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

Reproductive Services (cont.)

- *Fallopian tube ligations and vasectomy reversals*
- *Services determined to be not medically necessary*
- *Services, supplies, or drugs provided to individuals not enrolled in this Plan, including surrogates*

Standard Option - You Pay
All charges

Basic Option - You Pay
All charges

Benefit Description

Allergy Care

- Allergy testing
- Allergy treatment
- Sublingual allergy desensitization drugs as licensed by the U.S. FDA

Note: See earlier in this section for applicable office visit copayment.

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 primary care provider or other healthcare professional: $35 copayment

Preferred specialist: $50 copayment

Note: You pay 35% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care.

Participating/Non-participating: You pay all charges (except as noted below)

Note: For services billed by Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.

Benefit Description

- Allergy injections

Note: See earlier in this section for applicable office visit copayment.

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: Nothing

Participating/Non-participating: You pay all charges

Benefit Description

- Preparation of each multi-dose vial of antigen

Note: See earlier in this section for applicable office visit copayment.

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 primary care provider or other healthcare professional: $35 copayment per multi-dose vial of antigen

Preferred specialist: $50 copayment per multi-dose vial of antigen

Participating/Non-participating: You pay all charges (except as noted below)