IHSS Health Plan Benefits and Exclusions

Important Information: Services are covered as Health Plan benefits only if they are medically necessary and provided to members of CenCal Health's IHSS Health Plan. A service is medically necessary if it is recommended by a qualified medical professional, has been established as safe and effective, and is furnished in accordance with generally accepted professional standards to treat an illness or injury. In addition, such service must be consistent with the symptoms or diagnosis, not furnished primarily for the convenience of the member, the attending physician or other provider, and must be furnished at the most appropriate level at which the service can be provided safely and effectively to the member.

Services or procedures that require prior authorization for coverage are reviewed by CenCal Health's Utilization Management staff, consistent with generally accepted medical standards, and decisions to deny coverage are subject to appeal in accordance with the procedures outlined in *Section 7* of the Explanation of Coverage (EOC)*, "Member Grievance System"*.

Schedule of Benefits

Subject to referral by member's PCP, authorization, and applicable copayments or coinsurance, and all other terms, conditions, limitations and exclusions of the EOC, including those listed in *"Exclusions and Limitations"* the following IHSS services are covered when medically necessary:

Preventive Health Services

Scheduled routine physical examinations as follows:

- Periodic health exams, including all routine diagnostic testing and laboratory services appropriate for such examinations and based on age and other risk factors. The frequency of such examinations shall not be increased for reasons that are unrelated to member's medical needs, including member's desire for physical examinations, or reports or related services for employment, licenses, insurance, or school sports clearance.

- Immunizations consistent with the most current recommendations of the Centers for Disease Control and Prevention.
- Testing for venereal disease and confidential HIV/AIDS testing and counseling.
- Cancer screening exams for breast, cervical and prostate cancer to include mammography, PAP tests, and the option of any other cervical and prostate screening test approved by the Food and Drug Administration (FDA) upon referral by the member's health care provider and consistent with generally accepted medical practice and scientific evidence.
- Hearing tests and eye examinations by the PCP to determine the need for vision correction and to determine the need for an audiogram for hearing correction.

Exclusions/Limitations

- ***Exclusion -*** Preventative services related to travel, and routine physical examinations required for licensure, employment, insurance, recreational or organizational activities are not covered, unless the examination corresponds to the schedule of routine physical examinations provided in the Schedule of Benefits.
- ***Exclusion -*** Examinations, immunizations and treatment precedent to engaging in travel, or for pre-marital or pre-adoption purposes, and for any other purposes unrelated to screening for disease or prevention of disease.
- ***Exclusion -*** Eyeglasses and contact lenses other than those prescribed as necessary following cataract surgery.
- ***Limitation -*** Vision and hearing screening services limited to one (1) visit per year.
- ***Limitation -*** Routine Screening Mammography limited to once per benefit year or consistent with generally accepted medical practice and scientific evidence, upon referral by the Member's PCP or other appropriate provider. Diagnostic mammograms are covered under the outpatient benefit described in the section of the EOC titled *"Outpatient Hospital Services and Other Outpatient Facilities*".

Diabetes Management and Treatment

Diabetes outpatient care, services, and laboratory testing consistent with the American Diabetes Association practice recommendations. Diabetes self management, education, and medical nutrition services upon referral by the PCP. Applicable supplies and equipment used in the management and treatment of insulin dependent, non-insulin dependent and gestational diabetes, as medically necessary. Please also refer to the *"Prescription Drug Benefit"* and the *"Durable Medical Equipment"* sections for further information.

- Blood glucose monitors and blood glucose testing strips.
- Insulin pumps and necessary supplies.
- Ketone urine testing strips.
- Lancets and lancet puncture devices.
- Pen delivery systems for the administration of insulin.
- Insulin syringes.
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.
- Insulin.
- Prescriptive medications for the treatment of diabetes.
- Podiatry services and devices to prevent or treat diabetes complications.
- Outpatient self-management training, education and medical nutrition therapy necessary to enable you to properly use the equipment, supplies and medications as prescribed by your provider.

Pregnancy and Maternity Care

Prenatal and Postnatal Physician Office Visits and Delivery

- Prenatal physician office visits, laboratory testing including genetic and alpha-fetoprotein testing, and radiology services for complete prenatal and post-partum outpatient maternity care.

