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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

Vision Services (Testing, Treatment, and Supplies) (cont.)

- 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

Benefit Description

Foot Care

Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes

Note: See *Orthopedic and Prosthetic Devices* for information on podiatric shoe inserts.

Note: See Section 5(b) for our coverage for surgical procedures.

Standard Option - You Pay
Preferred primary care provider or other healthcare professional: $30 copayment for the office visit (no deductible); 15% of the Plan allowance for all other services (deductible applies)

Preferred specialist: $40 copayment for the office visit (no deductible); 15% of the Plan allowance for all other services (deductible applies)

Participating: 35% of the Plan allowance (deductible applies)

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

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