

**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
Page 54**

Benefit Description

**Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation
Therapy (cont.)**

Standard Option - You Pay

Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown on page [53](#), according to the contracting status of the facility.

Basic Option - You Pay

Benefit Description

Not covered:

- *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay*
- *Maintenance or palliative rehabilitative therapy*
- *Exercise programs*
- *Equine therapy and hippotherapy (exercise on horseback)*
- *Massage therapy*

Standard Option - You Pay

All charges

Basic Option - You Pay

All charges

Benefit Description**Hearing Services (Testing, Treatment, and Supplies)**

- Hearing tests related to illness or injury
- Testing and examinations for prescribing hearing aids

Note: For our coverage of hearing aids and related services, see page [57](#).

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 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:

- *Routine hearing tests (except as indicated on page [45](#))*
- *Hearing aids (except as described on page [57](#))*

Standard Option - You Pay

All charges

Basic Option - You Pay

All charges

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;

Standard Option - You Pay

Preferred: 15% of the Plan allowance (deductible applies)

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

Basic Option - You Pay

Preferred: 30% of the Plan allowance

Participating/Non-participating: You pay all charges

Vision Services (Testing, Treatment, and Supplies) - continued on next page

Go to page [53](#). Go to page [55](#).