2023 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus
Section 5. FEP Blue Focus Benefits
Section 5. FEP Blue Focus Overview

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The benefit package for FEP® Blue Focus is described in Section 5, which is divided into subsections 5(a) through 5(i).

Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about FEP Blue Focus benefits, contact us at the customer service phone number on the back of your ID card or go to our website at www.fepblue.org.

We have provided a new way for you to consider the benefits available to you under FEP Blue Focus to determine whether this product will be a good choice for you and your family. We have divided the benefits under FEP Blue Focus into three basic categories: CORE, NON-CORE and WRAP. The following information describes the portion you pay, based on the benefits you use. All benefits are subject to the definitions, limitations, and exclusions in this brochure. In the following charts, we summarize specific expenses we cover; for more detail, look inside. **Do not rely on the charts alone.** Note: For more information about services received overseas, see Section 5(i).

The "***CORE***" benefits are those under this program that form the most important level – the base of the program. These benefits have only a low or no copayment and are not subject to a deductible or coinsurance for the care received. These benefits are most commonly used to receive general care and to maintain your overall health and well-being, in addition to coverage for accidental injuries. For example, your first 10 healthcare visits with a primary care physician, specialist or other healthcare professional will be subject to a $10 copayment for each visit.

The "***NON-CORE***" benefits are there to provide coverage for any unexpected medical costs you may incur during the calendar year. These share the same annual deductible and the same co-insurance level (see *Annual Cost-Shares* below). When the catastrophic out-of-pocket maximum has been satisfied, we pay 100% of the Plan allowance for the remainder of the calendar year (see page 30 for more information). For example, after your first 10 visits (primary care, specialist or other healthcare provider), you will have a deductible to satisfy of $500 and then you will pay 30% of the Plan allowance for the visit. You may or may not have a need to use these benefits during the year.

"***WRAP***" benefits provide the final layer of protection and complete or "wrap-up" the FEP Blue Focus benefit package. These are benefits you may or may not have a need to use during the year. These benefits have visit limitations and/or different copayments or co-insurance levels than the "CORE" or "NON-CORE" benefit levels. The calendar year deductible does not apply to these benefits.

In addition to the general exclusions found in Section 6, this program does not provide benefits for some services that are covered under the Service Benefit Plan Standard or Basic Options. An example of services excluded under FEP Blue Focus is coverage for routine dental care. See the

charts below.

You must use Preferred providers for your care to be eligible for benefits, except in certain circumstances, such as medical emergency or accidental injury services. Preferred providers will submit claims to us on your behalf.

ANNUAL COST-SHARES
See above for information about when these cost-shares apply.

Cost-Share: Deductible
Member Responsibility (Self Only): $500
Member Responsibility (Self Plus One/Self and Family): $1,000

Cost-Share: Coinsurance (medical)
Member Responsibility (Self Only): 30% of the Plan Allowance
Member Responsibility (Self Plus One/Self and Family): 30% of the Plan Allowance

Cost-Share: Catastrophic Maximum
Member Responsibility (Self Only): $8,500
Member Responsibility (Self Plus One/Self and Family): $17,000

CORE
Key benefits with no or low member cost-share – not subject to deductible and coinsurance

Brochure Section: 5(a)
Benefit: Professional visit (combined medical and mental health and substance use disorder visits, see Section 5(e))
Member Payment & Calendar Year Limitations: $10 per visit for first 10 visits (See “Non-Core” for visits 11+.)
Page(s): 39, 86

Brochure Section: 5(a)
Benefit: Lab, X-ray and other diagnostic services
Member Payment & Calendar Year Limitations: $0 member cost-share for the first 10 laboratory tests performed in each of these different laboratory test categories (Basic metabolic panels; Cholesterol screenings; Complete blood counts; Fasting lipoprotein profiles; General health panels; Urinalysis) and 10 Venipunctures when not associated with preventive, maternity or accidental injury care
Page(s): 40

Brochure Section: 5(a)
Benefit: Telehealth

- Minor acute conditions
- Dermatology care
- Mental health and substance use disorder counseling

Member Payment & Calendar Year Limitations: $10 per visit
First 2 visits – no member cost-share
Page(s): 39, 86

Brochure Section: 5(a)
Benefit: Preventive care (adult/child)
Member Payment & Calendar Year Limitations: $0
Page(s): 41, 44

Brochure Section: 5(a)
Benefit: Family planning
Member Payment & Calendar Year Limitations: $0
Page(s): 47

Brochure Section: 5(a)
Benefit: Oral & transdermal contraceptives from Preferred pharmacy
Member Payment & Calendar Year Limitations: $0
Page(s): 95

Brochure Section: 5(a)
Benefit: Immunizations (preventive)
Member Payment & Calendar Year Limitations: $0
Page(s): 42, 44

Brochure Section: 5(a)
Benefit: Smoking cessation treatment
Member Payment & Calendar Year Limitations: $0
Page(s): 55, 98

Brochure Section: 5(a)
Benefit: Acupuncture and manipulative treatments
Member Payment & Calendar Year Limitations: $25 per visit
Limited to 10 visits combined
Page(s): 55

Brochure Section: 5(c), 5(d) & 5(g)
Benefit: Accidental injury

- Ambulance
- Dental
- Professional
- Outpatient hospital services
- Urgent Care

Member Payment & Calendar Year Limitations: $0
Within 72 hours of the accidental injury
Page(s): 80, 82, 101

Brochure Section: 5(d)

