Chapter 4: Benefits Chart

[Plans should refer members to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "see Chapter 9, Section A, page 1."   
An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

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# Understanding [insert if the plan has cost sharing: your out-of-pocket costs for]your covered services

This chapter tells you what services <plan name> pays for. [Insert if the plan has cost-sharing: It also tells how much you pay for each service.] You can also learn about services that are not covered. Information about drug benefits is in Chapter 5 [plans may insert reference, as applicable]. [Insert if applicable: This chapter also explains limits on some services.]

[Plans with cost sharing, insert: For some services, you will be charged an out-of-pocket cost called a co-pay. This is a fixed amount (for example, $5) you pay each time you receive that service. You pay the co-pay at the time you get the medical service.]

[Plans with **no** cost-sharing for any services described in this chapter, insert: Because you get assistance from Medi-Cal, you pay nothing for your covered services as long as you follow the plan’s rules. See Chapter 3 [plans may insert reference, as applicable] for details about the plan’s rules.]

If you need help understanding what services are covered, call your [plans may insert: care coordinator and/or Member Services at <member services number>. [Plans should replace the term “care coordinator” with the term they use and include a phone number or other contact information.]

# Our plan does not allow providers to charge you for services

We do not allow <plan name> providers to bill you for services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

* **You should never get a bill from a provider. If you do, see Chapter 7** [plans may insert reference, as applicable]**.**

# About the Benefits Chart

[Plans may add references to long-term care or home and community-based services.]

This benefits chart tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services. [Plans that include an index at the end of the chapter should insert: To find a service in the chart, you can also use the index at the end of the chapter.]

**We will pay for the services listed in the Benefits Chart only when the following rules are met.** [Plans that do not have cost-sharing, insert: **You do not pay anything for the service listed in the Benefits Chart, as long as you meet the coverage requirements described below.**]

* Your Medicare and Medi-Cal covered services must be provided according to the rules set by Medicare and Medi-Cal.
* The services (including medical care, behavioral health and substance use services, long term services and supports, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition. [Plans should add the state-specific definition of “medically necessary” as appropriate.]
* [Insert if applicable: You get your care from a network provider. A network provider is a provider who works with us. In most cases, we will not pay for care you get from an out-of-network provider. Chapter 3 [plans may insert reference, as applicable] has more information about using network and out-of-network providers.]
* [Insert if applicable: You have a primary care provider (PCP) or a care team that is providing and managing your care. [Plans that do not require referrals, omit the rest of this paragraph:] In most cases, your PCP must give you approval before you can see other network providers. This is called a referral. Chapter 3 [plans may insert reference, as applicable] has more information about getting a referral and explains when you do not need a referral.]
* [Insert if applicable: Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization. Covered services that need approval first are marked in the Benefits Chart [insert as appropriate: by an asterisk (\*) **or** by a footnote **or** in bold type **or** in italic type]. [Insert if applicable: In addition, you must get approval first for the following services that are not listed in the Benefits Chart: [insert list].]

[Insert as applicable: Most **or** All] preventive services are free. You will see this apple next to preventive services in the benefits chart.



[Instructions on completing the benefits chart:

* For all preventive care and screening test benefit information, plans that cover a richer benefit do not need to include the given description (unless it is still applicable) and may instead describe the plan benefit.
* Include the following where appropriate: You should talk to your provider and get a referral.
* Plans must include any services provided in excess of the Medicare and Medi-Cal requirements. Preventive services must be identified with the apple icon.
* Plans should clearly indicate which benefits are subject to prior authorization. (This can be done with asterisks, footnotes, bold type, or italic type. Plans should select one method of indication throughout the document; do not use multiple methods.)
* Plans may insert any additional benefits information based on the plan’s approved benefit package that is not captured in the Benefits Chart or in the exclusions section. Additional benefits should be placed alphabetically in the chart.
* Plans must describe any restrictive policies, limitations, or monetary limits that might affect a beneficiary’s access to services within the chart.
* Plans may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.
* Plans should include all non-waiver LTSS in the chart in alphabetical order.
* Plans with no cost sharing for any type of service (i.e. no cost sharing at all) may delete the “what you must pay” column from the table. Plans with any type of cost sharing for services, including for pharmacy services, must leave the “what you must pay” column in the table.]

