, limited to one per calendar year for members who are pregnant and/or nursing Note: Milk storage bags will be included with your breast pump. Note: Benefits for the breast pump and milk storage bags are only available when you order them through our fulfillment vendor by visiting www.fepblue.org/maternity or calling 1-800-411-2583.	Nothing (no deductible)	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* • *Genetic testing/screening of the baby's father (see page 41 for our coverage of medically necessary diagnostic genetic testing)* • *Childbirth preparation, Lamaze, and other birthing/ parenting classes* • *Breast pumps and milk storage bags except as stated above on this page*	*All charges*	*All charges*

Maternity Care - continued on next page

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
• *Breastfeeding supplies other than those contained in the breast pump kit described on the previous page 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 described on page 47* • *Maternity care for members not enrolled in the Service Benefit Plan*	*All charges*	*All charges*
Family Planning	**Standard Option**	**Basic Option**
A range of voluntary family planning services for women, limited to: • Contraceptive counseling • Diaphragms and contraceptive rings • Injectable contraceptives • Intrauterine devices (IUDs) • Implantable contraceptives • Tubal ligation or tubal occlusion/tubal blocking procedures only Family planning services for men, limited to: • Vasectomy Note: We also provide benefits for professional services associated with tubal ligation/occlusion/blocking procedures, vasectomy, and with the fitting, insertion, implantation, or removal of the contraceptives listed above at the payment levels shown here. Note: 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.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
• 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 or for Standard Option members and for Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program. See page 110 for more information. Note: 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.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered: • *Reversal of voluntary surgical sterilization* • *Contraceptive devices not described above* • *Over-the-counter (OTC) contraceptives, except as described in Section 5(f)*	*All charges*	*All charges*

Benefit Description	You Pay	
Reproductive Services	**Standard Option**	**Basic Option**
Diagnosis and treatment of infertility including covered: • Diagnostic and treatment services • Laboratory tests • Diagnostic tests • Surgical procedures • Prescription drugs Note: See Section 5(a) for covered labs, diagnostic tests, and X-rays. Note: See Section 5(b) for covered surgical services. Note: See Section 5(f) for covered prescription drugs. Note: See below for a list of services not covered as treatments for infertility or as alternatives to conventional conception.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other healthcare professional: $30 copayment per visit Preferred specialist: $40 copayment per visit Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about "agents.") Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
The services listed below are not covered as treatments for infertility or as alternatives to conventional conception: • *Assisted reproductive technology (ART) and assisted insemination procedures, including but not limited to:* - *Artificial insemination (AI)* - *In vitro fertilization (IVF)* - *Embryo transfer and gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intracytoplasmic sperm injection (ICSI)* - *Intrauterine insemination (IUI)* • *Services, procedures, and/or supplies that are related to ART and/or assisted insemination procedures* • *Cryopreservation or storage of sperm (sperm banking), eggs, or embryos* • *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* • *Services, supplies, or drugs provided to individuals not enrolled in this Plan*	*All charges*	*All charges*

Benefit Description	You Pay	
Allergy Care	**Standard Option**	**Basic Option**
• Allergy testing • Allergy treatment • Sublingual allergy desensitization drugs as licensed by the U.S. FDA Note: See page 39 for applicable office visit copayment.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other healthcare professional: $30 copayment Preferred specialist: $40 copayment Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about "agents.") Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
• Allergy injections Note: See page 39 for applicable office visit copayment.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
• Preparation of each multi-dose vial of antigen Note: See page 39 for applicable office visit copayment.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other healthcare professional: $30 copayment per multi-dose vial of antigen Preferred specialist: $40 copayment per multi-dose vial of antigen Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Not covered: Provocative food testing	*All charges*	*All charges*

Benefit Description	You Pay	
Treatment Therapies	**Standard Option**	**Basic Option**
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 (pages 21-24). • Intensity-modulated radiation therapy (IMRT) Note: **You must get prior approval for IMRT related to cancers, except head, neck, breast, prostate, or anal cancer.** Please refer to page 22 for more information. • Renal dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy – Home IV or infusion therapy Note: Home nursing visits associated with Home IV/ infusion therapy are covered as shown under *Home Health Services* on page 59. • Outpatient cardiac rehabilitation • Pulmonary rehabilitation therapy • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 22) Note: See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital. Note: See page 60 for our coverage of osteopathic and chiropractic manipulative treatment.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other healthcare professional: $30 copayment per visit Preferred specialist: $40 copayment per visit Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about “agents.”) Participating/Non-participating: You pay all charges
• Auto-immune infusion medications: Remicade, Renflexis and Inflectra Note: See above for your costs for intravenous (IV)/ infusion therapy - Home IV or infusion therapy.	Preferred: 10% of the Plan allowance (deductible applies) Participating: 15% of the Plan allowance (deductible applies) Non-participating: 15% of the Plan allowance (deductible applies), plus any difference between our allowance and billed amount	Preferred: 15% of the Plan allowance Participating/Non-participating: You pay all charges

Treatment Therapies - continued on next page

Benefit Description	You Pay	
Treatment Therapies (cont.)	**Standard Option**	**Basic Option**
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 (pages 21-24). • 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 (see prior approval requirements on page 22)	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy	**Standard Option**	**Basic Option**
• Physical therapy, occupational therapy, and speech therapy • Cognitive rehabilitation therapy Note: When billed by a skilled nursing facility, nursing home, extended care facility, or residential treatment center, we pay benefits as shown here for professional care, according to the contracting status of the facility.	Preferred primary care provider or other healthcare professional: $25 copayment per visit (no deductible) Preferred specialist: $35 copayment per visit (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. Note: Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.	Preferred primary care provider or other healthcare professional: $30 copayment per visit Preferred specialist: $40 copayment per visit Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about “agents.”) Note: Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. Participating/Non-participating: You pay all charges Note: See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.

Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy - continued on next page

Benefit Description	You Pay	
Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy (cont.)	**Standard Option**	**Basic Option**
	Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown on page 53, according to the contracting status of the facility.	
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* • *Equine therapy and hippotherapy (exercise on horseback)* • *Massage therapy*	*All charges*	*All charges*
Hearing Services (Testing, Treatment, and Supplies)	**Standard Option**	**Basic Option**
• Hearing tests related to illness or injury • Testing and examinations for prescribing hearing aids Note: For our coverage of hearing aids and related services, see page 57.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other healthcare professional: $30 copayment per visit Preferred specialist: $40 copayment per visit Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about "agents.") Participating/Non-participating: You pay all charges
Not covered: • *Routine hearing tests (except as indicated on page 45)* • *Hearing aids (except as described on page 57)*	*All charges*	*All charges*
Vision Services (Testing, Treatment, and Supplies)	**Standard Option**	**Basic Option**
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;	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies)	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Vision Services (Testing, Treatment, and Supplies) - continued on next page

Benefit Description	You Pay	
Vision Services (Testing, Treatment, and Supplies) (cont.)	**Standard Option**	**Basic Option**
• For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 Note: Benefits are provided for refractions 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 above and on page 54.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 Note: See above and on page 54 for our coverage of eyeglasses, replacement lenses, or contact lenses when prescribed as nonsurgical treatment for amblyopia and strabismus. Note: See Section 5(b), Surgical procedures, for coverage for surgical treatment of amblyopia and strabismus. Note: See pages 40-42 in this Section for our payment levels for Lab, X-ray, and other diagnostic tests performed or ordered by your provider. Benefits are not available for refractions except as described above.	Preferred primary care provider or other healthcare professional: $25 copayment (no deductible) Preferred specialist: $35 copayment (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other healthcare professional: $30 copayment per visit Preferred specialist: $40 copayment per visit Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about “agents.”) 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 and on page 54* • *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*	*All charges*

Benefit Description	You Pay	
Foot Care	**Standard Option**	**Basic Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes Note: See *Orthopedic and Prosthetic Devices* for information on podiatric shoe inserts. Note: See Section 5(b) for our coverage for surgical procedures.	Preferred primary care provider or other healthcare professional: $25 copayment for the office visit (no deductible); 15% of the Plan allowance for all other services (deductible applies) Preferred specialist: $35 copayment for the office visit (no deductible); 15% of the Plan allowance for all other services (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other healthcare professional: $30 copayment per visit Preferred specialist: $40 copayment per visit Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about "agents.") 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*	*All charges*
Orthopedic and Prosthetic Devices	**Standard Option**	**Basic Option**
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 or as part of an approved plan for gender reassignment surgery • 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: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Orthopedic and Prosthetic Devices - continued on next page

Benefit Description	You Pay	
Orthopedic and Prosthetic Devices (cont.)	**Standard Option**	**Basic Option**
• Hearing aids for children up to age 22, limited to $2,500 per calendar year • Hearing aids for adults age 22 and over, limited to $2,500 every 5 calendar years Note: Benefits for hearing aid dispensing fees, fittings, batteries, and repair services are included in the benefit limits described above.	Any amount over $2,500 (no deductible)	Any amount over $2,500
• Bone-anchored hearing aids when medically necessary, limited to $5,000 per calendar year	Any amount over $5,000 (no deductible)	Any amount over $5,000
• Wigs for hair loss due to the treatment of cancer Note: Benefits for wigs are paid at 100% of the billed amount, limited to $350 for one wig per lifetime.	Any amount over $350 for one wig per lifetime (no deductible)	Any amount over $350 for one wig per lifetime
Not covered: • *Shoes (including diabetic shoes)* • *Over-the-counter orthotics* • *Arch supports* • *Heel pads and heel cups* • *Wigs (including cranial prostheses), except for scalp hair prosthesis for hair loss due to the treatment of cancer, as stated above* • *Over the counter hearing aids, enhancement devices, accessories or supplies (including remote controls and warranty packages)*	*All charges*	*All charges*
Durable Medical Equipment (DME)	**Standard Option**	**Basic Option**
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 durable medical equipment, at our option, including repair and adjustment. Covered items include: • Home dialysis equipment • Oxygen equipment • Hospital beds	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: See Section 5(c) for our coverage of DME provided and billed by a facility.	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges Note: See Section 5(c) for our coverage of DME provided and billed by a facility.

Durable Medical Equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable Medical Equipment (DME) (cont.)	**Standard Option**	**Basic Option**
• 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 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.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: See Section 5(c) for our coverage of DME provided and billed by a facility.	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges Note: See Section 5(c) for our coverage of DME provided and billed by a facility.
• Speech-generating devices, limited to $1,250 per calendar year	Any amount over $1,250 per year (no deductible)	Any amount over $1,250 per year
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 when Medicare Part B is primary* • *Air conditioners, humidifiers, dehumidifiers, and purifiers* • *Breast pumps, except as described on page 48* • *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*	*All charges*
Medical Supplies	**Standard Option**	**Basic Option**
• Medical foods and nutritional supplements when administered by catheter or nasogastric tubes Note: See Section 10, *Definitions*, for more information about medical foods. • Ostomy and catheter supplies	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Medical Supplies - continued on next page

Benefit Description	You Pay	
Medical Supplies (cont.)	**Standard Option**	**Basic Option**
• 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. • 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: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance 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 when Medicare Part B is primary* • *Medical foods administered orally, except as described in Section 5(f)*	*All charges*	*All charges*
Home Health Services	**Standard Option**	**Basic Option**
Home nursing care (skilled) for two hours per day when: • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and • A physician orders the care	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: Benefits for home nursing care are limited to 50 visits per person, per calendar year. Note: Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.	Preferred: $30 copayment per visit Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about “agents.”) Note: Benefits for home nursing care are limited to 25 visits per person, per calendar year. Participating/Non-participating: You pay all charges
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*	*All charges*

Home Health Services - continued on next page

Benefit Description	You Pay	
Home Health Services (cont.)	**Standard Option**	**Basic Option**
• *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, except as included in the benefits described on pages 88-89.* • *Private duty nursing*	*All charges*	*All charges*
Manipulative Treatment	**Standard Option**	**Basic Option**
Manipulative treatment performed by a professional provider, when the provider is practicing within the scope of his/her license, limited to: • Osteopathic manipulative treatment to any body region • Chiropractic spinal and/or extraspinal manipulative treatment Note: Benefits for manipulative treatment are limited to the services and combined treatment visits stated here. Note: 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.	Preferred: $25 copayment per visit (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 12 visits per person, per calendar year. Note: Manipulation visits that you pay for while meeting your calendar year deductible count toward the treatment limit cited above.	Preferred: $30 copayment per visit Note: Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 20 visits per person, per calendar year. Participating/Non-participating: You pay all charges
Alternative Treatments	**Standard Option**	**Basic Option**
Acupuncture Note: Acupuncture must be 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 page 17 for more information. Note: When billed by a facility such as the outpatient department of a hospital, you are limited to the number of visits per calendar year listed on this page. See Section 5(c) for your cost-share. Note: See page 77 for our coverage of acupuncture when provided as anesthesia for covered surgery. Note: See page 47 for our coverage of acupuncture when provided as anesthesia for covered maternity care.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: Benefits for acupuncture are limited to 24 visits per calendar year. Note: Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.	Preferred primary care provider or other healthcare professional: $30 copayment per visit Preferred specialist: $40 copayment per visit Note: Benefits for acupuncture are limited to 10 visits per calendar year. Note: You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges

Alternative Treatments - continued on next page

Benefit Description	You Pay	
Alternative Treatments (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Biofeedback* • *Self-care or self-help training*	*All charges*	*All charges*
Educational Classes and Programs	**Standard Option**	**Basic Option**
• Smoking and tobacco cessation treatment - Counseling for smoking and tobacco cessation - Smoking and tobacco cessation classes Note: See Section 5(f) for our coverage of smoking and tobacco cessation drugs.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
• Diabetic education Note: See pages 40, 42 and 46 for our coverage of nutritional counseling services that are not part of a diabetic education program.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other healthcare professional: $30 copayment per visit Preferred specialist: $40 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Marital, family, 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 (except as described on page 47), headache, eating disorder (except as described on pages 40 and 42), and other educational clinics* • *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*	*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.).
- **YOU MUST GET PRIOR APPROVAL for the following surgical services: surgery for morbid obesity; surgical correction of congenital anomalies; and surgery needed to correct accidental injuries (see *Definitions*, page 152) to jaws, cheeks, lips, tongue, roof and floor of mouth, except when care is provided within 72 hours of the accidental injury. Please refer to page 22 for more information.**
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except corneal transplants); 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 gender reassignment surgery. Prior to any gender reassignment surgery, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan (including changes to the procedures to be performed or the anticipated dates for the procedures). See page 22 and page 66 for additional information. If your surgical procedure requires an inpatient admission, YOU MUST ALSO GET PRECERTIFICATION of the inpatient care.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 114 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 104).
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment).
  - We provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, 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 page 32, NSA, for information on when you are not responsible for this difference.
  - You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.

- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **You must use Preferred providers in order to receive benefits. See below and page 20 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, 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 page 32, NSA, for information on when you are not responsible for this difference.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Surgical Procedures	**Standard Option**	**Basic Option**
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 • Normal pre- and post-operative care by the surgeon • 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 page 42). 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 (see *Reconstructive Surgery* on page 66) • Treatment of burns • Male circumcision • Insertion of internal prosthetic devices. See Section 5(a), *Orthopedic and Prosthetic Devices*, and Section 5(c), *Other Hospital Services and Supplies*, for our coverage for the device.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about "agents.") Participating/Non-participating: You pay all charges

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• **Procedures to treat morbid obesity** – a condition in which an individual has a Body Mass Index (BMI) of 40 or more, or an individual with a BMI of 35 or more with one or more co-morbidities; eligible members must be age 18 or over. Benefits are available only for the following procedures: - Roux-en-Y - Gastric bypass - Laparoscopic adjustable gastric banding - Sleeve gastrectomy - Biliopancreatic bypass with duodenal switch **Note: Benefits for the surgical treatment of morbid obesity are subject to the requirements listed on pages 64-65.** Note: For certain surgical procedures, your out-of-pocket costs for facility services are reduced if you use a facility designated as a Blue Distinction Center. See pages 86-87 for information. Note: **Prior approval is required for surgery for morbid obesity.** For more information about prior approval, please refer to page 22. • Benefits for the surgical treatment of morbid obesity, performed on an inpatient or outpatient basis, are subject to the pre-surgical requirements listed below. **The member must meet all requirements.** - Diagnosis of morbid obesity (as defined above) for a period of 1 year prior to surgery - Participation in a medically supervised weight loss program, including nutritional counseling, for at least 3 months prior to the date of surgery. (Note: Benefits are not available for commercial weight loss programs; see pages 42 and 46 for our coverage of nutritional counseling services.) - Pre-operative nutritional assessment and nutritional counseling about pre- and post-operative nutrition, eating, and exercise - Evidence that attempts at weight loss in the 1-year period prior to surgery have been ineffective - Psychological clearance of the member's ability to understand and adhere to the pre- and post-operative program, based on a psychological assessment performed by a licensed professional mental health practitioner (see page 99 for our payment levels for mental health services) - Member has not smoked in the 6 months prior to surgery - Member has not been treated for substance use disorder for 1 year prior to surgery and there is no evidence of substance use disorder during the 1-year period prior to surgery	See page 63	See page 63

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• Benefits for subsequent surgery for morbid obesity, performed on an inpatient or outpatient basis, are subject to the following additional pre-surgical requirements: - All criteria listed above for the initial procedure must be met again, except when the subsequent surgery is necessary to treat a complication from the prior morbid obesity surgery. - Previous surgery for morbid obesity was at least 2 years prior to repeat procedure - Weight loss from the initial procedure was less than 50% of the member's excess body weight at the time of the initial procedure - Member complied with previously prescribed post-operative nutrition and exercise program - Claims for the surgical treatment of morbid obesity must include documentation from the member's provider(s) that all pre-surgical requirements have been met Note: 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. Note: We do not pay extra for "incidental" procedures (those that do not add time or complexity to patient care). Note: 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.	See page 63	See page 63
Not covered: • *Reversal of voluntary sterilization* • *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 and gender reassignment surgeries specifically listed as covered)* • *Reversal of gender reassignment surgery*	*All charges*	*All charges*

Benefit Description	You Pay	
Reconstructive Surgery	**Standard Option**	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly (See Section 10, page 152, 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 Note: Internal breast prostheses are paid as orthopedic and prosthetic devices; see Section 5(a). See Section 5(c) when billed by a facility. Note: 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: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about "agents.") Participating/Non-participating: You pay all charges
• **Gender reassignment surgical benefits** are limited to the following: - For female to male surgery: mastectomy (including nipple reconstruction), hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, electrolysis (hair removal at the covered operative site), and placement of testicular and erectile prosthesis - For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, labiaplasty, and electrolysis (hair removal at the covered operative site) **Note: Prior approval is required for gender reassignment surgery.** For more information about prior approval, please refer to page 22.	See above	See above

Reconstructive Surgery - continued on next page

Benefit Description	You Pay	
Reconstructive Surgery (cont.)	**Standard Option**	**Basic Option**
Note: Benefits for gender reassignment surgery are limited to once per covered procedure, per lifetime. Benefits are not available for repeat or revision procedures when benefits were provided for the initial procedure. Benefits are not available for gender reassignment surgery for any condition other than gender dysphoria. • Gender reassignment surgery on an inpatient or outpatient basis is subject to the pre-surgical requirements listed below. **The member must meet all requirements**. - **Prior approval is obtained** - **Member must be at least 18 years of age at the time prior approval is requested and the treatment plan is submitted** - Diagnosis of gender dysphoria by a qualified healthcare professional • New gender identity has been present for at least 24 continuous months • Member has a strong desire to be rid of primary and/or secondary sex characteristics because of a marked incongruence with the member's identified gender • Member's gender dysphoria is not a symptom of another mental disorder or chromosomal abnormality • Gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning - Member must meet the following criteria: • Living 12 months of continuous, full-time, real-life experience in the desired gender (including place of employment, family, social and community activities) • 12 months of continuous hormone therapy appropriate to the member's gender identity (not required for mastectomy) • Two referral letters from qualified mental health professionals – one must be from a psychotherapist who has treated the member for a minimum of 12 months. Letters must document: diagnosis of persistent and chronic gender dysphoria; any existing co-morbid conditions are stable; member is prepared to undergo surgery and understands all practical aspects of the planned surgery (one referral letter required for mastectomy) • If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled	See page 66	See page 66

Reconstructive Surgery - continued on next page

Benefit Description	You Pay	
Reconstructive Surgery (cont.)	**Standard Option**	**Basic Option**
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)* • *Surgeries related to sexual dysfunction or sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender reassignment surgeries specifically listed as covered)* • *Reversal of gender reassignment surgery*	*All charges*	*All charges*
Oral and Maxillofacial Surgery	**Standard Option**	**Basic Option**
Oral surgical procedures, 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 (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth Note: **Prior approval is required for oral/maxillofacial surgery needed to correct accidental injuries as described above, except when care is provided within 72 hours of the accidental injury.** Please refer to page 22 for more information. • 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 Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service phone number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about “agents.”) Participating/Non-participating: You pay all charges

Oral and Maxillofacial Surgery - continued on next page

Benefit Description	You Pay	
Oral and Maxillofacial Surgery (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Oral implants and transplants except for those required to treat accidental injuries as specifically described on page 68 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 on page 68 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 on page 68 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 on page 68 and in Section 5(g)*	*All charges*	*All charges*

Organ/Tissue Transplants

Prior approval requirements:

You must obtain prior approval (see page 23) from the Local Plan, for both the procedure and the facility, for the transplant procedures listed below. Prior approval is not required for transplants of corneal tissue.

- Blood or marrow stem cell transplant procedures (Note: Pages 73-74 have **additional requirements** that apply to blood or marrow stem cell transplants that are covered **only** as part of a **clinical trial**.)
- Autologous pancreas islet cell transplant
- Heart transplant
- Implantation of an artificial heart as a bridge to transplant or destination therapy
- Heart-lung transplant
- Intestinal transplants (small intestine with or without other organs)
- Kidney
- Liver transplant
- Lung (single, double, or lobar) transplant
- Pancreas transplant

Note: Refer to pages 21-22 for information about precertification of inpatient care.

Covered organ/tissue transplants are listed on pages 70-71. Benefits are subject to medical necessity and experimental/investigational review, and to the prior approval requirements shown above.

Organ 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 covered 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 on the back of your ID card.

Blood or marrow stem cell transplants are covered as shown on pages 71-75. Benefits are limited to the stages of the diagnoses listed.

Physicians consider many features to determine how diseases will respond to different types of treatments. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. For the diagnoses listed on pages 71-75, the medical necessity limitation is considered satisfied if the patient meets the staging description.

The blood or marrow stem cell transplants listed on pages 71-73 must be performed in a facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT), or in a facility designated as a Blue Distinction Center for Transplants or as a Cancer Research Facility. The **transplant procedures listed on page 74** must be performed at a FACT-accredited facility. See page 19 for more information about these types of facilities.

Not every facility 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 facility is specifically designated or accredited to perform that procedure. Before scheduling a transplant, call your Local Plan at the customer service phone number listed on the back of your ID card for assistance in locating an eligible facility and requesting prior approval for transplant services.

Note: Coverage for the blood or marrow stem cell transplants described on pages 71-72 includes benefits for those transplants performed in an approved clinical trial to treat any of the conditions listed when prior approval is obtained. Refer to pages 73-74 for information about **blood or marrow stem cell transplants covered only in clinical trials** and the **additional requirements** that apply.

Note: See pages 144-145 for our coverage of other costs associated with clinical trials.

Note: We provide enhanced benefits for covered transplant services performed at Blue Distinction Centers for Transplants (see page 76 for more information).

Benefit Description	You Pay	
Organ/Tissue Transplants	**Standard Option**	**Basic Option**
• Transplants of corneal tissue • Heart transplant • Heart-lung transplant • Kidney transplant • Liver transplant • Pancreas transplant • Combination liver-kidney transplant • Combination pancreas-kidney transplant • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Single, double, or lobar lung transplant	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: You may request prior approval and receive specific benefit information in advance for corneal transplants to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service.

Organ/Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• For members with end-stage cystic fibrosis, benefits for lung transplantation are limited to double lung transplants • Implantation of an artificial heart as a bridge to transplant or destination therapy Note: See pages 69-70 for the prior approval and facility requirements that apply to **organ/tissue transplants**.	See previous page	Continued from previous page: Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Allogeneic blood or marrow stem cell transplants for the diagnoses as indicated below: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) with poor response to therapy, short time to progression, transformed disease, or high-risk disease • Chronic myelogenous leukemia • Hemoglobinopathy (i.e., sickle cell anemia, thalassemia major) • High-risk neuroblastoma • Hodgkin's lymphoma • Infantile malignant osteopetrosis • Inherited metabolic disorders (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy, Hurler's syndrome and Maroteaux-Lamy syndrome variants) • Marrow failure (i.e., severe or very severe aplastic anemia, Fanconi's anemia, paroxysmal nocturnal hemoglobinuria (PNH), pure red cell aplasia, congenital thrombocytopenia) • MDS/MPN (e.g., chronic myelomonocytic leukemia (CMML)) • Myelodysplasia/myelodysplastic syndromes (MDS) • Myeloproliferative neoplasms (MPN) (e.g., polycythemia vera, essential thrombocythemia, primary myelofibrosis) • Non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt lymphoma) • Plasma cell disorders (e.g., multiple myeloma, amyloidosis, polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome)	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges.

Organ/Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• Primary immunodeficiencies (e.g., severe combined immunodeficiency, Wiskott-Aldrich syndrome, hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann's syndrome, leukocyte adhesion deficiencies) Note: See pages 69-70 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants**. Note: Refer to pages 73-75 for information about **blood or marrow stem cell transplants covered only in clinical trials**.	See previous page	See previous page
Autologous blood or marrow stem cell transplants for the diagnoses as indicated below: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Central nervous system (CNS) embryonal tumors (e.g., atypical teratoid/rhabdoid tumor, primitive neuroectodermal tumors (PNETs), medulloblastoma, pineoblastoma, ependymoblastoma) • Ewing's sarcoma • Germ cell tumors (e.g., testicular germ cell tumors) • High-risk neuroblastoma • Hodgkin's lymphoma • Non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt lymphoma) • Plasma cell disorders (e.g., multiple myeloma, amyloidosis, polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome) • Scleroderma Note: See pages 69-70 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants.** Note: Refer to pages 73-75 for information about **blood or marrow stem cell transplants covered only in clinical trials**.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Blood or marrow stem cell transplants for the diagnoses as indicated below, **only** when performed as part of a clinical trial that meets the facility criteria described on page 69 and the **requirements** listed on page 74: • Allogeneic blood or marrow stem cell transplants for: - Breast cancer - Colon cancer - Epidermolysis bullosa - Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Retinoblastoma - Rhabdomyosarcoma - Sarcoma - Wilm's tumor • Autologous blood or marrow stem cell transplants for: - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) - Retinoblastoma - Rhabdomyosarcoma - Wilm's tumor and other childhood kidney cancers Note: If a non-randomized clinical trial for a blood or marrow stem cell transplant listed above meeting the **requirements** shown on page 74 is not available, we will arrange for the transplant to be provided at an approved transplant facility, if available.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Blood or marrow stem cell transplants for the diagnoses as indicated below, **only** when performed at a FACT-accredited facility (see page 19) as part of a **clinical trial** that meets the **requirements** listed below: • Allogeneic blood or marrow stem cell transplants for: - Autoimmune disease (limited to: multiple sclerosis, scleroderma, systemic lupus erythematosus and chronic inflammatory demyelinating polyneuropathy) • Autologous blood or marrow stem cell transplants for: - Autoimmune disease (limited to: multiple sclerosis, systemic lupus erythematosus and chronic inflammatory demyelinating polyneuropathy) **Requirements** for **blood or marrow stem cell transplants** covered **only** under **clinical trials**: • You must contact us at the customer service phone number listed on the back of your ID card to obtain prior approval (see page 23); 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 (IRB) of the FACT-accredited facility where the procedure is to be performed; and - For the transplant procedures listed on page 73, the clinical trial must be reviewed and approved by the IRB of the FACT-accredited facility, Blue Distinction Center for Transplants, or Cancer Research Facility where the procedure is to be performed. Note: 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.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
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 FACT-accredited facility, Blue Distinction Center for Transplants, or Cancer Research Facility 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 Case Management Department at your Local Plan for assistance. Note: See pages 144-145 for our coverage of other costs associated with clinical trials.	See previous page	See previous page
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 listed on pages 71-74 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 listed on pages 71-74 • 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 up to three 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: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings Note: Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. Note: If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/Tissue Transplants at Blue Distinction Centers for Transplants®

We participate in the Blue Distinction Centers for Transplants Program for the organ/tissue transplants listed below.

