Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services <plan name> covers and any restrictions or limits on those services [insert if the plan has cost sharing: and how much you pay for each service]. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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

[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

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

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 copay. This is a fixed amount (for example, $5) you pay each time you get that service. You pay the copay 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. Refer to 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.]

## A1. During public health emergencies

[*Plans providing required coverage and permissible flexibilities to members subject to a public health emergency declaration (e.g., the COVID-19 pandemic) concisely describe the coverage and flexibilities here or include general information about the coverage and flexibilities along with any cross references, as applicable. Plans include whether such coverage and flexibilities are contingent upon the duration of the public health emergency, which may or may not last for the entire year. Plans also include any specific contact information, as applicable, where members can get more details.*]

# Rules against providers charging you for services

We do not allow <plan name> providers to bill you for covered 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 for covered services**. If you do, refer to Chapter 7 [plans may insert reference, as applicable] or call Member Services.

# Our plan’s Benefits Chart

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

The 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 services 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 or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. A service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
* [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 use someone that is not your PCP or use other providers in the plan’s network. 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: You must get care from providers that are affiliated with your PCP’s medical group. Refer to Chapter 3 [plans may insert reference, as applicable] for more information.]
* [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 prior authorization 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 prior authorization first for the following services that are not listed in the Benefits Chart: [insert list].]
* [Insert if plan is offering targeted “Uniformity Flexibility” supplemental benefits and/or “*Special Supplemental Benefits for the Chronically Ill (SSBCI)”* in section B-19 of the Plan Benefit Package submission: **Important Benefit Information for Members with Certain Chronic Conditions.** If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits [insert if applicable: and/or reduced cost sharing]:
  + [List all applicable chronic conditions here.]
  + [If offering SSBCI, include information about the process and/or criteria for determining eligibility for SSBCI. Plan must also deliver a written summary of the SSBCI offered to each chronically ill member eligible for SSBCI.]

Please refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.]

* [Insert as applicable: Most **or** All] preventive services are free. You will find this apple Apple icon represents preventive services in the benefits chart. next to preventive services in the Benefits Chart.
* Care Plan Optional (CPO) services may be available under your Individualized Care Plan. These services give you more help at home, like meals, help for you or your caregiver, or shower grab bars and ramps. These services can help you live more independently but do **not** replace long-term services and supports (LTSS) that you are authorized to get under Medi-Cal. [*Insert as applicable:* Examples of CPO services that <plan name> has offered in the past include: [*insert two examples*].] If you need help or would like to find out how CPO services may help you, contact your care coordinator.

[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 must select only one method of indication, describe it in terms easily understandable by members, make the indication and description prominently visible, and use it consistently throughout the document.)
* 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 member’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.
* Plans offering targeted supplemental benefits in section B-19 of the Plan Benefit Package submission must:
* Deliver to each clinically-targeted enrollee a written summary of those benefits so that such enrollees are notified of the “Uniformity Flexibility” benefits for which they are eligible.
* Update the Benefits Chart to include details, as applicable, about the exact targeted reduced cost sharing amount for each specific service and/or the additional supplemental benefits being offered.]

# The Benefits Chart

[When a benefit continues from one page to the next, plans enter a blank return before right aligning and inserting at the bottom of the first part of the description: **This benefit is continued on the next page.** At the top of the next page where the benefit description continues, plans enter the benefit name again in bold followed by**(continued)**. Plans may refer to**Durable medical equipment (DME) and related supplies** and other examples later in this chart as examples. Plans should also be aware that the flow of benefits from one page to the next may vary after plan-customized information is added, which may necessitate adding and/or removing these instructions in other services as needed.]

