Vision Services (Testing, Treatment, and Supplies)

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
Vision Services (Testing, Treatment, and Supplies)

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

Vision Services (Testing, Treatment, and Supplies)
Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed:

- To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery;
- If the condition can be corrected by surgery, but surgery is not an appropriate option due to age or medical condition;
- For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21

Note: Benefits are provided for refractions only when the refraction is performed to determine the prescription for the one pair of eyeglasses, replacement lenses, or contact lenses provided per incident as previously described.

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: 30% of the Plan allowance

Participating/Non-participating: You pay all charges

Benefit Description

- Eye examinations related to a specific medical condition
- Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21

Note: See Section 5(b), Surgical procedures, for coverage for surgical treatment of amblyopia and strabismus.

Note: See earlier in this section for our payment levels for Lab, X-ray, and other diagnostic tests performed or ordered by your provider.

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

Preferred specialist: $40 copayment (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

Not covered:

- *Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as previously described*
- *Deluxe eyeglass frames or lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc.*
- *Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom*
- *Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above*
- *LASIK, INTACS, radial keratotomy, and other refractive surgical services*
- *Refractions, including those performed during an eye examination related to a specific medical condition, except as described above*

Standard Option - You Pay
All charges

Basic Option - You Pay
All charges