

2023 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus**Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals****Page 54**

Benefit Description**Durable Medical Equipment (DME) (cont.)**

- *Communications equipment, devices, and aids (including computer equipment) such as “story boards” or other communication aids to assist communication-impaired individuals (except for speech-generating devices as listed above)*
- *Equipment for cosmetic purposes*
- *Topical Hyperbaric Oxygen Therapy (THBO)*
- *Charges associated with separate or extended warranties*

You Pay

All charges

Benefit Description**Medical Supplies**

Covered medical supplies include:

- Medical foods and nutritional supplements when administered by catheter or nasogastric tubes
Note: See page [131](#) for the definition of medical foods.
- Ostomy and catheter supplies
- Oxygen
Note: When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for oxygen, according to the contracting status of the facility. See page [77](#) for outpatient services received while in a skilled nursing facility.
- Blood and blood plasma, except when donated or replaced, and blood plasma expanders

Note: We cover medical supplies at Preferred benefit levels only when you use a Preferred medical supply provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred medical supply providers.

You Pay

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

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

Benefit Description

Not covered:

- *Infant formulas used as a substitute for breastfeeding*
- *Diabetic supplies, except as described in Section 5(f) or when Medicare Part B is primary*
- *Medical foods administered orally, except as described in Section 5(f)*

You Pay

All charges

Benefit Description**Home Health Services**

Home nursing care (skilled) for two hours per day limited to 10 visits when:

- A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and
- A physician orders the care.

You Pay

Preferred: \$25 copayment per visit (no deductible)

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

Note: You pay 30% of the Plan allowance (deductible applies) for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page [128](#) for more information about “agents.”)

Benefit Description

Not covered:

- *Nursing care requested by, or for the convenience of, the patient or the patient's family*
- *Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter*

You Pay

All charges

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