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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

You must use those “covered professional providers” or “covered facility providers” that are Preferred providers for FEP Blue Focus in order to receive benefits. Benefits are not available for care from Non-preferred providers, except in very limited situations. Please refer to page 18 for the exceptions to this requirement. Refer to page 13 for more information about Preferred providers.

You can also get care for the treatment of minor acute conditions (see page 131 for definition), dermatology care (see page 39), and counseling for behavioral health and substance use disorder (see page 86), and nutritional counseling (see pages 41 and 44), using teleconsultation services delivered via phone by calling 855-636-1579, TTY: 711, or via secure online video/messaging at www.fepblue.org/telehealth.

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) provider 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, coinsurance) 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 transgender, non-binary, and other gender diverse members require healthcare delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

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

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