Members who choose to use a Blue Distinction Center for Transplants for a covered transplant only pay the $350 per admission copayment under Standard Option, or the $175 per day copayment ($875 maximum) under Basic Option, for the transplant period. See page 159 for the definition of "transplant period." Members are not responsible for additional costs for included professional services.

Regular benefits (subject to the regular cost-sharing levels for facility and professional services) are paid for pre- and post-transplant services performed in Blue Distinction Centers for Transplants before and after the transplant period and for services unrelated to a covered 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. You will be referred to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants.

- Heart (adult and pediatric)
- Kidney (adult and pediatric)
- Liver (adult and pediatric liver alone; adult only for combination liver-kidney)
- Single or double lung (adult only)
- Blood or marrow stem cell transplants (adult and pediatric) listed on pages 71-74
- Related transplant services listed on page 75

Travel benefits:

Members who receive covered care at a Blue Distinction Center for Transplants for one of the transplants listed above can be reimbursed for incurred travel costs related to the transplant, subject to the criteria and limitations described here.

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. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. Reimbursement is subject to IRS regulations.

Note: You must obtain prior approval for travel benefits (see page 23).

Note: Benefits for cornea, intestinal, pancreas, pediatric lung, and heart-lung transplants are not available through Blue Distinction Centers for Transplants. See pages 70-71 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: See pages 70-76 for requirements related to blood or marrow stem cell transplant coverage.

Benefit Description	You Pay	
Organ/Tissue Transplants	**Standard Option**	**Basic Option**
Not covered: • *Any transplant not listed as covered and transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, including associated travel expenses, except as defined on page 75* • *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 described on pages 70-71* • *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*	*All charges*

Benefit Description	You Pay	
Anesthesia	**Standard Option**	**Basic Option**
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 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. Note: Anesthesia acupuncture services do not accumulate toward the member's annual maximum. Note: See Section 5(c) for our payment levels for anesthesia services billed by a facility.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
Not covered: • *Anesthesia related to noncovered surgeries or procedures*	*All charges*	*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.
- **YOU MUST GET PRECERTIFICATION FOR RESIDENTIAL TREATMENT CENTER AND SKILLED NURSING FACILITY STAYS.** Please refer to the precertification information listed in Section 3.
- Note: **Observation services** are billed as outpatient facility care. Benefits for observation services are provided at the outpatient facility benefit levels described on page 82. See page 155 for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following services: facility-based sleep studies; surgery for morbid obesity; surgical correction of congenital anomalies; and surgery needed to correct accidental injuries (see *Definitions*, page 152) to jaws, cheeks, lips, tongue, roof and floor of mouth, except when care is provided within 72 hours of the accidental injury. Please refer to page 22 for more information.**
- **YOU MUST GET PRIOR APPROVAL for gender reassignment surgery. See page 22 for prior approval and pages 66-67 for the surgical benefit.**
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- 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).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 114 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 104).
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment).
- **Under Basic Option,**
  - There is **no calendar year deductible.**

- **You must use Preferred providers in order to receive benefits.** See page 20 for the exceptions to this requirement.
- Your cost-share for care performed and billed by Preferred professional providers in the outpatient department of a Preferred hospital is waived for services other than surgical services, drugs, supplies, orthopedic and prosthetic devices, and durable medical equipment. You are responsible for the applicable cost-sharing amount(s) for the services performed and billed by the hospital.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Inpatient Hospital	**Standard Option**	**Basic Option**
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 Preferred or Member hospital only has private rooms. If a Preferred or Member hospital only has private rooms, we base our payment on the contractual status of the facility. If a Non-member hospital only has private rooms, we base our payment on the Plan allowance for your type of admission. Please see pages 155-157 for more information. See pages 87-88 and 100-101 for inpatient residential treatment center. Other hospital services and supplies, such as: • Operating, recovery, maternity, 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	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Note: For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility. Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment Note: If you are admitted to a Member or Non-member facility due to a **medical emergency or accidental injury**, you pay a $350 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.	Preferred facilities: $175 per day copayment up to $875 per admission for unlimited days Note: For Preferred facility care related to maternity (including inpatient facility care, care at birthing facilities, and services you receive on an outpatient basis), your responsibility for the covered services you receive is limited to $175 per admission. Member/Non-member facilities: You pay all charges

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
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 on page 82. See page 155 for more information about these types of services. Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 26 for other circumstances, such as extended stays for you or your newborn. • 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 page 26 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). Note: See pages 47-48 for other covered maternity services. Note: See page 59 for coverage of blood and blood products. Note: For certain surgical procedures, your out-of-pocket costs for facility services are reduced if you use a facility designated as a Blue Distinction Center. See pages 86-87 for information.	See previous page	See previous page
Not covered: • *Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, or residential treatment centers (except as described on pages 87-88 and 100-101)* • *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*	*All charges*	*All charges*

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
• *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 (see pages 18-19).*	*All charges*	*All charges*
Outpatient Hospital or Ambulatory Surgical Center	**Standard Option**	**Basic Option**
Outpatient **surgical and treatment services** performed and billed by a facility, such as: • Operating, recovery, and other treatment rooms • Anesthetics and anesthesia services • Acupuncture • 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 (see page 42). 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	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred facilities: $100 copayment per day per facility (except as noted below) Note: You may be responsible for paying a $150 copayment per day per facility if other diagnostic services are billed in addition to the services listed here. Note: You pay 30% of the Plan allowance for surgical implants, agents, or drugs administered or obtained in connection with your care. (See page 152 for more information about "agents.") Member/Non-member facilities: 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.)	**Standard Option**	**Basic Option**
• 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 Notes: • See pages 95-97 for our payment levels for care related to a medical emergency or accidental injury. • See page 49 for our coverage of family planning services. • For our coverage of hospital-based clinic visits, please refer to the professional benefits described on pages 39-40 and page 55 for vision services. • For certain surgical procedures, your out-of-pocket costs for facility services are reduced if you use a facility designated as a Blue Distinction Center. See pages 86-87 for information. • For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility. See pages 47-49 for other included maternity services. • See page 85 for outpatient drugs, medical devices, and durable medical equipment billed for by a facility. • We cover outpatient hospital services and supplies related to the treatment of children up to age 22 with severe dental caries. We cover outpatient care related to other types of 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*, for additional benefit information.	See previous page	See previous page
Outpatient **observation services** performed and billed by a hospital or freestanding ambulatory facility 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 pages 79-81 for information about benefits for inpatient admissions.	Preferred facilities: $350 copayment for the duration of services (no deductible) Member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible)	Preferred facilities: $175 per day copayment up to $875 Member/Non-member facilities: 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.)	**Standard Option**	**Basic Option**
Note: For outpatient observation services related to maternity, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.	Continued from previous page: Non-member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	See previous page
Outpatient **diagnostic testing and treatment services** performed and billed by a facility, limited to: • Angiographies • Bone density tests • CT scans/MRIs/PET scans • Nuclear medicine • Facility-based sleep studies (prior approval is required) • Genetic testing Note: We cover specialized diagnostic genetic testing billed for by a facility, such as the outpatient department of a hospital, as shown here. See page 41 for coverage criteria and limitations.	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred facilities: $150 copayment per day per facility Member facilities: $150 copayment per day per facility Non-member facilities: $150 copayment per day per facility, plus any difference between our allowance and the billed amount Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 152 for more information about “agents.”)
Outpatient **diagnostic testing services** performed and billed by a facility, such as: • Cardiovascular monitoring • EEGs • Home-based/unattended sleep studies • Ultrasounds • Neurological testing • X-rays (including set-up of portable X-ray equipment) Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred facilities: $40 copayment per day per facility Member facilities: $40 copayment per day per facility Non-member facilities: $40 copayment per day per facility, plus any difference between our allowance and the billed amount Note: You may be responsible for paying a higher copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here. Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 152 for more information about “agents.”)

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
Outpatient **treatment and therapy services** performed and billed by a facility, limited to: • Cognitive rehabilitation therapy • Physical, occupational, and speech therapy - Standard Option benefits are limited to a combined total of 75 visits per person per calendar year - Basic Option benefits are limited to a combined total of 50 visits per person per calendar year • Manipulative treatment services - Standard Option benefits are limited to a combined total of 12 visits per person per calendar year - Basic Option benefits are limited to a combined total of 20 visits per person per calendar year	Preferred facilities: $25 copayment per day per facility (no deductible) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred facilities: $30 copayment per day per facility Member/Non-member facilities: You pay all charges Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 152 for more information about “agents.”)
Outpatient **treatment services** performed and billed by a facility, limited to: • Cardiac rehabilitation • Pulmonary rehabilitation • Applied behavior analysis (ABA) for an autism spectrum disorder (see prior approval requirements on page 22)	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred facilities: $30 copayment per day per facility Note: You may be responsible for paying a higher copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here. Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 152 for more information about “agents.”) Member/Non-member facilities: 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.)	**Standard Option**	**Basic Option**
Outpatient **diagnostic and treatment services** performed and billed by a facility, limited to: • Laboratory tests and pathology services • EKGs Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred facilities: Nothing Member facilities: Nothing Non-member facilities: You pay any difference between our allowance and the billed amount Note: You may be responsible for paying a copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here. Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 152 for more information about "agents.")
Outpatient **adult preventive care** performed and billed by a facility, limited to: • Visits/exams for preventive care, screening procedures, and routine immunizations described on pages 42-45 • Cancer screenings listed on pages 42-43 and ultrasound screening for abdominal aortic aneurysm Note: See page 44 for our coverage requirements for preventive BRCA testing. Note: See pages 45-46 for our payment levels for covered preventive care services for children billed for by facilities and performed on an outpatient basis.	See page 42 for our payment levels for covered preventive care services for adults	Preferred facilities: Nothing Member/Non-member facilities: Nothing 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 Member or Non-member facilities.
Outpatient **drugs, medical devices, and durable medical equipment** billed for by a facility, such as: • Prescribed drugs • Orthopedic and prosthetic devices • Durable medical equipment • Surgical implants Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility. 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.	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred facilities: 30% of the Plan allowance Note: You may also be responsible for paying a copayment per day per facility for outpatient services. See above and pages 81-84 for specific coverage information. Member/Non-member facilities: You pay all charges

Benefit Description	You Pay	
Blue Distinction® Specialty Care	**Standard Option**	**Basic Option**
We provide enhanced benefits for covered inpatient facility services related to the surgical procedures listed below, when the surgery is performed at a facility designated as a Blue Distinction Center for Knee and Hip Replacement, Blue Distinction Center for Spine Surgery, or Blue Distinction Center for Comprehensive Bariatric Surgery. • Bariatric surgeries covered are: - Roux-en-Y - Gastric bypass - Laparoscopic adjustable gastric banding - Sleeve gastrectomy - Biliopancreatic bypass with duodenal switch • Total hip replacement or revision • Total knee replacement or revision • Spine surgery, limited to: - Cervical discectomy - Thoracic discectomy - Laminectomy - Laminoplasty - Spinal fusion Note: You must precertify your hospital stay and verify your facility's designation as a Blue Distinction Center for the type of surgery being scheduled. Contact us prior to your admission at the customer service phone number listed on the back of your ID card for assistance. Note: Members are responsible for regular cost-sharing amounts for the surgery and related professional services as described in Section 5(b). Note: These benefit levels do not apply to inpatient facility care related to other services or procedures, or to outpatient facility care, even if the services are performed at a Blue Distinction Center. See pages 78-80 for regular inpatient hospital benefits and pages 81-85 for outpatient facility benefit levels. Note: See pages 18-19 for more information about Blue Distinction Centers.	Blue Distinction Center: $150 per admission copayment for unlimited days (no deductible)	Blue Distinction Center: $100 per day copayment up to $500 per admission for unlimited days
Outpatient facility services related to specific covered bariatric surgical procedures, when the surgery is performed at a designated Blue Distinction Center for Bariatric Surgery. Outpatient facility services related to specific covered hip and knee replacement or revision surgeries and certain spine surgery procedures, when performed at a designated Blue Distinction Center for hip/knee/spine surgery.	Blue Distinction Center: $100 per day per facility (no deductible)	Blue Distinction Center: $25 per day per facility

Blue Distinction® Specialty Care - continued on next page

Benefit Description	You Pay	
Blue Distinction® Specialty Care (cont.)	**Standard Option**	**Basic Option**
Note: You must meet the pre-surgical requirements listed on pages 64-65 for bariatric surgeries. Note: In addition, you must obtain prior approval and verify the facility's designation as a Blue Distinction Center for the type of surgery being scheduled. Contact us prior to the procedure at the customer service phone number listed on the back of your ID card for assistance. Note: Members are responsible for regular cost-sharing amounts for the surgery and related professional services as described in Section 5(b). Note: These benefits do not apply to other types of outpatient surgical services, even when performed at a Blue Distinction Center. See pages 81-82 for the benefits we provide. Note: See pages 18-19 for more information about Blue Distinction Centers.	Blue Distinction Center: $100 per day per facility (no deductible)	Blue Distinction Center: $25 per day per facility
Residential Treatment Center	**Standard Option**	**Basic Option**
Precertification prior to admission is required. A preliminary treatment plan and discharge plan must be developed and agreed to by the member, provider (residential treatment center (RTC)), and case manager in the Local Plan where the RTC is located prior to admission. We cover inpatient care provided and billed by an RTC for members enrolled and participating in case management through the Local Plan, when the care is medically necessary for 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 (see page 39 for services billed by professional providers). Note: RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, halfway house, or similar type facility.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 35% of the Plan allowance (no deductible), and any remaining balance after our payment Note: Non-member RTCs must, prior to admission, agree to abide by the terms established by the Local Plan for the care of the particular member and for the submission and processing of related claims.	Preferred facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
Note: Benefits are not available for noncovered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of licensure; recreational therapy; educational therapy; educational classes; biofeedback; Outward Bound programs; equine/hippotherapy 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. Note: For outpatient residential treatment center services, see page 101.	See previous page	See previous page
Extended Care Benefits/Skilled Nursing Care Facility Benefits	**Standard Option**	**Basic Option**
When Medicare Part A is not your primary payor: For members who do not have Medicare Part A, we cover skilled nursing facility (SNF) inpatient care for a maximum of 30 days annually, when the member can be expected to benefit from short-term SNF services with a goal of returning home. The following criteria must also be met: • Member is enrolled in case management prior to admission to the SNF (signed consent required), and actively participates in case management both prior to and during admission to the SNF. • Precertification is obtained prior to admission (including overseas care). • We approve the preliminary treatment plan prior to admission (plan must include proposed therapies and document the need for inpatient care). • Member participates in all treatment and care planning activities, including discharge planning/transition to home. Benefits are not available for inpatient SNF care solely for management of tube feedings, for home level dialysis treatment, as an interim transition to long term care placement, or for any other noncovered services. Note: No inpatient benefits (such as room and board) will be provided if precertification is not obtained prior to admission (see page 21). Members are responsible for enrolling in case management (see page 21).	Preferred facilities: $175 (no deductible) per admission Member facilities: $275 plus 35% of the Plan allowance (no deductible) per admission Non-member facilities: $275 plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment, per admission	All charges

Extended Care Benefits/Skilled Nursing Care Facility Benefits - continued on next page

Benefit Description	You Pay	
Extended Care Benefits/Skilled Nursing Care Facility Benefits (cont.)	**Standard Option**	**Basic Option**
When Medicare Part A is your primary payor: When Medicare Part A is the primary payor (meaning it pays first) and has made a payment, **Standard Option** provides limited secondary benefits. We pay the applicable Medicare Part A copayments incurred **in full** during the first through the 30th day of confinement for each benefit period (as defined by Medicare) in a qualified skilled nursing facility. Note: See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf for complete Medicare benefit period definition. If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day. Note: See page 84 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy, and manipulative treatment services when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note: If Medicare Part A is your primary payor, we will only provide benefits if Medicare provided benefits for the admission.***	Preferred facilities: Nothing (no deductible) Member facilities: Nothing (no deductible) Non-member facilities: Nothing (no deductible) Note: You pay all charges not paid by Medicare after the 30th day.	All charges
Not covered: *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*	*All charges*
Hospice Care	**Standard Option**	**Basic Option**
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 pages 90-92.	See pages 90-92.