- Inpatient hospital services for the purposes of a normal delivery, cesarean section, complications or medical conditions arising from pregnancy or resulting childbirth. The length of inpatient hospital stay is based upon the unique characteristics of each mother. IHSS Health Plan will not restrict inpatient hospital care to less than forty-eight (48) hours following a normal vaginal delivery, and not less than ninety-six (96) hours following a cesarean section delivery. However, coverage of inpatient hospital care may be for a time period less than forty-eight (48) to ninety-six (96) hours if the following two (2) conditions are met:

  1) The discharge decision is made by the treating physician, in consultation with the mother; and;
  2) The treating physician schedules a follow-up visit for the mother and newborn within forty-eight (48) hours of discharge.

- One (1) well-baby care physician visit in the hospital after the birth of newborn which includes newborn evaluation services as recommended by the American Academy of Pediatrics.

Nurse midwife services are a benefit of IHSS. The chosen nurse midwife must be associated with a Participating Provider. Participating Providers who offer nurse midwives are listed in the Contracted Provider List.

Exclusions/Limitations

- ***Limitation*** - No dependent (inpatient/outpatient) benefit coverage for newborn with the exception of the one (1) well-baby care physician visit in the hospital after birth of newborn, including newborn evaluation services as recommended by the American Academy of Pediatrics.
- ***Exclusion*** **–** Ultrasound, amniocentesis, or any other procedure for the purpose of determining sex of fetus.

Physician and Professional Services

- Physician office visits for examination, diagnosis, and treatment of a medical condition, disease, or injury, including referral Specialist office visits, second opinions and consultations.
- Physician home visits when medically necessary.
- Medical and surgical physician services for examination, diagnosis, treatment, and consultation (including assistant surgeon, anesthesiologist,

pathologist and radiologist) while an inpatient at a hospital, skilled nursing facility, or rehabilitation facility for the following.

- Office visits for the purpose of allergy testing and treatment, including allergy injections and serum.

Exclusions/Limitations

- ***Exclusion -*** Infertility reversal for and incident to the reversal of a vasectomy or tubal ligation.
- ***Exclusion -*** Repeat vasectomy or tubal ligation.
- ***Exclusion -*** Infertility services for and incident to sexual dysfunction or sexual inadequacies (except as provided for treatment for organically based conditions), ovum transplants, artificial insemination, in vitro fertilization, including GIFT and ZIFT procedures or any other form of induced fertilization or services incident to or resulting from procedures for a surrogate mother who otherwise is not eligible for covered pregnancy and maternity care under the Plan's health care benefits.
- ***Exclusion -*** Experimental and investigational treatments unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Unless otherwise dictated by federal or state law, decisions as to whether a particular treatment is experimental or investigational, are determined by the IHSS Health Plan's Medical Director or his or her designee based upon criteria reflecting current standards of medical care, including but not limited to, published authoritative medical or scientific literature, established medical protocols, opinions of other medical agencies or professional review organizations, expert medical opinion, and regulations and other official actions and publications issued by the Food and Drug Administration (FDA) or Department of Health and Human Services (DHHS).

  Members may request an Independent Medical Review (IMR) by the DMHC if IHSS Health Plan denies or delays a requested service on the basis that it is experimental or investigational. The process for requesting an IMR is described in Section 7 of this EOC, *"Member Grievance System"*.
- ***Exclusion -*** Routine foot care, including, but not limited to, removal or reduction of corns and calluses, clipping of toenails, treatment of flat feet, fallen arches, and chronic foot strain, except for members with diabetes and as required for foot disfigurement from disease or accident. Specialized footwear, including foot orthotics, custom made standard orthopedic shoes, or customized footwear, which is not permanently attached to an orthopedic brace.
- ***Exclusion -*** Specialty pain management services (services provided by a pain management Specialist or in a pain management center or clinic) to treat or cure chronic pain, except as may be provided through a participating hospice agency under the hospice benefit.
- ***Exclusion*** for Duplicate Coverage - Workers' compensation services are subject to coordination of benefits and rights of recovery. See Section 6 of the EOC, *Coordination of Benefits and Third Party Liability*.

