

CenCal Health IHSS Health Plan

Summary of Benefits and Covered Services Matrix

This Benefit Summary is intended to compare coverage benefits and is a summary only. The most current version of this comparative benefit summary is available on www.cencalhealth.org.

Annual out-of-pocket copayment maximum of \$3,000 per calendar year.

Benefit	Description/Limitations	Copayment
Preventive Health Services	<ul style="list-style-type: none"> • Scheduled routine physical examinations. • Annual breast and pelvic exams and Pap tests. • Immunizations. • Venereal disease testing including confidential HIV/AIDS counseling and testing. • Cancer screening including mammography. • Vision and Hearing screening by Member's primary care provider to determine the need for vision correction and to determine the need for an audiogram for hearing correction. 	<ul style="list-style-type: none"> • No copayment • No copayment • No copayment • No copayment • No copayment • No copayment
Diabetes Management & Treatment	<ul style="list-style-type: none"> • Outpatient care and laboratory testing. • Diabetes self-management, education, and medical nutrition services. • Durable medical equipment (DME) used in the management and treatment of diabetes. • Applicable medications and supplies covered under the • Plan's prescription drug benefit. 	<ul style="list-style-type: none"> • No copayment • No copayment • DME coinsurance • Pharmacy copayment
Maternity Care	<ul style="list-style-type: none"> • Prenatal care physician visits, laboratory testing, including genetic and alpha-fetoprotein testing, and radiology services for complete prenatal and post-partum outpatient maternity care. • One (1) well-baby care physician visit to hospital after birth of newborn, including newborn evaluation services. 	<ul style="list-style-type: none"> • No copayment • No copayment
Physician and Professional Services	<ul style="list-style-type: none"> • Physician office visits, including specialty visits, consultations and examinations, and second opinions. • Physician home visits. • Allergy testing and treatment. • Physician services in a hospital, skilled nursing and rehabilitation facilities. 	<ul style="list-style-type: none"> • \$20 per visit • \$20 per visit • \$20 per visit • No copayment
Family Planning Services	<ul style="list-style-type: none"> • Voluntary family planning counseling. • Surgical procedures for sterilization, including but not limited to, tubal ligation and vasectomy. • Pregnancy test (by physician). 	<ul style="list-style-type: none"> • No copayment • No copayment • No copayment • No copayment

	<ul style="list-style-type: none"> • Abortion. • Contraceptive drugs and devices pursuant to the Plan's prescription drug benefit. 	<ul style="list-style-type: none"> • Applicable Pharmacy copay (refer below to "Prescription Drug Coverage")
--	--	---

Benefit	Description/Limitations	Copayment
Outpatient Hospital and Other Outpatient Facilities Outpatient Services	<ul style="list-style-type: none"> • Services and supplies for treatment or surgery in an outpatient hospital setting or ambulatory surgery center. • Diagnostic services including X-ray, mammography, CT scan, MRI, nuclear medicine, and laboratory services. • Physical, occupational, and speech therapy may be provided in a medical office, in the home, or other appropriate outpatient setting when ordered by the Member's PCP. 	<ul style="list-style-type: none"> • 20% Coinsurance • \$15 Copayment
Emergency and Urgent Health Care Services	<ul style="list-style-type: none"> • Emergency room services for emergency conditions. • Urgent Care services for urgent conditions. 	<ul style="list-style-type: none"> • \$75 Per visit • \$30 Per visit
Inpatient Hospital Services	<ul style="list-style-type: none"> • Inpatient acute care hospital room and board, general nursing care, ancillary services, including operating room, intensive care unit, prescribed drugs, laboratory and radiology, physical, occupational, and speech therapy, pain control, and symptom management. 	<ul style="list-style-type: none"> • \$500 Per stay
Inpatient Rehabilitation Services	<ul style="list-style-type: none"> • Inpatient rehabilitation facility room and board, general nursing care, ancillary services, and appropriate physical, occupational, and speech therapy. 	<ul style="list-style-type: none"> • \$500 Per stay
Medical Transportation	<ul style="list-style-type: none"> • Emergency medical transportation for transport to the nearest hospital which can provide such emergency care. • Non-Emergency medical transportation to transfer the Member from a non-participating hospital to a Plan hospital for admission. • Non-emergency medical transportation to transfer the Member from a hospital or other medical facility to the Member's residence only when the member requires transport in a prone or supine position or requires specialized safety equipment, for medical reasons. 	<ul style="list-style-type: none"> • \$50 Per ride • No copayment • \$50 Per ride • \$50 Per ride

