**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

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**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.

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

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