2027 Blue Cross and Blue Shield Service Benefit Plan
FEP Blue Standard and FEP Blue Basic
Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.

Benefit Description

Outpatient Hospital or Ambulatory Surgical Center
Outpatient **surgical and treatment services** performed and billed by a facility, such as:

- Operating, recovery, and other treatment rooms
- Anesthetics and anesthesia services
- Acupuncture
- Pre-surgical testing performed within one business day of the covered surgical services
- Chemotherapy and radiation therapy
- Colonoscopy, with or without biopsy
  Note: Preventive care benefits apply to the facility charges for your first covered colonoscopy of the calendar year, see *Preventive Care, Adult*, in Section 5(a). We provide diagnostic benefits for services related to subsequent colonoscopy procedures in the same year.
- Intravenous (IV)/infusion therapy
- Renal dialysis
- Visits to the outpatient department of a hospital for non-emergency treatment services
- Diabetic education
- Administration of blood, blood plasma, and other biologicals
- Blood and blood plasma, if not donated or replaced, and other biologicals
- Dressings, splints, casts, and sterile tray services
- Facility supplies for hemophilia home care
- Other medical supplies, including oxygen
- Surgical implants

Notes:

- See Section 5(d) for our payment levels for care related to a medical emergency or accidental injury.
- See Section 5(a) for our coverage of family planning services.
- For our coverage of hospital-based clinic visits, please refer to the professional benefits described in Section 5(a).
- For certain surgical procedures, your out-of-pocket costs for facility services are reduced if you use a facility designated as a Blue Distinction Center as described later in this section.
- For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility. See Section 5(a) for other included maternity services.
- See later in this section for outpatient drugs, medical devices, and durable medical equipment billed for by a facility.
- We cover outpatient hospital services and supplies related to the treatment of children up to age 22 with severe dental caries.

We cover outpatient care related to other types of dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section 5(g), *Dental Benefits*, for additional benefit information.

Standard Option - You Pay
Preferred facilities: 15% of the Plan allowance (deductible applies)

Member facilities: 35% of the Plan allowance (deductible applies)

Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.

Basic Option - You Pay
Preferred facilities: $250 copayment per day per facility

Note: You pay 35% of the Plan allowance for surgical implants, agents, or drugs administered or obtained in connection with your care.

Member/Non-member facilities: You pay all charges

Benefit Description
Outpatient **observation services** performed and billed by a hospital or freestanding ambulatory facility

Note: All outpatient services billed by the facility during the time you are receiving observation services are included in the cost-share amounts shown here. Please refer to Section 5(a) for services billed by professional providers during an observation stay and later in this section for information about benefits for inpatient admissions.

Note: For outpatient observation services related to maternity, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.

Standard Option - You Pay
Preferred facilities: $600 copayment for the duration of services (no deductible)

Member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible)

Non-member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment

Basic Option - You Pay
Preferred facilities: $500 per day copayment up to $3,500

Member/Non-member facilities: You pay all charges

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

- Angiographies
- Bone density tests
- CT scans/MRIs/PET scans (prior approval required)
- Nuclear medicine
- Facility-based sleep studies (prior approval required)
- Genetic testing (prior approval may be required; see Section 3)

Standard Option - You Pay
Preferred facilities: 15% of the Plan allowance (deductible applies)

Member facilities: 35% of the Plan allowance (deductible applies)

Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.

Basic Option - You Pay
Preferred facilities: $250 copayment per day per facility

Member facilities: $250 copayment per day per facility

Non-member facilities: $250 copayment per day per facility, plus any difference between our allowance and the billed amount

Note: You pay 35% of the Plan allowance for agents or drugs administered or obtained in connection with your care.

Benefit Description
Outpatient **diagnostic testing services** performed and billed by a facility, such as:

- Cardiovascular monitoring
- EEGs
- Home-based/unattended sleep studies
- Ultrasounds
- Neurological testing
- X-rays (including set-up of portable X-ray equipment)

Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.