| Services that our plan pays for | | What you must pay |
| --- | --- | --- |
| Apple indicates preventive benefit. | Abdominal aortic aneurysm screening  We will pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Acupuncture  We will pay for up to two outpatient acupuncture services in any one calendar month, or more often if they are medically necessary.  We will also pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as:   * lasting 12 weeks or longer; * not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); * not associated with surgery; **and** * not associated with pregnancy.   In addition, we will pay for an additional 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year.  Acupuncture treatments for chronic low back pain must be stopped if you don’t get better or if you get worse.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | [Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]  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 ground, fixed-wing, and rotary-wing 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 health or life. 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 |
| Apple icon indicates preventive services. | 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.  [List any additional benefits offered.] | $0 |
| Apple icon indicates preventive services. | 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 copays for additional benefits.] |
| Apple icon indicates preventive services. | 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 copays 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 |
| Apple icon indicates preventive services. | Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)  We pay for one visit a year, or more if medically necessary, with your primary care provider to help lower your risk for heart disease. During the [*insert:* visit *or* visits], 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 copays for additional benefits.] |
| Apple icon indicates preventive services. | 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 copays for additional benefits.] |
| Apple icon indicates preventive services. | 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 or vaginal cancer: one Pap test every 12 months * For women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months * For women aged 30-65: human papillomavirus (HPV) testing or Pap plus HPV testing once every 5 years   [List any additional benefits offered.] | $0  [List copays 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 copays.]  [List copays for supplemental benefits.] |
| Apple icon indicates preventive services. | 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 * Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months * DNA based colorectal screening, every 3 years * Colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy) * Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 months.   [List any additional benefits offered.] | $0  [List copays 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 separately. | $0 |
| Apple icon indicates preventive services. | Counseling to stop smoking or tobacco use  If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit:   * We will pay for two quit attempts in a 12 month period as a preventive service. This service is free for you. Each quit attempt includes up to four counseling 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 get unlimited tobacco cessation counseling with prior authorization.  [List any additional benefits offered.] | $0  [List copays for supplemental benefits.] |
|  | Dental services  Certain dental services, including cleanings, fillings, and dentures, are available through the Medi-Cal Dental Program. [*All plans, except Health Plan of San Mateo, insert:* Refer to Section F for more information about this benefit.]  [List any additional benefits offered.] | [If plan offers supplemental benefit, the maximum copay amount is $10.] |
| Apple icon indicates preventive services. | 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 copays for additional benefits.] |
| Apple icon indicates preventive services. | 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 copays for additional benefits.] |
| Apple icon indicates preventive services. | 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), including the fitting, and two extra pairs of inserts each calendar year, **or** * One pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) * We will pay for training to help you manage your diabetes, in some cases. To find out more, contact Member Services.   [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Durable medical equipment (DME) and related supplies  (For a definition of “Durable medical equipment (DME),” refer to Chapter 12 [plans may insert reference, as applicable] of this handbook.)  The following items are covered:   * Wheelchairs * Crutches * Powered mattress systems * Dry pressure pad for mattress * Diabetic supplies * Hospital beds ordered by a provider for use in the home * Intravenous (IV) infusion pumps and pole * Enteral pump and supplies * Speech generating devices * Oxygen equipment and supplies * Nebulizers * Walkers * Standard curved handle or quad cane and replacement supplies * Cervical traction (over the door) * Bone stimulator * Dialysis care equipment   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 DME 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.]  **This benefit is continued on the next page** | [List copays.] |
|  | Durable medical equipment (DME) and related supplies (continued)  [Plans that limit the DME brands and manufacturers that you will cover, insert the following (for more information about this requirement, refer to the Medicare Managed Care Manual, Chapter 4, Section 10.12.1 et seq.): With this Member Handbook, we sent you <plan name>’s list of DME. The list tells you the brands and makers of DME 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 DME 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 DME 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 them to refer you for a second opinion.)  If you (or your doctor) do not agree with the plan’s coverage decision, 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, refer to 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 does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:   * Serious risk to your health or to that of your unborn child; **or** * Serious harm to bodily functions; **or** * Serious dysfunction of any bodily organ or part; **or** * In the case of a pregnant woman in active labor, when: * There is not enough time to safely transfer you to another hospital before delivery. * A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.   [Also identify whether the plan only covers emergency care within the U.S. and its territories as required or also covers emergency care as a supplemental benefit that provides world-wide emergency/urgent coverage.] | $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 (IUC/IUD, implants, injections, birth control pills, patch, or ring) * Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) * Counseling and diagnosis of infertility and related services * Counseling, testing, and treatment for sexually transmitted infections (STIs) * Counseling and testing for HIV and AIDS, and other HIV-related conditions * Permanent Contraception (You must be age 21 or older to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) * Genetic counseling   We will also pay for some other family planning services. However, you must refer to 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 copays.] |