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
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 **Prior approval from the Local Plan is required for all hospice services.** Our prior approval decision will be based on the medical necessity of the hospice treatment plan and the clinical information provided to us by the primary care provider (or specialist) and the hospice provider. We may also request information from other providers who have treated the member. All hospice services must be billed by the approved hospice agency. **You are responsible for making sure the hospice care provider has received prior approval from the Local Plan** (see page 22 for instructions). 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, prior approval is not required. However, our benefits will be limited to those services listed on this page and on pages 91-92. **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 hospice services and Preferred hospice providers.**	Nothing (no deductible)	Nothing
Covered services We provide benefits for the hospice services listed below when the services have been included in an approved hospice treatment plan and are provided by the home hospice program in which the member is enrolled: • Advanced care planning (see Section 10, page 152) • Dietary counseling • Durable medical equipment rental • Medical social services • Medical supplies • Nursing care	See next page	See next page

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
• 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 below	See below
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. An episode of care is one home hospice treatment plan per calendar year. See page 90 for prior approval requirements.	Preferred facilities: Nothing (no deductible) Member/Non-member facilities: $450 copayment per episode (no deductible)	Preferred facilities: Nothing Member/Non-member facilities: You pay all charges
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.). Note: Members must receive prior approval from the Local Plan for each episode of continuous home hospice care (see page 90). An episode consists of up to seven consecutive days of continuous care. The member must be enrolled in a home hospice program in order to receive benefits for subsequent continuous home hospice care, and the services must be provided by the home hospice program in which the member is enrolled.	Preferred facilities: Nothing (no deductible) Member facilities: $450 per episode copayment (no deductible) Non-member facilities: $450 per episode copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: Nothing Member/Non-member facilities: 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. The member does not have to be enrolled in a home hospice care program to be eligible for the first inpatient stay. However, the member must be enrolled in a home hospice care program in order to receive benefits for subsequent inpatient stays.	Preferred facilities: Nothing (no deductible) Member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible) Non-member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: Nothing Member/Non-member facilities: You pay all charges

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Advanced care planning, except when provided as part of a covered hospice care treatment plan (see page 90)* • *Homemaker services* • *Home hospice care (e.g., care given by a home health aide) that is provided and billed for by other than the approved home hospice agency when the same type of care is already being provided by the home hospice agency*	*All charges*	*All charges*
Ambulance	**Standard Option**	**Basic Option**
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 Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.	$100 copayment per day for ground ambulance transport services (no deductible) $150 copayment per day for air or sea ambulance transport services	$100 copayment per day for ground ambulance transport services $150 copayment per day for air or sea ambulance transport services
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 Note: We also cover medically necessary emergency care provided at the scene when transport services are not required. Note: 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.	$100 copayment per day for ground ambulance transport services $150 copayment per day for air or sea ambulance transport services
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 GMMI) by calling 804-673-1678. See page 130 for more information.	$100 copayment per day for ground ambulance transport services (no deductible) $150 copayment per day for air or sea ambulance transport services	$100 copayment per day for ground ambulance transport services $150 copayment per day for air or sea ambulance transport services
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*	*All charges*	*All charges*

Ambulance - continued on next page

Benefit Description	You Pay	
Ambulance (cont.)	**Standard Option**	**Basic Option**
• *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*	*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.
- We provide benefits at Preferred benefit levels for emergency room 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. 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 page 32, NSA.
- PPO benefits apply only when you use a PPO provider (except as described above). When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment).
- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **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.**

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.

Basic Option benefits for emergency care

Under **Basic Option,** 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 their unborn child.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Accidental Injury	**Standard Option**	**Basic Option**
• **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	Preferred: Nothing (no deductible) Participating: Nothing (no deductible) Non-participating: Nothing (no deductible)	Preferred: Nothing Participating: Nothing Non-participating: Nothing
• **Professional provider services** in the providers 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)	Regular benefit levels apply to covered services provided in this setting. See Sections 5(a) and 5(b).
• Outpatient **hospital services** and supplies, including professional provider services, diagnostic studies, radiology services, laboratory tests, and pathology services, when billed by the hospital	Preferred: Nothing (no deductible) Member: Nothing (no deductible) Non-member: Nothing (no deductible)	Preferred emergency room: $175 copayment per day per facility Member emergency room: $175 copayment per day per facility Non-member emergency room: $175 copayment per day per facility Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the $175 emergency room copayment. However, the $175 per day copayment for Preferred inpatient care still 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 Note: The urgent care center must be licensed as and permitted to provide emergency services in order to receive protections under the NSA. See page 32 for more information.	Preferred urgent care center: Nothing (no deductible) Participating urgent care center: Nothing (no deductible) Non-participating urgent care center: Nothing (no deductible)	Preferred urgent care center: $35 copayment per visit Participating/Non-participating urgent care center: $35 copayment per visit
• 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) Participating urgent care center: Nothing (no deductible) Non-participating urgent care center: Any difference between our allowance and the billed amount (no deductible)	Preferred urgent care center: $35 copayment per visit Participating/Non-participating urgent care center: You pay all charges

Accidental Injury - continued on next page

Benefit Description	You Pay	
Accidental Injury (cont.)	**Standard Option**	**Basic Option**
Note: If you are treated by a non-PPO professional provider in a PPO facility, you will only be responsible for your cost-share and will not owe any difference between our allowance and the billed amount. (See page 32.) Note: We pay inpatient benefits if you are admitted. See Sections 5(a), 5(b), and 5(c) for those benefits. Note: See Section 5(g) for dental benefits for accidental injuries.	Note: The benefits described on page 95 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. Note: For drugs, services, supplies, and/or durable medical equipment billed by a provider other than a hospital, urgent care center, or physician, see Sections 5(a) and 5 (f) for the benefit levels that apply.	Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.
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*	*All charges*
Medical Emergency	**Standard Option**	**Basic Option**
• **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	Preferred: 15% of the Plan allowance (deductible applies) Participating: 15% of the Plan allowance (deductible applies) Non-participating: 15% of the Plan allowance (deductible applies)	Preferred: Nothing Participating: Nothing Non-participating: Nothing
• 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 Note: We pay inpatient benefits if you are admitted as a result of a medical emergency. See Section 5(c).	Preferred: 15% of the Plan allowance (deductible applies) Member: 15% of the Plan allowance (deductible applies) Non-member: 15% of the Plan allowance (deductible applies)	Preferred emergency room: $175 copayment per day per facility Member emergency room: $175 copayment per day per facility Non-member emergency room: $175 copayment per day per facility Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the $175 emergency room copayment. However, the $175 per day copayment for Preferred inpatient care still applies. Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

Medical Emergency - continued on next page

Benefit Description	You Pay	
Medical Emergency (cont.)	**Standard Option**	**Basic Option**
• 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 Note: The urgent care center must be licensed as and permitted to provide emergency services in order to receive protections under the NSA. See page 32 for more information. Note: Benefits for crutches, splints, braces, etc. when billed by a provider other than the urgent care center are stated in Section 5(a), pages 57-58.	Preferred urgent care center: $30 copayment per visit (no deductible) Participating urgent care center: $30 copayment per visit (no deductible) Non-participating urgent care center: $30 copayment per visit (no deductible)	Preferred urgent care center: $35 copayment per visit Participating/Non-participating urgent care center: $35 copayment per visit
• 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), pages 57-58.	Preferred urgent care center: $30 copayment per visit (no deductible) Participating urgent care center: 35% of the Plan allowance (deductible applies) Non-participating urgent care center: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred urgent care center: $35 copayment per visit Participating/Non-participating urgent care center: You pay all charges
Not covered: Emergency room professional charges for shift differentials	*All charges*	*All charges*
Ambulance	**Standard Option**	**Basic Option**
See pages 92-93 for complete ambulance benefit and coverage information.	See pages 92-93	See pages 92-93

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 page 128. Contact us at the phone number listed on the back of your Service Benefit Plan 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/
  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.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment).
  - You may choose to receive care from In-Network (Preferred) or Out-of-Network (Non-preferred) providers. Cost-sharing and limitations for In-Network (Preferred) and Out-of-Network (Non-preferred) mental health and substance use disorder benefits are no greater than for similar benefits for other illnesses and conditions.
- **Under Basic Option,**
  - **You must use Preferred providers in order to receive benefits. See page 20 for the exceptions to this requirement.**
  - There is **no calendar year deductible.**
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Professional Services	**Standard Option**	**Basic Option**
We cover professional services by licensed professional mental health and substance use disorder practitioners when acting within the scope of their license.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Services provided by licensed professional mental health and substance use disorder practitioners when acting within the scope of their license • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Psychological testing • Office visits • Clinic visits • Home visits • Phone consultations and online medical evaluation and management services (telemedicine) Note: 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. Note: See pages 61 and 117 for our coverage of smoking and tobacco cessation treatment. Note: See page 47 for our coverage of mental health visits to treat postpartum depression and depression during pregnancy. 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.	Preferred: $25 copayment for the visit (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus the difference between our allowance and the billed amount	Preferred: $30 copayment per visit Participating/Non-participating: You pay all charges
Telehealth professional services for: • Behavioral health counseling • Substance use disorder counseling Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access our telehealth provider network. Note: Benefits are combined with telehealth services listed in Section 5(a), page 39. Note: Copayments are waived for members with Medicare Part B primary.	Preferred Telehealth provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service $10 copayment per visit (no deductible) after the 2nd visit Participating/Non-participating: You pay all charges	Preferred Telehealth provider: Nothing for the first 2 visits per calendar year for any covered telehealth service $15 copayment per visit after the 2nd visit Participating/Non-participating: You pay all charges

Professional Services - continued on next page

Benefit Description	You Pay	
Professional Services (cont.)	**Standard Option**	**Basic Option**
• Inpatient professional services	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (no deductible) Non-participating: 35% of the Plan allowance (no deductible), plus the difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
• Professional charges for facility-based intensive outpatient treatment • Professional charges for outpatient diagnostic tests	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus the difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
Inpatient Hospital or Other Covered Facility	**Standard Option**	**Basic Option**
Inpatient services provided and billed by a hospital or other covered facility (See below for residential treatment center care.) • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Diagnostic tests Note: Inpatient care to treat substance use disorder includes room and board and ancillary charges for confinements in a hospital/treatment facility for rehabilitative treatment of alcoholism or substance use disorder. Note: You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 35% of the Plan allowance for unlimited days (no deductible), and any remaining balance after our payment	Preferred facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges
Residential Treatment Center	**Standard Option**	**Basic Option**
Precertification prior to admission is required. A preliminary treatment plan and discharge plan must be developed and agreed to by the member, provider (residential treatment center (RTC)), and case manager in the Local Plan where the RTC is located prior to admission.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible)	Preferred facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
We cover inpatient care provided and billed by an RTC for members enrolled and participating in case management through the Local Plan, when the care is medically necessary for 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 (see page 99 for services billed by professional providers) Note: RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, halfway house, or similar type facility. Note: 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*, page 153); and domiciliary care provided because care in the home is not available or is unsuitable. Note: For outpatient residential treatment center services, see the next Section.	Non-member facilities: 35% of the Plan allowance (no deductible), and any remaining balance after our payment Note: Non-member facilities must, prior to admission, agree to abide by the terms established by the Local Plan for the care of the particular member and for the submission and processing of related claims.	See previous page
Outpatient Hospital or Other Covered Facility	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a covered facility 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. • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Partial hospitalization • Intensive outpatient treatment	Preferred: 15% of the Plan allowance (deductible applies) Member: 35% of the Plan allowance (deductible applies) Non-member: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: $30 copayment per day per facility Member/Non-member: 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.)	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a covered facility • Diagnostic tests • Psychological testing Note: A residential treatment center is a covered facility for outpatient care (see Section 10, Definitions, for more information). We cover inpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers, other than room and board and inpatient physician care, at the levels shown here.	Preferred: 15% of the Plan allowance (deductible applies) Member: 35% of the Plan allowance (deductible applies) Non-member: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: Nothing Member/Non-member: Nothing
Not Covered (Inpatient or Outpatient)	**Standard Option**	**Basic Option**
• *Marital, family, 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 on pages 87-88 and 100-101* • *Services performed or billed by schools, halfway houses, group homes or members of their staffs* *Note: We cover professional services as described on pages 99-100 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.)* • *Hippotherapy/equine therapy (exercise on horseback)* • *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*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescription drugs and supplies, as described in the chart beginning on page 108.
- 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 tier cost-share plus the difference in the cost of the brand-name and generic drug. If the provider's prescription is for the brand-name drug and indicates "dispense as written," you are responsible only for the applicable tier cost-share.
- 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. See pages 114-115 for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.
- 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). See *Drugs From Other Sources* in this section, pages 119-120, 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, the Mail Service Prescription Drug Program, 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: 800-624-5077**
  - **Mail Service Prescription Drug Program: 800-262-7890, TTY: 800-216-5343**
  - **Specialty Drug Pharmacy Program: 888-346-3731, TTY: 877-853-9549**
- **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 refer to pages 106-107 for more information about the PSQM program and 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) to Tier 3 (non-preferred brand-name) if a generic equivalent becomes available or if new safety concerns arise. We may also move a specialty drug from Tier 4 (preferred) to Tier 5 (non-preferred) if a generic equivalent or biosimilar becomes available or if new safety concerns arise. If your drug is moved to a higher tier, your cost-share will increase. See pages 114-116 for the amounts members pay for Preferred retail, mail service, and specialty drug purchases. 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.
- The Standard Option and Basic Option formularies both contain a comprehensive list of drugs under all therapeutic categories with two exceptions: some drugs, nutritional supplements and supplies are not covered (see pages 118-119); we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. See pages 104 and 105 for details.

