

Chapter 4: Benefits chart

Introduction

This chapter tells you about the services our plan 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 your *Member Handbook*.

New members to <Insert plan name>: In most instances you will be enrolled in <insert plan name> for your Medicare benefits the 1st day of the month after you request to be enrolled in <insert plan name>. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through <insert plan name>. There will be no gap in your Medi-Cal coverage. Please call us at <phone and TTY/TDD numbers> if you have any questions

[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]

[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.]



Table of Contents

- A. Your covered services [*insert if the plan has cost-sharing: and your out-of-pocket costs*].....3
 - A1. During public health emergencies3
- B. Rules against providers charging you for services.....3
- C. About our plan’s Benefits Chart.....3
- D. Our plan’s Benefits Chart10
- E. Our plan’s visitor or traveler benefits57
- F. Benefits covered outside of our plan.....57
 - F1. California Community Transitions (CCT)58
 - F2. Medi-Cal Dental Program.....58
 - F3. Hospice care59
 - F4. In-Home Supportive Services (IHSS)60
 - F5. 1915(c) Home and Community Based Services (HCBS) Waiver Programs60
- G. Benefits not covered by our plan, Medicare, or Medi-Cal.....63



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 2

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

This chapter tells you about services our plan covers *[insert if the plan has cost-sharing: and 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** of your *Member Handbook*. *[Insert if applicable: This chapter also explains limits on some services.]*

[Plans with cost-sharing, insert: For some services, you are 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 our plan's rules. Refer to **Chapter 3** of your *Member Handbook* for details about the plan's rules.]*

If you need help understanding what services are covered, call *[insert: your care coordinator and/or Member Services at <phone number(s)>]*.

[As applicable, plans insert the subsection heading and information below.]

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.]

B. Rules against providers charging you for services

We don't allow our providers to bill you for in network 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** of your *Member Handbook* or call Member Services.

C. About our plan's Benefits Chart

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



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them. *[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 pay for the services listed in the Benefits Chart 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 requirements described below.]*

- We provide covered Medicare and Medi-Cal covered services 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 describes services, supplies, or drugs you need 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 facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans may revise and use the state-specific definition of “medically necessary” and ensure that it is updated and used consistently in Chapter 12 and throughout member materials.]*
- *[Insert if applicable: You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given you a referral. **Chapter 3** of your *Member Handbook* 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 a provider that is not your PCP or use other providers in the plan’s network. This is called a referral. **Chapter 3** of your *Member Handbook* has more information about getting a referral and when you do **not** need one.]*
- *[Insert if applicable: We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA [insert as appropriate: with an asterisk (*) **or** with a footnote **or** in bold type **or** in italic type].] [Insert if applicable: In addition, you must get PA for the following services not listed in the Benefits Chart: [insert list].]*

[Instructions to plans offering Value-Based Insurance Design (VBID) Model benefits:



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

- *Plans may deliver to each clinically-targeted enrollee a written summary of those benefits so that such enrollees are notified of VBID benefits for which they are eligible. For VBID plans that choose to deliver a written notice, VBID plans must follow the VBID guidance on communications for delivering a written notice when offering targeted supplemental or VBID benefits. (See CY 2024 Value-Based Insurance Design Communications and Marketing Guidelines).*
- *If applicable, plans must update the Benefits Chart and include a supplemental benefits chart including a column that details the exact targeted reduced cost-sharing amount for each specific service, and/or the additional supplemental benefits being offered. Specific services should include details as it relates to VBID benefits.*
- *If applicable, plans with VBID should mention reduced cost-sharing for their MA benefits, as well as that members may qualify for a reduction or elimination of their cost-sharing for Part D drugs in Plans with VBID may include the reduction or elimination of their cost-sharing for Part D drugs in Chapter 6, Section C.]*

[Insert if offering VBID Model benefits:

Important Benefit Information for Enrollees with Certain Chronic Conditions

- If you are diagnosed by a plan provider with any of the following chronic condition(s) identified below and meet certain medical criteria, you may be eligible for targeted supplemental benefits and/or reduced cost-sharing:
 - *[List all applicable chronic conditions here.]*
 - *[As applicable, plans offering benefits under VBID that require participation in a health and wellness program or to see a high-value provider, include those limitations and then direct the enrollee that they will be provided additional information with how to take advantage of these additional supplemental benefits. (See CY 2024 Value-Based Insurance Design Communications and Marketing Guidelines).]*
- For further detail, please go to the Help with Certain Chronic Conditions row in the Medical Benefits Chart below.]