	<ul style="list-style-type: none"> Air ambulance only in emergencies where ground transport is contraindicated due to distance and/or member's medical condition. 	
--	--	--

Benefit	Description/Limitations	Copayment
Prescription Drug Coverage	<ul style="list-style-type: none"> Generic formulary: 30 day or 1 month supply based on package size Brand formulary: 30 day or 1 month supply based on package size Non-formulary: 30 day or 1 month supply based on package size 	<ul style="list-style-type: none"> \$15 Copayment \$25 Copayment \$50 Copayment
	<ul style="list-style-type: none"> 90 day supply of maintenance drugs by Mail Order 	<ul style="list-style-type: none"> \$20 generic \$50 brand formulary \$150 non-formulary
	Contraceptive Drugs <ul style="list-style-type: none"> 90 day supply of oral contraceptive drugs by Mail Order Contraceptive devices Emergency contraceptives 	<ul style="list-style-type: none"> 2 X applicable 30 day copayment \$25 Copayment \$25 Copayment
	<ul style="list-style-type: none"> One cycle of tobacco cessation drugs per benefit year in conjunction with enrollment in tobacco cessation classes or program. <ul style="list-style-type: none"> Generic formulary Brand formulary Non-formulary 	<ul style="list-style-type: none"> \$15 Copayment \$25 Copayment \$50 Copayment
	<ul style="list-style-type: none"> Formula and special food products for the treatment of phenylketonuria (PKU). <ul style="list-style-type: none"> Generic formulary Brand formulary Non-formulary 	<ul style="list-style-type: none"> \$15 Copayment \$25 Copayment \$50 Copayment
	<ul style="list-style-type: none"> Inpatient drugs to member in an inpatient setting, or administered in the doctor's office, or in an outpatient facility setting during the member's stay at the facility. 	<ul style="list-style-type: none"> No copayment
Durable Medical Equipment	<ul style="list-style-type: none"> Durable medical equipment (DME) as prescribed, includes but is not limited to, the purchase or rental of equipment such as: ambulatory items, wheelchairs, oxygen and related respiratory equipment, hospital beds and accessories, bathroom safety equipment, home monitoring equipment for diabetes, asthma and high blood pressure management. Medically necessary repairs and replacement of DME as authorized unless necessitated by misuse or loss. 	<ul style="list-style-type: none"> 40% Coinsurance 50% Coinsurance
Medical Supplies	<ul style="list-style-type: none"> Medical supplies as prescribed to include, but are not limited to, wound care 	<ul style="list-style-type: none"> 40% Coinsurance

	dressings, urological supplies, ostomy supplies and diabetic supplies.	
--	--	--

Benefit	Description/Limitations	Copayment
Orthotic / Prosthetic Appliances	<ul style="list-style-type: none"> Orthotic and prosthetic (O&P) appliances when prescribed as necessary for the restoration of function or replacement of body parts, as prescribed. O & P items include, but are not limited to custom footwear required for foot disfigurement from disease or accident & for insulin dependent diabetics, devices used to restore a method of speaking following laryngectomy, & devices to restore and achieve symmetry incident to mastectomy. 	<ul style="list-style-type: none"> 40% Coinsurance
Hearing Aid Services	<ul style="list-style-type: none"> Audiological evaluation to measure the extent of hearing loss and hearing aid evaluation to determine the most appropriate make and model of hearing aid. Hearing Aids, monaural or binaural, including ear mold(s), hearing aid instrument, the initial battery, cords and other ancillary equipment. Includes visits for fitting, counseling, adjustments, and repairs. Visits for fitting, counseling, adjustments, and repairs. Surgically implanted FDA-approved hearing devices, including implantable cochlear devices for bilateral, profoundly hearing impaired individuals who are not benefited from conventional amplification (hearing aids). 	<ul style="list-style-type: none"> No copayment Maximum benefit of \$1,000 every 36 months for the hearing aid instrument and ancillary equipment. Does not apply to implantable cochlear devices and surgical services and procedures to implant a hearing device.
Mental Health Services Inpatient	<ul style="list-style-type: none"> Mental health care coverage during confinement limited to ten (10) days inpatient stay for mental health conditions other than Severe Mental Illness (SMI) or Serious Emotional Disturbances (SED). Severe Mental Illness (SMI) - no inpatient stay limit. Serious Emotional Disturbances (SED) – no inpatient stay limit. 	<ul style="list-style-type: none"> \$250 Copayment & 20% Coinsurance per stay <p>Maximum of \$500 per stay for SMI or SED conditions.</p>
Mental Health Services Outpatient	<ul style="list-style-type: none"> Mental health care coverage limited to ten (10) outpatient visits for mental health conditions other than Severe Mental Illness (SMI) or Serious Emotional Disturbances (SED). Severe Mental Illness (SMI) – no visit limits. 	<ul style="list-style-type: none"> \$20 Per Visit \$20 Per Visit \$20 Per Visit