# The Benefits Chart

| Services that our plan pays for | | What you must pay |
| --- | --- | --- |
|  | Abdominal aortic aneurysm screening  We will pay only once for an ultrasound screening for people at risk. You must get a referral for it at your “Welcome to Medicare” preventive visit.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | [Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate.]  Alcohol misuse screening and counseling  We will pay for one alcohol-misuse screening (SBIRT) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.  If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.  [List any additional benefits offered.] | $0 |
|  | Ambulance services  Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care.  Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by us.  In cases that are *not* emergencies, we *may* pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. | $0 |
|  | Annual wellness visit  You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We will pay for this once every 12 months. | $0 |
|  | Bone mass measurement  We will pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We will pay for the services once every 24 months, or more often if they are medically necessary. We will also pay for a doctor to look at and comment on the results.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Breast cancer screening (mammograms)  We will pay for the following services:  One baseline mammogram between the ages  of 35 and 39  One screening mammogram every 12 months  for women age 40 and older  Clinical breast exams once every 24 months  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Cardiac (heart) rehabilitation services  We will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor’s [insert as appropriate: referral or order]. We also cover *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. | $0 |
|  | Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)  We pay for one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may:  Discuss aspirin use,  Check your blood pressure, and/or  Give you tips to make sure you are eating well.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Cardiovascular (heart) disease testing  We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Cervical and vaginal cancer screening  We will pay for the following services:  For all women: Pap tests and pelvic exams once every 24 months  For women who are at high risk of cervical cancer: one Pap test every 12 months  For women who have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Chiropractic services  We will pay for the following services:  Adjustments of the spine to correct alignment  [List any Medi-Cal or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.] | [List co-pays.]  [List co-pays for supplemental benefits.] |
|  | Colorectal cancer screening  For people 50 and older, we will pay for the following services:  Flexible sigmoidoscopy (or screening barium enema) every 48 months  Fecal occult blood test, every 12 months  For people at high risk of colorectal cancer, we will pay for one screening colonoscopy (or screening barium enema) every 24 months  For people not at high risk of colorectal cancer, we will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Community Based Adult Services (CBAS)  CBAS is an outpatient, facility based service program where people attend according to a schedule. It delivers skilled nursing care, social services, therapies (including occupational, physical, and speech), personal care, family/caregiver training and support, nutrition services, transportation, and other services. We will pay for CBAS if you meet the eligibility criteria.  *Note: If a CBAS facility is not available, we can provide these services unbundled.* | $0 |
|  | Counseling to stop smoking or tobacco use  If you use tobacco but do not have signs or symptoms of tobacco-related disease:  We will pay for two counseling quit attempts in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits.  If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:  We will pay for two counseling quit attempts  within a 12 month period. Each counseling attempt includes up to four face-to-face visits.  If you are pregnant, you may receive unlimited tobacco cessation counseling with prior authorization.  [List any additional benefits offered.] | $0  [List co-pays for supplemental benefits.] |
|  | Dental services  Certain dental services, including dentures, will be provided by the state’s Denti-Cal program starting May 1, 2014. These services are not provided through our plan. For more information, call Denti-Cal at 1-800-322-6384. TTY users should call 1-800-735-2922.  [*Plans that cover dental services insert*: We will pay for the following services:   * List plan-covered supplemental benefits offered, such as routine dental care, dental X-rays, and cleanings.]   [*Plans must include this language regarding possible cost sharing if they offer the supplemental dental benefit:*  If the covered benefit is upgraded to include noble or high noble metal, the provider may charge you the additional lab cost of the upgraded metal.  Porcelain/resin fused to metal crowns on molar teeth is considered an upgrade. If a porcelain/resin fused to metal crown on a molar tooth is provided, the provider may charge you the additional lab cost of the porcelain/resin.  If the covered anterior fixed bridge is upgraded to include noble or high noble metal, the provider may charge you the additional lab cost of the upgraded metal.] | [If plan offers supplemental benefit, the maximum copay amount is $10] |