[Insert if offering VBID benefits:

[Plans participating in VBID should use this section to describe the plans strategy for advance care planning and any other wellness and health care planning (WHP) services that are being offered:]



Important Benefit Information for all Enrollees Participating in Wellness and Health Care Planning (WHP) Services

- Because *[insert 2024 plan name]* participates in *[insert VBID program name]*, you will be eligible for the following WHP services, including advance care planning (ACP) services:
 - *[Include a summary of WHP services that are to reach all VBID plan enrollees in CY 2024. The description must include language that WHP and ACP are voluntary and enrollees are free to decline the offers of WHP and ACP.]*
 - *[Include information on how and when the enrollee would be able to access WHP services.]*

[Instructions to plans offering WHP benefits:

- *In addition to offering advance care planning as a covered benefit, plans participating in the VBID Model may deliver to each VBID PBP enrollee a written summary of WHP benefits so that such enrollees are notified of the benefits for which they are eligible. For VBID plans that choose to deliver a written notice, VBID plans must follow the VBID guidance on communications for a written summary when offering WHP benefits (See CY 2024 Value-Based Insurance Design Communications and Marketing Guidelines).*
- *If applicable, plans should mention that enrollees may qualify for cost-sharing or co-payment reductions].*

[Insert if offering VBID flexibility benefits and targeted supplemental benefits to Low Income Subsidy (LIS) enrollees, as defined in the Plan Communication User Guide (PCUG):]

[Instructions to plans offering VBID benefits:]

- *Plans may deliver to each LIS-targeted enrollee a written summary of those benefits so that such enrollees are notified of VBID benefits for which they are eligible. For VBID plans that choose to deliver a written notice, VBID plans must follow the VBID guidance on communications for delivering such a written notice when offering targeted supplemental or VBID benefits. (See CY 2024 Value-Based Insurance Design Communications and Marketing Guidelines).*
- *Plans who choose to reduce cost-sharing for an item or service, including Part D drugs covered by Medicare Advantage Prescription Drug (MA-PD) plan through member participation in a plan-sponsored disease management or similar program, must include a summary of the additional supplemental benefits they would receive as well as the activities and/or programs the member must complete in order to receive the benefit.*



- *If applicable, plans must update the Benefits Chart and include a supplemental benefits chart including a column that details the exact targeted reduced cost-sharing amount for each specific service, and/or the additional supplemental benefits being offered. Specific services should include details as it relates to VBID benefits.*
- *If applicable, plans with VBID should mention that members may qualify for a reduction or elimination of their cost-sharing for Part D drugs in Chapter 6, Section C.*

[Insert only if offering VBID mandatory supplemental benefit flexibility to Cover New and Existing Technologies or Food and Drug Administration (FDA) approved Medical Devices:]

Important Benefit Information for VBID Plan Enrollees Eligible to Receive New and Existing Technologies or FDA-approved Medical Devices.

- Because *[insert 2024 plan name]* participates in *[insert VBID program name]*, you may be eligible to receive new and existing technologies or FDA-approved Medical Devices:
 - *[Include a description of the new and existing technologies or FDA approved medical devices specifying eligibility for the benefit and associated cost-sharing as an enrollee in the VBID plan in 2024. The description must include language that enrollees are free to decline the benefit and how they would notify the plan of declining this supplemental benefit.]*

[Instructions to plans offering Coverage of New and Existing Technologies or FDA-approved Medical Devices as a mandatory supplemental benefit:

- *Plans may deliver to each VBID PBP's enrollee a written summary of coverage of new and existing technologies or FDA-approved medical devices so that such enrollees are notified of the benefits for which they are eligible. For VBID plans that choose to deliver a written notice, VBID plans must follow the VBID guidance on communications for delivering a written summary when offering coverage of new and existing technologies or FDA-approved medical devices (See CY 2024 Value-Based Insurance Design Communications and Marketing Guidelines).]*
- *[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.]*

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 🍏 next to preventive services in the Benefits Chart.*
- *[Insert any additional applicable Medi-Cal program coverage here such as community supports.]*
- *[Insert if plan offers: **Community Supports**: Community Supports may be available under your Individualized Care Plan. Community Supports are medically appropriate and cost-effective alternative services or settings. These services are optional for members. If you qualify, these services may help you live more independently. They do not replace benefits that you already get under Medi-Cal. [Insert as applicable: Examples of Community Supports that we offer include medically-supportive food and meals or medically-tailored meals, help for you or your caregiver, or shower grab bars and ramps.] [Plan must include a short description of each available service, specifying the eligible population(s), limitations if applicable and information on how to access the service.] If you need help or would like to find out which Community Supports may be available for you, call [insert Member Services phone number or case management direct line] (TTY [insert Member Services TTY number] or 711) or call your health care provider.]*

[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.*
- *Optional supplemental benefits are not permitted in this chart; optional supplemental benefits should be described in Section E.*
- *Include the following where appropriate: Talk to your provider and get a referral.*
- *Plans must include any services provided in excess of the Medicare and Medi-Cal requirements and identify preventive services with the apple icon.*
- *HMO POS plan types must provide information about which services must be obtained from network providers, which services can be obtained out-of-network*



under the POS benefit, and any differences in cost-sharing for covered services obtained out-of-network under the POS benefit.


- *Plans should clearly indicate which benefits are subject to PA. (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 benefit information that is based on the plan’s approved benefit package and not already included in the Benefits Chart or in the exclusions section. Plans insert any additional benefits in the chart alphabetically.*
- *Plans must add any Medi-Cal benefits covered to the chart as instructed by the state. Insert any additional benefits in the chart alphabetically. If directed by the state, include all non-waiver services in the chart and all HCBS waiver services as a separate section after 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 member a written summary of those benefits so that such member 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.]*



D. Our plan’s 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 benefits 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.]*

[Plans should modify this section throughout to reflect Medi-Cal or plan-covered supplemental benefits as appropriate as well as any copays that may differ for Medi-Cal.]