- ***Limitation -*** Allergy testing and treatment: maximum of eight (8) allergy injections within a 120 day period without prior authorization from the Plan.
- ***Limitation -*** Inpatient professional services, including hospital, skilled nursing or rehabilitation facility services, are covered only if referred by the member's PCP.
- ***Exclusion -*** Spinal manipulation or adjustments other than those provided under the Plan's Chiropractic benefit.
- ***Exclusion -*** Surgery for morbid obesity, including gastric bypass, gastric stapling, prescription medications, and other procedures for the treatment of obesity, except when medically necessary.

Family Planning

- Family planning counseling.
- Counseling, professional services, and surgical procedures for sterilization as permitted by state and federal law, including but not limited to tubal ligation and vasectomy.
- Pregnancy test performed by a physician.
- Contraceptive drugs and devices pursuant to the Plan's prescription drug benefit, including insertion or removal of an Intrauterine device (IUD). Please refer to the Prescription Drug Benefit in this section for more information.
- Therapeutic and elective abortion.

Exclusions/Limitations

- ***Limitation -*** Family planning counseling limited to 15 visits per year.
- ***Exclusion -*** Infertility services and treatment, including artificial insemination and sperm storage.
- ***Exclusion -*** Over-the-counter condoms and spermicides (creams and gels).

Outpatient Hospital Services and Other Outpatient Facilities

- Services and supplies for treatment, therapeutic services (including radiation and chemotherapy) 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 PCP.
- General anesthesia and associated facility charges are covered for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental

procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting. Prior authorization for general anesthesia required for dental care procedures may be required in the same manner that prior authorization is required for other covered diseases or conditions.

- General anesthesia and associated facility charges are covered only if member is less than seven years of age; developmentally disabled, regardless of age; or if member's health is compromised and general anesthesia is medically necessary, regardless of age.

- Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery.

Exclusions/Limitations

- ***Exclusion -*** Dental procedures, including but not limited to the professional fee of the dentist.
- ***Exclusion -*** Unauthorized non-urgent or non-emergency services.
- ***Limitation*** - Physical, occupational, and speech therapy visits limited to 36 visits per benefit year. Additional visits may be authorized as medically necessary, with evidence of continued significant improvement, as part of an approved treatment plan.

Emergency Health Care Services

You are encouraged to appropriately use the "911" emergency response system when you have an emergency medical condition. Please notify your IHSS Health Plan within twenty-four (24) hours or as soon as possible.

An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Payment for emergency services and care may be denied only if the IHSS Health Plan reasonably determines that the emergency services and care were never performed; or when the member did not require emergency services and care and he or she reasonably should have known that an emergency did not exist. The determination as to whether the member reasonably believed that the medical condition was an emergency medical condition that required an emergency response will not be based solely upon a retrospective analysis of the level of care eventually provided to the member, or your final discharge diagnosis. If you receive non-authorized services in a situation that the IHSS health plan determines was not an emergency, and in which it was not reasonable to believe that the situation was an emergency, the member will be responsible for the costs of those services.

Inpatient Hospital Services

The following hospital services are IHSS Health Plan benefits when provided at a Participating Provider hospital as referred by the member's PCP and authorized in accordance with IHSS Health Plan rules. Emergency care and urgent care services do not need to be authorized or referred.

- Semi-private room and board, unless a private room is medically necessary and authorized. If a private room is used without authorization, member will be responsible for the difference between the IHSS Health Plan's rate for a semi-private room and the hospital's rate for a private room.
- General nursing care and special duty nursing when medically necessary and authorized.
- Intensive care services.
- Delivery room and newborn nursery.
- Hospital ancillary services including operating room, diagnostic laboratory, radiology, physical, occupational and speech language therapy services, pain control and symptom management.
- Prescribed drugs, medications, IV fluids, biologicals, and oxygen administered in the hospital. Up to three (3) days supply of drugs as prescribed upon discharge by a Participating Provider to cover transition from the hospital to home.
- Surgical and anesthetic supplies, dressings and cast materials, surgically implanted devices and prostheses (not including surgically implanted hearing aids), other medical supplies, medical appliances, and equipment administered in the hospital, and prosthetic devices to restore and achieve symmetry after mastectomy or to restore speech after laryngectomy.
- Administration of blood and blood products.
- Radiation therapy, chemotherapy, and renal dialysis.

Exclusions/Limitations

- ***Exclusion -*** Personal comfort and convenience items such as telephones, televisions, guest trays, and personal hygiene items and private rooms.

