

**2023 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**

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

Note: See page [39](#) 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: \$30 copayment

Preferred specialist: \$40 copayment

Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page [152](#) for more information about “agents.”)

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.

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**Benefit Description**

- Allergy injections

Note: See page [39](#) 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

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**Benefit Description**

- Preparation of each multi-dose vial of antigen

Note: See page [39](#) 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: \$30 copayment per multi-dose vial of antigen

Preferred specialist: \$40 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.

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**Benefit Description**

*Not covered: Provocative food testing*

**Standard Option - You Pay**

*All charges*

**Basic Option - You Pay**

*All charges*

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