Services that our plan pays for		What you must pay
	<p>Abdominal aortic aneurysm screening</p> <p>We 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.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



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Services that our plan pays for	What you must pay
<p>Acupuncture</p> <p>We pay for up to two outpatient acupuncture services in any one calendar month, or more often if they are medically necessary.</p> <p>We also pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as:</p> <ul style="list-style-type: none"> • 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. <p>In addition, we pay for an additional eight 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.</p> <p>Acupuncture treatments must be stopped if you don't get better or if you get worse.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>
<p> <i>[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.]</i></p> <p>Alcohol misuse screening and counseling</p> <p>We pay for one alcohol-misuse screening (SABIRT) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.</p> <p>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 (PCP) or practitioner in a primary care setting.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Ambulance services</p> <p>Covered ambulance services include ground and air (airplane and helicopter). The ambulance will take you to the nearest place that can give you care.</p> <p>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life.</p> <p>Ambulance services for other cases (non-emergent) 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.</p>	<p>\$0</p>
<p> Annual wellness visit</p> <p>You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare visit. However, you don't need to have had a Welcome to Medicare visit to get annual wellness visits after you've had Part B for 12 months.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p>
<p>Asthma Preventive Services</p> <p>You can receive asthma education and a home environment assessment for triggers commonly found in the home for people with poorly controlled asthma.</p>	<p>\$0</p>






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Services that our plan pays for		What you must pay
	<p>Bone mass measurement</p> <p>We 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.</p> <p>We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>
	<p>Breast cancer screening (mammograms)</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> • one baseline mammogram between the ages of 35 and 39 <i>[plans that only cover ages 65 and over should delete]</i> • one screening mammogram every 12 months <i>[plans that cover women under 65 should include: for women age 40 and over]</i> • clinical breast exams once every 24 months <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>
	<p>Cardiac (heart) rehabilitation services</p> <p>We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor’s <i>[insert as appropriate: referral or order]</i>.</p> <p>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.</p>	<p>\$0</p>



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.


Services that our plan pays for		What you must pay
	<p>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</p> <p>We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the <i>[insert: visit or visits]</i>, your doctor may:</p> <ul style="list-style-type: none"> • discuss aspirin use, • check your blood pressure, and/or • give you tips to make sure you are eating well. <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>
	<p>Cardiovascular (heart) disease testing</p> <p>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.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>
	<p>Cervical and vaginal cancer screening</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> • 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 • <i>[Plans that cover women under 65 must include:</i> for women who have had an abnormal Pap test within the last three 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 <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



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Services that our plan pays for	What you must pay
<p>Chiropractic services</p> <p>We pay for the following services:</p> <ul style="list-style-type: none">• adjustments of the spine to correct alignment <p><i>[List any Medi-Cal or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.]</i></p>	<p><i>[List copays.]</i></p> <p><i>[List copays for supplemental benefits.]</i></p>




Services that our plan pays for	What you must pay
<p> Colorectal cancer screening</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. <p>As of January 1, 2023, colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>




If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p>Dental services</p> <p>We pay for certain dental services, including but not limited to, cleanings, fillings, and dentures. What we do not cover is available through the Medi-Cal Dental Program, described in F2 below.</p> <p>We pay for some dental services when the service is an integral part of specific treatment of a beneficiary’s primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.</p> <p><i>[List/adjust as needed any supplemental benefits offered. Other common dental services include examinations, scaling and root planing (deep cleaning), emergency treatment, tooth removal, root canals, laboratory crowns, and partial dentures. Program medical necessity criteria must be met.]</i></p>	<p><i>[If plan offers supplemental benefit, The maximum copay amount for dental is \$105.00.]</i></p>
<p> Depression screening</p> <p>We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



Services that our plan pays for		What you must pay
	<p>Diabetes screening</p> <p>We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:</p> <ul style="list-style-type: none">• high blood pressure (hypertension)• history of abnormal cholesterol and triglyceride levels (dyslipidemia)• obesity• history of high blood sugar (glucose) <p>Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.</p> <p>Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



Services that our plan pays for	What you must pay
<p> Diabetic self-management training, services, and supplies</p> <p>We pay for the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> • Supplies to monitor your blood glucose, including the following: <ul style="list-style-type: none"> ○ 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 pay for the following: <ul style="list-style-type: none"> ○ 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) • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services. <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>
<p>Doula Services</p> <p>For individuals who are pregnant we pay for nine visits with a doula during the prenatal and postpartum period as well as support during labor and delivery.</p>	<p>\$0</p>



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p>Durable medical equipment (DME) and related supplies</p> <p>Refer to Chapter 12 of your <i>Member Handbook</i> for a definition of “Durable medical equipment (DME).”</p> <p>We cover the following items:</p> <ul style="list-style-type: none"> • wheelchairs, including electric 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 • 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 <p>Other items may be covered.</p> <p style="text-align: center;">This benefit is continued on the next page</p>	<p><i>[List copays, including how they vary for equipment covered by Medicare and Medicaid, if applicable.]</i></p> <p><i>[Include if applicable: Your cost-sharing for Medicare oxygen equipment coverage is [insert copay amount or coinsurance percentage], every [insert required frequency of payment].]</i></p> <p><i>[Plans that use a constant cost-sharing structure for oxygen equipment insert: Your cost-sharing will not change after being enrolled for 36 months.]</i></p>



