
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

Preventive Care, Child (cont.)

Note: If your child receives both preventive and diagnostic services from a Preferred provider on the same day, you are responsible for paying the cost-share for the diagnostic services.

Note: When nutritional counseling is via the contracted telehealth provider network, we provide benefits as shown here for Preferred providers. Refer to Section 5(h), *Wellness and Other Special Features*, for information on how to access a telehealth provider.

Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.

See page [96](#) for our payment levels for medications to promote better health as recommended under the Affordable Care Act.

You Pay

See previous page

Benefit Description

Not covered:

- *Self-administered health risk assessments (other than the Blue Health Assessment)*
- *Screening services requested solely by the member, such as commercially advertised heart scans, body scans, and tests performed in mobile traveling vans*
- *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel*

- *Immunizations, boosters, and medications for travel or work-related exposure. Medical benefits may be available for these services.*
- *Phone consultations and online medical evaluation and management services (telemedicine) for preventive services, except as noted above for nutritional counseling.*

You Pay

All charges

Benefit Description

Maternity Care

We encourage you to notify us of your pregnancy during the first trimester, see page [24](#).

Maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage, such as:

- Prenatal care (including ultrasound, laboratory, and diagnostic tests)
- Delivery
- Postpartum care

Note: We cover up to 8 visits per year in full to treat depression associated with pregnancy (i.e., depression during pregnancy, postpartum depression, or both) when you use a Preferred provider. See Section 5(e) for our coverage and benefits for additional mental health services.

- Assistant surgeons/surgical assistance if required because of the complexity of the delivery
- Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant
- Tocolytic therapy and related services when provided on an inpatient basis during a covered hospital admission or during a covered observation stay

You Pay

Preferred: Nothing (no deductible)

Note: For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered facility care is limited to \$1,500 per pregnancy. See Section 5(c), page [71](#).

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:

- Participating laboratories or radiologists: Nothing (no deductible)
 - Non-participating laboratories or radiologists: The difference between our allowance and the billed amount (no deductible)
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Maternity Care - continued on next page

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