Benefit: Medical emergencies – urgent care
Member Payment & Calendar Year Limitations: $25 per visit
Page(s): 83

Brochure Section: 5(f)
Benefit: Preferred retail pharmacy - Tier 1: (Preferred Generic Drugs at a Preferred retail pharmacy)
Member Payment & Calendar Year Limitations: $5 for up to a 30-day supply
$15 for up to a 90-day supply
Page(s): 93

***The Core benefits do not include Tier 2 brand-name drugs or any specialty drugs (including generic specialty drugs), see WRAP benefits listed on page 37.**

NON-CORE
Benefits that share a common deductible and coinsurance

Brochure Section: 5(a)
Benefit: Professional visits (combined medical and mental health and substance use disorder visits, see Section 5(e))
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance Beginning with visit 11 and after
Page(s): 39, 86

Brochure Section: 5(a)
Benefit: Inpatient physician
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance
Page(s): 39-40

Brochure Section: 5(a)
Benefit: Lab, X-ray & other diagnostic services
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance
Page(s): 40-41

Brochure Section: 5(a)
Benefit: Lab, X-ray & other diagnostic services
Member Payment & Calendar Year Limitations (Deductible Applies): Beginning with the 11th occurrence of laboratory tests performed in each of these different laboratory test categories (Basic metabolic panels; Cholesterol screenings; Complete blood counts; Fasting lipoprotein profiles; General health panels; Urinalysis) and Venipunctures when not associated with preventive, maternity or accidental injury care, 30% of Plan Allowance after CYD
Page(s): 40

Brochure Section: 5(a)
Benefit: Allergy – testing, injections, multi-dose antigens
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance
Page(s): 48

Brochure Section: 5(a)
Benefit: Outpatient applied behavior analysis (ABA)
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance Limited to 200 hours
Page(s): 49, 75

Brochure Section: 5(a)
Benefit: Inpatient and outpatient therapies
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance
Page(s): 49

Brochure Section: 5(a)
Benefit: Durable medical equipment
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance
Page(s): 53

Brochure Section: 5(b)
Benefit: Surgical care – including Blue Distinction® Center
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance
Page(s): 57, 68

Brochure Section: 5(c)
Benefit: Inpatient hospital
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance
Page(s): 70-71

Brochure Section: 5(c)
Benefit: Outpatient hospital or ambulatory surgical center
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance
Page(s): 73-76

Brochure Section: 5(c)
Benefit: Ambulance – medical emergency
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance
Page(s): 80

Brochure Section: 5(c) & 5(e)
Benefit: Inpatient residential treatment centers (RTCs)
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance Limited to 30 days
Page(s): 76,87

Brochure Section: 5(d)
Benefit: Accidental injury – inpatient
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance
Page(s): 82

Brochure Section: 5(d)
Benefit: Medical emergencies (Professional, Hospital emergency room)

Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance
Page(s): 83

Brochure Section: 5(e)
Benefit: Mental health visits (combined medical and mental health and substance use disorder visits, see Section 5(e))
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance Beginning with visit 11 and after
Page(s): 86

Brochure Section: 5(e)
Benefit: Mental health inpatient and outpatient professional
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance
Page(s): 86

Brochure Section: 5(e)
Benefit: Mental health inpatient, outpatient, and intensive outpatient care – facility
Member Payment & Calendar Year Limitations (Deductible Applies): 30% of the Plan Allowance
Page(s): 87-88

WRAP
Benefits with different copayments or coinsurance and no deductible - limits may apply

Brochure Section: 5(a)
Benefit: Maternity – professional
Member Payment & Calendar Year Limitations: $0
Page(s): 45

Brochure Section: 5(c)
Benefit: Maternity – facility
Member Payment & Calendar Year Limitations: $1,500 per pregnancy
Page(s): 71-72

Brochure Section: 5(a)
Benefit: Occupational, physical or speech therapy
Member Payment & Calendar Year Limitations: $25/visit Limited to 25 visits combined
Page(s): 50

Brochure Section: 5(c)
Benefit: Hospice – Traditional (home)
Member Payment & Calendar Year Limitations: $0
Page(s): 79

Brochure Section: 5(f)
Benefit: Preferred retail pharmacy – Tier 2 (Preferred Brand-name drugs)
Member Payment & Calendar Year Limitations: 40% of the Plan allowance (up to a $350 maximum) for up to a 30-day supply

40% of the Plan allowance (up to a $1,050 maximum) for up to a 90-day supply
Page(s): 93

Brochure Section: 5(f)
Benefit: Specialty pharmacy – Tier 2 (Preferred Generic Specialty drugs and Preferred Brand-name Specialty Drugs)
Member Payment & Calendar Year Limitations: 40% of the Plan allowance (up to a $350 maximum) for up to a 30-day supply
Page(s): 93

NOT COVERED
See "Not covered" at the end of each sub-section and Section 6, General Exclusions, page 111, for complete information regarding services, drugs or supplies not covered under FEP Blue Focus.

Benefit: Hearing aids including bone-anchored hearing aids
Member Payment: All charges

Benefit: Wigs
Member Payment: All charges

Benefit: Skilled nursing facility
Member Payment: All charges

Benefit: Non-preferred generic, non-preferred brand-name and non-preferred specialty generic and brand-name drugs (drugs not on the FEP Blue Focus formulary)
Member Payment: All charges

Benefit: Dental care (except accidental injury)
Member Payment: All charges