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**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**  
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**Benefit Description**

**Maternity Care (cont.)**

- *Childbirth preparation, Lamaze, and other birthing/parenting classes*
- *Breast pumps and milk storage bags except as stated on page [46](#)*
- *Breastfeeding supplies other than those contained in the breast pump kit described on page [46](#) including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or convenience (e.g., nursing pads)*
- *Tocolytic therapy and related services except as described on page [45](#)*
- *Maternity care for members not enrolled in the Service Benefit Plan*

**You Pay**  
*All charges*

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**Benefit Description**

**Family Planning**

A range of voluntary family planning services for women, limited to:

- Contraceptive counseling
- Diaphragms and contraceptive rings
- Injectable contraceptives

- Intrauterine devices (IUDs)
- Implantable contraceptives
- Tubal ligation or tubal occlusion/tubal blocking procedures only

Family planning services for men, limited to:

- Vasectomy

Notes:

- We also provide benefits for professional services associated with tubal ligation/occlusion/blocking procedures, vasectomy, and with the fitting, insertion, or removal of the contraceptives as shown on the previous page.
- When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.

### **You Pay**

Preferred: Nothing (no deductible)

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

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### **Benefit Description**

- Oral and transdermal contraceptives

Note: We waive your cost-share for generic oral and transdermal contraceptives when you purchase them at a Preferred retail pharmacy; see Section 5(f) page [95](#).

### **You Pay**

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

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

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## Benefit Description

*Not covered:*

- *Reversal of voluntary surgical sterilization*
- *Contraceptive devices not described above*
- *Over-the-counter (OTC) contraceptives, except as described in Section 5(f)*

## You Pay

*All charges*

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## Benefit Description

### Reproductive Services

Diagnosis of infertility, limited to:

- Diagnostic services
- Laboratory tests
- Diagnostic tests
- Agents, drugs, and/or supplies administered or obtained in connection with your care

## You Pay

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

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

Note: When care is provided by a Non-preferred laboratory and/or radiologist, as stated on page [18](#) for an exception, you pay:

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*Reproductive Services - continued on next page*

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Go to page [46](#). Go to page [48](#).