

2023 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.)

- 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 described above and on page [54](#).

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 above and on page [54](#) for our coverage of eyeglasses, replacement lenses, or contact lenses when prescribed as nonsurgical treatment for amblyopia and strabismus.

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

Note: See pages [40-42](#) in this Section for our payment levels for Lab, X-ray, and other diagnostic tests performed or ordered by your provider. Benefits are not available for refractions except as described above.

Standard Option - You Pay

Preferred primary care provider or other healthcare professional: \$25 copayment (no deductible)

Preferred specialist: \$35 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: \$30 copayment per visit

Preferred specialist: \$40 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. (See page [152](#) for more information about “agents.”)

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 described above and on page [54](#)*
- *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

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