Inpatient Rehabilitation Services

The following hospital services are IHSS Health Plan benefits when provided at a hospital that is a Participating Provider if referred by member's PCP and authorized in accordance with IHSS Health Plan requirements.

Rehabilitation facility room and board, general nursing care, ancillary services and appropriate physical, occupational, and speech therapy services.

Exclusions/Limitations

- ***Limitation*** - Coverage is limited to a maximum 30 days per benefit year. Additional days may be authorized as medically necessary, with evidence of continued significant improvement.
- ***Exclusion -*** Vocational rehabilitation services (therapy services for the purpose or goal of gaining or maintaining employment).

Medical Transportation Services

Emergency Transportation Services

Ambulance transportation to the nearest hospital is covered if the transportation:

- Was for an Emergency Medical Condition and ambulance transport services were required, OR
- The member reasonably believed their medical condition was an Emergency Medical Condition and reasonably believed that the condition required ambulance transport services.

This includes ambulance transportation services provided through the "911" emergency response system.

Air ambulance is covered only in emergencies when ground transport is contraindicated due to distance and/or member's medical condition.

Non-Emergency Transportation Services

- Ambulance transportation for non-emergency medical transportation to transfer the member from a Non-participating Provider hospital to a Participating Provider hospital for admission.
- Non-emergency medical transportation to transfer the member from a hospital or other medical facility to their residence only when member requires transport in a prone or supine position or requires specialized safety equipment, for medical reasons.

Exclusions/Limitations

Exclusions **-** Transportation services other than those specifically provided for in section, *"Medical Transportation Services"*, or in the *"Summary of Benefits and Covered Services Matrix*", including but not limited to airplane, passenger car, taxi, or other form of public or private conveyance.

Prescription Drugs

Benefits are provided for outpatient prescription drugs which meet all of the requirements specified in this section, are prescribed by a physician or other licensed health care provider within the scope of his or her license as long as the prescriber is a Participating Provider, are obtained from a participating

pharmacy, and are listed on the Drug Formulary. Drug coverage is based on the use of CenCal Health's Choice Formulary and is administered in cooperation with MedImpact. The Drug Formulary is updated on an ongoing basis by MedImpact's Pharmacy and Therapeutics Committee and reviewed by CenCal Health's Pharmacy and Therapeutics Committee. Non-formulary drugs may be covered subject to higher copayments. Selected drugs and drug dosages may require prior authorization by the IHSS Health Plan for medical necessity and appropriateness of therapy. Non-formulary drugs, which are medically necessary, are covered if the physician obtains prior authorization by sending an authorization request form to the IHSS Health Plan. Off label use of drugs is not precluded by this formulary.

Outpatient Prescription Drug Formulary

The Drug Formulary applies only to outpatient drugs provided to the member, and does not apply to medications used in inpatient settings. Medications are selected for inclusion in the IHSS Health Plan Choice Formulary based on safety, efficacy, FDA bioequivalence data, and cost. New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by CenCal Health's Pharmacy and Therapeutics Committee.

You may call MedImpact at 1-800-788-2949 to inquire if a specific drug is included in the Formulary. You may also access the Formulary through the CenCal Health Website at http://www.cencalhealth.org.

Generic substitution

- When available, FDA approved generic drugs are to be used in all situations, regardless of the brand name indicated (except as noted below). The generic names are **bolded** in the formulary listing whenever an FDA approved generic drug product is available. This policy is not meant to replace any state statutes that may exist. All drugs that are or become available generically are subject to review by the Plan's Pharmacy and Therapeutics Committee in cooperation with MedImpact's Pharmacy and Therapeutics Committee.
- The member is responsible for paying the applicable copayment for each covered new and refill prescription drug. The applicable copayment should be collected from the member at time the drugs are dispensed.
    - $15 generic
    - $25 Formulary brand name
    - $50 non-Formulary brand name per prescription for the amount prescribed not to exceed a 30-day supply.

  Note: For diabetic supplies (including needles and syringes) the Formulary brand name copayment applies.
- If the member requests a Formulary brand name drug when a Formulary generic drug equivalent is available, member is responsible for paying the

difference in cost in addition to the applicable Formulary brand name drug copayment.

