

---

**2023 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus**  
**Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals**  
**Page 49**

---

**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 [19-22](#)).

- Intensity-modulated radiation therapy (IMRT)\*, proton beam therapy\*, stereotactic radiosurgery\* and stereotactic body radiation therapy

Note: **You must get prior approval for IMRT related to cancers, except head, neck, breast, prostate, or anal cancer.** Please refer to page [20](#) for more information.

- Renal dialysis – Hemodialysis and peritoneal dialysis
- Intravenous (IV)/infusion therapy – Home IV or infusion therapy  
Note: Home nursing visits (skilled) associated with Home IV/infusion therapy are covered as shown under *Home Health Services* on page [54](#).
- Outpatient cardiac rehabilitation
- Pulmonary rehabilitation therapy
- Applied behavior analysis (ABA)\* for the treatment of an autism spectrum disorder limited to 200 hours per person, per calendar year (see prior approval requirements on page [19](#))
- Auto-immune infusion medications: Remicade, Renflexis or Inflectra

- Agents, drugs, and/or supplies administered or obtained in connection with your care

Notes:

- See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital.
- See page [55](#) for our coverage of osteopathic and chiropractic manipulative treatment.

**\*Prior approval required**

**You Pay**

Preferred: 30% of the Plan allowance (deductible applies)

Non-preferred (Participating/Non-participating): You pay all charges

---

**Benefit Description**

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 [19-22](#)).
- 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 [19](#))

**\*Prior approval required**

## You Pay

Preferred: 30% of the Plan allowance (deductible applies)

Non-preferred (Participating/Non-participating): You pay all charges

---

Go to page [48](#). Go to page [50](#).