Section 2. Changes for 2024

2024 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus
Section 2. Changes for 2024

Section 2. Changes for 2024

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 (Benefits). Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to our FEP Blue Focus

- We no longer require written consent and participation in a case management program prior to admission for inpatient care provided by a residential treatment center (RTC). Previously, this was required prior to admission into an RTC.
- We now provide benefits for medically necessary genetic testing for members requesting this service due to susceptibility or possible high-risk of disease once prior approval has been obtained. Previously, we did not provide benefits for these services.
- We now provide coverage for bariatric surgeries in accordance with our medical policy. Previously, the criteria was listed in the brochure. (See page 22.)
- We no longer require prior approval for the surgical treatment of a congenital anomaly. Previously, prior approval was required.
- We no longer require prior approval for intensity-modulated radiation therapy (IMRT). Previously, IMRT required prior approval for the treatment of certain cancers.
- We no longer require prior approval for proton beam therapy for members aged 21 and younger, or when care is related to the treatment of neoplasms of the nervous system including the brain and spinal cord; malignant neoplasms of the thymus; Hodgkin and non-Hodgkin lymphomas. Previously, prior approval was required regardless of the age of the patient, or the condition being treated. (See page 22.)

- We no longer require prior approval for stereotactic radiosurgery related to the treatment of malignant neoplasms of the brain and of the eye specific to the choroid and ciliary body; benign neoplasms of the cranial nerves, pituitary gland, aortic body, or paraganglia; neoplasms of the craniopharyngeal duct and glomus jugular tumors; trigeminal neuralgias, temporal sclerosis, certain epilepsy conditions, or arteriovenous malformations. Previously, prior approval was required regardless of the condition being treated. (See page 22.)

- We now provide coverage for the following artificial insemination (AI) procedures once prior approval has been obtained: intracervical insemination (ICI), intrauterine insemination (IUI), and intravaginal insemination (IVI) for individuals meeting our definition of infertility. (See pages 22, 46, and 132.)

- We will now provide coverage for stays in residential treatment centers (RTCs) that are medically necessary without a calendar year limitation. Previously, we limited stays to 30 days of inpatient care per calendar year.

- For Self Only contracts, your Preferred Provider catastrophic out-of-pocket maximum is now $9,000. For Self Plus One and Self and Family contracts, your Preferred Provider catastrophic out-of-pocket maximum is now $18,000. Previously, the Preferred Provider out-of-pocket maximum for Self Only contracts was $8,500; for Self Plus One and Self and Family Contracts, the Preferred Provider out-of-pocket maximum was $17,000. (See page 32.)

- For eligible members, prescription drug benefits will now be provided under a new FEP Medicare Prescription Drug Program. Previously, we did not offer a separate prescription drug program. (See page 91.)

- Members covered under the FEP Medicare Prescription Drug Program will have a separate pharmacy drug out-of-pocket catastrophic maximum of $3,250. Previously, there was no separate catastrophic maximum. (See page 94.)

- For members enrolled in the FEP Medicare Prescription Drug Program, your copayment for Tier 1 generic drugs purchased at a network pharmacy is $5 for each purchase of up to a 30-day supply and $15 for a 31 to 90-day supply, deductible does not apply. Previously, we did not provide this separate prescription drug program. (See page 95.)

- For members enrolled in the FEP Medicare Prescription Drug Program, your coinsurance for Tier 2 preferred brand-name drugs purchased at a network pharmacy is 40% of the Plan allowance (up to a $350 maximum) for each purchase of up to a 30-day supply, and 40% of the Plan allowance up to a ($1,050 maximum) for each purchase of up to a 90-day supply, deductible does not apply. Previously, we did not provide this separate prescription drug program. (See page 95.)

- For members enrolled in the FEP Medicare Prescription Drug Program, your coinsurance for Tier 3 non-preferred brand-name drugs purchased at a network pharmacy is 40% of the Plan allowance (up to a $350 maximum) for each purchase of up to a 30-day supply, and 40% of the Plan allowance up to a ($1,050 maximum) for each purchase of up to a 90-day supply, deductible does not apply. Previously, we did not provide this separate prescription drug program. (See page 95.)

- For members enrolled in the FEP Medicare Prescription Drug Program, your coinsurance for Tier 4 specialty drugs purchased at a network pharmacy is 40% of the Plan allowance (up to a $350 maximum) for each purchase of up to a 30-day supply, and 40% of the Plan allowance up to a ($1,050 maximum) for each purchase of up to a 90-day supply, deductible does not apply. Previously, we did not provide this separate prescription drug program. (See page 95.)

