

**2023 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****Page 74**

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**Benefit Description****Outpatient Hospital or Ambulatory Surgical Center (cont.)**

- 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 page [70](#) 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*, page [102](#).

**Notes:**

- See pages [81-84](#) for our payment levels for care related to a medical emergency or accidental injury.
- See page [47](#) for our coverage of family planning services.
- See page [76](#) for outpatient drugs, medical devices, and durable medical equipment billed for by a facility.
- See page [71](#) 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

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**Benefit Description**

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

- Angiographies
- Bone density tests
- CT scans\*/MRIs\*/PET scans\*
- 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 [43](#) for coverage criteria and limitations.

- 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*, page [71](#) 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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*Outpatient Hospital or Ambulatory Surgical Center – continued on next page*

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