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2024 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

- *Services, procedures, and/or supplies that are related to ART and assisted insemination procedures except as described above*
- *Cryopreservation or storage of sperm (sperm banking), eggs, or embryos except as described above*
- *Preimplantation diagnosis, testing, and/or screening, including the testing or screening of eggs, sperm, or embryos*
- *Drugs used in conjunction with ART and assisted insemination procedures except as described above and in Section 5(f) Prescription Drug Benefits*
- *Services, supplies, or drugs provided to individuals not enrolled in this Plan including surrogates*

You Pay
All charge

Benefit Description

Allergy Care

- Allergy testing
- Allergy treatment

- Allergy injections
- Sublingual allergy desensitization drugs as licensed by the U.S. FDA
- Preparation of each multi-dose vial of antigen
- Agents, drugs, and/or supplies administered or obtained in connection with your care

Note: See earlier in this section for applicable office visit copayment.

You Pay
Preferred: 30% of the Plan allowance (deductible applies)

Non-preferred (Participating/Non-participating): You pay all charges

Note: When care is provided by a Non-preferred laboratory and/or radiologist, as stated in Section 3 for an exception, you pay:

- Participating laboratories or radiologists: 30% of the Plan allowance (deductible applies)
- Non-participating laboratories or radiologists: 30% of the Plan allowance, plus any difference between our allowance and the billed amount (deductible applies)

Benefit Description
Not covered: Provocative food testing

You Pay
All charges

Benefit Description

Treatment Therapies
Outpatient treatment therapies:

- Chemotherapy and radiation therapy
  Note: We cover high-dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/Tissue Transplants* in Section 5(b). See also, *Other services* under *You need prior Plan approval*

for certain services in Section 3.

- Proton beam therapy*, stereotactic radiosurgery* and stereotactic body radiation therapy*
- Renal dialysis – Hemodialysis and peritoneal dialysis
- Intravenous (IV)/infusion therapy – Home IV or infusion therapy
  Note: Home nursing visits (skilled) associated with Home IV/infusion therapy are covered as shown under *Home Health Services* later in this section.
- Outpatient cardiac rehabilitation
- Pulmonary rehabilitation therapy

You Pay
Preferred: 30% of the Plan allowance (deductible applies)

Non-preferred (Participating/Non-participating): You pay all charges

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Treatment Therapies - continued on next page

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