# Allergy Care

## 2024 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
## Section 5. Benefits
## Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals
## Allergy Care

**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: $45 copayment

Note: You pay 30% 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.

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**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

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**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: $45 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*