2025 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

Outpatient Hospital or Ambulatory Surgical Center (cont.)

- Other medical supplies, including oxygen
- Surgical implants

Notes:

- See Section 5(d) for our payment levels for care related to a medical emergency or accidental injury.
- See Section 5(a) for our coverage of family planning services.
- For our coverage of hospital-based clinic visits, please refer to the professional benefits described in Section 5(a).
- 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 as described later in this section.
- For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility. See Section 5(a) for other included maternity services.
- See later in this section for outpatient drugs, medical devices, and durable medical equipment billed for by a facility.
- We cover outpatient hospital services and supplies related to the treatment of children up to age 22 with severe dental caries.

We cover outpatient care related to other types of 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*, for additional benefit information.

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: $250 copayment per day per facility (except as noted below)

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

Benefit Description
Outpatient **observation services** performed and billed by a hospital or freestanding ambulatory facility

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 later in this section for information about benefits for inpatient admissions.

Note: For outpatient observation services related to maternity, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.

Standard Option - You Pay
Preferred facilities: $350 copayment for the duration of services (no deductible)

Member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible)

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

Basic Option - You Pay
Preferred facilities: $350 per day copayment up to $1,750

Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

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