Outpatient Hospital or Ambulatory Surgical Center

2025 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
Outpatient Hospital or Ambulatory Surgical Center

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Outpatient **surgical and treatment services** performed and billed by a facility, such as:

- Operating, recovery, and other treatment rooms
- Anesthetics and anesthesia services
- 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. 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
- Cardiac rehabilitation
- Observation services

  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 earlier in this section for information about benefits for inpatient admissions.

- Pulmonary rehabilitation
- Hospital-based clinic visits
- Outpatient hospital services and supplies related to:
  - Treatment of children up to age 22 with severe dental caries.
  - 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*.

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.
- See later in this section for outpatient drugs, medical devices, and durable medical equipment billed for by a facility.
- See earlier in this section for maternity care provided in an outpatient facility.

You Pay
Preferred facilities: 30% of the Plan allowance (deductible applies)

Non-preferred facilities (Member/Non-member): You pay all charges

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

- Angiographies
- Bone density tests
- CT scans*/MRIs*/PET scans*
- Genetic testing*
- Nuclear medicine
- Sleep studies
- Cardiovascular monitoring
- EEGs
- Ultrasounds
- Neurological testing
- X-rays (including set-up of portable X-ray equipment)
- EKGs
- Laboratory tests and pathology services

Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, see *Maternity – Facility*, earlier in this section.

***Prior approval is required.**

You Pay
Preferred facilities: 30% of the Plan allowance (deductible applies)

Non-preferred facilities (Member/Non-member):

- Member: 30% of the Plan allowance (deductible applies)
- Non-member: 30% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount

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

- Cognitive rehabilitation therapy limited to 25 visits per person per calendar year
- Physical therapy, occupational therapy, and speech therapy limited to 25 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.
- Manipulative treatment and acupuncture services, limited to a combined 10 visits per person.

  Notes:

  - We provide benefits for manipulative treatment and acupuncture services as described in Section 5(a).
  - See Section 5(b) for our coverage of acupuncture when provided as anesthesia for covered surgery.
  - See earlier in this section for our coverage of acupuncture when provided as anesthesia for covered maternity care.

Note: The limitations listed above are a combined total regardless of the type of covered provider or facility billing for the services.

You Pay
Preferred facilities: $25 copayment per visit (no deductible)

Non-preferred facilities (Member/Non-member): You pay all charges

Note: You pay 30% of the Plan allowance (deductible applies) for supplies or drugs administered or obtained in connection with your care.

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

- Outpatient applied behavior analysis* (ABA) for an autism spectrum disorder performed and billed by a facility limited to 200 hours per person, per calendar year.

  Note: The limitations listed is a combined total regardless of the type of covered provider or facility billing for the services.

***Prior approval is required**, see Section 3 for prior approval requirements.

You Pay
Preferred facilities: 30% of the Plan allowance (deductible applies)

Non-preferred facilities (Member/Non-member): You pay all charges

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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.

You Pay
Preferred facilities: Nothing (no deductible)

Non-preferred facilities (Member/Non-Member): Nothing (no deductible) 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 Non-preferred (Member/Non-member) facilities.

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

- Prescribed drugs and medications
  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 you are enrolled in the FEP Medicare Prescription Drug Program. See Section 5(f) for information about specialty drug fills from a Preferred pharmacy.
- Orthopedic and prosthetic devices
- Durable medical equipment
- Surgical implants
- Oral and transdermal contraceptives

  Note: We waive your cost-share for generic oral and transdermal contraceptives when you purchase them at a Preferred retail pharmacy; see Section 5(f).

You Pay
Preferred facilities: 30% of the Plan allowance (deductible applies)

Non-preferred facilities (Member/Non-member): You pay all charges