- **Under Standard Option,**
  - You may use the Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program to fill your prescriptions.
  - There is no calendar year deductible for the Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program.
  - PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Basic Option,**
  - **You must use Preferred retail pharmacies or the Specialty Drug Pharmacy Program in order to receive benefits.** Our specialty drug pharmacy is a Preferred pharmacy.
  - The Mail Service Prescription Drug Program is available only to members with primary Medicare Part B coverage.
  - There is **no calendar year deductible.**
  - We use a managed formulary for certain drug classes.

We will send each new enrollee a Plan identification card, which covers pharmacy and medical benefits. Standard Option members, and Basic Option members with primary Medicare Part B coverage, are eligible to use the Mail Service Prescription Drug Program and will also receive a mail service order form and a pre-addressed reply envelope.

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.**

Under Standard Option, you may fill prescriptions at a Preferred retail pharmacy, at a Non-preferred retail pharmacy, through our Mail Service Prescription Drug Program, or through the Specialty Drug Pharmacy Program. Under Standard Option, we pay a higher level of benefits when you use a Preferred retail pharmacy, our Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program. See page 159 for the definition of “specialty drugs.”

Under Basic Option, you must fill prescriptions only at a Preferred retail pharmacy or through the Specialty Drug Pharmacy Program, in order to receive benefits. If Medicare Part B is your primary coverage, you may also fill prescriptions through our Mail Service Prescription Drug Program. See page 159 for the definition of “specialty drugs.”

Under Standard Option and Basic Option

Note: The Mail Service Prescription Drug Program will not fill your prescription for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

Note: The Specialty Drug Pharmacy Program will not fill your prescription for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

Note: Both Preferred and Non-preferred retail pharmacies may offer options for ordering prescription drugs online. Drugs ordered online may be delivered to your home; however, these online orders are not a part of the Mail Service Prescription Drug Program, described on pages 115-116.

Note: 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 pages 114-115 for information about your cost-share for specialty drugs purchased at a Preferred retail pharmacy that are affected by these restrictions.

- **What is covered.**

  Under Basic Option, we use a managed formulary for certain drug classes. If you purchase a drug in a class included in the managed formulary that is not on the managed formulary, you will pay the full cost of that drug since that drug is not covered under your benefit.

  Under Standard Option and Basic Option

  Note: Both formularies include lists of preferred drugs that are safe, effective and appropriate for our members, and are available at lower costs than non-preferred drugs. If your physician prescribed a more expensive non-preferred drug for you, we may ask that he or she prescribe a preferred drug instead; we encourage you to do the same. If you purchase a drug that is not on our preferred drug list, your cost will be higher. Your cooperation with our cost-savings efforts helps keep your premium affordable.

  Note: Some drugs, nutritional supplements, and supplies are not covered (see pages 118-119); 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.

  Note: **Before filling your prescription, please check the preferred/non-preferred status of the drug.** Other than changes resulting from new drugs or safety issues, the preferred drug list is updated periodically during the year. Changes to the preferred drug list are not considered benefit changes.

  Note: 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 drugs will provide you with a high-quality, cost-effective prescription drug benefit.

  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
  Tier 5: Includes non-preferred specialty drugs

  You can view both the Standard Option and Basic Option formularies, which include the preferred drug list for each, on our website at www.fepblue.org or call 800-624-5060, TTY: 800-624-5077, for assistance. 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 retail pharmacy, through the Specialty Drug Pharmacy Program, or, for Standard Option members and for Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program, you authorize the pharmacist to substitute any available Federally approved generic equivalent, unless you or your physician specifically requests a brand-name drug and indicates "dispense as written." Keep in mind that **Basic Option members must use Preferred providers in order to receive benefits.** See Section 10, *Definitions*, page 154, for more information about 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.**

  Standard Option: 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 Retail Pharmacy Program. You may purchase a supply of **more than** 21 days **up to** 90 days through the Mail Service Prescription Drug Program for a single copayment.

  Basic Option: When you fill Tier 1 (generic), Tier 2 (preferred brand-name), and Tier 3 (non-preferred brand-name) prescriptions at a Preferred retail pharmacy, you may purchase **up to** a 30-day supply for a single copayment, or **up to** a 90-day supply for additional copayments unless otherwise noted. Members with primary Medicare Part B coverage may purchase a supply of **more than** 21 days **up to** 90 days through the Mail Service Prescription Drug Program for a single copayment.

  Under Standard Option and Basic Option

  Benefits for Tier 4 and Tier 5 specialty drugs purchased at a 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. Benefits for the first three fills of each Tier 4 or Tier 5 specialty drug are limited to a 30-day supply. Benefits are available for a 90-day supply after the third fill of the specialty drug. See page 116 for more information.

  Note: 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 and Prevention, 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 22, 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. See the contact information below.

  Note: 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. See pages 114-115 for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.

  Note: Benefits for certain auto-immune infusion medications (Remicade, Renflexis and Inflectra) are provided only when 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, page 120, for more information.

- **Important contact information**

  Retail Pharmacy Program: 800-624-5060, TTY: 800-624-5077;
  Mail Service Prescription Drug Program: 800-262-7890, TTY: 800-216-5343;
  Specialty Drug Pharmacy Program: 888-346-3731, TTY: 877-853-9549; or www.fepblue.org.

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 on page 107, 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 and Prevention, 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: 800-624-5077.

Prior Approval

As part of our Patient Safety and Quality Monitoring (PSQM) program (see page 106), **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 Retail Pharmacy Program at 800-624-5060, TTY: 800-624-5077. 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.

Please note that 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.

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.

Note: 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.

Standard Option Generic Incentive Program

Your cost-share will be waived for the first 4 generic prescriptions filled (and/or refills ordered) per drug if you purchase a brand-name drug on the Generic Incentive Program List while a member of the Service Benefit Plan and then change to a corresponding generic drug replacement while still a member of the Plan.

- If you switch from one generic drug to another, you will be responsible for your copayment.

Note: The list of eligible generic drug replacements may change and is not considered a benefit change. For the most up-to-date information, please visit www.fepblue.org/en/benefit-plans/coverage/pharmacy/generic-incentive-program or call:

Retail Pharmacy Program: 800-624-5060, TTY: 800-624-5077
Mail Service Prescription Drug Program: 800-262-7890, TTY: 800-216-5343
Specialty Drug Pharmacy Program: 888-346-3731, TTY: 877-853-9549

Benefits Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Covered Medications and Supplies	**Standard Option**	**Basic Option**
Asthma Medications **Preferred Retail Pharmacies:** Note: See page 24 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): 20% of the Plan allowance (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply Tier 2 (preferred brand-name drug): $35 copayment for each purchase of up to a 30-day supply ($105 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $30 copayment for each purchase of up to a 30-day supply ($90 copayment for a 31 to 90-day supply)
Mail Service Prescription Drug Program: Note: See page 24 for information about drugs and supplies that require prior approval. You must obtain prior approval before Mail Service will fill your prescription. See pages 24 and 107. Note: See pages 114-116 for Tier 3, 4 and 5 prescription drug benefits.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): $65 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $75 copayment
Anti-hypertensive Medications **Preferred Retail Pharmacies:** Note: See page 24 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $3 copayment (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply
Mail Service Prescription Drug Program: Note: See page 24 for information about drugs and supplies that require prior approval. You must obtain prior approval before Mail Service will fill your prescription. See pages 24 and 107. Note: See pages 114-116 for Tier 2, 3, 4, and 5 prescription drug benefits.	Tier 1 (generic drug): $3 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase Note: See pages 112-113 for our coverage of medications to promote better health as recommended under the Affordable Care Act. • 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. (See Coverage below) - Must meet the definition of medical food (see definition on page 155) - 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 up to age 22 - 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 Note: 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. Note: See Section 5(a), page 58, for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube under the medical benefit.	See page 108 and pages 110-116	See page 108 and pages 110-116

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• Insulin, diabetic test strips, lancets, and tubeless insulin delivery systems Note: See page 58 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	See page 108 and pages 110-116	See page 108 and pages 110-116
• Drugs to aid smoking and tobacco cessation that require a prescription by Federal law Note: We provide benefits for over-the-counter (OTC) smoking and tobacco cessation medications only as described on page 117. Note: You may be eligible to receive smoking and tobacco cessation medications at no charge. See page 117 for more information. • Drugs for the diagnosis and treatment of infertility, except as described on pages 118-119 • Drugs to treat gender dysphoria (gonadotropin-releasing hormone (GnRH) antagonists and testosterones) • Contraceptive drugs and devices, limited to: - Diaphragms and contraceptive rings - Injectable contraceptives - Intrauterine devices (IUDs) - Implantable contraceptives - Oral and transdermal contraceptives Note: We waive your cost-share for generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative, when you purchase them at a Preferred retail pharmacy or, for Standard Option members and Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program. See pages 115 and 116 for details.	See below and pages 111-117	See below and pages 111-117
• Over-the-counter (OTC) contraceptive drugs and devices, for women only, limited to: - Emergency contraceptive pills - Female condoms - Spermicides - Sponges	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: We provide benefits in full for OTC contraceptive drugs and devices for women only when the contraceptives meet U.S. FDA standards for OTC products. To receive benefits, you must use a retail pharmacy and present the pharmacist with a written prescription from your physician.	See previous page	See previous page
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. See pages 43 and 45 for specific coverage. 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: 800-624-5077, to find out which vaccines your pharmacy can provide.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges (except as noted below) Note: You pay nothing for influenza (flu) vaccines obtained at Non-preferred retail pharmacies.	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges (except as noted below) Note: You pay nothing for influenza (flu) vaccines obtained at Non-preferred retail pharmacies.
Diabetic Meter 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 the 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. See page 112 for more information.	Nothing for a glucose meter kit ordered through the Diabetic Meter Program	Nothing for a glucose meter kit ordered through the Diabetic Meter Program
Metformin and metformin extended release (excluding osmotic and modified release generic drugs) **Preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:**	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible) Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Other Preferred Diabetic Medications, Test Strips, and Supplies **Preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:** **Note: See pages 115-116 for Tier 2, 3, 4, and 5 prescription drug benefits.** Benefits will be provided for syringes, pens and pen needles and test strips at Tier 2 (diabetic medications and supplies) for Standard Option members, and Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program. See pages 115-116 for more information.	Tier 2 (preferred diabetic medications and supplies): 20% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Non-preferred retail pharmacies: You pay all charges Tier 2 (preferred brand-name drug): $40 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 2 (preferred diabetic medications and supplies): $35 copayment for each purchase of up to a 30-day supply ($65 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs): $30 copayment for each purchase of up to a 30-day supply ($60 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs) $50 copayment for each purchase of up to a 90-day supply
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, 0.4 mg to 0.8 mg, for women 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 Note: Benefits are not available for acetaminophen, ibuprofen, naproxen, etc.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: Benefits for the medications listed on the previous page are subject to the dispensing limitations described on page 106 and are limited to recommended prescribed limits. Note: To receive benefits, you must use a Preferred retail pharmacy and present a written prescription from your physician to the pharmacist. Note: A complete list of USPSTF-recommended preventive care services is available online at: www.healthcare.gov/preventive-care-benefits. See pages 42-46 in Section 5(a) for information about other covered preventive care services. Note: See page 117 for our coverage of smoking and tobacco cessation medications.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges	Preferred retail pharmacy: Nothing 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: 800-624-5077, to request this form. You can also obtain the Coverage Request Form through our website at www.fepblue.org.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges Mail Service Prescription Drug Program: Nothing (no deductible)	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges **When Medicare Part B is primary, you pay the following:** Mail Service Prescription Drug Program: Nothing
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: 800-624-5077, for assistance.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges Mail Service Prescription Drug Program: Nothing (no deductible)	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges **When Medicare Part B is primary, you pay the following:** Mail Service Prescription Drug Program: Nothing
Opioid Reversal Agents: Tier 1 medications limited to Narcan nasal spray and naloxone generic injectable		
Preferred Retail Pharmacies	Tier 1: Nothing for the purchase of up to a 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.	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year 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 Pharmacies	You pay all charges	You pay all charges

