

**2024 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**

**Inpatient Hospital (cont.)**

- *Admissions for, or consisting primarily of, observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician's office)*
- *Admissions primarily for diagnostic studies, radiology services, laboratory tests, or pathology services that could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician's office)*

*Note: If we determine that an inpatient admission is one of the types listed above, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting. Benefits are limited to care provided by covered facility providers (see Section 3).*

**Standard Option - You Pay**

*All charges*

**Basic Option - You Pay**

*All charges*

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**Benefit Description**

**Outpatient Hospital or Ambulatory Surgical Center**

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

- Operating, recovery, and other treatment rooms
- Anesthetics and anesthesia services
- Acupuncture
- 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, see *Preventive Care, Adult*, in Section 5(a). 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

### **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: \$150 copayment per day per facility (except as noted below)

Note: You may be responsible for paying a \$200 copayment per day per facility if other diagnostic services are billed in addition to the services listed here.

Note: You pay 30% of the Plan allowance for surgical implants, agents, or drugs administered or obtained in connection with your care.

Member/Non-member facilities: You pay all charges

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*Outpatient Hospital or Ambulatory Surgical Center - continued on next page*

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