

**2026 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 – 2026**

**Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this 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](http://www.fepblue.org/brochure).

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

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

**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

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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**Emergency benefits: Accidental injury**

**You pay:**

Preferred: Nothing for outpatient hospital and physician services within 72 hours (regular benefits apply thereafter)

Non-preferred:

- Participating: Nothing for outpatient hospital and physician services within 72 hours (regular benefits thereafter)
- Non-participating: Any difference between the Plan allowance and billed amount for outpatient hospital and physician services within 72 hours; regular benefits thereafter

Ambulance transport services: Nothing

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**Emergency benefits: Medical emergency**

**You pay:**

Professional, outpatient hospital:

Preferred urgent care: \$25 copayment; PPO and Non-PPO emergency room care: 30%\* of our allowance (deductible applies); Regular benefits for physician and hospital care\* provided in other than the emergency room/PPO urgent care center

Maternity:

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

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

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**Mental health 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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**Mental health and substance use disorder treatment (inpatient and outpatient)**

**You pay:**

Preferred provider: 30%\* of the Plan allowance (deductible applies)  
Non-preferred (Participating/Non-participating): You pay all charges  
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**Prescription drugs: Retail Pharmacy Program**

**You pay:**

Preferred retail pharmacy Tier 1 (generic): \$5 copayment up to a 30-day supply  
Preferred retail pharmacy Tier 2 (brand name): 40% coinsurance of the Plan allowance (up to a \$500 maximum) for up to a 30-day supply  
Non-preferred pharmacy: You pay all charges  
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**Prescription drugs: Specialty Drug Pharmacy Program**

**You pay:**

Preferred specialty pharmacy  
Tier 2: 40% coinsurance of the Plan allowance (up to a \$500 maximum) for up to a 30-day supply  
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**Dental care**

Treatment of an accidental dental injury within 72 hours (regular benefits apply thereafter)

**You pay:**

Preferred: Nothing  
Non-Preferred:

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

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**Wellness and Other Special Features:** Health Tools; Blue Health Assessment; MyBlue® Customer eService; National Doctor and Hospital Finder; Healthy Families; Travel Benefit/Services Overseas; Care Management Programs; and Routine Annual Physical Incentive Program

**You pay:**

See Section 5(h).  
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**Protection against catastrophic costs** (your catastrophic protection out-of-pocket maximum)

**You pay:**

- Self Only: Nothing after \$10,000 per contract per year
- Self Plus One: Nothing after \$20,000 (PPO) per contract per year
- Self and Family: Nothing after \$20,000 per family per year

Notes:

- Some costs do not count toward this protection.
- When one covered family member (Self Plus One and Self and Family contracts) reaches the Self Only maximum during the calendar year, that member's claims will no longer be subject to associated member cost-share amounts for the remainder of the year. All remaining family members will be required to meet the balance of the catastrophic protection out-of-pocket maximum.

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