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Opioid Reversal Agents (cont.) **Mail Service Prescription Drug Program**	Tier 1: Nothing for the purchase of up to a 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.	**When Medicare Part B is primary, you pay the following:** Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year 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.
Here is how to obtain your prescription drugs and supplies: **Preferred Retail Pharmacies** • Make sure you have your Plan ID card when you are ready to purchase your prescription. • Go to any Preferred retail pharmacy, or • Visit the website of your retail pharmacy to request your prescriptions online and delivery, if available. • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 800-624-5060, TTY: 800-624-5077, or visit our website, www.fepblue.org. Note: Retail pharmacies that are Preferred for prescription drugs are not necessarily Preferred for durable medical equipment (DME) and medical supplies. To receive Preferred benefits for DME and covered medical supplies, you must use a Preferred DME or medical supply provider. See Section 5(a) for the benefit levels that apply to DME and medical supplies. Note: Benefits for Tier 4 and Tier 5 specialty drugs purchased at a Preferred 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. See page 116 for more information. Note: For prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown on this page for drugs obtained from a Preferred retail pharmacy, as long as the pharmacy supplying the prescription drugs to the facility is a Preferred pharmacy. **For benefit information about prescription drugs supplied by Non-preferred retail pharmacies, please refer to page 115.**	Tier 1 (generic drug): $7.50 copayment for each purchase of up to a 30-day supply ($22.50 copayment for a 31 to 90-day supply) (no deductible) Note: You pay a $5 copayment for each purchase of up to a 30-day supply ($15 copayment for a 31 to 90-day supply) when Medicare Part B is primary. Note: You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 107 for information. Tier 2 (preferred brand-name drug): 30% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Tier 4 (preferred specialty drug): 30% of the Plan allowance (no deductible), limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): 30% of the Plan allowance (no deductible), limited to one purchase of up to a 30-day supply	Tier 1 (generic drug): $10 copayment for each purchase of up to a 30-day supply ($30 copayment for a 31 to 90-day supply) Tier 2 (preferred brand-name drug): $55 copayment for each purchase of up to a 30-day supply ($165 copayment for a 90-day supply) Tier 3 (non-preferred brand-name drug): 60% of the Plan allowance ($75 minimum) for each purchase of up to a 30-day supply ($210 minimum for a 31 to 90-day supply) Tier 4 (preferred specialty drug): $85 copayment limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): $110 copayment limited to one purchase of up to a 30-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): see above Tier 2 (preferred brand-name drug): $50 copayment for each purchase of up to a 30-day supply ($150 copayment for a 31 to 90-day supply) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance ($60 minimum) for each purchase of up to a 30-day supply ($175 minimum for a 31 to 90-day supply)

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: For a list of the Preferred Network Long Term Care pharmacies, call 800-624-5060, TTY: 800-624-5077. Note: For coordination of benefits purposes, if you need a statement of Preferred retail pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payor, call the Retail Pharmacy Program at 800-624-5060, TTY: 800-624-5077, or visit our website at www.fepblue.org. 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.	See previous page	Continued from previous page: Tier 4 (preferred specialty drug): $80 copayment limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): $100 copayment limited to one purchase of up to a 30-day supply
Non-preferred Retail Pharmacies	45% of the Plan allowance (Average wholesale price – AWP), plus any difference between our allowance and the billed amount (no deductible) Note: If you use a Non-preferred retail pharmacy, 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.	All charges
Mail Service Prescription Drug Program For Standard Option and Basic Option members when Medicare Part B is Primary, if your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills. Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program. Note: See page 24 for information about drugs and supplies that require prior approval. You must obtain prior approval before Mail Service will fill your prescription. See pages 24 and 107. Note: Not all drugs are available through the Mail Service Prescription Drug Program. There are no specialty drugs available through the Mail Service Program. Note: Please refer to page 116 for information about the Specialty Drug Pharmacy Program.	Tier 1 (generic drug): $15 copayment (no deductible) Note: You pay a $10 copayment per generic prescription filled (and/or refill ordered) when Medicare Part B is primary. Note: You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 107 for information. Tier 2 (preferred brand-name drug): $90 copayment (no deductible) Tier 3 (non-preferred brand-name drug): $125 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $20 copayment Tier 2 (preferred brand-name drug): $100 copayment Tier 3 (non-preferred brand-name drug): $125 copayment **When Medicare Part B is not primary: No benefits** Note: Although you do not have access to the Mail Service Prescription Drug Program, you may request home delivery of prescription drugs you purchase from Preferred retail pharmacies offering options for online ordering. See page 108 of this Section for our payment levels for drugs obtained through Preferred retail pharmacies.

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
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. ***Contact Us:*** If you have any questions about this program, or need assistance with your Mail Service drug orders, please call 800-262-7890, TTY: 800-216-5343. Note: If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.	See previous page	See previous page
Specialty Drug Pharmacy Program We cover specialty drugs that are listed on the Service Benefit Plan 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 page 159 for the definition of "specialty drugs.") 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 page 138 for more details about the Program. Note: Benefits for the first three fills of each Tier 4 or Tier 5 specialty drug are limited to a 30-day supply. Benefits are available for a 31 to 90-day supply after the third fill. Note: Due to manufacturer restrictions, a small number of specialty drugs may only be available through a Preferred retail pharmacy. You will be responsible for paying only the copayments shown here for specialty drugs affected by these restrictions. ***Contact Us:*** If you have any questions about this program, or need assistance with your specialty drug orders, please call 888-346-3731, TTY: 877-853-9549.	Tier 4 (preferred specialty drug): $65 copayment for each purchase of up to a 30-day supply ($185 copayment for a 31 to 90-day supply) (no deductible) Tier 5 (non-preferred specialty drug): $85 copayment for each purchase of up to a 30-day supply ($240 copayment for a 31 to 90-day supply) (no deductible)	Tier 4 (preferred specialty drug): $85 copayment for each purchase of up to a 30-day supply ($235 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $110 copayment for each purchase of up to a 30-day supply ($300 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 4 (preferred specialty drug): $80 copayment for each purchase of up to a 30-day supply ($210 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $100 copayment for each purchase of up to a 30-day supply ($255 copayment for a 31 to 90-day supply)

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
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. To qualify, create a Tobacco Cessation Quit Plan using our Online Health Coach. For more information, see page 125. 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 • Brand-name medications available by prescription: - Chantix 0.5 mg tablet - Chantix 1 mg continuing monthly pack - Chantix 1 mg tablet - Chantix starting monthly pack - Nicotrol cartridge inhaler - Nicotrol NS Spray 10 mg/ml • Over-the-counter (OTC) medications Note: 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. Note: These benefits apply only when all of the criteria listed above are met. 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. Note: See page 61 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	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Remicade, Renflexis, and Inflectra are not covered for prescriptions obtained from a retail pharmacy, Mail Service Prescription or through the Specialty Drug Program* • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Drugs and supplies for weight loss* • *Drugs for orthodontic care, dental implants, and periodontal disease* • *Drugs used in conjunction with assisted reproductive technology (ART) and assisted insemination procedures* • *Insulin and diabetic supplies except when obtained from a retail pharmacy or through the Mail Service Prescription Drug Program, or except when Medicare Part B is primary (see pages 58 and 110)* • *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 page 112 for our coverage of medications recommended under the Affordable Care Act and page 117 for smoking and tobacco cessation medications.* • *Medical foods administered orally are not covered if not obtained at a retail pharmacy or through the Mail Service Prescription Drug Program* *Note: See Section 5(a), page 58, 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), page 58 for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.* • *Infant formula other than described on pages 58 and 109*	*All charges*	*All charges*

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• *Drugs for which prior approval has been denied or not obtained* • *Drugs and supplies related to sexual dysfunction or sexual inadequacy* • *Drugs and covered-drug-related supplies for the treatment of gender dysphoria if not obtained from a retail pharmacy or through the Mail Service Prescription Drug Program or Specialty Drug Pharmacy Program as described on page 110* • *Drugs purchased through the mail or internet from pharmacies outside the United States by members located in the United States* • *Over-the-counter (OTC) contraceptive drugs and devices, except as described on page 110* • *Drugs used to terminate pregnancy* • *Sublingual allergy desensitization drugs, except as described on page 51*	*All charges*	*All charges*
Drugs From Other Sources	**Standard Option**	**Basic Option**
Covered prescription drugs and supplies not obtained at a retail pharmacy, through the Specialty Drug Pharmacy Program, or, for Standard Option members and Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program. This includes drugs and supplies covered only under the medical benefit. Note: We cover drugs and supplies purchased overseas as shown here, as long as they are the equivalent to drugs and supplies that by Federal law of the United States require a prescription. Please refer to page 131 in Section 5(i) for more information. Note: For covered prescription drugs and supplies purchased outside of the United States, Puerto Rico, and the U.S. Virgin Islands, please submit claims on an Overseas Claim Form. See Section 5(i) for information on how to file claims for overseas services. • Please refer to the Sections indicated for additional benefit information related to drugs obtained from other sources: - Physician's office – Section 5(a) - Facility (inpatient or outpatient) – Section 5(c) - Hospice agency – Section 5(c) • Please refer to page 114 for prescription drugs obtained from a Preferred retail pharmacy, that are billed for by a skilled nursing facility, nursing home, or extended care facility.	Preferred: 15% of the Plan allowance (deductible applies) Participating professional provider: 35% of the Plan allowance (deductible applies) Non-participating professional provider: 35% of the Plan allowance (deductible applies) plus any difference between our allowance and the billed amount Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating professional provider: You pay all charges Non-participating professional provider: You pay all charges Member/Non-member facilities: You pay all charges

Drugs From Other Sources - continued on next page

Benefits Description	You Pay	
Drugs From Other Sources (cont.)	**Standard Option**	**Basic Option**
• Auto-immune infusion medications: Remicade, Renflexis and Inflectra Note: 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).	Preferred: 10% of the Plan allowance (deductible applies) Participating professional provider: 15% of the Plan allowance (deductible applies) Non-participating professional provider: 15% of the Plan allowance (deductible applies) plus any difference between our allowance and the billed amount Member facilities: 15% of the Plan allowance (deductible applies) Non-member facilities: 15% of the Plan allowance (deductible applies), plus any difference between our allowance and billed amount.	Preferred: 15% of the Plan allowance Participating professional provider: You pay all charges Non-participating professional provider: You pay all charges Member/Non-member facilities: 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 FEHB Plan will be the primary payor for any covered services and your FEDVIP Plan will be secondary to your FEHB 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.
- Note: 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. We cover these services 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 (even if the dental procedure itself is not covered). See Section 5(c) for inpatient and outpatient hospital benefits.
- **Under Standard Option,**
  - The calendar year deductible of $350 per person ($700 per Self Plus One or Self and Family enrollment) applies only to the accidental injury benefit below.
- **Under Basic Option,**
  - There is **no calendar year deductible.**
  - **You must use Preferred providers in order to receive benefits, except in cases of dental care resulting from an accidental injury as described below.**

Benefit Description	You Pay	
Accidental Injury Benefit	**Standard Option**	**Basic Option**
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. Note: 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.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Note: Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.	$30 copayment for associated oral evaluations 30% of the Plan allowance for all other care Note: **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 amounts as shown above. If you use a non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

Accidental Injury Benefit - continued on next page

Benefit Description	You Pay	
Accidental Injury Benefit (cont.)	**Standard Option**	**Basic Option**
Note: 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.	See previous page	See previous page

Dental Benefits

What is Covered

Standard Option dental benefits are presented in the chart on the following page.

Basic Option dental benefits appear on page 124.

Note: See Section 5(b) for our benefits for Oral and maxillofacial surgery, and Section 5(c) for our benefits for hospital services (inpatient/outpatient) in connection with dental services, available under both Standard Option and Basic Option.

Preferred Dental Network

All Local Plans contract with Preferred dentists who are available in most areas. Preferred dentists agree to accept a negotiated, discounted amount called the Maximum Allowable Charge (MAC) as payment in full for the following services. They will also file your dental claims for you. Under Standard Option, you are responsible, as an out-of-pocket expense, for the difference between the amount specified in this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you, 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. You can also call us to obtain a copy of the applicable MAC listing.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service phone number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

Standard Option Dental Benefits

Under Standard Option, we pay billed charges for the following services, up to the amounts shown per service as listed in the Schedule of Dental Allowances below and on the following page. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments, or coinsurance. When you use non-preferred dentists, you pay all charges in excess of the listed fee schedule amounts. For Preferred dentists, you pay the difference between the fee schedule amount and the MAC (see page 122).

Standard Option Dental Benefits	Standard Option Only		
Covered Service	**We Pay to Age 13**	**We Pay Age 13 and Over**	**You Pay**
Clinical oral evaluations			All charges in excess of the scheduled amounts listed to the left Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Periodic oral evaluation *(up to 2 per person per calendar year)*	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
Diagnostic imaging			All charges in excess of the scheduled amounts listed to the left Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Intraoral complete series	$36	$22	
Palliative treatment			All charges in excess of the scheduled amounts listed to the left Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Palliative treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive			All charges in excess of the scheduled amounts listed to the left Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Prophylaxis – adult *(up to 2 per person per calendar year)*	---	$16	
Prophylaxis – child *(up to 2 per person per calendar year)*	$22	$14	
Topical application of fluoride or fluoride varnish (*up to 2 per person per calendar year*)	$13	$8	
Not covered: Any service not specifically listed above	*Nothing*	*Nothing*	*All charges*

Basic Option Dental Benefits

Under Basic Option, we provide benefits for the services listed below. You pay a $30 copayment for each evaluation, and we pay any balances up to the Maximum Allowable Charge (MAC; see page 122). This is a complete list of dental services covered under this benefit for Basic Option. You **must** use a Preferred dentist in order to receive benefits. For a list of Preferred dentists, 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.

Basic Option Dental Benefits	Basic Option Only	
Covered Service	**We Pay**	**You Pay**
Clinical oral evaluations Periodic oral evaluation* Limited oral evaluation Comprehensive oral evaluation* *Benefits are limited to a combined total of 2 evaluations per person per calendar year	Preferred: All charges in excess of your $30 copayment Participating/Non-participating: Nothing	Preferred: $30 copayment per evaluation Participating/Non-participating: You pay all charges
Diagnostic imaging Intraoral – complete series including bitewings (*limited to 1 complete series every 3 years*)	Preferred: All charges in excess of your $30 copayment Participating/Non-participating: Nothing	Preferred: $30 copayment per evaluation Participating/Non-participating: You pay all charges
Preventive Prophylaxis – adult *(up to 2 per calendar year)* Prophylaxis – child *(up to 2 per calendar year)* Topical application of fluoride or fluoride varnish – for children only *(up to 2 per calendar year)* Sealant – per tooth, first and second molars only *(once per tooth for children up to age 16 only)*	Preferred: All charges in excess of your $30 copayment Participating/Non-participating: Nothing	Preferred: $30 copayment per evaluation Participating/Non-participating: You pay all charges
Not covered: Any service not specifically listed above	*Nothing*	*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** – Complete this online health and lifestyle questionnaire and receive additional assistance with your healthcare expenses. See below and page 126 for more information. • **Online Health Coach (OHC)** – Manage your health proactively by setting and managing health goals, create a plan of care, track your progress, and pursue healthy activities. The OHC offers members a combination of guidance, support, and resources. • **Tobacco Cessation Incentive Program** – If you would like to quit smoking, you can participate in this program and receive tobacco cessation products at no charge. Create a Tobacco Cessation Quit Plan using our Online Health Coach. You will then be eligible to receive certain smoking and tobacco cessation medications at no charge. Both prescription and over-the-counter (OTC) tobacco cessation products obtained from a Preferred retail pharmacy are included in this program. See page 117 for more information. Note: There may be age-restrictions based on U.S. FDA guidelines for these medications. • **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.
Diabetes Management Program	The Diabetes Management Program is a program to help members with diabetes manage their condition. All members with type 1 and type 2 diabetes, including those for whom Medicare is primary, are eligible for this program. You will receive a free glucose meter and have unlimited test strips and lancets shipped directly to you. Automated reordering is based on your usage. Personalized coaching and support are also provided. The program offers live interventions triggered by acute alerts based on your glucose meter test results. Member support is offered 24/7/365. For more information go to www.fepblue.org/diabetes.
Blue Health Assessment	The **Blue Health Assessment (BHA**) questionnaire is an easy and engaging online health evaluation program which can be completed in 10-15 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 Health Coach.

