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2025 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

Not covered:

- *Communications equipment, devices, and aids (including computer equipment) such as "story boards" or other communication aids to assist communication-impaired individuals (except for speech-generating devices as listed above)*
- *Equipment for cosmetic purposes*
- *Topical Hyperbaric Oxygen Therapy (THBO)*
- *Charges associated with separate or extended warranties*

You Pay
All charges

Benefit Description

Medical Supplies
Covered medical supplies include:

- Medical foods and nutritional supplements when administered by catheter or nasogastric tubes
  Note: See Section 10 for the definition of medical foods.
- Ostomy and catheter supplies
- 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

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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*

You Pay
All charges

Home Health Services - continued on next page

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