2023 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.)

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
Continued from previous page:

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
See previous page

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
- Nuclear medicine
- Facility-based sleep studies (prior approval is required)
- Genetic testing

  Note: We cover specialized diagnostic genetic testing billed for by a facility, such as the outpatient department of a hospital, as shown here. See page 41 for coverage criteria and limitations.

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: $200 copayment per day per facility

Member facilities: $200 copayment per day per facility

Non-member facilities: $200 copayment per day per facility, plus any difference between our allowance and the billed amount

Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 152 for more information about “agents.”)

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 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 152 for more information about “agents.”)

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

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