



# IHSS Benefits Matrix



This matrix is intended to be used to help you compare covered benefits and is a summary only. Please consult the benefit description section for a detailed description of covered benefits and limitations.

Benefits*	Services	Cost to Member (copayment)
Inpatient Hospital Services	Room and board, nursing care and all medically necessary ancillary services.	No copayment.
Outpatient Hospital Services	Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility.	No copayment except: <ul style="list-style-type: none"><li>▪ \$10 per visit for physical, occupational and speech therapy performed on an outpatient basis.</li><li>▪ \$25 per visit for emergency health care services (waived if the Member is admitted to the hospital).</li></ul>
Professional Services	Services and consultations by a physician or other licensed health care provider.	\$10 per office visit or telehealth appointment except: <ul style="list-style-type: none"><li>▪ No copayment for hospital inpatient professional services.</li><li>▪ No copayment for surgery, anesthesia, or radiation, chemotherapy or dialysis treatments.</li><li>▪ No copayment for pediatric vision screening.</li></ul>



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		<ul style="list-style-type: none"><li>No copayment for hearing testing or for hearing aids.</li></ul>
Preventive Health Service	Periodic health examinations including all routine diagnostic testing, Sexually Transmitted Diseases (STD) testing, Human Immunodeficiency Virus (HIV) testing, laboratory services appropriate for such examinations, colorectal cancer screening and testing, immunizations and services for the detection of asymptomatic diseases.	No copayment.
Diagnostic, X-Ray and Laboratory Services	Laboratory services and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose and treat Members.	No copayment.
Diabetes Care	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes and gestational diabetes as medically necessary, even if the items are available without prescription.	\$10 copayment per office visit; copayment for prescriptions as described in the Prescription Drug Program section of this chart.



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Prescription Drug Program	Drugs prescribed by a licensed practitioner.	<p>\$5 per prescription for a 30-day supply of generic drugs (Drug Tier 1), \$15 per prescription for a 30-day supply of brand name drugs (Drug Tier 2). \$5 per prescription for a 90-day supply of maintenance drugs of generic drugs (Drug Tier 1), \$15 per prescription for a 90-day supply of brand name drugs (Drug Tier 2).</p> <p>If the cost of drug is lower than the copayment, member will pay for the lower cost.</p> <p>No copayment for prescription drugs provided in an inpatient setting.</p> <p>No copayment for drugs administered in the doctor's office or in an outpatient facility.</p> <p>No copayments for contraceptives.</p> <p><i>*coinsurance amounts in accordance with Health and safety code 1367.656.</i></p>



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Durable Medical Equipment	Medical equipment appropriate for use in the home that primarily serves a medical purpose, is intended for repeated use and is generally not useful to a person in the absence of illness or injury.	▪ No copayment.
Orthotics and Prosthetics	Original and replacement devices as prescribed by a licensed practitioner.	▪ No copayment.
Cataract Spectacles and Lenses	Cataract spectacles and lenses, cataract contact lenses or intraocular lenses that replace the natural lens of the eye after cataract surgery.	▪ No copayment.
Maternity Care	Professional and hospital services relating to maternity care.	▪ No copayment.
Family Planning Services	Voluntary family planning services. Contraceptive drugs and devices pursuant to the Plan's prescription drug benefit.	▪ No copayment.
Medical Transportation Services	Emergency ambulance, including air ambulance transportation and non-emergency transportation to transfer a Member from a hospital to another hospital or facility, or facility to home.	▪ No copayment.
Emergency Health Care Services	Emergency services are covered both in and out of the Plan's Service Area and in and out of the Plan's contracted facilities.	\$25 per visit (waived if the Member is admitted to the hospital).



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Mental Health Care Services	Diagnosis and treatment of a mental health condition.	No copayment. Unlimited days.
Inpatient Mental Health Care Services	Mental health care in a contracted hospital when ordered and performed by a Participating Mental Health Provider for the treatment of a mental health condition.	
Outpatient Mental Health Care Services	Mental health care when ordered and performed by a Participating Mental Health Provider.	\$10 per visit. Unlimited visits.
Inpatient Substance Use Disorder Services	Inpatient substance abuse treatment services and residential treatment services.	No copayment. Unlimited days.
Outpatient Substance Use Disorder Services	Crisis intervention and outpatient treatment of a substance use disorder condition.	\$10 per visit. Unlimited visits.
Home Health Care Services	Services provided at the home by health care personnel.	No copayment, except \$10 per visit for physical, occupational and speech therapy.
Skilled Nursing Care	Services provided in a licensed skilled nursing facility.	No copayment. Benefit is limited to a maximum of 100 days per benefit year.
Rehabilitative (Physical, Occupational and Speech) Therapy	Therapy may be provided in a medical office or other appropriate outpatient setting.	\$10 per visit when performed in an outpatient setting. No copayment for inpatient therapy.



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Blood and Blood Products	Includes processing, storage and administration of blood and blood products in inpatient and outpatient settings.	No copayment.
Organ Transplants	Coverage for organ transplants and bone marrow transplants that are not experimental or investigational.	No copayment.
Reconstructive Surgery	Performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors or disease and are performed to improve function or create a normal appearance.	No copayment.
Phenylketonuria (PKU)	Testing and treatment of PKU.	No copayment.
Clinical Cancer Trials	Coverage for a Member's participation in a cancer clinical trial, Phase I through IV, when the Member's physician has recommended participation in the trial and Member meets certain requirements.	\$10 copayment per office visit. Copayment for prescriptions as described in the Prescription Drug Program section.
Acupuncture	Requires a referral from the Member's PCP and prior authorization from the Alliance. Services must be obtained from an In Service Area Contracted Provider.	\$10 per visit. Benefit is limited to 20 visits per benefit year.
Chiropractic	Requires a referral from the Member's PCP and prior authorization from the Alliance. Services must be obtained from an In Service Area Contracted Provider.	\$10 per visit. Benefit is limited to 20 visits per benefit year.



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Biofeedback	Requires a referral from the Member's PCP and prior authorization from the Alliance. Services must be obtained from an In Service Area Contracted Provider.	\$10 per visit.
Deductibles	No deductibles will be charged for covered benefits.	
Lifetime Maximums	No lifetime maximum limits on benefits apply under this Plan.	
Annual Copayment Maximum	\$3,000 per benefit year.	

Benefits are provided only for services that are medically necessary.