|  | Depression screening  We will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Diabetes screening  We will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:  High blood pressure (hypertension)  History of abnormal cholesterol and triglyceride levels (dyslipidemia)  Obesity  History of high blood sugar (glucose)  Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.  Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Diabetic self-management training, services, and supplies  We will pay for the following services for all people who have diabetes (whether they use insulin or not):  Supplies to monitor your blood glucose, including  the following:  A blood glucose monitor  Blood glucose test strips  Lancet devices and lancets  Glucose-control solutions for checking the accuracy of test strips and monitors  For people with diabetes who have severe diabetic foot disease, we will pay for the following:  One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, ***or***  One pair of depth shoes and three pairs of inserts each year (not including the  non-customized removable inserts provided with such shoes)  We will also pay for fitting the therapeutic custom-molded shoes or depth shoes.  We will pay for training to help you manage your diabetes, in some cases.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Durable medical equipment and related supplies  (For a definition of “Durable medical equipment,” see Chapter 12 [plans may insert reference, as applicable] of this handbook.)  The following items are covered:  Wheelchairs ◾ Oxygen equipment  Crutches ◾ IV infusion pumps  Hospital beds ◾ Walkers  Nebulizers  Other items *may* be covered.  [Plans that do not limit the DME brands and manufacturers that you will cover, insert:We will pay for all medically necessary durable medical equipment that Medicare and Medi-Cal usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.]  [Plans that limit the DME brands and manufacturers that you will cover, insert: With this Member Handbook, we sent you <plan name>’s list of durable medical equipment. The list tells you the brands and makers of durable medical equipment that we will pay for. This most recent list of brands, makers, and suppliers is also available on our website at <URL>.  Generally, <plan name> covers any durable medical equipment covered by Medicare and Medi-Cal from the brands and makers on this list. We will not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to <plan name> and are using a brand of durable medical equipment that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically right for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.) | [List co-pays.] |
|  | Durable medical equipment and related supplies  (continued)  If you (or your doctor) do not agree with the plan’s decision about paying for your equipment, you or your doctor may file an appeal. You can also file an appeal if you do not agree with your doctor’s decision about what product or brand is right for your medical condition. (For more information about appeals, see Chapter 9 [plans may insert reference, as applicable]*.*)] |  |
|  | Emergency care  *Emergency care* means services that are:  Given by a provider trained to give emergency services, ***and***  Needed to treat a medical emergency.  A *medical emergency* is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:  Placing the person’s health in serious risk; ***or***  Serious harm to bodily functions; ***or***  Serious dysfunction of any bodily organ or part; ***or***  In the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur:  There is not enough time to safely transfer the member to another hospital before delivery.  The transfer may pose a threat to the health or safety of the member or unborn child.  [Also identify whether this coverage is within the U.S. or world-wide.] | $0  If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, [plans should insert information as needed to accurately describe emergency care benefits:(e.g. you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay.)]. |
|  | [Plans should modify this as necessary.]  Family planning services  The law lets you choose any provider for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.  We will pay for the following services:  Family planning exam and medical treatment  Family planning lab and diagnostic tests  Family planning methods (birth control pills, patch, ring, IUD, injections, implants)  Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)  Counseling and diagnosis of infertility, and related services  Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions  Treatment for sexually transmitted infections (STIs)  Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.)  Genetic counseling  We will also pay for some other family planning services. However, you must see a provider in our provider network for the following services:  Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)  Treatment for AIDS and other HIV-related conditions  Genetic testing | [List co-pays.] |
|  | Health and wellness education programs  We offer many programs that focus on certain health conditions. These include:   * Health Education classes; * Nutrition Education classes; * Smoking and Tobacco Use Cessation; and * Nursing Hotline   [List any additional benefits offered.] | [List co-pays.] |
|  | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]  **Hearing services**  We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.  If you are under 21 years old, pregnant, or reside in a nursing facility, we will also pay for hearing aids, including:   * Molds, supplies, and inserts * Repairs that cost more than $25 per repair * An initial set of batteries * Six visits for training, adjustments, and fitting with the same vendor after you get the hearing aid * Trial period rental of hearing aids | [List co-pays.]  [List co-pays for additional benefits.] |
|  | HIV screening  We pay for one HIV screening exam every 12 months for people who:  Ask for an HIV screening test, ***or***  Are at increased risk for HIV infection.  For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Home health agency care  [Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate.]  Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency.  We will pay for the following services, and maybe other services not listed here:  Physical therapy, occupational therapy, and speech therapy  Medical and social services  Medical equipment and supplies | [List co-pays.] |
|  | [Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate.]  Hospice care  You can get care from any hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider.  The plan will pay for the following:  Drugs to treat symptoms and pain  Short-term respite care  Home care  ***For hospice services and services covered by Medicare Part A or B that relate to your terminal illness:***  The hospice provider will bill Medicare for your services. Medicare will pay for hospice services and any Medicare Part A or B services. You pay nothing for these services.  ***For services covered by Medicare Part A or B that are not related to your terminal illness*** (except for emergency care or urgently needed care):  The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.  ***For services covered by <plan name> but not covered by Medicare Part A or B:***  <Plan name> will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal illness. You pay [insert as appropriate: the plan’s cost-sharing amount ***or*** nothing] for these services.  **Note:** If you need non-hospice care, you should call your care coordinator to arrange the services. Non-hospice care is care that is not related to your terminal illness. [Plans should replace the term “care coordinator” with the term they use and include a phone number or other contact information.] | $0  When you are in a hospice program certified by Medicare, your hospice services and your Medicare Part A and B services related to your terminal illness are paid for by Medicare. <Plan name> does not pay for your services.  [Include information about cost sharing for hospice consultation services if applicable.] |
