2026 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

Hospice Care (cont.)

Traditional Home Hospice Care
Periodic visits to the member's home for the management of the terminal medical condition and to provide limited patient care in the home.

Standard Option - You Pay
Preferred facilities: Nothing (no deductible)

Member/Non-member facilities: $450 copayment per episode (no deductible)

Basic Option - You Pay
Preferred facilities: Nothing

Member/Non-member facilities: You pay all charges

Benefit Description

Continuous Home Hospice Care
Services provided in the home during a period of crisis, such as frequent medication adjustments to control symptoms or to manage a significant change in the member's condition, requiring a minimum of 8 hours of care during each 24-hour period by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).

Standard Option - You Pay
Preferred facilities: Nothing (no deductible)

Member facilities: $450 per episode copayment (no deductible)

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

Basic Option - You Pay
Preferred facilities: Nothing

Member/Non-member facilities: You pay all charges

Benefit Description

Inpatient Hospice Care
Benefits are available for inpatient hospice care when provided by a facility that is licensed as an inpatient hospice facility and when:

- Inpatient services are necessary to control pain and/or manage the member's symptoms;
- Death is imminent; or
- Inpatient services are necessary to provide an interval of relief (respite) to the caregiver

Note: Benefits are provided for up to 30 consecutive days in a facility licensed as an inpatient hospice facility.

Standard Option - You Pay
Preferred facilities: Nothing (no deductible)

Member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible)

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

Basic Option - You Pay
Preferred facilities: Nothing

Member/Non-member facilities: You pay all charges

Benefit Description

Not covered:

- *Advanced care planning, except when provided as part of a covered hospice care treatment plan*
- *Homemaker services*

Standard Option - You Pay
All charges

Basic Option - You Pay
All charges

Benefit Description

Ambulance
Professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically necessary, and:

- Associated with covered hospital inpatient care
- Related to medical emergency
- Associated with covered hospice care

Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.

Standard Option - You Pay
$100 copayment per day for ground ambulance transport services (no deductible)

$150 copayment per day for air or sea ambulance transport services

Basic Option - You Pay
$100 copayment per day for ground ambulance transport services

$150 copayment per day for air or sea ambulance transport services