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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

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

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 *Orthopedic and Prosthetic Devices* in this section.

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: $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:

- *Routine hearing tests*
- *Hearing aids (except as described later in this section)*

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;
- 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 previously described.

Standard Option - You Pay
Preferred: 15% of the Plan allowance (deductible applies)

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

Added, 3/13/2024
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

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

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