- If a prescription specifies a Formulary brand name drug and the prescribing provider had written “Dispense as Written” or “Do not Substitute” on the prescription, or if a Formulary generic drug equivalent drug is not available, member is responsible for paying the applicable Formulary brand name drug copayment or the non-Formulary brand name drug copayment.

  Note: Certain drug products will not be subject to substitution: These products are:

  - Dilantin (except suspension)
  - Neoral Oral Solution
  - Lanoxin

Prescription Drug Benefit Coverage and Limitations

The Formulary does not provide information regarding specific coverage and limitations an individual IHSS Health Plan Member may have. Many Health Plan Members have specific inclusions, exclusions, copayments, or a lack of coverage, which are not reflected in the Formulary.

Exclusions/Limitations

- ***Limitation –*** Some drugs may be subject to specific quantity limits. Some prescription drugs may be subject to specific quantity limits as dictated by the medical necessity to adequately treat the condition. Drugs exceeding quantity limits which are medically necessary, are covered if your physician obtains prior authorization by sending an authorization request form to the IHSS Health Plan.
- ***Exclusion -*** Over the Counter (OTC) medications or their equivalents, unless otherwise specified in the Formulary listing.
- ***Exclusion -*** Drugs listed as not covered.
- ***Exclusion -*** Any drug products used for cosmetic purposes. Some drugs used for cosmetic purposes may be covered with a doctor’s prescription for a medically necessary condition.
- ***Exclusion -*** Experimental drug products or any drug product used in an experimental manner.
- ***Exclusion -*** Replacement of lost or stolen medication.
- ***Exclusion -*** Non-self-administered injectable drug products, unless otherwise noted. Injectables administered by a Participating Provider are covered under the IHSS Health Plan’s medical benefit.
- ***Exclusion -*** Drugs not approved by the United States Food and Drug Administration.
- ***Exclusion -*** Take home drugs received from a hospital, convalescent home, skilled nursing facility, or similar facility.

- ***Exclusion -*** Dietary or nutritional products except for medical formulas or special food products required for treatment of PKU.
- ***Exclusion -*** Medical devices or supplies, except as specifically listed as covered.
- ***Exclusion -*** Appetite suppressants and other weight loss medications, unless specifically listed as covered or as medically necessary for the treatment of morbid obesity.
- ***Exclusion -*** Compounded medications with Formulary alternatives or those with no FDA approved indications.

Durable Medical Equipment

Durable medical equipment (DME) is covered when prescribed in writing by the member's PCP or other Participating Provider. DME 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; and
- Home monitoring equipment for diabetes, asthma, and high blood pressure management.

Rental charges for DME are covered up to the purchase price.

- Medically necessary repairs and replacement of DME are covered as authorized unless necessitated by misuse or loss.

Exclusions/Limitations

- ***Exclusion -*** Home monitoring equipment except for those provided under the diabetes management program, asthma and high blood pressure benefit.
- ***Exclusions -*** Customization of living environment or motor vehicles; experimental equipment; items that duplicate the function of other equipment; and other convenience items not generally used primarily for medical care. Examples include, but are not limited to, exercise equipment, air conditioners or heaters, lighting devices, orthopedic mattresses, recliners, seat lift chairs, elevators, waterbeds, household and furniture items.
- ***Limitation*** – Certification by a licensed Occupational or Physical Therapist or certified Rehabilitation Technician is required for custom made manual wheelchairs and power operated wheelchairs/scooters.

Medical Supplies

- Medical supplies are covered as prescribed in writing by your PCP or other Participating Provider. Medical supplies include, but are not limited to:
  - Wound care dressings
  - Urological supplies
  - Ostomy supplies
  - Diabetic supplies

Exclusion/ Limitations

- ***Exclusion -*** Therapeutic devices or apparatuses, regardless of therapeutic effect (e.g. hypodermic needles and syringes, except as needed for insulin and covered injectable medications), support garments and similar items.
- ***Exclusion -*** Incontinence supplies.
- ***Exclusion -*** Over-the-counter medical supplies. Examples of over-the counter medical supplies include, but are not limited to, incontinence supplies, wipes / towelettes, thermometers, band-aids, elastic wraps, tape, and batteries.