|  | Hospice care  (continued)  [Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.] |  |
|  | Immunizations  We will pay for the following services:  Pneumonia vaccine  Flu shots, once a year, in the fall or winter  Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B  Other vaccines if you are at risk and they meet Medicare Part B coverage rules  We will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 [plans may insert reference, as applicable] to learn more.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | **In-Home Supportive Services (IHSS)**  We will pay for services provided to you so that you can remain safely in your own home.  The types of IHSS which can be authorized through the County Department of Social Services are:   * Housecleaning * Meal preparation * Laundry * Grocery shopping * Personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services) * Accompaniment to medical appointments * Protective supervision for the mentally impaired   To qualify for IHSS, you must be aged, blind, or disabled and, in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary Program.  If eligible, you may receive up to 283 hours of IHSS if approved by your county social worker. | [List co-pays.] |
|  | Inpatient hospital care  [List any restrictions that apply.]  We will pay for the following services, and maybe other services not listed here:  Semi-private room (or a private room if it is medically necessary)  Meals, including special diets  Regular nursing services  Costs of special care units, such as intensive care or coronary care units  Drugs and medications  Lab tests  X-rays and other radiology services  Needed surgical and medical supplies  Appliances, such as wheelchairs  Operating and recovery room services  Physical, occupational, and speech therapy  Inpatient substance abuse services  In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. | $0  You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control. |
|  | Inpatient hospital care  (continued)  If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. [Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or at a distant location outside the service area. If <plan name> provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.]  Blood, including storage and administration  Physician services |  |
|  | Inpatient mental health care  We will pay for mental health care services that require a hospital stay.   * If you need inpatient services in a freestanding psychiatric hospital, we will pay for the first 190 days. After that, the local county mental health agency will pay for inpatient psychiatric services that are medically necessary. Authorization for care beyond the 190 days will be coordinated with the local county mental health agency.   + The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. * If you are 65 years or older, we will pay for services received in an Institute for Mental Diseases (IMD). | $0 |
|  | [Plans with no day limitations on a plan’s hospital or nursing facility coverage may modify or delete this row as appropriate.]  Inpatient services covered during a non-covered inpatient stay  If your inpatient stay is not reasonable and needed, we will not pay for it.  However, in some cases we will pay for services you get while you are in the hospital or a nursing facility. We will pay for the following services, and maybe other services not listed here:  Doctor services  Diagnostic tests, like lab tests  X-ray, radium, and isotope therapy, including technician materials and services  Surgical dressings  Splints, casts, and other devices used for fractures and dislocations  Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that:  Replace all or part of an internal body organ (including contiguous tissue), or  Replace all or part of the function of an inoperative or malfunctioning internal body organ.  Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient’s condition  Physical therapy, speech therapy, and occupational therapy | $0 |
|  | Kidney disease services and supplies  We will pay for the following services:  Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. We will cover up to six sessions of kidney disease education services.  Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 [plans may insert reference, as applicable]  Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care  Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments  Home dialysis equipment and supplies  Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply.  **Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see “Medicare Part B prescription drugs” below.** | $0 |
|  | Medical nutrition therapy  This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when [insert as appropriate: referred **or** ordered] by your doctor.  We will pay for three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor’s [insert as appropriate: referral **or** order]. A doctor must prescribe these services and renew the [insert as appropriate: referral **or** order] each year if your treatment is needed in the next calendar year.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Medicare Part B prescription drugs  These drugs are covered under Part B of Medicare. <Plan name> will pay for the following drugs:  Drugs you don’t usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services  Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan  Clotting factors you give yourself by injection if you have hemophilia  Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant  Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself  Antigens  Certain oral anti-cancer drugs and anti-nausea drugs  Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoisis-stimulating agents [plans may delete any of the following drugs that are not covered under the plan] (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)  IV immune globulin for the home treatment of primary immune deficiency diseases   * **Chapter 5** [plans may insert reference, as applicable] **explains the outpatient prescription drug benefit.** It explains rules you must follow to have prescriptions covered. * **Chapter 6** [plans may insert reference, as applicable] **explains what you pay for your outpatient prescription drugs through our plan.** | $0 |
