2020 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus
Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services
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Benefit Description

Outpatient Hospital or Ambulatory Surgical Center (cont.)

Outpatient **drugs, medical devices, and durable medical equipment** billed for by a facility, such as:

- Prescribed drugs and medications

  Note: Certain self-injectable drugs are covered only when dispensed by a pharmacy under the pharmacy benefit. These drugs will be covered once per lifetime per therapeutic category of drugs when dispensed by a non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 95 for information about specialty drug fills from a Preferred pharmacy.

- Orthopedic and prosthetic devices
- Durable medical equipment
- Surgical implants
- 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 97.

You Pay
Preferred facilities: 30% of the Plan allowance

Non-preferred facilities (Member/Non-member): You pay all charges

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Benefit Description

Residential Treatment Center

Inpatient Residential Treatment Center:

Precertification prior to admission is required.

A preliminary treatment plan and discharge plan must be developed and agreed to by the member,

provider (residential treatment center (RTC)), and case manager in the Local Plan where the RTC is located prior to admission.

We cover up to a combined total (medical and mental health and substance use disorder) of 30 days per calendar year of inpatient care provided and billed by an RTC for members enrolled and participating in case management through the Local Plan, when the care is medically necessary for treatment of a medical, mental health, and/or substance use disorder:

- Room and board, such as semiprivate room, nursing care, meals, special diets, ancillary charges, and covered therapy services when billed by the facility (see page 89 for services billed by professional providers).

Notes:

- For inpatient care received overseas, refer to Section 5(i), page 109.
- For outpatient residential treatment center services, see pages 90.

You Pay
Preferred facilities: 30% of the Plan allowance

Non-preferred facilities (Member/Non-member): You pay all charges

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Benefit Description
Not covered services, such as:

- *Biofeedback*
- *Custodial or long term care (see* Definitions*)*
- *Domiciliary care provided because care in the home is not available or is unsuitable*
- *Educational therapy or educational classes*
- *Equine/hippotherapy provided during the approved stay*
- *Recreational therapy*
- *Respite care*

You Pay
All charges

Residential Treatment Center - continued on next page