2023 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
Section 2. Changes for 2023
Page 15

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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

- Preferred insulins are now covered with a $35 copayment for up to a 30-day supply or a $65 copayment for a 31 to 90-day supply, when dispensed by a Preferred retail pharmacy. Previously, you paid 20% of the Plan allowance for each purchase of up to a 90-day supply. (See page 112.)

Changes to our Basic Option only

- Your cost-share for outpatient surgical and treatment services performed and billed by a facility is now a $150 copayment per day per facility. Previously, you paid a $100 copayment per day per facility for these services. (See page 81.)

- Your cost-share for laboratory tests (such as blood tests and urinalysis), pathology services, and EKGs is now a 15% coinsurance. Previously, you paid nothing for these services. (See page 40 and 85.)

- Your copayment for an inpatient admission is now a $250 per day copayment for up to $1,500 per admission for unlimited days. Previously, you paid a $175 copayment per admission up to $875 for unlimited days. (See pages 47, 76, 79, 87 and 100.)

- We now cover 12 acupuncture visits per calendar year. Previously, we covered 10 acupuncture visits per calendar year. (See page 60.)

- Your copayment for outpatient observation services performed and billed by a hospital or freestanding ambulatory facility is now a $250 per day copayment up to $1,500. Previously, you paid a $175 per day copayment up to $875. (See page 82.)

- Your cost-share for outpatient diagnostic testing and treatment services performed and billed by a facility is now a $200 copayment per day per facility. Previously, you paid a $150 copayment per day per facility for these services. (See page 83.)

- Your cost-share for outpatient hospital emergency room services and supplies, including professional provider services, diagnostic studies, radiology services, laboratory tests, and pathology services, when billed by the hospital is now a $250 per day per facility copayment. Previously, your copayment for these services was $175. (See pages 95 and 96.)

- Your copayment for Tier 1 (generic drugs) without Medicare Part B primary, is now $15 for each purchase of up to a 30-day supply ($40 for a 31 to 90-day supply). Previously, your copayment was $10 for each purchase of up to a 30-day supply ($30 for a 31 to 90-day supply). (See page 114.)

- Your copayment for Tier 2 (preferred brand-name drugs) without Medicare Part B primary, is now $60 for each purchase of up to a 30-day supply ($180 for a 31 to 90-day supply). Previously, your copayment was $55 for each purchase of up to a 30-day supply ($165 for a 31 to 90-day supply). (See page 114.)

- You are now responsible for up to a $90 minimum copayment for Tier 3 (non-preferred brand-name) drugs for up to a 30-day supply ($250 minimum for a 31 to 90-day supply) without Medicare Part B primary. Previously, you were responsible for a $75 minimum for up to a 30-day supply ($210 minimum for a 31 to 90-day supply). (See page 114.)

Changes to both our Standard and Basic Options

- We now cover preventive low-dose CT screenings for lung cancer for members aged 50 to 80. Previously, preventive benefits did not start until age 55.

- We now require prior approval for certain high-cost drugs obtained outside of a pharmacy setting. Previously, prior approval was not required. (See page 22.)

- We now require prior approval for proton beam therapy. Previously, prior approval was not required. (See page 22.)

- We now require prior approval for stereotactic radiosurgery and stereotactic body radiation therapy. Previously, prior approval was not required. (See page 22.)

Go to page 14 , . Go to page 16.