|  | **Multi-Purpose Senior Services Program (MSSP)**  MSSP is a case management program that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals.  To be eligible, you must be 65 years of age or older, live within a site's service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility.  MSSP services include:   * Adult Day Care / Support Center * Housing Assistance * Chore and Personal Care Assistance * Protective Supervision * Care Management * Respite * Transportation * Meal Services * Social Services * Communications Services   This benefit is covered up to $4,285 per year. | [List co-pays.] |
|  | **Non-emergency medical transportation**  This benefit allows for transportation that is the most cost effective and accessible. This can include: ambulance, litter van, wheelchair van medical transportation services, and coordinating with para transit.  The forms of transportation are authorized when:   * Your medical and/or physical condition does not allow you to travel by bus, passenger car, taxicab, or another form of public or private transportation, and * Transportation is required for the purpose of obtaining needed medical care.   Depending on the service, prior authorization may be required. | [List co-pays.] |
|  | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]  **Non-medical transportation**  This benefitallows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation.  You will have access to 30 one-way trips per year.  This benefit does not limit your non-emergency medical transportation benefit. | [List co-pays.] |
|  | [Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate.]  Nursing facility care  A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital.  Services that we will pay for include, but are not limited to, the following:   * Semiprivate room (or a private room if it is medically needed) * Meals, including special diets * Nursing services * Physical therapy, occupational therapy, and speech therapy * Drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) * Blood, including storage and administration * Medical and surgical supplies usually given by nursing facilities * Lab tests usually given by nursing facilities * X-rays and other radiology services usually given by nursing facilities * Use of appliances, such as wheelchairs usually given by nursing facilities * Physician/practitioner services * Durable medical equipment * Dental services, including dentures * Vision benefits * Hearing exams * Chiropractic care * Podiatry services | [List co-pays.] |
|  | Nursing facility care  (continued)  You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan’s amounts for payment:   * A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). * A nursing facility where your spouse is living at the time you leave the hospital. |  |
|  | Obesity screening and therapy to keep weight down  If you have a body mass index of 30 or more, we will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Outpatient diagnostic tests and therapeutic services and supplies  We will pay for the following services, and maybe other services not listed here:  X-rays  Radiation (radium and isotope) therapy, including technician materials and supplies  Surgical supplies, such as dressings  Splints, casts, and other devices used for fractures and dislocations  Lab tests  Blood, including storage and administration  Other outpatient diagnostic tests  [Plans can include other covered tests as appropriate.] | $0 |
|  | Outpatient hospital services  We pay for medically needed services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.  We will pay for the following services, and maybe other services not listed here:  Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery  Labs and diagnostic tests billed by the hospital  Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it  X-rays and other radiology services billed by the hospital  Medical supplies, such as splints and casts  Some screenings and preventive services  Some drugs that you can’t give yourself  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | [Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate.]  Outpatient mental health care  We will pay for mental health services provided by:  A state-licensed psychiatrist or doctor  A clinical psychologist  A clinical social worker  A clinical nurse specialist  A nurse practitioner  A physician assistant  Any other Medicare-qualified mental health care professional as allowed under applicable state laws  We will pay for the following services, and maybe other services not listed here:  Clinic services [Plans should include any Medi-Cal limitations that apply (e.g., number of visits)]  Day treatment [Plans should include any Medi-Cal limitations that apply (e.g., number of visits)]  Psychosocial rehab services [Plans should include any Medi-Cal limitations that apply (e.g., number of visits)]  Partial hospitalization/Intensive outpatient programs  Individual and group mental health evaluation and treatment  Psychological testing when clinically indicated to evaluate a mental health outcome  Outpatient services for the purposes of monitoring drug therapy  Outpatient laboratory, drugs, supplies and supplements  Psychiatric consultation  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | [Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate.]  Outpatient rehabilitation services  We will pay for physical therapy, occupational therapy, and speech therapy.  You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. | $0 |
|  | Outpatient substance abuse services  We will pay for the following services, and maybe other services not listed here:   * Alcohol misuse screening and counseling * Treatment of drug abuse * Group or individual counseling by a qualified clinician * Subacute detoxification in a residential addiction program * Alcohol and/or drug services in an intensive outpatient treatment center * Extended release Naltrexone (vivitrol) treatment   [List any additional benefits offered.] | [List co-pays.] |
