2027 Blue Cross and Blue Shield Service Benefit Plan
FEP Blue Standard and FEP Blue Basic
Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.

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 center.

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.

Notes:

- You do not need to precertify your delivery; see Section 3 for other circumstances, such as extended stays for you or your newborn.
- If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days.
- We pay inpatient hospital benefits for an admission in connection with the treatment of children up to age 22 with severe dental caries. We cover hospitalization for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(g).

Note: See Section 5(a) for other covered maternity services.

Note: See Section 5(a) for coverage of blood and blood products.

Note: For certain surgical procedures, your out-of-pocket costs for facility services are reduced if you use a facility designated as a Blue Distinction Center. Keep reading this section for more information.

Standard Option - You Pay
Preferred facilities: $450 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 $450 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.

Basic Option - You Pay
Preferred facilities: $500 per day copayment up to $3,500 per admission

Note: Your responsibility for maternity care in a Preferred facility, or birthing center, is limited to a $500 copayment associated with the charges incurred during delivery. This copayment is waived if you deliver in a Blue Distinction Center for maternity.

Member/Non-member facilities: You pay all charges

Benefit Description

Not covered:

- *Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, or residential treatment centers (except as described later in this section and in Section 5(e))*
- *Personal comfort items, such as guest meals and beds, phone, television, beauty and barber services*
- *Private duty nursing*
- *Facility room and board expenses when, in our judgment, an admission or portion of an admission is:*
    - *Custodial or long term care (see Definitions)*
    - *Convalescent care or a rest cure*
    - *Domiciliary care provided because care in the home is not available or is unsuitable*
- *Care that is not medically necessary, such as:*
    - *When services did not require the acute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive.*
    - *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