2027 Blue Cross and Blue Shield Service Benefit Plan
FEP Blue Standard and FEP Blue Basic
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.

Advance 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. Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment. OPM’s contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is 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 an ovulating individual, combine them with sperm in the laboratory, and then

implant the embryos or donate them to an individual capable of pregnancy.

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.

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

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.

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.

Doula
A doula is a non-medical trained professional who provides emotional, physical, and informational support during pregnancy, labor/delivery, and post-partum periods. Doulas must be certified to provide doula services to meet the Plan requirements of a covered provider.

Doulas eligible to provide services for any state Medicaid program in the United States or certified by

any organization recognized as providing acceptable training by any state Medicaid program will be considered a certified doula and eligible for reimbursement for services from the Plan. Training organizations include, but are not limited to:

- Childbirth and Postpartum Professional Association (CAPPA)
- Childbirth International
- Commonsense Childbirth Institute
- Doulas of North America (DONA)
- Doula Trainings International (DTI)
- International Childbirth Education Association
- National Black Doulas Association

Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.

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 Section 3 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.

Iatrogenic infertility
Infertility caused by a medically necessary medical or surgical intervention used to treat a condition or disease.

Infertility
A disease or condition characterized by the failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse, or a person's inability to reproduce either as a single individual or with their partner without medical intervention, or a licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, and/or diagnostic testing.

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 Section 3.

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.

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. Call the number on the back of your ID card for help in obtaining the Plan allowance.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 Section 5(g) 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 Section 4) 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 BCBS Global Solutions), 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 percentage 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 Section 3.

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see Section 5(i).

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*.

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).

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, dermatology care, behavioral health and substance use disorder counseling, and nutritional counseling. Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 711, 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.