|  | Outpatient surgery  We will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. | $0 |
|  | [Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate.]  Partial hospitalization services  *Partial hospitalization* is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care you get in your doctor’s or therapist’s office. It can help keep you from having to stay in the hospital.  [Network plans that do not have an in-network community mental health center may add: **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting.] | $0 |
|  | Physician/provider services, including doctor’s office visits  We will pay for the following services:  Medically necessary health care or surgery services given in places such as:  Physician’s office  Certified ambulatory surgical center  Hospital outpatient department  Consultation, diagnosis, and treatment by a specialist  Basic hearing and balance exams given by your [insert as applicable: primary care provider **or** specialist], if your doctor orders it to see whether you need treatment  [Insert if the plan has a service area and providers/locations that qualify for telehealth services under the Medicare requirements: Some telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for patients in rural areas or other places approved by Medicare]  Second opinion [insert if appropriate: by another network provider] before a medical procedure  Non-routine dental care. Covered services are limited to:  Surgery of the jaw or related structures  Setting fractures of the jaw or facial bones  Pulling teeth before radiation treatments of neoplastic cancer  Services that would be covered when provided by a physician  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Podiatry services  We will pay for the following services:  Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)  Routine foot care for members with conditions affecting the legs, such as diabetes  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Prostate cancer screening exams  For men age 50 and older, we will pay for the following services once every 12 months:  A digital rectal exam  A prostate specific antigen (PSA) test  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | [Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate.]  Prosthetic devices and related supplies  *Prosthetic devices* replace all or part of a body part or function. We will pay for the following prosthetic devices, and maybe other devices not listed here:  Colostomy bags and supplies related to colostomy care  Pacemakers  Braces  Prosthetic shoes  Artificial arms and legs  Breast prostheses (including a surgical brassiere after a mastectomy)  Incontinence cream and diapers  We will also pay for some supplies related to prosthetic devices. We will also pay to repair or replace prosthetic devices.  We offer some coverage after cataract removal or cataract surgery. See “Vision Care” later in this section [plans may insert reference, as applicable] for details.  [Plans that pay for prosthetic dental devices, delete the following sentence:] We will not pay for prosthetic dental devices. | $0 |
|  | Pulmonary rehabilitation services  We will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have [insert as appropriate: a referral **or** an order] for pulmonary rehabilitation from the doctor or provider treating the COPD.  We will pay for respiratory services for ventilator-dependent patients.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Sexually transmitted infections (STIs) screening and counseling  We will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.  We will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We will pay for these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor’s office.  [Also list any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Skilled nursing facility care  We will pay for the following services, and maybe other services not listed here:  A semi-private room, or a private room if it is medically needed  Meals, including special diets  Nursing services  Physical therapy, occupational therapy, and speech therapy  Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors  Blood, including storage and administration  Medical and surgical supplies given by nursing facilities  Lab tests given by nursing facilities  X-rays and other radiology services given by nursing facilities  Appliances, such as wheelchairs, usually given by nursing facilities  Physician/provider services  You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan’s amounts for payment:  A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care)  A nursing facility where your spouse lives at the time you leave the hospital | $0 |
|  | Urgent care  *Urgent care* is care given to treat:  A non-emergency, ***or***  A sudden medical illness, ***or***  An injury, ***or***  A condition that needs care right away.  If you require urgent care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider.  [Include in-network benefits. Also identify whether this coverage is within the U.S. or world-wide.] | $0 |
|  | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]  Vision care  We will pay for the following services:   * One routine eye exam every year; and * Up to $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses every two years.   We will pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. This includes treatment for age-related macular degeneration.  For people at high risk of glaucoma, we will pay for one glaucoma screening each year. People at high risk of glaucoma include:  People with a family history of glaucoma  People with diabetes  African-Americans who are age 50 and older  [Plans should modify this description if the plan offers more than is covered by Medicare.] We will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery). We will also pay for corrective lenses, and frames, and replacements if you need them after a cataract removal without a lens implant. | [List co-pays.]  [List co-pays for additional benefits.] |
|  | “Welcome to Medicare” Preventive Visit  We cover the one-time “Welcome to Medicare” preventive visit. The visit includes:  A review of your health,  Education and counseling about the preventive services you need (including screenings and shots), and  Referrals for other care if you need it.  **Important:** We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit. | $0 |