	<ul style="list-style-type: none"> • Serious Emotional Disturbances (SED) - no visit limits. 	
Skilled Nursing Facility Services	<ul style="list-style-type: none"> • Inpatient care limited to 100 days per benefit year. • Physical, occupational and speech language pathology services as medically necessary while inpatient at a Skilled Nursing Facility. 	<ul style="list-style-type: none"> • \$50 Per day • No copayment

Benefit	Description/Limitations	Copayment
Hospice	<ul style="list-style-type: none"> • Hospice services in an approved hospice program to include nursing care, home health aid, counseling and medications. Hospice care is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of twelve (12) months or less. 	<ul style="list-style-type: none"> • No copayment
Home Health Services	<ul style="list-style-type: none"> • Home Health Care Services when the Member is required to be at home for medically necessary purposes at the direction of the Member's primary care physician or other appropriate authority designated by Plan. • Medical supplies given to recipients by home health agency personnel. 	<ul style="list-style-type: none"> • \$20 Per visit • DME & Prescription Copayments apply
Organ Transplants	<ul style="list-style-type: none"> • Medically necessary major organ transplants, which are not experimental or investigational in nature by current standards of medical care, and are performed at an approved transplant facility. 	<ul style="list-style-type: none"> • Inpatient / Outpatient, Professional and Prescription Copayments apply
Reconstructive Surgery	<ul style="list-style-type: none"> • Reconstructive surgical services to correct a disfigurement or physical function disorder caused by injury, disease, congenital abnormality or medically necessary surgery. • Following medically necessary mastectomy surgery. 	<ul style="list-style-type: none"> • Inpatient / Outpatient, Professional and Prescription Copayments apply
Blood and Blood Products	<ul style="list-style-type: none"> • Processing, storing, administering of blood and blood products including collecting and storing of autologous blood when medically necessary. 	<ul style="list-style-type: none"> • No copayment
Routine Care for Patients in Cancer Clinical Trials	<p>To participate in clinical trials:</p> <ul style="list-style-type: none"> • Member must be diagnosed with cancer; • Treating physician must have recommended participation in the clinical trial as potential benefit to Member's health; and • Member must then be accepted into the clinical trial. 	<ul style="list-style-type: none"> • \$20 Per visit, Inpatient / Outpatient Copayments apply
Chiropractic Care	Chiropractic services for an injury or illness	<ul style="list-style-type: none"> • \$20 Per visit

Services	when referred to a Plan chiropractor by member's PCP; including visits, examinations and procedures performed in the chiropractic office.	
Acupuncture Care Services	Acupuncture services after an illness or injury when referred by Member's PCP.	<ul style="list-style-type: none"> • \$20 Per visit
Health Education	<ul style="list-style-type: none"> • Health education is offered if associated with disease management programs provided by the Plan, or by providers affiliated with the Plan. • Nutritional counseling is offered through the Plan's contracted Registered Dietitians, Certified Diabetes Educators, and other designated providers. • Personalized health education, is offered by Plan PCPs. 	<ul style="list-style-type: none"> • No copayment

11-5-04 DMHC