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

Allergy Care (cont.)

Standard Option - You Pay

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

Benefit Description

Not covered: Provocative food testing

Standard Option - You Pay
All charges

Basic Option - You Pay
All charges

Benefit Description

Treatment Therapies

Outpatient treatment therapies:

- Chemotherapy and radiation therapy

  Note: We cover high-dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/Tissue Transplants* in Section 5(b). See also, *Other services* under *You need prior Plan approval for certain services* in Section 3.

  Note: **You must get prior approval for certain radiation therapy treatments.** Please refer to Section 3 for more information.

- Renal dialysis – Hemodialysis and peritoneal dialysis
- Intravenous (IV)/infusion therapy – Home IV or infusion therapy

  Note: Home nursing visits associated with Home IV/infusion therapy are covered as shown under *Home Health Services* later in this section.
- Outpatient cardiac rehabilitation
- Pulmonary rehabilitation therapy
- Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements in Section 3)

Note: See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital.

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 visit

Preferred specialist: $50 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.

Participating/Non-participating: You pay all charges

Benefit Description

- Auto-immune infusion medications: Remicade, Renflexis and Inflectra

Note: See above for your costs for intravenous (IV)/infusion therapy - Home IV or infusion therapy.

Standard Option - You Pay
Preferred: 10% of the Plan allowance (deductible applies)

Participating: 15% of the Plan allowance (deductible applies)

Non-participating: 15% of the Plan allowance (deductible applies), plus any difference between our allowance and billed amount

Basic Option - You Pay
Preferred: 15% of the Plan allowance

Participating or Non-participating: You pay all charges

Treatment Therapies - continued on next page