Services that our plan pays for	What you must pay
<p>Durable medical equipment (DME) and related supplies (continued)</p> <p><i>[Plans that do not limit the DME brands and manufacturers that they cover, insert: We 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.]</i></p> <p><i>[Plans that limit the DME brands and manufacturers that they cover, insert the following (for more information about this requirement, refer to Chapter 4 of the Medicare Managed Care Manual): With this Member Handbook, we sent you our plan’s list of DME. The list tells you the brands and makers of DME that we pay for. You may also find the most recent list of brands, makers, and suppliers on our website at <URL>.</i></p> <p>Generally, our plan covers any DME covered by Medicare and Medi-Cal from the brands and makers on this list. We do 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 our plan 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, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)</p> <p>If you (or your doctor) don’t agree with our plan’s coverage decision, you or your doctor may file an appeal. You can also file an appeal if you don’t 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 of your <i>Member Handbook</i>.]</p>	<p><i>[Plans that wish to vary cost-sharing for oxygen equipment after 36 months insert details including whether original cost-sharing resumes after 5 years and you are still in the plan.] [If cost-sharing is different for members who made 36 months of rental payments prior to joining the plan insert: If prior to enrolling in [insert plan name] is [insert cost-sharing].]</i></p>




Services that our plan pays for	What you must pay
<p>Emergency care</p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> • given by a provider trained to give emergency services, and • needed to treat a medical emergency. <p>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:</p> <ul style="list-style-type: none"> • serious risk to your health [<i>Plans that cover women under 65 must include:</i> or to that of your unborn child]; or • serious harm to bodily functions; or • serious dysfunction of any bodily organ or part. • [<i>Plans that cover women under 65 must include:</i> In the case of a pregnant woman in active labor, when: <ul style="list-style-type: none"> ○ 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.] <p><i>[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.]</i></p>	<p>\$0</p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, [<i>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 our plan approves your stay.)</i>].</p>



Services that our plan pays for	What you must pay
<p><i>[If family planning services are covered, plans should modify this as necessary.]</i></p> <p>Family planning services</p> <p>The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> • 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 over 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 <p>We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:</p> <ul style="list-style-type: none"> • 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 	<p><i>[List copays.]</i></p>




If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for		What you must pay
 <p>Health and wellness education programs</p> <p>We offer many programs that focus on certain health conditions. These include:</p> <ul style="list-style-type: none"> • Health Education classes; • Nutrition Education classes; • Smoking and Tobacco Use Cessation; and • Nursing Hotline <p><i>[List any additional benefits offered.]</i></p>	<p><i>[List copays.]</i></p>	
<p><i>[Plans should modify this section to reflect plan-covered benefits as appropriate.]</i></p> <p>Hearing services</p> <p>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.</p> <p>If you are pregnant or reside in a nursing facility, we also pay for hearing aids, including:</p> <ul style="list-style-type: none"> • 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 • assistive listening devices, surface-worn bone conduction hearing devices • hearing aid-related audiology and post-evaluation services 	<p><i>[List copays.]</i></p> <p><i>[List copays for additional benefits.]</i></p>	



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p><i>[If this benefit is not applicable, plans should delete this row.]</i></p> <p>Help with certain chronic conditions</p> <p><i>[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.]</i></p>	<p><i>[List copays.]</i></p>
<p> HIV screening</p> <p>We pay for one HIV screening exam every 12 months for people who:</p> <ul style="list-style-type: none"> • ask for an HIV screening test, or • are at increased risk for HIV infection. <p>For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.</p> <p>We also pay for additional HIV screening(s) when recommended by your provider.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p>Home health agency care</p> <p><i>[Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate.]</i></p> <p>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. You must be homebound, which means leaving home is a major effort.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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 	<p><i>[List copays.]</i></p>



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.


Services that our plan pays for	What you must pay
<p>Home infusion therapy</p> <p>Our plan pays 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:</p> <ul style="list-style-type: none"> • 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. <p>Our plan covers home infusion services that include but are not limited to:</p> <ul style="list-style-type: none"> • 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. <p><i>[List any additional benefits offered.]</i></p>	<p><i>[List copays.]</i></p> <p><i>[List copays for additional benefits.]</i></p>



Services that our plan pays for	What you must pay
<p>Hospice care</p> <p>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. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan’s service area. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • drugs to treat symptoms and pain • short-term respite care • home care <p>Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.</p> <ul style="list-style-type: none"> • Refer to Section F of this chapter for more information. <p>For services covered by our plan but not covered by Medicare Part A or Medicare Part B:</p> <ul style="list-style-type: none"> • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay <i>[insert as appropriate: our plan’s cost-sharing amount or nothing]</i> for these services. <p>For drugs that may be covered by our plan’s Medicare Part D benefit:</p> <ul style="list-style-type: none"> • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to Chapter 5 of your <i>Member Handbook</i>. <p>Note: If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that is not related to your terminal prognosis.</p> <p><i>[Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.]</i></p>	<p><i>[List copays.]</i></p> <p><i>[Include information about cost-sharing for hospice consultation services if applicable.]</i></p>



