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
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Benefit Description

Treatment Therapies (cont.)
Inpatient 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).

- Renal dialysis – Hemodialysis and peritoneal dialysis
- Pharmacotherapy (medication management) (See Section 5(c) for our coverage of drugs administered in connection with these treatment therapies.)
- Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 22)

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: Nothing

Participating/Non-participating: You pay all charges

Benefit Description

Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation

Therapy

- Physical therapy, occupational therapy, and speech therapy
- Cognitive rehabilitation therapy

Note: When billed by a skilled nursing facility, nursing home, extended care facility, or residential treatment center, we pay benefits as shown here for professional care, according to the contracting status of the facility.

Standard Option - You Pay
Preferred primary care provider or other healthcare professional: $25 copayment per visit (no deductible)

Preferred specialist: $35 copayment per visit (no deductible)

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

Note: Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.

Note: Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.

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.”)

Note: Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.

Participating/Non-participating: You pay all charges

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

Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy - continued on next page

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