2026 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
Section 5. Benefits
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals
Maternity Care

Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.

Benefit Description

Maternity Care
Maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage, such as:

- Prenatal and postpartum care (including ultrasound, laboratory, and diagnostic tests)
  Note: See Section 5(h) for details about our Pregnancy Care Incentive Program.
- Delivery
- Assistant surgeons/surgical assistance if required because of the complexity of the delivery
- Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant
- Tocolytic therapy and related services when provided on an inpatient basis during a covered hospital admission or during a covered observation stay
- Breastfeeding education and individual coaching on breastfeeding by healthcare providers such as physicians, physician assistants, midwives, nurse practitioners/clinical specialists, and lactation specialists for each birth
- Mental health treatment for postpartum depression and depression during pregnancy
  Note: We provide benefits to cover up to 8 visits per year in full to treat depression associated with pregnancy (i.e., depression during pregnancy, postpartum depression, or both) when you use a Preferred provider. See Section 5(e) for our coverage of mental health visits to Non-preferred providers and benefits for additional mental health services.

Note: See *Preventive Care, Adult*, earlier in this section for our coverage of nutritional counseling.

Note: *Home Health Services* benefits for home nursing visits (skilled) related to covered maternity care are subject to the visit limitations described later in this section.

Note: Maternity care benefits are not provided for prescription drugs required during pregnancy,

except as recommended under the Affordable Care Act. See Section 5(f) for your prescription drug coverage.

Notes:

- You do not need to precertify your delivery; see Section 3 for other circumstances, such as extended stays for you or your newborn.
- You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary.
- We cover routine nursery care of the newborn when performed during the covered portion of the mother's maternity stay and billed by the facility. We cover other care of a newborn who requires professional services or non-routine treatment, only if we cover the newborn under a Self Plus One or Self and Family enrollment. Surgical benefits apply to circumcision when billed by a professional provider for a male newborn.
- Hospital services are listed in Section 5(c) and Surgical benefits are in Section 5(b).

Note: See Section 10 for our allowance for inpatient stays resulting from an emergency delivery at a hospital or other facility not contracted with your Local Plan.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. Regular medical or surgical benefits apply rather than maternity benefits. See Section 5(b) for our payment levels for circumcision.

Standard Option - You Pay
Preferred: Nothing (no deductible)

Note: For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers.

Participating: 35% of the Plan allowance (deductible applies)

Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount

Note: You may request prior approval and receive specific benefit information in advance for the delivery itself and any other maternity-related surgical procedures to be provided by a Non-participating physician when the charge for that care will be **$5,000 or more**. Call your Local Plan at the customer service phone number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services.

Basic Option - You Pay
Preferred: Nothing

Note: For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered inpatient services is limited to $425 per admission. This copayment is waived if you deliver in a Blue Distinction Center for maternity. For outpatient facility services related to maternity, see the notes throughout Section 5(c).

Participating/Non-participating: You pay all charges (except as noted below)

Note: For services billed by Non-participating laboratories or radiologists, you are responsible only for any difference between our allowance and the billed amount.

Benefit Description

- Breast pump, limited to one per calendar year for members who are pregnant and/or nursing
- Blood pressure monitor, limited to one every two years

Note: Benefits for the breast pump, milk storage bags, and blood pressure monitors are only available when you order them through our fulfillment vendor by visiting www.fepblue.org/maternity or calling 1-800-411-2583. Milk storage bags will be included with your breast pump.

Standard Option - You Pay
Nothing (no deductible)

Basic Option - You Pay
Nothing

Benefit Description
Not covered:

- *Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest*
- *Childbirth preparation, Lamaze, and other birthing/parenting classes*
- *Doula, birth companion, and similar supporter*
- *Breast pumps and milk storage bags except as previously noted*
- *Breastfeeding supplies other than those contained in the breast pump kit previously described including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or*

convenience (e.g., nursing pads)

- *Tocolytic therapy and related services except as previously described*
- *Maternity care for members not enrolled in the Service Benefit Plan*

Standard Option - You Pay
All charges

Basic Option - You Pay
All charges