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for		What you must pay
 <p>Immunizations</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> • 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 • COVID-19 vaccines • other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to Chapter 6 of your <i>Member Handbook</i> to learn more.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>	



Services that our plan pays for	What you must pay
<p>Inpatient hospital care</p> <p><i>[List any restrictions that apply.]</i></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> • semi-private room (or a private room if 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/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. <p style="text-align: center;">This benefit is continued on the next page</p>	<p>\$0</p> <p>You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.</p>



Services that our plan pays for	What you must pay
<p>Inpatient hospital care (continued)</p> <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. <i>[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 our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.]</i></p> <ul style="list-style-type: none"> • blood, including storage and administration • physician services <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are you a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!”. This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p>Inpatient services in a psychiatric hospital</p> <p>We pay for mental health care services that require a hospital stay.</p> <ul style="list-style-type: none">• If you need inpatient services in a freestanding psychiatric hospital, we pay for the first 190 days. After that, the local county mental health agency pays for medically necessary inpatient psychiatric services. Authorization for care beyond the 190 days is coordinated with the local county mental health agency.<ul style="list-style-type: none">○ 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 pay for services you get in an Institute for Mental Diseases (IMD).	\$0



Services that our plan pays for	What you must pay
<p><i>[Plans with no day limitations on a plan’s hospital or nursing facility coverage may modify or delete this row as appropriate.]</i></p> <p>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay</p> <p>We do not pay for your inpatient stay if you have used all of your inpatient benefit or if the stay is not reasonable and medically necessary.</p> <p>However, in certain situations where inpatient care is not covered, we may pay for services you get while you’re in a hospital or nursing facility. To find out more, contact Member Services.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ an internal body organ (including contiguous tissue), or ○ 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 your condition • physical therapy, speech therapy, and occupational therapy 	<p>\$0</p>





If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p>Kidney disease services and supplies</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We 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 of your <i>Member Handbook</i>, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're 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. <p>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart.</p>	<p>\$0</p>




If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for		What you must pay
 <p>Lung cancer screening</p> <p>Our plan pays for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> • are aged 50-77, 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 <p>After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.</p> <p><i>[Modify section to accurately describe benefits and list any additional benefits offered.]</i></p>	<p>\$0</p>	
 <p>Medical nutrition therapy</p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when <i>[insert as appropriate: referred or ordered]</i> by your doctor.</p> <p>We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.</p> <p>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 <i>[insert as appropriate: referral or order]</i>. A doctor must prescribe these services and renew the <i>[insert as appropriate: referral or order]</i> each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>	



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for		What you must pay
	<p>Medicare Diabetes Prevention Program (MDPP)</p> <p>Our plan pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:</p> <ul style="list-style-type: none">• long-term dietary change, and• increased physical activity, and• ways to maintain weight loss and a healthy lifestyle.	\$0



Services that our plan pays for	What you must pay
<p>Medicare Part B prescription drugs</p> <p><i>[Plans that do or expect to use Medicare Part B step therapy should indicate the Medicare Part B drug categories below that are or may be subject to Medicare Part B step therapy as well as a link to a list of drugs subject to Medicare Part B step therapy. Plans may update the link throughout the year and add any changes at least 30 days prior to implementation per 42 CFR 422.111(d).]</i></p> <p>These drugs are covered under Part B of Medicare. Our plan pays for the following drugs:</p> <ul style="list-style-type: none"> ● drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services ● insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) ● other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized ● 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. We pay for these drugs 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 <p style="text-align: center;">This benefit is continued on the next page</p>	<p>\$0</p>




Services that our plan pays for	What you must pay
<p>Medicare Part B prescription drugs (continued)</p> <ul style="list-style-type: none"> • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents [<i>plans may delete any of the following drugs that they do not cover</i>] (such as Epogen[®], Procrit[®], Epoetin Alfa, Aranesp[®], or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases <p>[<i>Insert if applicable:</i> The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: <hyperlink>.]</p> <p>We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit.</p> <p>Chapter 5 of your <i>Member Handbook</i> explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p>Chapter 6 of your <i>Member Handbook</i> explains what you pay for your outpatient prescription drugs through our plan.</p>	



Services that our plan pays for	What you must pay
<p><i>[Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate or eliminate this section if not covered.]</i></p> <p>Nursing facility care</p> <p>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.</p> <p>Services that we pay for include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • semiprivate room (or a private room if 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 <p style="text-align: center;">This benefit is continued on the next page</p>	<p><i>[List copays.]</i></p>



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p>Nursing facility care (continued)</p> <ul style="list-style-type: none"> • hearing exams • chiropractic care • podiatry services <p>You 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:</p> <ul style="list-style-type: none"> • a nursing facility 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. 	
<p> Obesity screening and therapy to keep weight down</p> <p>If you have a body mass index of 30 or more, we 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.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