Orthotic and Prosthetic Appliances

Orthotic and Prosthetic (O&P) appliances are covered when such appliances are necessary for the restoration of function or replacement of body parts, as prescribed in writing by a Participating Provider.

O&P services will be covered only when medically necessary to restore bodily functions essential to activities of daily living, prevent significant physical disability or serious deterioration of health or to alleviate severe pain.

O&P items include, but are not limited to:

- Custom footwear required for foot disfigurement from disease or accident and for insulin dependent diabetics.
- Devices to restore and achieve symmetry incident to mastectomy.
- Devices to restore a method of speaking following laryngectomy

In the event that more than one type of prosthetic device or corrective appliance is available, benefits will be provided only for the device or appliance which is medically and reasonably indicated in accordance with accepted medical practice.

Exclusions/Limitations

- ***Exclusion*** - Miscellaneous equipment for orthopedic shoes, except for therapeutic footwear for diabetes, and except as provided under the Diabetes Management and Treatment benefit.

- ***Exclusion*** - Over-the-counter items including but not limited to: shoe inserts; arch supports; elastic stockings; and items used for fitness or athletic activities.

Hearing Aid Services

- Audiological evaluation to measure the extent of hearing loss, and a hearing aid evaluation to determine the most appropriate make and model of hearing aid are covered.
- Hearing Aid - monaural or binaural hearing aids, including ear molds(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment.
- Visits for fitting, counseling, adjustments, repairs, etc., at no charge for one (1) year following the provision of a covered hearing aid.
- 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).

Exclusions/Limitations

- ***Limitation*** - no charge for visits for a 1-year period following the provision of a covered hearing aid.
- ***Limitation*** - Up to a 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.
- ***Exclusion -*** Batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase. Charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss. Replacement parts for hearing aids, repair of hearing aid after the covered 1-year warranty period and replacement of a hearing aid more than once in any period of 36 months.

Mental Health Care

IHSS Health Plan provides for mental health coverage including the diagnosis and medically necessary treatment of Serious Mental Illness (SMI) and Serious Emotional Disturbances (SED). Benefits include outpatient and inpatient hospital services and partial hospital services. IHSS Health Plan provides limited coverage for mental health conditions other than SMI or SED. See Definitions Section 11.

Inpatient Mental Health Services

Mental health care in an IHSS Health Plan hospital when ordered and performed by a mental health Participating Provider for the treatment of a mental health condition. Except for the treatment of SMI and SED, inpatient mental health services are limited to ten (10) days in a calendar year.

With Member's agreement, or the agreement of another adult who is legally empowered to make treatment decisions on member's behalf, each day of inpatient hospitalization may be substituted for two (2) outpatient visits.

Exclusions/Limitations (Inpatient)

- ***Limitation -*** benefit limited to ten (10) days inpatient stay per benefit year for non-SMI or non-SED conditions.
- ***Limitation -*** Maximum benefit per year is limited to $10,000 for non-SMI or non-SED conditions.

Outpatient Mental Health Services

Mental health care when ordered and performed by a Health Plan mental health professional. Except for the treatment of SMI and SED, outpatient services for evaluation and care are limited to ten (10) visits in a calendar year. This outpatient benefit is in addition to any outpatient visits substituted for inpatient days.

Outpatient Mental Health Services for the treatment of SMI and SED are provided with no visit limitations.

Exclusions/Limitations (Outpatient)

- ***Limitation -*** benefit limited to ten (10) outpatient visits per benefit year for non-SMI or non-SED conditions.

Skilled Nursing Facility Services

Skilled nursing care is covered in a nursing facility licensed by the State of California. A skilled nursing facility may be a distinct part of a hospital, and use of such a distinct part is counted towards the maximum number of days described below.

This benefit is limited to one hundred (100) days during any benefit year. Subject to this limitation, the following skilled nursing facility benefits are provided when medically necessary and authorized, and are not for custodial, convalescent or domiciliary care:

- Semi-private room and board, unless a private room is medically necessary and authorized. If a private room is used without authorization, the member will be responsible for the difference between the skilled nursing facility's customary charge for a two (2) bed room and the private room;
- General nursing care and special duty nursing when authorized;
- Physical, occupational, and speech language pathology while inpatient under the SNF benefit of 100 days.

- Durable medical equipment utilized by member during an authorized stay in the skilled nursing facility.