| Apple icon indicates preventive services. | 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 copays.] |
|  | [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 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 copays.]  [List copays for additional benefits.] |
|  | [If this benefit is not applicable, plans should delete this row.]  Help with certain chronic conditions  [Plans that offer targeted “Uniformity Flexibility” supplemental benefits and/or “*Special Supplemental Benefits for the Chronically Ill (SSBCI),”* which members with certain chronic condition(s) may be eligible to receive from a network provider, should include information about the specific benefits and (as applicable) reduced cost sharing. If offering SSBCI, plans must also list the chronic conditions and benefits and describe the nature of the benefits and the eligibility criteria. The benefits listed here must be approved in the Plan Benefit Package submission.] | [List copays.] |
| Apple icon indicates preventive services. | 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.  We will also pay for additional HIV screening(s) when recommended by your provider.  [List any additional benefits offered.] | $0  [List copays 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:   * Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) * Physical therapy, occupational therapy, and speech therapy * Medical and social services * Medical equipment and supplies | [List copays.] |
|  | **Home infusion therapy**  The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:   * The drug or biological substance, such as an antiviral or immune globulin; * Equipment, such as a pump; **and** * Supplies, such as tubing or a catheter.   The plan will cover home infusion services that include but are not limited to:   * Professional services, including nursing services, provided in accordance with your care plan; * Member training and education not already included in the DME benefit; * Remote monitoring; **and** * Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.   [List any additional benefits offered.] | [List copays.]  [List copays for additional benefits.] |
|  | Hospice care  You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Your hospice doctor can be a network provider or an out-of-network provider.  The plan will pay for the following while you are getting hospice services:   * Drugs to treat symptoms and pain * Short-term respite care * Home care   **This benefit is continued on the next page** | [List copays.] |
|  | Hospice care (continued)  **Hospice services and services covered by Medicare Part A or B are billed to Medicare.**   * Refer to Section F of this chapter for more information.   **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 prognosis. You pay [insert as appropriate: the plan’s cost-sharing amount **or** nothing] for these services.   **For drugs that may be covered by <plan name>’s Medicare Part D benefit:**   * Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5 [plans may insert reference, as applicable].   **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 prognosis. [Plans should replace the term “care coordinator” with the term they use and include a phone number or other contact information.]  [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.] |  |
| Apple icon indicates preventive services. | Immunizations  We will pay for the following services:   * Pneumonia vaccine * Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary * 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.  We also pay for all vaccines for adults as recommended by the Advisory Committee on Immunization Practices (ACIP).  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Inpatient hospital care  [List any restrictions that apply.]  We will pay for the following services and other medically necessary 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   **This benefit is continued on the next page** | $0  You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is stabilized. |
|  | Inpatient hospital care (continued)   * 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/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.   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 outside the pattern of care for your community. If <plan name> provides transplant services outside the pattern of care for our community 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 you got 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 stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay  If your inpatient stay is not reasonable and medically necessary, we will not pay for it.  However, in certain situations where inpatient care is not covered, we may still pay for services you get while you are in a hospital or nursing facility. To find out more, contact Member Services.  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 refer to “Medicare Part B prescription drugs” in this chart. | $0 |
| Apple icon indicates preventive services. | Lung cancer screening  The plan will pay for lung cancer screening every 12 months if you:   * Are aged 50-80, **and** * Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** * Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.   After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.  [List any additional benefits offered.] | $0 |
| Apple icon indicates preventive services. | 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 get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We may approve additional services if medically necessary.  We will 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. We may approve additional services if medically necessary.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Apple icon indicates preventive services. | Medicare Diabetes Prevention Program (MDPP)  The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:   * long-term dietary change, **and** * increased physical activity, **and** * ways to maintain weight loss and a healthy lifestyle. | $0 |
|  | Medicare Part B prescription drugs  [*Plans that will or expect to use Part B step therapy should indicate the Part B drug categories below that will or may be subject to Part B step therapy as well as a link to a list of drugs that will be subject to Part B step therapy. The link may be updated throughout the year and any changes added at least 30 days prior to implementation per 42 CFR 422.111(d).*]  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   **This benefit is continued on the next page** | $0 |
|  | **Medicare Part B prescription drugs (continued)**   * Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-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   [Insert if applicable: The following link will take you to a list of Part B drugs that may be subject to step therapy: <hyperlink>.]  We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit.  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. |  |
|  | 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.  [Plans should include instructions on how member can get this service.] | [List copays.] |
