

**2026 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus****Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services****Page 70**

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**Benefit Description****Residential Treatment Center (cont.)**

- *Services provided outside of the provider's licensure/scope of practice*

*Note: Residential treatment center benefits are not available for facilities licensed as skilled nursing facilities, group home, halfway house or similar type facilities.*

**You Pay**

*All charges*

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**Benefit Description****Extended Care Benefits/Skilled Nursing Care Facility Benefits**

**There are no benefits for admissions to an extended care or skilled nursing facility.**

**You Pay**

*All charges*

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**Benefit Description**

Benefits are available for the following covered services when provided as outpatient services and billed by a skilled nursing facility:

- Oxygen

Note: See Section 5(f), or 5(f)(a) if applicable, for benefits for prescription drugs.

**You Pay**

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

Non-preferred facilities (Member/Non-member): You pay all charges

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**Benefit Description**

Benefits are available for the following covered professional services when provided as outpatient services and billed by a skilled nursing facility:

- Cognitive rehabilitation therapy, limited to 25 visits per calendar year, regardless of the provider billing the service
- Physical therapy, occupational therapy, or speech therapy or a combination of all three (regardless of the provider or facility billing for the services) limited to 25 visits per person, per calendar year

**You Pay**

Preferred: \$25 copayment per visit (no deductible)

Non-preferred (Member/Non-member): You pay all charges

Note: You pay 30% of the Plan allowance (deductible applies) for agents, drugs, and/or supplies administered or obtained in connection with your care.

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**Benefit Description**

*Not covered:*

- *Inpatient room and board billed by a skilled nursing facility*
- *Phone; television; personal comfort items, such as guest meals and beds, beauty and barber services, recreational outings/trips, stretcher or wheelchair transportation; non-emergent ambulance transport that is requested beyond the nearest facility adequately equipped to treat the member's condition, by patient or physician for continuity of care or other reason; custodial or long-term care (see Definitions), and domiciliary care provided because care in the home is not available or is unsuitable.*

**You Pay**

*All charges*

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**Benefit Description****Hospice Care**

**Hospice care** is an integrated set of services and supplies designed to provide palliative and supportive care to members with a projected life expectancy of six months or less due to a terminal

medical condition, as certified by the member's primary care provider or specialist.

**You Pay**

See the following

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**Benefit Description****Pre-Hospice Enrollment Benefits****Prior approval is not required.**

Before home hospice care begins, members may be evaluated by a physician to determine if home hospice care is appropriate. We provide benefits for pre-enrollment visits when provided by a physician who is employed by the home hospice agency and when billed by the agency employing the physician. The pre-enrollment visit includes services such as:

- Evaluating the member's need for pain and/or symptom management; and
- Counseling regarding hospice and other care options

**You Pay**

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

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

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*Hospice Care - continued on next page*