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
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Benefit Description

Diagnostic and Treatment Services (cont.)

- Second surgical opinion

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

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

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Benefit Description
Not covered:

- *Routine services except for those Preventive care services described later in this section*
- *Costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies, non-interactive telecommunication such as email communications, or asynchronous store-and-forward telehealth services*
- *Private duty nursing*
- *Standby physicians*
- *Routine radiological and staff consultations required by facility rules and regulations*
- *Inpatient physician care when your admission or portion of an admission is not covered (See Section 5(c).)*
  Note: If we determine that an inpatient admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.

You Pay
All charges

Benefit Description

Lab, X-ray and Other Diagnostic Tests
Diagnostic tests, such as:

- Laboratory tests (such as blood tests and urinalysis)
- Pathology services
- EKGs
- Cardiovascular monitoring
- EEGs
- Neurological testing
- Ultrasounds
- X-rays (including set-up of portable X-ray equipment)
- Bone density tests
- CT scans*/MRIs*/PET scans*
- Angiographies
- Genetic testing - prior approval is required for genetic testing performed in the absence of signs, symptoms, or diagnosis of an active disease, or to assess the risk of passing genetic conditions to a child.
- Nuclear medicine
- Sleep studies|

Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.

***Prior approval is required**

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

Note: $0 member cost-share for the first 10 laboratory tests performed in each of these different laboratory test categories (Basic metabolic panels; Cholesterol screenings; Complete blood counts, Fasting lipoprotein profiles; General health panels; Urinalysis) and 10 Venipunctures when not associated with preventive maternity or accidental injury care.

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)