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## 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

#### Page 75

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**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**

##### **Inpatient Hospital**

Room and board, such as:

- Semiprivate or intensive care accommodations
- General nursing care
- Meals and special diets

Note: We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a Preferred or Member hospital only has private rooms. If a Preferred or Member hospital only has private rooms, we base our payment on the contractual status of the facility. If a Non-member hospital only has private rooms, we base our payment on the Plan allowance for your type of admission. Please see Section 10, *Definitions*, for more information.

See later in this Section and Section 5(e) for inpatient residential treatment coverage.

Other hospital services and supplies, such as:

- Operating, recovery, maternity, and other treatment rooms
- Prescribed drugs and medications
- Diagnostic studies, radiology services, laboratory tests, and pathology services

- Administration of blood or blood plasma
- Dressings, splints, casts, and sterile tray services
- Internal prosthetic devices
- Other medical supplies and equipment, including oxygen
- Anesthetics and anesthesia services
- Take-home items
- Pre-admission testing recognized as part of the hospital admissions process
- Nutritional counseling
- Acute inpatient rehabilitation

Note: **Observation services** are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described in this section. See Section 10, *Definitions*, for more information about these types of services.

Note: Here are some things to keep in mind:

- You do not need to precertify your delivery; see Section 3 for other circumstances, such as extended stays for you or your newborn.

### **Standard Option - You Pay**

Preferred facilities: \$350 per admission copayment for unlimited days (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 a Preferred facility.

Member facilities: \$450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible)

Non-member facilities: \$450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment

Note: If you are admitted to a Member or Non-member facility due to a **medical emergency or**

**accidental injury**, you pay a \$350 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.

**Basic Option - You Pay**

Preferred facilities: \$250 per day copayment up to \$1,500 per admission for unlimited days

Note: Your responsibility for maternity care in a preferred facility, or birthing center, is limited to a \$250 copayment associated with the charges incurred during delivery.

Member/Non-member facilities: You pay all charges

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*Inpatient Hospital - continued on next page*

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Go to page [74](#). Go to page [76](#).