

## SECTION XI

### Inpatient Services

Please refer to the Schedule of Benefits section of this [Contract; Policy] for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

*{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage.}*

#### **A. Hospital Services.**

We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits section of this [Contract; Policy] apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital that occur within a period of not more than 90 days for the same or related causes.

#### **B. Observation Services.**

We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other

licensed staff.

**C. Inpatient Medical Services.**

We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this [Contract; Policy].

**D. Inpatient Stay for Maternity Care.**

We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this [Contract; Policy] and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this [Contract; Policy] that apply to home care benefits.

We also Cover the inpatient use of pasteurized donor human milk, which may include fortifiers, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

**E. Inpatient Stay for Mastectomy Care.**

We Cover inpatient services for Subscribers undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

**F. Autologous Blood Banking Services.**

We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

**G. Habilitation Services.**

*{Drafting Note: Use the paragraph below for Essential Plans 1, 2, and 250}*

We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy for 60 days per Plan Year. The visit limit applies to all therapies combined.

*{Drafting Note: Use the paragraph below for Essential Plans 3 and 4}*

We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy.

#### **H. Rehabilitation Services.**

*{Drafting Note: Use the paragraph below for Essential Plans 1, 2, and 200-250}*

We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for 60 days per Plan Year. The visit applies to all therapies combined.

*{Drafting Note: Use the paragraph below for Essential Plans 3 and 4}*

We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy.

We Cover speech and physical therapy only when:

1. Such therapy is related to the treatment or diagnosis of Your illness or injury;
2. The therapy is ordered by a Physician; and
3. You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:

1. The date of the injury or illness that caused the need for the therapy;
2. The date You are discharged from a Hospital where surgical treatment was rendered; or
3. The date outpatient surgical care is rendered.

#### **I. Skilled Nursing Facility.**

We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the Exclusions and Limitations section of this [Contract; Policy]). [An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us.] We Cover up to 200 days per Plan Year for non-custodial care.

#### **J. End of Life Care.**

If You are diagnosed with advanced cancer and You have fewer than 60 days to live,

We will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited external appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this [Contract; Policy] until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

*Insert the bracketed language regarding contact information as applicable. When services are only covered at Centers of Excellence, such services should be limited to those that are not widely available from all Hospitals within the network, such as organ transplants. If a plan uses a designation other than "Centers of Excellence" insert the appropriate designation.}*

**[K.] [[Centers of Excellence; Designated Hospitals.]**

Centers of Excellence; Designated Hospitals are Hospitals that We have approved and designated for certain services. To find out if a Hospital is a Center of Excellence; designated Hospital] [check our Provider directory, available at Your request; call [XXX; the number on Your ID card]; [or] visit Our website [at XXX]]. We Cover the following Services [only] when performed at Centers of Excellence; designated Hospital]:  
[insert list of services]  
[insert any plan specific language regarding the centers of excellence program]]

See the Utilization Review and External Appeal sections of this [Contract; Policy] for Your right to an internal Appeal and external appeal if We determine that the above services must be performed at a Center of Excellence; designated Hospital]].

**[L.] Limitations/Terms of Coverage.**

1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
- [3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, unless Our denial is

overturned by an External Appeal Agent.]

*{Drafting Note: The bracketed language above is optional.}*