2023 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 77

Benefit Description

Residential Treatment Center (cont.)

- *Outdoor residential programs*
- *Outward Bound programs*
- *Personal comfort items, such as guest meals and beds, phone, television, beauty and barber service*
- *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

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

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) 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

---

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. (See page 128 for more information about “agents.”)

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

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 pages 78-79

Go to page 76. Go to page 78.