2027 Blue Cross and Blue Shield Service Benefit Plan
FEP Blue Standard and FEP Blue Basic
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.

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.

  Note: **You must get prior approval for certain radiation therapy treatments.** Please refer to Section 3 for more information.

- Renal dialysis – Hemodialysis and peritoneal dialysis

- Intravenous (IV)/infusion therapy – Home IV or infusion therapy

  Note: Home nursing visits 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 (see prior approval requirements in Section 3)

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

Standard Option - You Pay
Preferred: 15% of the Plan allowance (deductible applies)

Participating: 35% of the Plan allowance (deductible applies)

Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount

Basic Option - You Pay
Preferred primary care provider or other healthcare professional: $35 copayment per visit; $20 copayment per visit for members up to age 18

Preferred specialist: $50 copayment per visit

Note: You pay 35% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care.

Participating/Non-participating: You pay all charges

Benefit Description

- Auto-immune infusion medications: Remicade, Renflexis and Inflectra

Note: See above for your costs for intravenous (IV)/infusion therapy - Home IV or infusion therapy.

Standard Option - You Pay
Preferred: 10% of the Plan allowance (deductible applies)

Participating: 15% of the Plan allowance (deductible applies)

Non-participating: 15% of the Plan allowance (deductible applies), plus any difference between our allowance and billed amount

Basic Option - You Pay
Preferred: 15% of the Plan allowance

Participating or Non-participating: You pay all charges

Benefit Description

Inpatient 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.

- Renal dialysis – Hemodialysis and peritoneal dialysis
- Pharmacotherapy (medication management) (See Section 5(c) for our coverage of drugs administered in connection with these treatment therapies.)
- Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements in Section 3)

Standard Option - You Pay
Preferred: 15% of the Plan allowance (deductible applies)

Participating: 35% of the Plan allowance (deductible applies)

Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount

Basic Option - You Pay
Preferred: Nothing

Participating/Non-participating: You pay all charges