2026 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
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 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

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.

Outpatient Hospital or Ambulatory Surgical Center - continued on next page