Services that our plan pays for	What you must pay
<p>Opioid treatment program (OTP) services</p> <p>Our plan pays for the following services to treat opioid use disorder (OUD):</p> <ul style="list-style-type: none"> • intake activities • periodic assessments • medications approved by the 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) <p><i>[List any other medically necessary treatment or additional benefits offered, with the exception of meals and transportation.]</i></p>	<p>\$0</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> • 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 <p><i>[Plans can include other covered tests as appropriate.]</i></p>	<p>\$0</p>



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p>Outpatient hospital services</p> <p>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:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services <ul style="list-style-type: none"> ○ Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.” ○ Sometimes you can be in the hospital overnight and still be “outpatient.” ○ You can get more information about being inpatient or outpatient in this fact sheet: www.medicare.gov/sites/default/files/2021-10/11435-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 <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p><i>[Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate.]</i></p> <p>Outpatient mental health care</p> <p>We pay for mental health services provided by:</p> <ul style="list-style-type: none"> • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Clinic services <i>[Plans should include any Medi-Cal limitations that apply (e.g., number of visits)]</i> • Day treatment <i>[Plans should include any Medi-Cal limitations that apply (e.g., number of visits)]</i> • Psychosocial rehab services <i>[Plans should include any Medi-Cal limitations that apply (e.g., number of visits)]</i> • Partial hospitalization or 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 <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p><i>[Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate.]</i></p> <p>Outpatient rehabilitation services</p> <p>We pay for physical therapy, occupational therapy, and speech therapy.</p> <p>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.</p>	<p>\$0</p>
<p>Outpatient substance abuse services</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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 <p><i>[Modify this list accurately describe benefits offered or add any additional benefits offered.]</i></p>	<p><i>[List copays.]</i></p>
<p>Outpatient surgery</p> <p>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p>	<p>\$0</p>



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p><i>[Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate.]</i></p> <p>Partial hospitalization services</p> <p>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.</p> <p><i>[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.]</i></p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Physician/provider services, including doctor’s office visits</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> • 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 <i>[insert as applicable: primary care provider or specialist]</i>, if your doctor orders them to find out whether you need treatment • <i>[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 Medicare 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].]</i> <p style="text-align: center;">This benefit is continued on the next page</p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>




Services that our plan pays for	What you must pay
<p>Physician/provider services, including doctor’s office visits (continued)</p> <ul style="list-style-type: none"> ○ 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. <i>[Plans may modify as necessary if benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits.]</i> ○ <i>[List the available means of electronic exchange used for each Medicare Part B service offered as an additional telehealth benefit along with any other access instructions that may apply.]</i> ● <i>[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]</i> ● 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 at 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 <p style="text-align: center;">This benefit is continued on the next page</p>	



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p>Physician/provider services, including doctor’s office visits (continued)</p> <ul style="list-style-type: none"> • telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> ○ you have an in-person visit within 6 months prior to your first telehealth visit ○ you have an in-person visit every 12 months while receiving these telehealth services ○ exceptions can be made to the above for certain circumstances • telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers. • virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if <ul style="list-style-type: none"> ○ you’re not a new patient and ○ the check-in isn’t related to an office visit in the past 7 days and ○ the check-in doesn’t lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if: <ul style="list-style-type: none"> ○ you’re not a new patient and ○ the evaluation isn’t related to an office visit in the past 7 days and ○ the evaluation doesn’t lead to an office visit within 24 hours or the soonest available appointment <p style="text-align: center;">This benefit is continued on the next page</p>	




Services that our plan pays for	What you must pay
<p>Physician/provider services, including doctor’s office visits (continued)</p> <ul style="list-style-type: none"> • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you’re not a new patient • Second opinion <i>[insert if appropriate: by another network provider]</i> before surgery • Non-routine dental care. Covered services are limited to: <ul style="list-style-type: none"> ○ 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 <p><i>[List any additional benefits offered.]</i></p>	
<p>Podiatry services</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> • 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 <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>
<p> Prostate cancer screening exams</p> <p>For men age 50 and over, we pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> • a digital rectal exam • a prostate specific antigen (PSA) test <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



Services that our plan pays for	What you must pay
<p><i>[Plans should modify this section to reflect Medi-Cal or plan-covered supplemental benefits as appropriate.]</i></p> <p>Prosthetic devices and related supplies</p> <p>Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here:</p> <ul style="list-style-type: none"> • 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 was removed or impaired as a result of disease, injury, or congenital defect • incontinence cream and diapers <p>We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.</p> <p><i>[Plans that pay for prosthetic dental devices, delete the following sentence:]</i> We will not pay for prosthetic dental devices.</p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Pulmonary rehabilitation services</p> <p>We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have <i>[insert as appropriate: a referral or an order]</i> for pulmonary rehabilitation from the doctor or provider treating the COPD.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>
<p> Sexually transmitted infections (STIs) screening and counseling</p> <p>We 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.</p> <p>We 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 pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.</p> <p><i>[Also list any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>




If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p>Skilled nursing facility (SNF) care</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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 <p>You 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:</p> <ul style="list-style-type: none"> • a nursing facility 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 	<p>\$0</p>