|  | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]  Non-medical transportation  This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation.  This benefit does not limit your non-emergency medical transportation benefit.  [Plans should include instructions on how members can get this service.] | [List copays.] |
|  | [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 necessary) * Meals, including special diets * Nursing services * Physical therapy, occupational therapy, and speech therapy * Respiratory 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   **This benefit is continued on the next page** | [List copays.] |
|  | Nursing facility care (continued)   * Hearing exams * Chiropractic care * Podiatry 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 were living right before you went to the hospital (as long as it provides nursing facility care). * A nursing facility where your spouse or domestic partner is living at the time you leave the hospital. |  |
| Apple icon indicates preventive services. | 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 copays for additional benefits.] |
|  | Opioid treatment program (OTP) services  The plan will pay for the following services to treat opioid use disorder (OUD):   * Intake activities * Periodic assessments * Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications * Substance use counseling * Individual and group therapy * Testing for drugs or chemicals in your body (toxicology testing)   [List any other medically necessary treatment or additional benefits offered, with the exception of meals and transportation.] | $0 |
|  | Outpatient diagnostic tests and therapeutic services and supplies  We will pay for the following services and other medically necessary 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 necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:   * Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services * Observation services help your doctor know if you need to be admitted to the hospital as an “inpatient.” * Sometimes you can be in the hospital overnight and still be an “outpatient.” * You can get more information about being an inpatient or an outpatient in this fact sheet: [www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf](https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf) * 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 * Preventive screenings and services listed throughout the Benefits Chart * Some drugs that you can’t give yourself   [List any additional benefits offered.] | $0  [List copays 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 copays 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 copays.] |
|  | 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 as a hospital outpatient service 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 as a hospital outpatient service.] | $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 them to find out whether you need treatment   **This benefit is continued on the next page** | $0  [List copays for additional benefits.] |
|  | Physician/provider services, including doctor’s office visits (continued)   * [Insert if providing any additional telehealth benefits consistent with 42 CFR §422.135 in the plan’s approved Plan Benefit Package submission: Certain telehealth services, including [insert general description of covered additional telehealth benefits (i.e., the specific Part B service(s) the plan has identified as clinically appropriate for offering through electronic exchange when the provider is not in the same location as the member). Plans may refer members to their medical coverage policy here].] * You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth*.* [Plans may modify as necessary if benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits.] * [*List the available means of electronic exchange used for each Part B service offered as an additional telehealth benefit along with any other access instructions that may apply.*] * [*Insert if the plan’s service area and providers/locations qualify for telehealth services under original Medicare requirements in section 1834(m) of the Act:* Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare] * Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member’s home * Telehealth services to diagnose, evaluate, or treat symptoms of a stroke * Telehealth services for members with a substance use disorder or co-occurring mental health disorder   **This benefit is continued on the next page**  Physician/provider services, including doctor’s office visits (continued)   * + Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if you’re not a new patient.   + Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if you’re not a new patient. * Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you’re not a new patient * Second opinion [insert if appropriate: by another network provider] before surgery * 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.] |  |
|  | 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 copays for additional benefits.] |
| Apple icon indicates preventive services. | 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 copays 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 * Enteral and parenteral nutrition, including feeding supply kits, infusion pump, tubing and adaptor, solutions, and supplies for self-administered injections * Pacemakers * Braces * Prosthetic shoes * Artificial arms and legs * Breast prostheses (including a surgical brassiere after a mastectomy) * Prostheses to replace all of part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect * 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. Refer to “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 copays for additional benefits.] |
| Apple icon indicates preventive services. | 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 copays for additional benefits.] |
|  | Skilled nursing facility (SNF) 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 necessary * 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 or domestic partner lives at the time you leave the hospital | $0 |
|  | **Supervised exercise therapy (SET)**  The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) [*insert if applicable:* who have a referral for PAD from the physician responsible for PAD treatment]. The plan will pay for:   * Up to 36 sessions during a 12-week period if all SET requirements are met * An additional 36 sessions over time if deemed medically necessary by a health care provider   The SET program must be:   * 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) * In a hospital outpatient setting or in a physician’s office * Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD * Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques | $0 |
|  | Urgent care  Urgent care is care given to treat:   * A non-emergency that requires immediate medical care, **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. and its territories or is supplemental world-wide emergency/urgent coverage.] | $0 |
| Apple icon indicates preventive services. | [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. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and 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 * Hispanic Americans who are 65 or 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). | [List copays.]  [List copays for additional benefits.] |
| Apple icon indicates preventive services. | “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.   **Note:** 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 |

