

**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 52**

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## Benefit Description

### Treatment Therapies

Outpatient treatment therapies:

- Chemotherapy and radiation therapy

Note: We cover high-dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/Tissue Transplants* in Section 5(b). See also, *Other services* under *You need prior Plan approval for certain services* in Section 3 (pages [21-24](#)).

Note: **You must get prior approval for certain radiation therapy treatments.** Please refer to page [22](#) for more information.

- Renal dialysis – Hemodialysis and peritoneal dialysis
- Intravenous (IV)/infusion therapy – Home IV or infusion therapy

Note: Home nursing visits associated with Home IV/infusion therapy are covered as shown under *Home Health Services* on page [59](#).

- Outpatient cardiac rehabilitation
- Pulmonary rehabilitation therapy
- Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page [22](#))

Note: See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital.

Note: See page [60](#) for our coverage of osteopathic and chiropractic manipulative treatment.

### 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

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**Benefit Description**

- Auto-immune infusion medications: Remicade, Renflexis and Inflectra

Note: See above for your costs for intravenous (IV)/infusion therapy - Home IV or infusion therapy.

**Standard Option - You Pay**

Preferred: 10% of the Plan allowance (deductible applies)

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

Non-participating: 15% of the Plan allowance (deductible applies), plus any difference between our allowance and billed amount

**Basic Option - You Pay**

Preferred: 15% of the Plan allowance

Participating or Non-participating: You pay all charges

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*Treatment Therapies - continued on next page*

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Go to page [51](#) , . Go to page [53](#).