Exclusions/Limitations

- ***Limitation*** – 100 days per benefit year
- ***Limitation –*** If private room requested, member must pay the difference between the private and semi-private room charges.
- ***Limitation*** - Physical, occupational, and speech language pathology services only while inpatient under the IHSS Health Plan benefit.
- ***Exclusion -*** Any services or supplies furnished by a non-eligible institution, which is defined as other than a legally operated hospital or Medicare-approved skilled nursing facility, or which is primarily a place of rest, a place for the aged, a nursing home, or any similar institution, regardless of how denominated.
- ***Exclusion –***Long term, maintenance, or chronic level rehabilitation services including physical, occupational, and speech therapy provided on an inpatient or outpatient basis, except for the restricted and limited rehabilitation services provided in the Summary of Benefits.
- ***Exclusion -*** Skilled nursing care, skilled nursing facility room and board and ancillary charges incurred beyond the 100 days per benefit year.

Hospice Care

Hospice services are provided upon formal admission to an approved hospice program, through a hospice agency that is a Participating Provider. The IHSS Health Plan will provide hospice care for members who are terminally ill and if member elects palliative care instead of other benefits for terminal illness that are provided by the IHSS Health Plan. Terminal illness is defined as a medical condition resulting in a prognosis for life expectancy of twelve (12) months or less, if the disease follows its natural course.

The member may change his or her decision to receive hospice care at any time, and request other services offered as benefits of the IHSS Health Plan.

When ordered by a Participating Provider, hospice benefits include:

- Skilled nursing services, certified health aide services, and homemaker services under the supervision of a qualified registered nurse;
- Bereavement services;
- Social services, counseling services with medical social services provided by a qualified social worker;
- Dietary counseling by a qualified provider when needed;
- Medical direction with the hospice facility's medical director being also responsible for meeting member's general medical needs for the terminal illness, to the extent that these needs are not met by a personal physician;
- Volunteer services;

- Short-term inpatient care arrangements related to the hospice terminal illness;
- Pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the management of the terminal illness and related conditions;
- Physical, occupational, and speech language pathology services, for the purpose of symptom control, or to enable the member to maintain activities of daily living and basic functional skills;
- Nursing care services covered on a continuous basis for as much as twenty four (24) hours a day during periods of crisis as necessary to keep the member at home; and
- Respite care services for up to five (5) consecutive inpatient days to provide relief to families.

Exclusions/Limitations

- ***Limitation -*** Hospice care is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of twelve (12) months or less.

Home Health Care Services

Home health care services are covered when the member is required to be at home for medically necessary purposes at the direction of member's PCP or other appropriate authority designated by the Health Plan. This benefit provides skilled medical services to members who are homebound to transition from institutionalization or to prevent institutionalization.

Home health care services are provided pursuant to an authorized home health treatment plan and only when medically necessary and authorized.

Home visits to provide skilled services by any of the following professional providers are covered:

- Registered nurse;
- Licensed vocational nurse;
- Certified home health aid in conjunction with the service of a registered nurse or licensed vocational nurse;
- Physical therapist, occupational therapist, speech therapist or respiratory therapist;
- Medical social worker; and
- Medical supplies given to the member by the home health agency's personnel if they are provided in accordance with member's written treatment plan.

Exclusions/Limitations

- ***Exclusion -*** Custodial maintenance or domiciliary care, except as provided under the Hospice benefit.

Other Benefits

Organ Transplant Benefits

- Medically necessary major organ transplants that are not experimental or investigational by current standards of care. If IHSS Health Plan denies a requested service on the basis that it is experimental or investigational, the member may request an Independent Medical Review (IMR) by the DMHC. The process for requesting an IMR is described in Section 7 of the EOC, *"Member Grievance System."*

Hospital and professional services are covered for certain major organ transplants only if:

1) Performed at a Medicare approved transplant center. A "transplant center" is a medical institution that operates an organ transplant program;
2) Prior authorization is obtained, in writing, from the Health Plan; and
3) Member is the recipient of the transplanted organ and meets all other IHSS Health Plan eligibility requirements.

The medical and hospital expenses incident to obtaining the human organ transplant material from a living donor are covered benefits, subject to the annual benefit maximum dollars.

