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

- Angiographies
- Bone density tests
- CT scans/MRIs/PET scans
- Nuclear medicine
- Facility-based sleep studies (prior approval is required)
- Genetic testing (prior approval is 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

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.

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