# Using our plan’s visitor or traveler benefits

[If your plan offers a visitor/traveler program to members who are out of your service area, insert this section, adapting and expanding the following paragraphs as needed to describe the traveler benefits and rules related to receiving the out-of-area coverage. If you allow extended periods of enrollment out-of-area per the exception in 42 CFR §422.74(b)(4)(iii) (for more than 6 months up to 12 months), also explain that here based on the language suggested below:

If you are out of the plan’s service area for more than 6 months at a time, we usually must drop you from our plan. However, we offer a visitor/traveler program [specify areas where the visitor/traveler program is being offered] that will allow you to remain enrolled in our plan when you are outside of our service area for up to 12 months. This program is available to all <plan name> members who are in a visitor/traveler area. Under our visitor/traveler program, you can get all plan-covered services at in-network cost-sharing prices. You can contact the plan for help in finding a provider when you use the visitor/traveler benefit.

If you are in a visitor/traveler area, you can stay enrolled in the plan until <end date>.   
If you have not returned to the plan’s service area by <end date>, you will be dropped from the plan.]

# Benefits *not* covered by the plan

This section tells you what kinds of benefits are excluded by the plan. *Excluded* means that we do not pay for these benefits.

The list below describes some services and items that are not covered by us under any conditions and some that are excluded by us only in some cases.

We will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*). Medicare and Medi-Cal will not pay for them either. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9 [plans may insert reference, as applicable].

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Member Handbook*, [mention any other places where exclusions are given, such as addenda] the following items and services are not covered by our plan:

[The services listed in the remaining bullets are excluded from Medicare’s and Medi-Cal’s benefit packages. If any services below are plan-covered supplemental benefits or are required to be covered by Medi-Cal or under a State’s demonstration, delete them from this list. When plans partially exclude services excluded by Medicare, they need not delete the item but may revise the text to describe the extent of the exclusion. Plans may add parenthetical references to the Benefits Chart for descriptions of covered services/items as appropriate. Plans may also add exclusions as needed.]

Services considered not “reasonable and medically necessary,” according to the standards of Medicare and Medi-Cal, unless these services are listed by our plan as covered services.

Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See pages <page numbers> for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.

Surgical treatment for morbid obesity, except when it is medically needed and Medicare pays for it.

A private room in a hospital, except when it is medically needed.

Private duty nurses.

Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.

Full-time nursing care in your home.

Fees charged by your immediate relatives or members of your household.

[Plans should delete this if State allows for this: Meals delivered to your home.

Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed.

Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.

Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.

Routine foot care, except for the limited coverage provided according to Medicare guidelines.

Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.

Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.

[Plans should delete this if supplemental: Regular hearing exams, hearing aids, or exams to fit hearing aids.

[Plans should delete this if supplemental: Radial keratotomy, LASIK surgery, vision therapy, and other low-vision aids.

Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.

Acupuncture.

* Naturopath services (the use of natural or alternative treatments).

Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.