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.)

Go to page 14. Go to page 16.