

Section 2. Changes for 2024

2024 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option Section 2. Changes for 2024

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 Standard Option only

- We no longer require a signed consent form agreeing to enrollment into and active participation in case management during a skilled nursing facility (SNF) stay prior to admission for members who do not have primary Medicare Part A. Previously, this was required prior to admission into a SNF.
- We now provide coverage for assisted reproductive technology (ART) procedures and services, limited to \$25,000 annually for members who meet our definition of infertility and obtain prior approval. Previously, we did not provide coverage for these services. (See page [48](#).)
- Your copayment for office visits, physical therapy, occupational therapy, speech therapy, cognitive rehabilitation therapy, vision services, foot care services, and manipulative treatments when performed by Preferred primary care providers or other healthcare professionals, and when applicable Preferred facilities, is now \$30 per visit. Previously, your copayment for these services was \$25 per visit. (See pages [28](#), [37](#), [39](#), [51](#), [53](#), [57](#), [75](#), [89](#), [151](#), [163](#), and [164](#).)
- Your copayment for office visits, physical therapy, occupational therapy, speech therapy, cognitive rehabilitation therapy, vision services, and foot care services when performed by a Preferred specialist is now \$40 per visit. Previously, your copayment for these services was \$35 per visit. (See pages [37](#), [39](#), [51](#), [53](#), [151](#), and [163](#).)
- 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 [113](#).)

- Members enrolled under the FEP Medicare Prescription Drug Program will have a separate pharmacy drug out-of-pocket catastrophic maximum of \$2,000. Previously, there was no separate catastrophic maximum. (See page [107](#).)
- 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. Tier 1 generic drugs purchased through the Mail Service Prescription Drug Program are subject to a \$5 copayment. Previously, we did not provide this separate prescription drug program. (See pages [107-106](#).)
- 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 15% of the Plan allowance for each purchase of up to a 90-day supply, deductible does not apply. Tier 2 preferred brand-name drugs purchased through the Mail Service Prescription Drug Program are subject to an \$85 copayment. Previously, we did not provide this separate prescription drug program. (See pages [107-106](#).)
- For members enrolled in the FEP Medicare Prescription Drug Program, your coinsurance for Tier 3 non-preferred brand-name drugs purchased at a network pharmacy is 50% of the Plan allowance for each purchase of up to a 90-day supply, deductible does not apply. Tier 3 non-preferred brand-name drugs purchased through the Mail Service Prescription Drug Program are subject to a \$125 copayment. Previously, we did not provide this separate prescription drug program. (See pages [107-106](#).)
- For members enrolled in the FEP Medicare Prescription Drug Program, your copayment for Tier 4 specialty drugs purchased at a network pharmacy is \$60 for each purchase of up to a 30-day supply; \$170 for a 31 to 90-day supply, deductible does not apply. Tier 4 specialty drugs purchased through the Mail Service Prescription Drug Program are subject to a \$150 copayment. Previously, we did not provide this separate prescription drug program. (See pages [107-106](#).)

Changes to our Basic Option only

- Your copayment for office visits, allergy care, treatment therapies and services, physical therapy, occupational therapy, speech therapy, cognitive rehabilitation therapy, hearing services, vision services, foot care services, skilled home nursing care, manipulative and alternative treatments, diabetic education, and dental services when performed by Preferred primary care providers or other healthcare professionals, and when applicable Preferred facilities is now \$35 per visit. Previously, your copayment for these services was \$30 per visit. (See pages [29](#), [32](#), [37](#), [39](#), [49](#), [50](#), [51](#), [52](#), [53](#), [57](#), [58](#), [59](#), [75](#), [76](#), [89](#), [91](#), [121](#), [124](#), [151](#), [165](#), and [166](#))

- Your copayment for office visits, allergy care, treatment therapies and services, physical therapy, occupational therapy, speech therapy, cognitive rehabilitation therapy, hearing services, vision services, foot care services, alternative treatments, and diabetic education, when performed by Preferred specialists is now \$45 per visit. Previously, your copayment for these services was \$40 per visit. (See pages [37](#), [39](#), [49](#), [50](#), [51](#), [52](#), [53](#), [57](#), [58](#), [59](#), [151](#), and [165](#).)
- 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 [113](#).)
- Members enrolled in 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 [107](#).)
- For members enrolled in the FEP Medicare Prescription Drug Program, your copayment for Tier 1 generic drugs purchased at a network pharmacy is \$10 for each purchase of up to a 30-day supply and \$30 for a 31 to 90-day supply. Tier 1 generic drugs purchased through the Mail Service Prescription Drug Program are subject to a \$15 copayment. Previously, we did not provide this separate prescription drug program. (See pages [107-106](#).)
- For members enrolled in the FEP Medicare Prescription Drug Program, your copayment for Tier 2 preferred brand-name drugs purchased at a network pharmacy is \$45 for each purchase of up to a 30-day supply and \$135 for a 31 to 90-day supply. Tier 2 preferred brand-name drugs purchased through the Mail Service Prescription Drug Program are subject to a \$95 copayment. Previously, we did not provide this separate prescription drug program. (See pages [107-106](#).)
- For members enrolled in the FEP Medicare Prescription Drug Program, your coinsurance for Tier 3 non-preferred brand-name drugs purchased at a network pharmacy is 50% of the Plan allowance (\$60 minimum) for each purchase of up to a 30-day supply, and 50% of the Plan allowance (\$175 minimum) for a 31 to 90-day supply. Tier 3 non-preferred brand-name drugs purchased through the Mail Service Prescription Drug Program are subject to a \$125 copayment. Previously, we did not provide this separate prescription drug program. (See pages [107-106](#).)
- For members enrolled in the FEP Medicare Prescription Drug Program, your copayment for Tier 4 specialty drugs purchased at a network pharmacy is \$75 for each purchase of up to a 30-day supply and \$195 for a 31 to 90-day supply. Tier 4 specialty drugs purchased through the Mail Service Prescription Drug Program are subject to a \$150 copayment. Previously, we did not provide this separate prescription drug program. (See pages [107-106](#).)

