2026 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 56

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.

- 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 in Section 3)

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

Standard Option - You Pay
Preferred primary care provider or other healthcare professional: $30 copayment per visit (no deductible)

Preferred specialist: $40 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: $35 copayment per visit

Preferred specialist: $50 copayment per visit

Note: You pay 35% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care.

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

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