2027 Blue Cross and Blue Shield Service Benefit Plan
FEP Blue Standard and FEP Blue Basic
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.

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)

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