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

Services that our plan pays for	What you must pay
<p> Smoking and tobacco use cessation</p> <p>If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit:</p> <ul style="list-style-type: none"> • We 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 face-to-face counseling visits. <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</p> <ul style="list-style-type: none"> • We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for supplemental benefits.]</i></p>




Services that our plan pays for	What you must pay
<p>Supervised exercise therapy (SET)</p> <p>We pay for SET for members with symptomatic peripheral artery disease (PAD) <i>[insert if applicable: who have a referral for PAD from the physician responsible for PAD treatment]</i>.</p> <p>Our plan pays for:</p> <ul style="list-style-type: none"> • 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 <p>The SET program must be:</p> <ul style="list-style-type: none"> • 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 	<p>\$0</p>
<p>Transportation: Non-emergency medical transportation</p> <p>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.</p> <p>The forms of transportation are authorized when:</p> <ul style="list-style-type: none"> • 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 <p>Depending on the service, prior authorization may be required.</p> <p><i>[Plans should include instructions on how members can get this service.]</i></p>	<p><i>[List copays.]</i></p>




Services that our plan pays for	What you must pay
<p>Transportation: Non-medical transportation</p> <p><i>[Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]</i></p> <p>This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation.</p> <p>Transportation is required for the purpose of obtaining needed medical care, including travel to dental appointments and to pick up prescription drugs.</p> <p>This benefit does not limit your non-emergency medical transportation benefit.</p> <p><i>[Plans should include instructions on how members can get this service.]</i></p>	<p><i>[List copays.]</i></p>
<p>Urgently needed care</p> <p>Urgently needed care is care given to treat:</p> <ul style="list-style-type: none"> • a non-emergency that requires immediate medical care, or • a sudden medical illness, or • an injury, or • a condition that needs care right away. <p>If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider because given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency).</p> <p><i>[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.]</i></p>	<p>\$0</p>



Services that our plan pays for	What you must pay
 <p><i>[Plans should modify this section to reflect Medi-Cal and plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]</i></p> <p>Vision care</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> • 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 <p>We 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.</p> <p>For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include:</p> <ul style="list-style-type: none"> • people with a family history of glaucoma • people with diabetes • African-Americans who are age 50 and over • Hispanic Americans who are 65 or over <p><i>[Plans should modify this description if the plan offers more than is covered by Medicare.]</i> We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.</p> <p>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.</p>	<p><i>[List copays.]</i></p> <p><i>[List copays for additional benefits.]</i></p>



Services that our plan pays for	What you must pay
 <p>“Welcome to Medicare” preventive visit</p> <p>We cover the one-time “Welcome to Medicare” preventive visit. The visit includes:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>	<p>\$0</p>

E. 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 section 422.74(d)(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 but do not permanently move, we usually must disenroll you from our plan. However, we offer a visitor/traveler program [*specify areas where the visitor/traveler program is being offered*] that allows you to remain enrolled in our plan when you are outside of our service area for up to 12 months. Under our visitor/traveler program, you get all plan-covered services at in-network cost-sharing prices. Contact us 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 don’t return to our plan’s service area by *<end date>*, we will end your membership in our plan.]

F. Benefits covered outside of our plan

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



If you have questions, please call *<plan name>* at *<toll-free phone and TTY numbers>*, *<days and hours of operation>*. The call is free. **For more information**, visit *<web address>*. 57

We don't cover the following services, but they are available through Original Medicare or Medi-Cal fee-for service.

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 get 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.

For CCT transition coordination services

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

For services not related to your CCT transition

The provider bills us for your services. Our plan pays for the services provided after your transition. You pay nothing for these services.

While you get CCT transition coordination services, we pay for services listed in the Benefits Chart in **Section D**.

No change in drug coverage benefit

The CCT program does **not** cover drugs. You continue to get your normal drug benefit through our plan. For more information, refer to **Chapter 5** of your *Member Handbook*.

Note: If you need non-CCT transition care, call your care coordinator to arrange the services. Non-CCT transition care is care **not** related to your transition from an institution or facility.

F2. Medi-Cal Dental Program

Certain dental services are available through the Medi-Cal Dental Program; includes but is not limited to, services such as:

- initial examinations, X-rays, cleanings, and fluoride treatments
- restorations and crowns
- root canal therapy
- partial and complete dentures, adjustments, repairs, and relines



Dental benefits are available in the Medi-Cal Dental Fee-For-Service Program. For more information, or if you need help finding a dentist who accepts the Medi-Cal, 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 www.dental.dhcs.ca.gov for more information.

In addition to the Medi-Cal Dental Fee-For-Service Program, you may get dental benefits through a dental managed care plan. Dental managed care plans are available in Sacramento and Los Angeles Counties. If you want more information about dental plans or want to change dental plans, 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:** Our plan offers additional dental services. Refer to the Benefits Chart in **Section D** for more information.]*

F3. Hospice care

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. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

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

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

For drugs that may be covered by our plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Member Handbook*.



Note: If you need non-hospice care, call your care coordinator to arrange the services. Non-hospice care is care not related to your terminal prognosis.

