**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**

**Reproductive Services (cont.)**

- Procurement of sperm or eggs including medical, surgical, and pharmacy claims associated with retrieval;
- Cryopreservation of sperm and mature oocytes; and
- Cryopreservation storage costs for one year.

Note: See other sections in this brochure for benefits associated with any other services performed to diagnose and treat the cause of infertility.

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

- *Assisted reproductive technology (ART), including but not limited to:*
  - *In vitro fertilization (IVF)*
  - *Embryo transfer and gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)*
- *Intracytoplasmic sperm injection (ICSI)*

- *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), or 5(f)(a) if applicable, Prescription Drug Benefits*
- *Services, supplies, or drugs provided to individuals not enrolled in this Plan including surrogates*

**You Pay**
*All charges*

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**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)

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**Benefit Description**
*Not covered: Provocative food testing*

**You Pay**
*All charges*