Changes to both our Standard and Basic Options

- 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 coverage for bariatric surgeries in accordance with our medical policy. Previously, the criteria was listed in the brochure. (See page [22](#).)
- 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. (See pages [22](#) and [41](#).)
- You now must obtain prior approval to receive benefit reimbursement for hearing aids. Previously, prior approval was not required for hearing aids. (See pages [22](#) and [54](#).)
- 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; and 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, 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](#), [48](#), and [154](#).)
- We now provide coverage for breast augmentation for male to female gender affirming care. Previously, we did not list this as a covered service. (See page [64](#).)

- We now provide coverage for a mastectomy beginning at the age of 16 for female to male gender affirming care. Previously, we did not provide benefits until the age of 18. (See page [63](#).)
- We now require only 6 months of continuous hormone therapy appropriate to the member's gender identity, unless medically contraindicated. Previously, we required 12 months of continuous hormone therapy. (See page [63](#).)
- We have reduced the number of referral letters documenting the diagnosis of gender dysphoria and other criteria to one. Previously, we required two letters. (See page [63](#).)
- We now cover certain facial surgeries for gender affirming care and no longer limit covered medically necessary gender affirming surgical services to once per lifetime. Previously, we did not cover facial gender affirming surgery, and we limited covered procedures to once per lifetime. (See page [64](#).)
- We have added the following diagnoses and/or stages of diagnoses to the allogeneic blood or marrow stem cell transplants that do not require a clinical trial: Blastic plasmacytoid dendritic cell neoplasm; Adrenoleukodystrophy, Globoid cell leukodystrophy (Krabbe's leukodystrophy); IPEX (immune dysregulation, polyendocrinopathy, enteropathy, X-linked syndrome); Dyskeratosis congenita; Hypereosinophilic syndromes; plasma cell leukemia; severe congenital neutropenia, common variable immunodeficiency, chronic granulomatous disease/phagocytic cell disorders; and Systemic mastocytosis, aggressive. Previously, we did not cover these diagnoses. (See page [66](#).)
- We have added the following diagnoses and/or stages of diagnoses to the autologous blood or marrow stem cell transplants that do not require a clinical trial: autoimmune – limited to: idiopathic (juvenile) rheumatoid arthritis, multiple sclerosis (treatment-refractory relapsing with high risk of future disability) and scleroderma/systemic sclerosis); chronic lymphocytic leukemia (e.g., T cell prolymphocytic leukemia, B cell prolymphocytic leukemia, hairy cell leukemia); relapsed neuroblastoma; osteosarcoma; plasma cell leukemia; and Wilms Tumor. Previously, we did not cover these diagnoses, or we required they be done as part of a clinical trial. (See page [67](#).)
- We no longer require a clinical trial for allogeneic or autologous bone or marrow stem cell transplants with the following diagnoses: Multiple Sclerosis and Wilms Tumor.
- We no longer cover allogeneic bone or marrow stem cell transplants with the following diagnoses: colon cancer; epidermolysis bullosa; glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme); ovarian cancer; prostate cancer; or autologous bone or marrow transplants for retinoblastoma.

- For allogeneic blood or marrow stem cell transplants, we now cover additional diagnoses only when performed as part of a clinical trial: autoimmune disease (limited to scleroderma/systemic sclerosis, systemic lupus erythematosus, Idiopathic (juvenile) rheumatoid arthritis, CIDP (chronic inflammatory demyelinating polyneuropathy); Germ Cell Tumors; high-risk or relapsed neuroblastoma; lysosomal metabolic diseases: e.g., Mucopolysaccharidosis type II (Hunter syndrome), Mucopolysaccharidosis type IV (Morquio syndrome), Mucopolysaccharidosis type VI (Maroteaux-Lamy syndrome), Fabry disease, Gaucher disease. (See page [67](#).)
- For autologous blood or marrow stem cell transplants, we now cover additional diagnoses only when performed as part of a clinical trial: autoimmune disease (e.g., systemic lupus erythematosus, Crohn's disease, Polymyositis-dermatomyositis, rheumatoid arthritis, CIDP (chronic inflammatory demyelinating polyneuropathy); and sarcoma (e.g., rhabdomyosarcoma, soft tissue sarcoma). Previously, we did not cover transplants for these diagnoses. (See page [70](#).)
- We now provide coverage for marital and family counseling and psychotherapy services. Previously, we excluded care for these services. (See page [89](#).)
- We now provide benefits for drugs associated with covered artificial insemination (AI) procedures. Previously, we did not cover these drugs when associated with AI procedures. (See pages [98](#) and [107](#).)
- We now cover invitro fertilization related drugs limited to three cycles annually once prior approval has been obtained for individuals that meet our definition of infertility. (See pages [98](#) and [107](#).)
- We no longer offer the Diabetes Management Incentive Program. Members who qualified for the program and completed the program in 2023 will still receive their earned rewards. For more information about the ending of this program, please visit us at www.fepblue.org.