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.”)

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

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

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