	When you complete your BHA, you are entitled to receive a $50 health account to be used for most qualified medical expenses. For those with Self Plus One or Self and Family coverage, both the contract holder and spouse are eligible for the $50 health account. We will send each eligible member a debit card to access their account. Please keep your card for future use even if you use all of your health account dollars; you may be eligible for wellness incentives in subsequent benefit years. We do not send new cards to continuing participants until the card expires. If you leave the Service Benefit Plan, any money remaining in your account will be forfeited. In addition to the $50 health account, you are entitled to receive a maximum of $120 in additional credit to your health account for achieving up to three personalized goals. After completing the BHA, you may access the Online Health Coach to set personalized goals designed to improve your health through increased exercise, healthier nutrition habits, managing your weight, reduced stress, better emotional health, or goals that focus on managing a specific condition. We will add $40 to your health account for each goal achieved, up to a maximum of three goals per year. By completing the BHA and a maximum of three health goals, you can earn up to a total of $170 in health account dollars. You must complete the BHA and your selected goals during the calendar year in order to receive these incentives. **Health account dollars are available only when you complete goals related to exercise, nutrition, weight management, stress, emotional health, heart disease, heart failure, hypertension, chronic obstructive pulmonary disease (COPD) and asthma and are limited to a maximum of three completed goals per calendar year.** Note: In order to receive your incentives, **you must complete all eligible activities no later than December 31, 2021**. Please allow ample time to complete all activities by this date. 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.
Diabetes Management Incentive Program	The **Diabetes Management Incentive Program** is designed to encourage members to achieve and maintain control of their blood sugar and help manage or slow the progression of complications related to diabetes. Through this program you can earn a maximum of $100 toward a health account to be used for most qualified medical expenses. This incentive is in addition to other incentives described in this brochure and is available to all covered adult members, age 18 and over. To qualify for the Diabetes Management Incentive Program, each eligible member must have at least one medical claim that has been processed during the past 12 months with a reported diagnosis of diabetes and complete the following steps: • Provide us with lab test results for an HbA1c performed in the first 6 months of the calendar year (January 1 to June 30) to receive a $25 incentive reward. • Provide us with lab test results for an HbA1c performed in the last 6 months of the calendar year (July 1 to December 31) to receive a $75 incentive reward; the test results must show: - Your HbA1c result is less than 8 percent; or - If your HbA1c is greater than or equal to 8 percent, you will receive the incentive if we provided benefits for three nutritional counseling visits performed during the calendar year. Note: See pages 43 and 46 for information on nutritional counseling. Information on how to submit your HbA1c lab results can be found on our website, www.fepblue.org/diabetes. See page 111 for information about the Diabetic Meter Program.
Hypertension Management Program	The **Hypertension Management Program** gives members age 18 and older 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. This program is available to the contract holder and spouse who meet the following criteria. You will be automatically enrolled in the program, and will be informed of your eligibility to receive a free BPM after the following criteria are met:

	• You complete the Blue Health Assessment (BHA), and indicate that you have been diagnosed with hypertension. • At least one medical claim has been processed during the past 12 months with a reported diagnosis of hypertension. Once you meet these criteria, you will be sent a letter advising you of your eligibility for the free BPM. You are eligible to receive a free BPM every two calendar years. You must follow the directions in the letter, which include taking the letter to your healthcare provider. Your provider is responsible for documenting your most recent blood pressure reading, and identifying the appropriate BPM size for you. 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. See page 108 for information on preferred generic anti-hypertensive medications.
Pregnancy Care Incentive Program	The **Pregnancy Care Incentive Program** is designed to encourage early and ongoing prenatal care that improves baby's birth weight and decreased risk of preterm labor. Pregnant members can earn a Pregnancy Care Box (with pregnancy gifts and information) and $75 toward a health account to be used for most qualified medical expenses. This incentive is in addition to other incentives described in this brochure. All covered adult members, age 18 and over may be eligible for this incentive. To qualify for the Pregnancy Care Box, you must be pregnant. Information on the program is available on our website, www.fepblue.org. To qualify for the $75 incentive, you must meet the criteria above for the Pregnancy Care Box and send us a copy of your healthcare provider's medical record that confirms you had a prenatal care visit during the first trimester of your pregnancy. Information that must be included when submitting your medical record can be found on our website, www.fepblue.org/maternity. To receive the Pregnancy Care Box or the $75 incentive reward, members must complete all requirements of the program during the benefit year, and either the first prenatal visit or the delivery must occur during the benefit year. These incentives are offered per pregnancy and are limited to two pregnancies per calendar year.
Annual Incentive Limitation	Financial incentives earned through participation in the Blue Health Assessment, personalized goals through the Online Health Coach, the Diabetes Management Incentive Program, and the Pregnancy Care Incentive Program are limited to a total of $420 per person per calendar year for the contract holder and spouse.
Reimbursement Account for Basic Option Members Enrolled in Medicare Part A and Part B	Basic Option members enrolled in Medicare Part A and Part B are eligible to be reimbursed up to $800 per calendar year for their Medicare Part B premium payments. The account is used to reimburse member-paid Medicare Part B premiums. For more information on how to obtain reimbursement, please visit www.fepblue.org/mra or call 888-706-2583.
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 a duplicate or replacement Service Benefit Plan ID card, and track how you use your benefits. Additional features include: • **Online EOBs** – You can view, download, and print your explanation of benefits (EOB) forms. Simply log on to MyBlue Customer eService 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. You can also access EOBs via the fepblue mobile app. Simply link to MyBlue, and click on Claims.

	• **Opt In or Out of Mailed Paper EOBs** – The Service Benefit Plan offers an environmentally friendly way of accessing your EOBs via www.fepblue.org/myblue. You can opt in or out of receiving mailed paper EOBs by following the on-screen instructions. • **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, MyBlue Wellness Card balance, 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. Note: Benefits for care provided by residential treatment centers and for inpatient care provided by skilled nursing facilities for members enrolled in Standard Option who do not have Medicare Part A require written consent and participation in Case Management prior to admission; please see pages 87-88, 100 and 130 for additional information. • **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, 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: 855-636-1578, 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 (see page 155 for definition), dermatology care, counseling for behavioral health and substance use disorder, and nutritional counseling. Note: This benefit is available only through the contracted telehealth provider network.
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 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 Explanations of Benefits (EOBs), view/share member ID cards, locate in-network providers, and connect with our telehealth services.

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 below and pages 131-132 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 for gender reassignment surgery (see pages 22 and 66-67 for information) and admissions to residential treatment centers and skilled nursing facilities. Prior approval is required for all non-emergent air ambulance transport services for overseas members (refer to page 92 for more information). Protections offered under the NSA (see page 32) do not apply to overseas claims.

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 GMMI), 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@gmmi.com. GMMI 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 Basic Option requirement to use Preferred providers in order to receive benefits does not apply when you receive overseas care. Standard Option members have no deductible for overseas services.**

Under both Standard and Basic Options, 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 your coinsurance and/or copayment amounts. You must also pay any charges for noncovered services.

For **inpatient facility care** you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options. For Basic Option, there is no member cost-share** for admissions to a DoD facility, or when the Overseas Assistance Center (provided by GMMI) has arranged direct billing or acceptance of a guarantee of benefits with the facility. For all other inpatient facility care, Basic Option members are responsible for the per admission copayment. Standard Option members have no cost-share for inpatient facility care.

For **outpatient facility care** you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options** after you pay the applicable copayment or coinsurance. Standard Option members have no deductible for overseas services.

For **dental care** you receive overseas, we provide benefits as described in Section 5(g). **Under Standard Option,** you must pay any difference between the Schedule of Dental Allowances and the dentist's charge, in addition to any charges for noncovered services. **Under Basic Option**, you must pay the $30 copayment plus any difference between our payment and the dentist's charge, as well as any charges for noncovered services.

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. **Under Standard and Basic Options**, members pay the applicable copayment.

Pharmacy benefits

For **prescription drugs purchased at overseas pharmacies,** we provide benefits at Preferred benefit levels, using the billed charge as our Plan allowance. Under both Standard and Basic Options, members pay the applicable coinsurance. Standard Option members are not required to meet the calendar year deductible when they purchase drugs at pharmacies located overseas. See page 119 in 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 260070, Pembroke Pines, FL 33026.
2. Fax: 001-954-308-3957. 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@gmmi.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. Timely filing 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 the Mail Service Prescription Drug Program or 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 U.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 options, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program.

The Mail Service Prescription Drug Program is available to Standard Option members and to Basic Option members with primary Medicare Part B coverage.

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 either our Mail Service Prescription Drug Program or 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-FEHB Benefits Available to Plan Members

These benefits are not part of the FEHB contract or premium, and you cannot file an FEHB dispute regarding these benefits. Fees paid for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. In addition, these services are not eligible for benefits under the FEHB 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 offers exclusive health and wellness deals that will assist in your efforts to be healthy and happy, every day of the year. Blue365 delivers top discounts from national and local retailers such as hearing aids through TruHearing, healthy food delivery via Sun Basket, wearable devices from Fitbit, and genetic composition testing by Molecular Fitness, just to name a few. Each week, Blue365 members receive great health and wellness deals via email. With Blue365, there is no paperwork to fill out. Just visit www.fepblue.org/blue365. Select Get Started and then log in to MyBlue with your username and password 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.

Health Club Memberships – Fitness Your Way by Tivity Health can help you meet your health and fitness goals, on your budget, and on your own time. Fitness Your Way by Tivity Health offers access to more than 10,000 different fitness locations for a discounted monthly rate. You'll have access to well-being support, health articles, and online health coaching, as well as exercise tracking and nutrition goals, social networking, rewards, and the Daily Challenge 24 hours a day, 7 days a week. For more information or to enroll, visit www.fepblue.org/healthclub or call customer service at 888-242-2060, Monday through Friday, 8 a.m. – 8 p.m., in all U.S. time zones.

Discount Drug Program – The Discount Drug Program is available to members 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 Service Benefit Plan 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.

Vision Care Affinity Program – Service Benefit Plan members can receive routine eye exams, frames, lenses, and conventional contact lenses at substantial savings when using Davis Vision network providers. Members can also save up to 25% off the provider's usual fee, or 5% off sales pricing, on laser vision correction procedures. There are over 48,000 points of access including optometrists, ophthalmologists, and many retailers. For a complete description of the program or to find a provider near you, go to www.fepblue.org/vcap. You may also call us at 888-897-9350 between 8:00 a.m. and 11:00 p.m. Eastern Time, Monday to Friday; 9:00 a.m. to 4:00 p.m. on Saturday; or noon to 4:00 p.m. on Sunday. Please be sure to verify that the provider participates in our Vision Care Affinity Program and ask about the discounts available before your visit, as discounts may vary.

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 (see definition on page 155).
- 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 and gender reassignment surgeries specifically listed as covered).
- Travel expenses except as specifically provided for covered transplants performed in a Blue Distinction Center for Transplant (see page 76).
- Services, drugs, or supplies you receive from a provider or facility barred or suspended from the FEHB 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 (see page 149), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 150), or state premium taxes however applied.
- 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, drugs, or supplies for the treatment of obesity, weight reduction, or dietary control, except for office visits, diagnostic tests, and procedures and services for the treatment of morbid obesity listed on page 65.
- 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*.
- 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), the preventive screenings specifically listed on pages 42-46 and page 85; and certain routine services associated with covered clinical trials (see page 144).
- 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 (see page 118), meditation techniques, relaxation techniques, movement therapies, and energy therapies.
- Services, drugs, or supplies related to medical marijuana.
- Advanced care planning, except when provided as part of a covered hospice care treatment plan (see page 90).
- 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.

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 Service Benefit Plan ID card, or at our website at www.fepblue.org.

In most cases, physicians and facilities file claims for you. Just present your Service Benefit Plan ID card when you receive services. Your 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, through the Mail Service Prescription Drug Program, or through the Specialty Drug Pharmacy Program must include receipts that show the prescription number, name of drug or supply, prescribing provider's name, date, and charge. (See pages 137-138 for information on how to obtain benefits from the Retail Pharmacy Program, the Mail Service Prescription Drug 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 Service Benefit Plan 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 Service Benefit Plan ID card;
- You do not use your valid Service Benefit Plan ID card at the time of purchase; or
- You did not obtain prior approval when required (see page 24).

See the following paragraphs for claim filing instructions.

Non-preferred Retail Pharmacies

Standard Option: You must file a paper claim for any covered drugs or supplies you purchase at Non-preferred retail pharmacies. Contact your Local Plan or call 800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TTY equipment may call 800-624-5077. Follow the instructions on the prescription drug claim form and submit the completed form to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

Basic Option: There are **no benefits** for drugs or supplies purchased at Non-preferred retail pharmacies.

Mail Service Prescription Drug Program

Eligible members: We will send you information on our Mail Service Prescription Drug Program, including an initial mail order form. To use this program:

1. Complete the initial mail order form;
2. Enclose your prescription and copayment;
3. Mail your order to CVS Caremark, P.O. Box 1590, Pittsburgh, PA 15230-1590; and
4. Allow up to two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 800-262-7890, TTY: 800-216-5343. You are responsible for the copayment. You are also responsible for the copayments for refills ordered by your physician.

