

**2023 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option  
Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services  
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### **Benefit Description**

#### **Outpatient Hospital or Ambulatory Surgical Center (cont.)**

Outpatient **treatment and therapy services** performed and billed by a facility, limited to:

- Cognitive rehabilitation therapy
- Physical, occupational, and speech therapy
  - Standard Option benefits are limited to a combined total of 75 visits per person per calendar year
  - Basic Option benefits are limited to a combined total of 50 visits per person per calendar year
- Manipulative treatment services
  - Standard Option benefits are limited to a combined total of 12 visits per person per calendar year
  - Basic Option benefits are limited to a combined total of 20 visits per person per calendar year

#### **Standard Option - You Pay**

Preferred facilities: \$25 copayment per day per facility (no deductible)

Member facilities: 35% of the Plan allowance (deductible applies)

Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.

#### **Basic Option - You Pay**

Preferred facilities: \$30 copayment per day per facility

Member/Non-member facilities: You pay all charges

Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page [152](#) for more information about “agents.”)

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**Benefit Description**

Outpatient **treatment services** performed and billed by a facility, limited to:

- Cardiac rehabilitation
- Pulmonary rehabilitation
- Applied behavior analysis (ABA) for an autism spectrum disorder (see prior approval requirements on page [22](#))

**Standard Option - You Pay**

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

Member facilities: 35% of the Plan allowance (deductible applies)

Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.

**Basic Option - You Pay**

Preferred facilities: \$30 copayment per day per facility

Note: You may be responsible for paying a higher copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here.

Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page [152](#) for more information about “agents.”)

Member/Non-member facilities: You pay all charges

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*Outpatient Hospital or Ambulatory Surgical Center - continued on next page*

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