67

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
Page 67

Benefit Description

Inpatient Hospital (cont.)

Not covered:

- *Admission to noncovered facilities, such as nursing homes, extended care/skilled nursing facilities, schools, or residential treatment centers (except as described later in this section and 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 described in Section 3.

You Pay
All charges

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

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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Maternity – Facility – continued on next page

Go to page 66. Go to page 68.