Maternity - Facility

2025 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus
Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services
Maternity – Facility

Note: We state whether or not the calendar year deductible applies for each benefit listed in this section.

Benefit Description

Maternity – Facility
We encourage you to notify us of your pregnancy during the first trimester, see Section 3.

Maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage, such as:

- Inpatient facility care,
- Care at birthing facilities,
- Services you receive on an outpatient basis, and
- Tocolytic therapy and related services when provided on an inpatient basis during a covered hospital admission or during a covered observation stay

Notes:

- We cover up to 8 visits per year in full to treat depression associated with pregnancy (i.e., depression during pregnancy, postpartum depression, or both) when you use a Preferred provider. See Section 5(a).
- Preventive care benefits apply to the screening of pregnant members for HIV, syphilis and unhealthy alcohol use/substance use when billed by a facility.

Room and board, such as:

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

Other inpatient hospital services and supplies, such as:

- Administration of blood or blood plasma
- Anesthetics and anesthesia services
- Breastfeeding education
- Covered medical supplies and equipment, including oxygen
- Delivery, operating, recovery, and other treatment rooms
- Diagnostic studies, radiology services, laboratory tests, and pathology services
- Dressings and sterile tray services
- Nutritional counseling
- Prescribed drugs and medications
- Take-home items

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.
- You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary.
- We cover routine nursery care of the newborn when performed during the covered portion of the mother’s maternity stay and billed by the facility. We cover other care of a newborn who requires professional services or non-routine treatment, only if we cover the newborn under a Self Plus One or Self and Family enrollment. Surgical benefits apply to circumcision if billed by a professional provider for a male newborn.

- When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. Regular medical or surgical benefits apply rather than maternity benefits.
- See Section 5(b) for our payment levels for circumcision.
- For inpatient care received overseas, refer to Section 5(i).

You Pay
Preferred facilities: $1,500 copayment per pregnancy (no deductible)

Non-preferred facilities (Member/Non-member): You pay all charges

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Not covered:

- *Breast pumps and milk storage bags except as stated in Section 5(a)*
- *Breastfeeding supplies other than those contained in the breast pump kit described in Section 5(a) including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or convenience (e.g., nursing pads)*
- *Childbirth preparation, Lamaze, and other birthing/parenting classes*
- *Doula, birth companion, and similar supporter*
- *Maternity care for members not enrolled in this Plan*
- *Personal comfort items, such as guest meals and beds, phone, television, beauty and barber services*
- *Private duty nursing*
- *Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest*
- *Tocolytic therapy and related services except as previously described*

You Pay
All charges