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2024 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

Medical Supplies (cont.)

Not covered:

- *Medical foods administered orally, except as described in Section 5(f)*

Standard Option - You Pay
All charges

Basic Option - You Pay
All charges

Benefit Description

Home Health Services

Home nursing care (skilled) for two hours per day when:

- A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and
- A physician orders the care

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

Note: Benefits for home nursing care are limited to 50 visits per person, per calendar year.

Note: Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.

Basic Option - You Pay
Preferred: $35 copayment per visit

Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care.

Note: Benefits for home nursing care are limited to 25 visits per person, per calendar year.

Participating/Non-participating: You pay all charges

Benefit Description
Not covered:

- *Nursing care requested by, or for the convenience of, the patient or the patient's family*
- *Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter*
- *Services provided by a nurse, nursing assistant, health aide, or other similarly licensed or unlicensed person that are billed by a skilled nursing facility, extended care facility, or nursing home, except as described in Section 5(c) under Skilled Nursing Care.*
- *Private duty nursing*

Standard Option - You Pay
All charges

Basic Option - You Pay
All charges

Benefit Description

Manipulative Treatment
Manipulative treatment performed by a professional provider, when the provider is practicing within the scope of his/her license, limited to:

- Osteopathic manipulative treatment to any body region
- Chiropractic spinal and/or extraspinal manipulative treatment

Note: Benefits for manipulative treatment are limited to the services and combined treatment visits stated here.

Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.

Standard Option - You Pay
Preferred: $30 copayment per visit (no deductible)

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: $35 copayment per visit

Note: Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 20 visits per person, per calendar year.

Participating/Non-participating: You pay all charges

Manipulative Treatment - continued on next page

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