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2024 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan FEP Blue Focus – 2024 Page 140

Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan FEP Blue Focus – 2024

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure.

You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.fepblue.org/brochure.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the \$500 per person (\$1,000 per Self Plus One or Self and Family enrollment) calendar year deductible. If you use a Non-PPO physician, benefits are not provided.

Medical services provided by physicians, specialists and other healthcare professionals: Preventive, adult

You pay:

Preferred provider: Nothing

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

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Medical services provided by physicians, specialists and other healthcare professionals: Preventive, child

You pay:

Preferred provider: Nothing

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

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Medical services provided by physicians, specialists and other healthcare professionals:

Professional Visits

You pay:

Preferred provider: \$10 for the first 10 visits per calendar year (combined medical and mental health and substance use disorder)

After the 10th visit: 30%* of the Plan allowance (deductible applies)

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

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Medical services provided by physicians, specialists and other healthcare professionals: Diagnostic and treatment services provided in the office

You pay:

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

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

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Medical services provided by physicians, specialists and other healthcare professionals: Telehealth services

You pay:

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

After the 2nd visit: \$10 copayment per visit

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

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Services provided by a hospital: Inpatient

You pay:

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

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

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Services provided by a hospital: Outpatient

You pay:

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

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

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