2026 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
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Benefit Description

- 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

***Prior approval required**

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

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

Benefit Description

Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy
Outpatient treatment therapies, subject to visit limits:

- Physical therapy, occupational therapy, and speech therapy:
  - Benefits are limited to 25 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three; regardless of the provider or facility billing for the services

- Cognitive rehabilitation therapy, limited to 25 visits per calendar year, regardless of the provider billing the service

You Pay
Preferred: $25 copayment per visit (no deductible)

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

Notes:

- You pay 30% of the Plan allowance (deductible applies) for agents, drugs, and/or supplies administered or obtained in connection with your care.
- See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.

Benefit Description

Not covered:

- *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay*
- *Maintenance or palliative rehabilitative therapy*
- *Exercise programs*
- *Hippotherapy/Equine therapy*
- *Massage therapy*

You Pay
All charges

Benefit Description

Hearing Services
Visits related to the covered hearing services listed below

You Pay
Preferred: $10 copayment (no deductible) per visit up to a combined total of 10 visits per calendar year (benefits combined with visits in Section 5(a))

Preferred provider, visits after the 10th visit: 30% of the Plan allowance (deductible applies)

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

Hearing Services - continued on next page