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2024 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

Medical Supplies (cont.)

- 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 Section 5(c) 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, or you are enrolled in the FEP Medicare Prescription Drug Program*

- *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.

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*
- *Services provided by a nurse, nursing assistant, health aide, or other similarly licensed or unlicensed person that are billed by a skilled nursing facility, extended care facility, or nursing home*
- *Private duty nursing*

You Pay
All charges

Benefit Description

Alternative/Manipulative Treatment

Benefits for manipulative treatment and acupuncture are subject to a combined limit of 10 visits per person per calendar year

- Acupuncture is covered when performed and billed by a healthcare provider who is licensed or certified to perform acupuncture by the state where the services are provided, and who is acting within the scope of that license or certification. See Section 3 for more information.

  Note: See Section 5(b) for our coverage of acupuncture when provided as anesthesia for covered surgery.

  Note: See earlier in this section for our coverage of acupuncture when provided as anesthesia for covered maternity 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.

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