2023 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 81

Benefit Description

Inpatient Hospital (cont.)

- *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 pages 18-19).

Standard Option - You Pay
All charges

Basic Option - You Pay
All charges

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 page 42). 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

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. (See page 152 for more information about “agents.”)

Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

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Go to page 80 , . Go to page 82.