Standard Option - You Pay
Preferred facilities: 15% of the Plan allowance (deductible applies)

Member facilities: 35% of the Plan allowance (deductible applies)

Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.

Basic Option - You Pay
Preferred facilities: $40 copayment per day per facility

Member facilities: $40 copayment per day per facility

Non-member facilities: $40 copayment per day per facility, plus any difference between our allowance and the billed amount

Note: You may be responsible for paying a higher copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here.

Note: You pay 35% of the Plan allowance for agents or drugs administered or obtained in connection with your care.

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

- Cognitive rehabilitation therapy
- Physical, occupational, and speech therapy
    - Standard Option benefits are limited to a combined total of 75 visits per person per calendar year
    - Basic Option benefits are limited to a combined total of 50 visits per person per calendar year
- Manipulative treatment services
    - Standard Option benefits are limited to a combined total of 12 visits per person per calendar year
    - Basic Option benefits are limited to a combined total of 20 visits per person per calendar year

Standard Option - You Pay
Preferred facilities: $30 copayment per day per facility (no deductible)

Member facilities: 35% of the Plan allowance (deductible applies)

Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.

Basic Option - You Pay
Preferred facilities: $35 copayment per day per facility; $20 copayment per day for members up to age 18

Member/Non-member facilities: You pay all charges

Note: You pay 35% of the Plan allowance for agents or drugs administered or obtained in connection with your care.

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

- Cardiac rehabilitation
- Pulmonary rehabilitation
- Applied behavior analysis (ABA) for an autism spectrum disorder (see prior approval requirements in Section 3)

Standard Option - You Pay
Preferred facilities: 15% of the Plan allowance (deductible applies)

Member facilities: 35% of the Plan allowance (deductible applies)

Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.

Basic Option - You Pay
Preferred facilities: $35 copayment per day per facility; $20 copayment per day for members up to age 18

Note: You may be responsible for paying a higher copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here.

Note: You pay 35% of the Plan allowance for agents or drugs administered or obtained in connection with your care.

Member/Non-member facilities: You pay all charges

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

- Laboratory tests and pathology services
- EKGs

Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.

Standard Option - You Pay
Preferred facilities: 15% of the Plan allowance (deductible applies)

Member facilities: 35% of the Plan allowance (deductible applies)

Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.

Basic Option - You Pay
Preferred facilities: 15% of the Plan allowance

Member facilities: 15% of the Plan allowance

Non-member facilities: 15% of the Plan allowance plus any difference between our allowance and the billed amount

Note: You may be responsible for paying a copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here.

Note: You pay 35% of the Plan allowance for agents or drugs administered or obtained in connection with your care.

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.

Standard Option - You Pay
See Section 5(a) for our payment levels for covered preventive care services for adults

Basic Option - You Pay
Preferred facilities: Nothing

Member/Non-member facilities: Nothing 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 Member or Non-member facilities.

Benefit Description
Outpatient **drugs, medical devices, and durable medical equipment** billed for by a facility, such as:

- Prescribed drugs
- Orthopedic and prosthetic devices
- Durable medical equipment
- Surgical implants

Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.

Note: Certain self-injectable drugs are covered only when dispensed by a pharmacy under the pharmacy benefit. These drugs will be covered once per lifetime per therapeutic category of drugs when dispensed by a non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage or are enrolled in the FEP Medicare Prescription Drug Program. See Section 5(f), or 5(f)(a) if applicable, for information about specialty drug fills from a Preferred pharmacy.

Standard Option - You Pay
Preferred facilities: 15% of the Plan allowance (deductible applies)

Member facilities: 35% of the Plan allowance (deductible applies)

Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.

Basic Option - You Pay
Preferred facilities: 35% of the Plan allowance

Note: You may also be responsible for paying a copayment per day per facility for outpatient services listed in this section.

Member/Non-member facilities: You pay all charges