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

Diagnostic and Treatment Services (cont.)

- 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

Benefit Description

Lab, X-ray and Other Diagnostic Tests

Diagnostic tests limited to:

- Laboratory tests (such as blood tests and urinalysis)
- Pathology services
- EKGs

Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.

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: 15% of the Plan allowance

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

Lab, X-ray and Other Diagnostic Tests - continued on next page

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