Exclusions/Limitations

- ***Limitation –*** Preoperative evaluation, surgery, and follow-up care will be provided at centers that have been designated by the IHSS Health Plan as an approved transplant centers. Non-acute/non-emergency evaluations, transplantations and follow-ups at facilities that have not been designated by the IHSS Health Plan will not be approved.
- ***Limitation –*** The patient-selection committee of the approved transplant center will select recipients. If a Participating Provider or the referral facility determines that the member does not satisfy the patient selection criteria for the transplant, tissue and organ transplant procedures and services will be excluded. Health Plan will pay only for the services the member received before that decision is made.
- ***Exclusion -*** Organ transplants, anti-rejection drugs, biologicals and procedures that are considered experimental or investigational in nature by current standards of medical care and/or non-human or artificial organs and their implantation.
- ***Exclusion –*** Recipient or donor lodging, meals, and transportation costs to and from the transplant center.
- ***Exclusion –*** Charges associated with the procurement of donor organ or tissue.

Reconstructive Surgery

Reconstructive surgery is limited to those surgical services that:

- Are performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, and are likely to improve physical function or create a normal appearance, to the extent possible; or
- Follows medically necessary mastectomy surgery (including implants) which resulted from disease, illness, or injury

Exclusions/Limitations

- ***Exclusion -*** Surgical procedures that are defined as cosmetic and implants that are experimental or investigational.
- ***Exclusion -*** Cosmetic surgery or any resulting complications, except medically necessary services to treat complications of cosmetic surgery (e.g. infections or hemorrhages), but only upon review and approval by the Plan's Medical Director or designee. When services are determined to be cosmetic, all services to be provided as part of the cosmetic treatment plan are also excluded, including hospital, physician, medical supplies, or medications.
- ***Exclusion -*** Penile implant devices and surgery, and any related services, except for any resulting complications and medically necessary services as provided under covered reconstructive surgery benefits.
- ***Exclusion -*** Reconstructive surgery and procedures: (a) where there is another more appropriate surgical procedure that is approved by Plan's Medical Director or physician consultant; or (b) when the surgery or procedure offers only a minimal improvement in function or appearance.
- ***Exclusion -*** Sex transformations and related procedures, services, medications, and supplies.

Blood and Blood Products

- The processing, storage, and administration of blood and blood products are covered in inpatient and outpatient settings, including the collection and storage of autologous blood when medically indicated. (See Definition Section 11)

Phenylketonuria (PKU)

Benefits are provided for testing for PKU and for providing enteral formulas, special food products, and other treatments consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of, phenylketonuria (PKU), and that are medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of

phenylketonuria (PKU). "Special food product" is defined as a food product that is:

- Specially formulated to have less than one gram of protein per serving, but does not include food that is naturally low in protein; and
- Used in place of normal food products, such as foods found in retail food stores and used by the general population.

Cancer Clinical Trials

IHSS Health Plan covers routine patient care costs that would otherwise be benefits when related to member's participation in a cancer clinical trial. In order to participate in a clinical trial, the member must be diagnosed with cancer, his or her treating physician must have recommended the participation in the clinical trial based upon the potential benefit to their health, and member must be accepted into the clinical trial. Coverage includes costs for benefits described in the EOC.

Exclusions/Limitations

- ***Exclusion*** - Drugs or devices that have not been approved by the Food and Drug Administration (FDA) and which are not associated with a cancer clinical trial.
- ***Exclusion -*** Travel or housing expenses, companion expenses and other non-clinical expenses that may be incurred as a result of participation in a clinical trial.
- ***Exclusion -*** Any item or service provided solely for the purpose of data collection and that is not used in the clinical management of the patient.
- ***Exclusion -*** Services that are specifically excluded from coverage under this plan.
- ***Exclusion -*** Services customarily provided by the research sponsors free of charge to participants of a clinical trial.

Chiropractic Care

- Chiropractic services are covered for an injury or illness when referred by member's PCP**;** including visits, examinations and procedures performed in the chiropractor's office.

Limitations – Maximum of 20 visits per benefit year

Acupuncture

- Acupuncture services are covered following an illness or injury when referred by member's PCP.

Limitations – Maximum of 20 visits per benefit year.

Health Education

Exclusions/Limitations

- ***Limitation –*** Health education benefits are limited to $1,000 per benefit year.