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
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Benefit Description

Outpatient Hospital or Ambulatory Surgical Center (cont.)
Outpatient **treatment and therapy services** performed and billed by a facility, limited to:

- Cognitive rehabilitation therapy limited to 25 visits per person per calendar year
- Physical therapy, occupational therapy, and speech therapy limited to 25 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.
- Manipulative treatment and acupuncture services, limited to a combined 10 visits per person.

  Notes:

  - We provide benefits for manipulative treatment and acupuncture services as described in Section 5(a).
  - See Section 5(b) for our coverage of acupuncture when provided as anesthesia for covered surgery.
  - See earlier in this section for our coverage of acupuncture when provided as anesthesia for covered maternity care.

Note: The limitations listed above are a combined total regardless of the type of covered provider or facility billing for the services.

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

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

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

Benefit Description
Outpatient **treatment services** performed and billed by a facility, are limited to:

- Outpatient applied behavior analysis* (ABA) for an autism spectrum disorder performed and billed by a facility limited to 200 hours per person, per calendar year.

Note: The limitations listed is a combined total regardless of the type of covered provider or facility billing for the services.

***Prior approval is required**, see Section 3 for prior approval requirements.

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

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

Benefit Description
Outpatient **adult preventive care** performed and billed by a facility, limited to:

- Visits/exams for preventive care, screening procedures, and routine immunizations described in Section 5(a)
- Cancer screenings listed in Section 5(a) and ultrasound screening for abdominal aortic aneurysm

Note:

- See Section 5(a) for our payment levels for covered preventive care services for children billed for by facilities and performed on an outpatient basis.

You Pay
Preferred facilities: Nothing (no deductible)

Non-preferred facilities (Member/Non-Member): Nothing (no deductible) for cancer screenings and ultrasound screening for abdominal aortic aneurysm

Note: Benefits are not available for routine adult physical examinations, associated laboratory tests, colonoscopies, or routine immunizations performed at Non-preferred (Member/Non-member) facilities.

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