- We now provide coverage for marital and family counseling, Previously, we did not cover these visits. (See page 82.)

- We now provide coverage for breast augmentation for male to female gender affirming care. Previously, we did not list this as a covered service. (See page 58.)

- We now provide coverage for a mastectomy beginning at the age of 16 for female to male gender affirming care. Previously, we did not provide benefits until the age of 18. (See page 58.)

- We now require only 6 months of continuous hormone therapy appropriate to the member's gender identity, unless medically contraindicated. Previously, we required 12 months of continuous hormone therapy. (See page 58.)

- We now cover certain facial surgeries for gender affirming care and no longer limit covered medically necessary gender affirming surgical services to once per lifetime. Previously, we did not cover facial gender affirming surgery, and we limited covered procedures to once per lifetime. (See pages 57 and 58.)

- We have reduced the number of referral letters documenting the diagnosis of gender dysphoria and other criteria to one. Previously, we required two letters. (See page 58.)

- Kidney transplants will now require prior approval, and corneal transplants are now covered under the regular surgical benefit. Previously, kidney transplants did not require prior approval. (See page 23.)

- We have added the following diagnoses and/or stages of diagnoses to the allogeneic blood or marrow stem cell transplants that do not require a clinical trial: Blastic plasmacytoid dendritic cell neoplasm; Adrenoleukodystrophy, Globoid cell leukodystrophy (Krabbe's leukodystrophy); IPEX (immune dysregulation, polyendocrinopathy, enteropathy, X-linked syndrome);

Dyskeratosis congenita; Hypereosinophilic syndromes; plasma cell leukemia; severe congenital neutropenia, common variable immunodeficiency, chronic granulomatous disease/phagocytic cell disorders; and Systemic mastocytosis, aggressive. Previously, we did not cover these diagnoses. (See page 61.)

- We have added the following diagnoses and/or stages of diagnoses to the autologous blood or marrow stem cell transplants that do not require a clinical trial: autoimmune – limited to idiopathic (juvenile) rheumatoid arthritis, multiple sclerosis (treatment-refractory relapsing with high risk of future disability) and scleroderma/systemic sclerosis); chronic lymphocytic leukemia (e.g., T cell prolymphocytic leukemia, B cell prolymphocytic leukemia, hairy cell leukemia); relapsed neuroblastoma; osteosarcoma; plasma cell leukemia; and Wilms Tumor. Previously, we did not cover these diagnoses, or we required they be done as part of a clinical trial. (See pages 61-62.)

- We no longer require a clinical trial for allogeneic or autologous bone or marrow stem cell transplants with the following diagnoses: Multiple Sclerosis and Wilms Tumor.

- We no longer cover allogeneic bone or marrow stem cell transplants with the following diagnoses: colon cancer; epidermolysis bullosa; glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme); ovarian cancer; prostate cancer; or autologous bone or marrow transplants for retinoblastoma.

- For allogeneic blood or marrow stem cell transplants, we now cover additional diagnoses only when performed as part of a clinical trial: autoimmune disease (limited to scleroderma/systemic sclerosis, systemic lupus erythematosus, Idiopathic (juvenile) rheumatoid arthritis, CIDP (chronic inflammatory demyelinating polyneuropathy); Germ Cell Tumors; high-risk or relapsed neuroblastoma; lysosomal metabolic diseases: e.g., Mucopolysaccharidosis type II (Hunter syndrome), Mucopolysaccharidosis type IV (Morquio syndrome), Mucopolysaccharidosis type VI (Maroteaux-Lamy syndrome), Fabry disease, Gaucher disease. (See page 62.)

- For autologous blood or marrow stem cell transplants, we now cover additional diagnoses only when performed as part of a clinical trial: autoimmune disease (e.g., systemic lupus erythematosus, Crohn's disease, Polymyositis-dermatomyositis, rheumatoid arthritis, CIDP (chronic inflammatory demyelinating polyneuropathy); and sarcoma (e.g., rhabdomyosarcoma, soft tissue sarcoma). Previously, we did not cover transplants for these diagnoses. (See page 62.)

- We now provide benefits for drugs associated with covered artificial insemination (AI) procedures. Previously, we did not cover these drugs when associated with AI procedures. (See pages 89 and 95.)

- We now cover invitro fertilization related drugs limited to three cycles annually once prior approval has been obtained for individuals that meet our definition of infertility. (See pages

89 and 95.)

- Members with primary Medicare will now be responsible for the applicable the calendar year deductible. Previously, this cost-share was waived. (See pages 122 and 123.)