2026 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
Section 3. How You Get Care
You need prior Plan approval for certain services:
Other services

• Other services

You must obtain prior approval for these services under both Standard and Basic Option in all outpatient and inpatient settings unless otherwise noted. Precertification is also required if the service or procedure requires an inpatient hospital admission. Contact us using the customer service phone number listed on the back of your ID card before receiving these types of services, and we will request the medical evidence needed to make a coverage determination:

- **Gene therapy and cellular immunotherapy, for example CAR-T and T-Cell receptor therapy**
- **Medical benefit drugs** – We require prior approval for certain drugs that will be submitted on a medical claim for reimbursement. Contact the customer service number on the back of your ID card or visit us at www.fepblue.org/medicalbenefitdrugs for a list of these drugs.
- **Air Ambulance Transport (non-emergent)** – Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval.
- **Outpatient facility-based sleep studies** – Prior approval is required for sleep studies performed in a provider's office, sleep center, clinic, any type of outpatient center, or any location other than your home.
- **Applied behavior analysis (ABA)** – Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
- **Genetic testing** - Prior approval for genetic testing will be required when the test is being performed to assess the risk of passing a genetic condition to a child, or when the member has no active disease or signs or symptoms of the disease that is being screened. Prior approval is not required when a member has an active disease, signs and symptoms of a genetic condition that could be passed to a child, or when the test is needed to determine a course of treatment for a disease.
- **Hearing aids – prior approval is required to receive coverage for hearing aids**
- **Surgical services** – The surgical services on the following list require prior approval for care performed by Preferred, Participating/Member, and Non-participating/Non-member professional and facility providers:
    - Surgery for elective non-urgent orthopedic procedures: hip, knee, and spine.

- Surgery for severe obesity;
  Note: Benefits for the surgical treatment of severe obesity – performed on an inpatient or outpatient basis – are subject to the pre-surgical requirements listed in our *Bariatric* medical policy. See Section 5(b).

- Surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth except when care is provided within 72 hours of the accidental injury

- **Proton beam therapy** – Prior approval is required for all proton beam therapy services except for members aged 21 and younger, or when related to the treatment of neoplasms of the nervous system including the brain and spinal cord; malignant neoplasms of the thymus; Hodgkin and non-Hodgkin lymphomas.

- **Stereotactic radiosurgery** – Prior approval is required for all stereotactic radiosurgery except when related to the treatment of malignant neoplasms of the brain, and of the eye specific to the choroid and ciliary body; benign neoplasms of the cranial nerves, pituitary gland, aortic body, or paraganglia; neoplasms of the craniopharyngeal duct and glomus jugular tumors; trigeminal neuralgias, temporal sclerosis, certain epilepsy conditions, or arteriovenous malformations.

- **Stereotactic body radiation therapy**

- **Reproductive Services** – Prior approval is required for intracervical insemination (ICI), intrauterine insemination (IUI), intravaginal insemination (IVI), and assisted reproductive technologies (ART).

- **Sperm/egg storage** – Prior approval is required for the storage of sperm and eggs for individuals facing iatrogenic infertility.

- **Organ/tissue transplants** – **Prior approval is required** for both the procedure and the facility. Contact us at the customer service phone number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.

  Some **organ transplant procedures** listed in Section 5(b) must be performed in a facility with a Medicare-Approved Transplant Program for the type of transplant anticipated. Transplants involving more than one organ must be performed in a facility that offers a Medicare-Approved Transplant Program for each organ transplanted. Contact your local Plan for Medicare's approved transplant programs.

  If Medicare does not offer an approved program for a certain type of organ transplant procedure, this requirement does not apply and you may use any covered facility that performs the procedure. If Medicare offers an approved program for an anticipated organ transplant, but your facility is not approved by Medicare for the procedure, please contact your Local Plan at the customer service phone number listed on the back of your ID card.

  Some blood or marrow stem cell transplants listed in Section 5(b) must be performed in a facility with a transplant program accredited by the Foundation for the Accreditation of

Cellular Therapy (FACT), or in a facility designated as a Blue Distinction Center for Transplants or as a Cancer Research Facility. Other **transplant procedures listed in Section 5(b)** must be performed at a FACT-accredited facility. We described these types of facilities earlier in this section.

Not every transplant program provides transplant services for every type of transplant procedure or condition listed, or is designated or accredited for every covered transplant. Benefits are not provided for a covered transplant procedure unless the facility is specifically designated or accredited to perform that procedure. Before scheduling a transplant, call your Local Plan at the customer service phone number listed on the back of your ID card for assistance in locating an eligible facility and requesting prior approval for transplant services.

- **Clinical trials for certain blood or marrow stem cell transplants** – In Section 5(b) we provide the list of conditions covered **only** in clinical trials. Contact us at the customer service phone number on the back of your ID card for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination.

  Even though we may state benefits are available for a specific type of clinical trial, you may not be eligible for inclusion in these trials or there may not be any trials available in a Blue Distinction Center for Transplants to treat your condition. If your physician has recommended you receive a transplant or that you participate in a transplant clinical trial, we encourage you to contact the Case Management Department at your Local Plan.

  Note: For the purposes of the blood or marrow stem cell clinical trial transplants covered under this Plan, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board (IRB) of the FACT-accredited facility, Blue Distinction Center for Transplants, or Cancer Research Facility where the procedure is to be performed.

- **Transplant travel** – We reimburse costs for transportation (air, rail, bus, and/or taxi) and lodging if you live 50 miles or more from the facility, up to a maximum of $5,000 per transplant for the member and companions. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. Reimbursement is subject to IRS regulations.

- **Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.** Contact CVS Caremark, our Pharmacy Program administrator, at 800-624-5060, TTY: 711, to request prior approval, or to obtain a list of drugs and supplies that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See Section 5(f) for more information about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

  Please note that updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change. Changes to the prior approval list or to prior approval criteria are not considered benefit changes.

  Note: Until we approve them, you must pay for these drugs in full when you purchase them –

even if you purchase them at a Preferred retail pharmacy or through our Specialty Drug Pharmacy Program – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.

Standard Option members may use our Mail Service Prescription Drug Program to fill their prescriptions. **Basic Option** members with primary Medicare Part B coverage also may use this program once prior approval is obtained.

Note: Neither the Mail Service Prescription Drug Program, nor the Specialty Drug Pharmacy Program, will fill your prescription for a drug requiring prior approval until you have obtained prior approval. CVS Caremark, the program administrator, will hold your prescription for you up to 30 days. If prior approval is not obtained within 30 days, your prescription will be unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

- **Medical foods covered under the pharmacy benefit require prior approval.** See Section 5(f), or 5(f)(a) if applicable, for more information.