2026 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
Page 46

Benefit Description

Allergy Care (cont.)

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)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
- Applied behavior analysis (ABA)* for the treatment of an autism spectrum disorder limited to 200 hours per person, per calendar year (see prior approval requirements in Section 3)
- Auto-immune infusion medications: Remicade, Renflexis or Inflectra
- Agents, drugs, and/or supplies administered or obtained in connection with your care

Notes:

- See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital.

***Prior approval required**

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

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

Benefit Description

Inpatient treatment therapies:

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

Treatment Therapies - continued on next page