After that, to order refills either call the same phone number or access our website at www.fepblue.org and either charge your copayment to your credit card or have it billed to you later. Allow up to ten days for delivery on refills.

Note: Specialty drugs will not be dispensed through the Mail Service Prescription Drug Program. See page 116 for information about the Specialty Drug Pharmacy Program.

Basic Option: The Mail Service Prescription Drug Program is available only to members with primary Medicare Part B coverage under Basic Option.

Specialty Drug Pharmacy Program

Standard and Basic Options: If your physician prescribes a specialty drug that appears on our Service Benefit Plan Specialty Drug List, your physician may order the initial prescription by calling our Specialty Drug Pharmacy Program at 888-346-3731, TTY: 877-853-9549, 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 are 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: 877-853-9549, or visit our website, www.fepblue.org.

Records

Keep a separate record of the medical expenses of each covered family member, because deductibles (under Standard Option) and benefit maximums (such as those for outpatient physical therapy or preventive dental care) apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible under Standard Option. 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 year after the year 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 from the prescription fill date.

Note: Once we pay benefits, there is a five-year limitation on the re-issuance of uncashed checks.

Overseas claims

Please refer to the claims filing information on pages 131-132 of this brochure.

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 percent 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 Federal Employees 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 enrollment card, our brochure, or our website (www.fepblue.org).

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 Service Benefit Plan 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, Mail Service Prescription Drug 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, Mail Service Prescription Drug 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, Federal Employee Insurance Operations, FEHB 1, 1900 E Street NW, Washington, DC 20415-3610.

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 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 Service Benefit Plan 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 FEHB 1 at 202-606-0727 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 dependent 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.

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 pays, 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 (under Standard Option) and coinsurance or copayment amounts, except when Medicare is the primary payor (see page 150). 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 (under Standard Option) 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 FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable Plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

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 Programs (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 FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB 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 FEHB plans already cover some dental and vision services. When you are covered by more than one dental/vision plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB 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 pages 69-76. **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 "Should I enroll in Medicare?" please contact Medicare at 1-800-Medicare 800-633-4227, TTY: 877-486-2048, or at www.medicare.gov.

- **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 page 21 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 Service Benefit Plan ID card or visit our website at www.fepblue.org.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

When Medicare Part A is primary –

- Under **Standard Option,** we will waive our:
  - Inpatient hospital per-admission copayments; and

- Inpatient Member and Non-member hospital coinsurance.

- Under **Basic Option,** we will waive our:
  - Inpatient hospital per-day copayments.

Note: Once you have exhausted your Medicare Part A benefits:

- Under **Standard Option**, you must then pay any difference between our allowance and the billed amount at Non-member hospitals.
- Under **Basic Option**, you must then pay the inpatient hospital per-day copayments.

When Medicare Part B is primary –

- Under **Standard Option**, we will waive our:
  - Calendar year deductible;
  - Coinsurance and copayments for inpatient and outpatient services and supplies provided by physicians and other covered healthcare professionals; and
  - Coinsurance for outpatient facility services.
- Under **Basic Option**, we will waive our:
  - Copayments and coinsurance for care received from covered professional and facility providers.

Note: We do not waive benefit limitations, such as the 25-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: 877-486-2048, 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 Medicare Advantage plan and also remain enrolled in our FEHB 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.

Under Standard Option, we will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments, coinsurance, or deductibles, if you receive services from providers who do not participate in the Medicare Advantage plan.

Under Basic Option, 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. However, we will not waive any of our copayments or coinsurance for services you receive from Preferred providers who do not participate in the Medicare Advantage plan. Please remember that you must receive care from Preferred providers in order to receive Basic Option benefits. See page 20 for the exceptions to this requirement.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB 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 enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

- **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 FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓*
9) Are a Federal 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 FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*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, 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 FEHB 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 former spouse, or as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB 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 deductible (Standard Option only), 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 applicable 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:	Then you are responsible for:	
	Standard Option	**Basic Option**
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	your deductibles, coinsurance, and copayments.	your copayments and coinsurance.
Participates with Medicare or accepts Medicare assignment and is not in our Preferred network	your deductibles, coinsurance, and copayments, and any balance up to the Medicare-approved amount.	all charges.
Does not participate with Medicare and is in our Preferred network 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.	your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare-approved amount.	your copayments and coinsurance, and any balance up to 115% of the Medicare-approved amount.
Does not participate with Medicare and is not in our Preferred network	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare-approved amount.	all charges.
Opts-out of Medicare via private contract	your deductibles, coinsurance, copayments, and any balance your physician charges.	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.

- If your physician **accepts** Medicare assignment, you pay nothing for covered charges (see note below for Basic Option).
- 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 (see note below for Basic Option).

Note: **Under Basic Option,** you must see **Preferred** providers in order to receive benefits. See page 20 for the exceptions to this requirement.

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 table 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
Standard Option You Pay **Without** Medicare: $350-Self, $700-Family
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: N/A
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
Standard Option You Pay **Without** Medicare: $8,000-Self, $16,000-Family
Standard Option You Pay **With** Medicare Parts A & B: $8,000-Self, $16,000-Family
Basic Option You Pay **Without** Medicare: $6,500-Self, $13,000-Family
Basic Option **With** Medicare Parts A & B: $6,500-Self, $13,000-Family

Benefit Description: Part B Premium Reimbursement
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Parts A & B: N/A
Basic Option You Pay **Without** Medicare: N/A
Basic Option **With** Medicare Parts A & B: $800

Benefit Description: Primary Care Physician
Standard Option You Pay **Without** Medicare: $25
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: $30
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Specialist
Standard Option You Pay **Without** Medicare: $35
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: $40
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Inpatient Hospital
Standard Option You Pay **Without** Medicare: $450
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: $175/day up to $875
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Outpatient Hospital
Standard Option You Pay **Without** Medicare: 15% or $25 copayment
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: 30% or $30-$500 copayment
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Incentives Offered
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Parts A & B: N/A
Basic Option You Pay **Without** Medicare: N/A
Basic Option **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.

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 a woman, combine them with sperm in the laboratory, and then implant the embryos or donate them to another woman.

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 page 29.

Concurrent care claims — A claim for continuing care or an ongoing course of treatment that is subject to prior approval. See page 26 in 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 page 28.

Cosmetic surgery Any surgical procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury, or to restore or correct a part of the body that has been altered as a result of disease or surgery or to correct a congenital anomaly.

Cost-sharing See Section 4 page 28.

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 page 17 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.

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 pages 21-26.

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.

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. For more information, see pages 7-8.

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. 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** – 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. (See page 123 for special information about limits on the amounts Preferred dentists can charge you under Standard Option.)
- **Participating providers**– Our allowance (which we may refer to as the "PAR" for "Participating Provider Allowance") 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** – We have no agreements with these providers to limit what they can bill you for their services. This means that using Non-participating providers 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, non-emergency 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 the Local Plan Allowance. This allowance applies to all of the covered services billed by the hospital. If you plan on using a Non-member hospital, or other Non-member facility, for your outpatient procedure, please call us before you receive services at the customer service phone number on the back of your ID card to obtain the current allowed amount and assistance in estimating your total out-of-pocket expenses.
  - For outpatient dialysis services performed or billed by hospitals and other facilities that do not contract with the local Blue Cross and Blue Shield Plan ("Non-member facilities"), our allowance is the Local Plan allowance in the geographic area in which the care was performed or obtained. This allowance applies to the covered dialysis services billed by the hospital or facility. Contact your Local Plan if you need more information.

    Please keep in mind that Non-member facilities may bill you for any difference between the allowance and the billed amount. You may be able to reduce your out-of-pocket expenses by using a Preferred hospital for your outpatient surgical procedure or dialysis. To locate a Preferred provider, visit www.fepblue.org/provider to use our National Doctor and Hospital Finder, or call us at the customer service phone number on the back of your ID card;

- 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 non-emergency medical services performed in Preferred hospitals provided by physicians and other covered healthcare professionals identified under the NSA (see page 32) 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 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 Allowance. 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 emergency medical 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 the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations;
- For prescription drugs furnished by retail pharmacies that do not contract with CVS Caremark, our allowance is the average wholesale price ("AWP") of a drug on the date it is dispensed, as set forth by Medi-Span in its national drug data file; and
- 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 GMMI), 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 Non-participating providers!

Note: **Using Non-participating or Non-member providers 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 page 32.

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see pages 32 and 130.

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 or prior approval, and (2) where failure to obtain precertification or prior approval 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; 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, the Mail Service Prescription Drug 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*, on pages 21-24.

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 on page 144).

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 Service Benefit Plan 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 (see page 155 for definition), dermatology care, behavioral health and substance use disorder counseling, and nutritional counseling. Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 855-636-1578, toll free to access this benefit. After your telehealth visit, please follow up with your primary care provider.

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 Service Benefit Plan 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.

You/Your "You" and "your" refer to the enrollee (the contract holder eligible for enrollment and coverage under the Federal Employees 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 Standard Option – 2022

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 decision, please read this FEHB 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 $350 per person ($700 per Self Plus One or Self and Family enrollment) calendar year deductible. If you use a Non-PPO physician or other healthcare professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

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.

Standard Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	PPO: Nothing for preventive care; 15%* of our allowance; $25 per office visit for primary care physicians and other healthcare professionals $35 per office visit for specialists Non-PPO: 35%* of our allowance	39-46
Medical services provided by physicians: Telehealth services	PPO: Nothing for the first 2 visits per calendar year after the 2nd visit: $10 copayment per visit Non-PPO: You pay all charges	39, 99
Services provided by a hospital: Inpatient	PPO: $350 per admission Non-PPO: $450 per admission, plus 35% of our allowance	79-81
Services provided by a hospital: Outpatient	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	81-85
Emergency benefits: Accidental injury	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: 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	95-96
Emergency benefits: Medical emergency	PPO urgent care: $30 copayment; PPO and Non-PPO emergency room care: 15%* of our allowance; Regular benefits for physician and hospital care* provided in other than the emergency room/PPO urgent care center Ambulance transport services: $100 per day for ground ambulance (no deductible); $150 per day for air or sea ambulance (no deductible)	96-97

Standard Option Benefits	You pay	Page
Mental health and substance use disorder treatment	PPO: Regular cost-sharing, such as $25 office visit copay; $350 per inpatient admission Non-PPO: Regular cost-sharing, such as 35%* of our allowance for office visits; $450 per inpatient admission to Member facilities, plus 35% of our allowance	98-102
Prescription drugs	**Retail Pharmacy Program:** • PPO: $7.50 for each purchase of up to a 30-day supply generic ($5.00 for a 30-day supply if you have Medicare Part B primary)/30% of our allowance Preferred brand-name/50% of our allowance non-preferred brand-name • Non-PPO: 45% of our allowance (AWP) **Mail Service Prescription Drug Program:** • $15 generic ($10 if you have Medicare Part B primary)/$90 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply **Specialty Drug Pharmacy Program:** • $65 preferred specialty drug for a purchase of up to a 30-day supply; $85 non-preferred specialty drug for a purchase of up to a 30-day supply	108-120
Dental care	Scheduled allowances for diagnostic and preventive services; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	123
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option	See Section 5(h).	125-129
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $6,000 (PPO) or $8,000 (PPO/Non-PPO) per contract per year • Self Plus One: Nothing after $12,000 (PPO) or $16,000 (PPO/Non-PPO) per contract per year • Self and Family: Nothing after $12,000 (PPO) or $16,000 (PPO/Non-PPO) per contract per year Note: Some costs do not count toward this protection. Note: 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.	32-33

Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2022

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 decision, please read this FEHB 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.

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 20. There is no deductible for Basic Option.

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.

Basic Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	PPO: Nothing for preventive care; $30 per office visit for primary care physicians and other healthcare professionals; $40 per office visit for specialists Non-PPO: You pay all charges	39-46
Medical services provided by physicians: Telehealth services	PPO: Nothing for the first 2 visits per calendar year after the 2nd visit: $15 copayment per visit Non-PPO: You pay all charges	39, 99
Services provided by a hospital: Inpatient	PPO: $175 per day up to $875 per admission Non-PPO: You pay all charges	79-81
Services provided by a hospital: Outpatient	PPO: $100 per day per facility Non-PPO: You pay all charges	81-85
Emergency benefits: Accidental injury	PPO: $35 copayment for urgent care; $175 copayment for emergency room care Non-PPO: $175 copayment for emergency room care; you pay all charges for care in settings other than the emergency room Ambulance transport services: $100 per day for ground ambulance; $150 per day for air or sea ambulance	95-96
Emergency benefits: Medical emergency	Same as for accidental injury	96-97
Mental health and substance use disorder treatment	PPO: Regular cost-sharing, such as $30 office visit copayment; $175 per day up to $875 per inpatient admission Non-PPO: You pay all charges	98-102

Basic Option Benefits	You pay	Page
Prescription drugs	**Retail Pharmacy Program:** • PPO: $10 generic/$55 Preferred brand-name per prescription ($50 if you have primary Medicare Part B)/60% coinsurance ($75 minimum) for non-preferred brand-name drugs (50% ($60 minimum) if you have primary Medicare Part B) • Non-PPO: You pay all charges **Specialty Drug Pharmacy Program:** • $85 preferred specialty drug for a purchase of up to a 30-day supply; $110 non-preferred specialty drug for a purchase of up to a 30-day supply **Mail Service Prescription Drug Program** (for primary Medicare Part B members only): • $20 generic/$100 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply	108-120
Dental care	PPO: $30 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; $30 copayment for associated oral evaluations required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	124
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option	See Section 5(h).	125-129
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $6,500 (PPO) per contract per year • Self Plus One: Nothing after $13,000 (PPO) per contract per year • Self and Family: Nothing after $13,000 (PPO) per contract per year; nothing after $6,500 (PPO) per individual per year Note: Some costs do not count toward this protection. Note: 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.	32-33

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2022 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Nationwide Standard Option					
Standard Option Self Only	104	$244.86	$127.47	$530.53	$276.19
Standard Option Self Plus One	106	$524.63	$289.61	$1,136.70	$627.49
Standard Option Self and Family	105	$574.13	$314.11	$1,243.95	$680.57
Nationwide Basic Option					
Basic Option Self Only	111	$240.56	$80.18	$521.21	$173.73
Basic Option Self Plus One	113	$524.63	$196.13	$1,136.70	$424.95
Basic Option Self and Family	112	$574.13	$212.29	$1,243.95	$459.96