# 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 getting 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 covered outside of <plan name>

[Plans should modify this section to include additional benefits covered outside the plan by Medicare fee-for-service and/or Medi-Cal fee-for-service,as appropriate.]

The following services are not covered by <plan name> but are available through Medicare or Medi‑Cal.

## F1. California Community Transitions (CCT)

The California Community Transitions (CCT) program uses local Lead Organizations to help eligible Medi-Cal beneficiaries, who have lived in an inpatient facility for at least 90 consecutive days, transition back to, and remaining safely in, a community setting. The CCT program funds transition coordination services during the pre-transition period and for 365 days post transition to assist beneficiaries with moving back to a community setting.

You can receive transition coordination services from any CCT Lead Organization that serves the county you live in. You can find a list of CCT Lead Organizations and the counties they serve on the Department of Health Care Services website at: [www.dhcs.ca.gov/services/ltc/Pages/CCT](https://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx).

**For CCT transition coordination services:**

Medi-Cal will pay for the transition coordination services. You pay nothing for these services.

**For services that are not related to your CCT transition**:

The provider will bill <plan name> for your services. <Plan name> will pay for the services provided after your transition. You pay nothing for these services.

While you are getting CCT transition coordination services, <plan name> will pay for the services that are listed in the Benefits Chart in Section D of this chapter.

**No change in <plan name> drug coverage benefit:**

Drugs are not covered by the CCT program. You will continue to get your normal drug benefit through <plan name>. For more information, please refer to Chapter 5 [plans may insert reference, as applicable].

**Note:** If you need non-CCT transition care, you should call your care coordinator to arrange the services. Non-CCT transition care is care that is not related to your transition from an institution/facility. [Plans should replace the term “care coordinator” with the term they use and include a phone number or other contact information.]

[*All plans, except Health Plan of San Mateo, insert F2, Medi-Cal Dental Program, as indicated below. Health Plan of San Mateo removes the section below and the reference in the Table of Contents and follows the instructions in Section D, Dental services*.]

## F2. Medi-Cal Dental Program

Certain dental services are available through the Medi-Cal Dental Program; for example, services such as:

* Initial examinations, X-rays, cleanings, and fluoride treatments
* Restorations and crowns
* Root canal therapy
* Dentures, adjustments, repairs, and relines

Dental benefits are available in the Medi-Cal Dental Program as fee-for-service. For more information, or if you need help finding a dentist who accepts the Medi-Cal Dental Program, please contact the Customer Service Line at 1-800-322-6384 (TTY users call 1-800-735-2922). The call is free. Medi-Cal Dental Services Program representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday. You can also visit the website at [dental.dhcs.ca.gov/](https://dental.dhcs.ca.gov/) for more information.

In addition to the fee-for-service Medi-Cal Dental Program, you may get dental benefits through a dental managed care plan. Dental managed care plans are available in Los Angeles County. If you want more information about dental plans, need assistance identifying your dental plan, or want to change dental plans, please contact Health Care Options at 1-800-430-4263 (TTY users call 1-800-430-7077), Monday through Friday, 8:00 a.m. to 6:00 p.m. The call is free.

[Plans that offer supplemental dental benefits insert: **Note:** Additional dental services are offered through <plan name>. Refer to the Benefits Chart in Section D of this chapter for more information.]

## F3. Hospice care

You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what <plan name> pays for while you are getting hospice care services.

**For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:**

* The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

**For services covered by Medicare Part A or B that are not related to your terminal prognosis (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 drugs that may be covered by <plan name>’s Medicare Part D benefit:**

* Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5 [plans may insert reference, as applicable].

**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 prognosis. [Plans should replace the term “care coordinator” with the term they use and include a phone number or other contact information.]

# Benefits not covered by <plan name>, Medicare, or Medi-Cal

This section tells you what kinds of benefits are excluded by the plan. Excluded means that we do not pay for these benefits. Medicare and Medi-Cal will not pay for them either.

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*) except under the specific conditions listed. 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, refer to Chapter 9 [plans may insert reference, as applicable].

In addition to any exclusions or limitations described in the Benefits Chart, 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, are required to be covered by Medi-Cal or under a State’s demonstration, or have become covered due to a Medicare or Medi-Cal change in coverage policy, 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. Refer to Chapter 3 [plans may insert reference, as applicable] 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 necessary and Medicare pays for it.
* A private room in a hospital, except when it is medically necessary.
* 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 necessary.
* 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 coverage guidelines.
* Routine foot care, except as described in Podiatry services in the Benefits Chart in Section D.
* 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, and other low-vision aids.
* Reversal of sterilization procedures and non-prescription contraceptive supplies.
* 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.