2026 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals
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Benefit Description

Medical Supplies (cont.)

- Oxygen
  Note: When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for oxygen, according to the contracting status of the facility.

- Blood and blood plasma, except when donated or replaced, and blood plasma expanders

Note: We cover medical supplies at Preferred benefit levels only when you use a Preferred medical supply provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred medical supply providers.

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: 35% of the Plan allowance

Participating/Non-participating: You pay all charges

Benefit Description

Not covered:

- *Infant formulas used as a substitute for breastfeeding*

- *Diabetic supplies, except as described in Section 5(f), or 5(f)(a) if applicable, or when Medicare Part B is primary, or are enrolled in the FEP Medicare Prescription Drug Program*

- *Medical foods administered orally, except as described in Section 5(f), or 5(f)(a) if applicable*

Standard Option - You Pay
All charges

Basic Option - You Pay
All charges

Benefit Description

Home Health Services

Home nursing care (skilled) for two hours per day when:

- A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and
- A physician orders the care

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

Note: Benefits for home nursing care are limited to 50 visits per person, per calendar year.

Note: Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.

Basic Option - You Pay
Preferred: $35 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.

Note: Benefits for home nursing care are limited to 25 visits per person, per calendar year.

Participating/Non-participating: You pay all charges

Benefit Description

Not covered:

- *Nursing care requested by, or for the convenience of, the patient or the patient's family*
- *Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter*

Standard Option - You Pay
All charges

Basic Option - You Pay
All charges

Home Health Services - continued on next page