# Diagnostic and Treatment Services

## 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
## Diagnostic and Treatment Services

**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**

**Diagnostic and Treatment Services**
Outpatient professional services of physicians and other healthcare professionals:

- Consultations
- Genetic counseling
- Second surgical opinions
- Clinic visits
- Office visits
- Home visits
- Initial examination of a newborn needing definitive treatment when covered under a Self Plus One or Self and Family enrollment
- Pharmacotherapy (medication management) (See Section 5(f) for prescription drug coverage)
- Phone consultations and online medical evaluation and management services (telemedicine)

Note: Please refer to Section 5(c) for our coverage of these services when billed for by a facility, such as the outpatient department of a hospital.

**Standard Option - You Pay**
Preferred primary care provider or other healthcare professional: $30 copayment per visit (no deductible)

Preferred specialist: $40 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 primary care provider or other healthcare professional: $35 copayment per visit

Preferred specialist: $45 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.

Participating/Non-participating: You pay all charges

---

**Benefit Description**

Telehealth professional services for:

- Minor acute conditions
- Dermatology care

Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access a provider.

Note: Benefits are combined with telehealth services listed in Section 5(e).

Note: Copayments are waived for members with Medicare Part B primary.

**Standard Option - You Pay**
Preferred Telehealth Provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service

$10 copayment per visit (no deductible) after the 2nd visit

Participating/Non-participating: You pay all charges

**Basic Option - You Pay**
Preferred Telehealth Provider: Nothing for the first 2 visits per calendar year for any covered telehealth service

$15 copayment per visit after the 2nd visit

Participating/Non-participating: You pay all charges

---

**Benefit Description**

Inpatient professional services:

- During a covered hospital stay
- Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission
- Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay hospital benefits
  Note: A consulting physician employed by the hospital is not the attending physician.
- Consultations when requested by the attending physician
- Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care
- Physical therapy by a physician other than the attending physician
- Initial examination of a newborn needing definitive treatment when covered under a Self Plus One or Self and Family enrollment
- Pharmacotherapy (medication management) (See Section 5(c) for our coverage of drugs you receive while in the hospital.)

- Second surgical opinion
- Nutritional counseling when billed by a covered provider

**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**

*Not covered:*

- *Routine services except for those Preventive care services described later in this section*
- *Costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies, non-interactive telecommunication such as email communications, or asynchronous store-and-forward telehealth services*
- *Private duty nursing*
- *Standby physicians*
- *Routine radiological and staff consultations required by facility rules and regulations*
- *Inpatient physician care when your admission or portion of an admission is not covered (See Section 5(c).)*

*Note: If we determine that an inpatient admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.*

### Standard Option - You Pay

*All charges*

### Basic Option - You Pay

*All charges*