2026 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus
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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 PSHB 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 $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
Page(s): 38-40

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
Page(s): 40-42

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
Page(s): 36

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
Page(s): 37

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
Page(s): 36, 79

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
Page(s): 63

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
Page(s): 66-69

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)