F4. In-Home Supportive Services (IHSS)

- The IHSS Program will help pay for services provided to you so that you can remain safely in your own home. IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities.
- The types of services which can be authorized through IHSS 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, and protective supervision for the mentally impaired.
- Your care coordinator can help you apply for IHSS with your county social service agency. *[Plans should insert county social service agency IHSS contact information.]*

F5. 1915(c) Home and Community Based Services (HCBS) Waiver Programs

Assisted Living Waiver (ALW)

- The Assisted Living Waiver (ALW) offers Medi-Cal eligible beneficiaries the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. The goal of the ALW is to facilitate nursing facility transition back into a homelike and community setting or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility placement.
- Members who are enrolled in ALW and were transitioned into Medi-Cal Managed Care can remain enrolled in ALW while also receiving benefits provided by our plan. Our plan works with your ALW Care Coordination Agency to coordinate the services you receive.
- Your care coordinator can help you apply for the ALW. *[Plan insert local ALW care coordination agencies contact info.]*

HCBS Waiver for Californians with Developmental Disabilities (HCBS-DD)

California Self-Determination Program (SDP) Waiver for Individuals with Developmental Disabilities

- There are two 1915(c) waivers, the HCBS-DD Waiver and SDP Waiver, that provide services to people who have been diagnosed with a developmental disability that begins before the individual's 18th birthday and is expected to continue indefinitely. Both waivers are a way to fund certain services that allow persons with developmental disabilities to live at home or in the community rather



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 60

than residing in a licensed health facility. Costs for these services are funded jointly by the federal government's Medicaid program and the State of California. Your care coordinator can help connect you to DD Waiver services.

Home and Community-Based Alternative (HCBA) Waiver

- The HCBA Waiver provides care management services to persons at risk for nursing home or institutional placement. The care management services are provided by a multidisciplinary Care Management Team comprised of a nurse and social worker. The team coordinates Waiver and State Plan services (such as medical, behavioral health, In-Home Supportive Services, etc.), and arranges for other long-term services and supports available in the local community. Care management and Waiver services are provided in the participant's community-based residence. This residence can be privately owned, secured through a tenant lease arrangement, or the residence of a participant's family member.
- Members who are enrolled in the HCBA Waiver and were transitioned into Medi-Cal Managed Care can remain enrolled in the HCBA Waiver while also receiving benefits provided by our plan. Our plan works with your HCBA waiver agency to coordinate the services you receive.
- Your care coordinator can help you apply for the ALW. *[Plans should insert local HCBA agency contact info.]*

Medi-Cal Waiver Program (MCWP)

- The Medi-Cal Waiver Program (MCWP) provides comprehensive case management and direct care services to persons living with HIV as an alternative to nursing facility care or hospitalization. Case management is a participant centered, team approach consisting of a registered nurse and social work case manager. Case managers work with the participant and primary care provider(s), family, caregiver(s), and other service providers, to assess care needs to keep the participant in their home and community.
- The goals of the MCWP are to: (1) provide home and community-based services for persons with HIV who may otherwise require institutional services; (2) assist participants with HIV health management; (3) improve access to social and behavioral health support and (4) coordinate service providers and eliminate duplication of services.
- Members who are enrolled in the MCWP Waiver and were transitioned into Medi-Cal Managed Care can remain enrolled in the MCWP Waiver while also receiving benefits provided by our plan. Our plan works with your MCWP waiver agency to coordinate the services you receive.



- Your care coordinator can help you apply for the MCWP. [*Plan insert local MCWP agency contact info.*]

Multipurpose Senior Services Program (MSSP)

- The Multipurpose Senior Services Program (MSSP) provides both social and health care management services to assist individuals remain in their own homes and communities.
- While most of the program participants also receive In-Home Supportive Services, MSSP provides on-going care coordination, links participants to other needed community services and resources, coordinates with health care providers, and purchases some needed services that are not otherwise available to prevent or delay institutionalization. The total annual combined cost of care management and other services must be lower than the cost of receiving care in a skilled nursing facility.
- A team of health and social service professionals provides each MSSP participant with a complete health and psychosocial assessment to determine needed services. The team then works with the MSSP participant, their physician, family, and others to develop an individualized care plan. Services include:
 - care management
 - adult day care
 - minor home repair/maintenance
 - supplemental in-home chore, personal care, and protective supervision services
 - respite services
 - transportation services
 - counseling and therapeutic services
 - meal services
 - communication services.
- Members who are enrolled in the MSSP Waiver and were transitioned into Medi-Cal Managed Care can remain enrolled in the MSSP Waiver while also receiving benefits provided by our plan. Our plan works with your MSSP provider to coordinate the services you receive.



- Your care coordinator can help you apply for MSSP. *[Plans should insert local MSSP agency contact info.]*

G. Benefits not covered by our plan, Medicare, or Medi-Cal

This section tells you about benefits excluded by our plan. “Excluded” means that we do not pay for these benefits. Medicare and Medi-Cal do not pay for them either.

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

We do not pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan does not cover the following items and services:

[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 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 and items as appropriate. Plans may also add exclusions as needed.]

- services considered not “reasonable and medically necessary”, according to Medicare and Medi-Cal, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of your *Member Handbook* 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 medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- private duty nurses



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 63

- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- full-time nursing care in your home
- fees charged by your immediate relatives or members of your household
- 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 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 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.

