2023 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 48

Benefit Description

Reproductive Services (cont.)

- We cover one year of sperm and egg storage for individuals facing iatrogenic infertility, once per lifetime. We provide the benefits seen here when billed by a facility. See page 21 for prior approval requirements. See Section 10 for our definition of iatrogenic infertility.

Note: See Section 5(a) for covered labs, diagnostic tests, and X-rays.

You Pay
Continued from previous page:

- 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: The services listed below are not covered as treatments for infertility or as alternatives to conventional conception:

- *Assisted reproductive technology (ART) and assisted insemination procedures, including but not limited to:*
  - *Artificial insemination (AI)*
  - *In vitro fertilization (IVF)*
  - *Embryo transfer and gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)*
  - *Intravaginal insemination (IVI)*

  - *Intracervical insemination (ICI)*
  - *Intracytoplasmic sperm injection (ICSI)*
  - *Intrauterine insemination (IUI)*

- *Services, procedures, and/or supplies that are related to ART and assisted insemination procedures*
- *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*
- *Drugs to treat infertility*
- *Services, supplies, or drugs provided to individuals not enrolled in this Plan*

You Pay
All charges

Note: We state whether or not the calendar year deductible applies for each benefit listed in this section.

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 page 39 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 on page 18 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

Go to page 47. Go to page 49.