HealthPlan OF SAN MATEO
Healthy is for everyone

Summary of Benefits

HealthWorx HMO

Last Updated 03/08/2023

EN

Our Member Services department Is Available to Help You

Call us at **1-800-750-4776** (toll free) or **650-616-2133**

Hearing Impaired: **TTY 1-800-735-2929** or dial **7-1-1**

Monday-Friday:
Phone 8:00am-6:00pm
Office hours 8:00am-5:00pm

Large-print Request
If you would like a large-print copy of this book, please call Member Services

Privacy Statement
Health Plan of San Mateo ensures the privacy of your medical record. For questions and more information, please call Member Services.

我們的會員服務部可為您提供協助

請撥打我們的電話 **1-800-750-4776**
(免費) 或 **650-616-2133**

有聽力障礙者：TTY **1-800-735-2929** 或撥 **7-1-1**

星期一到星期五
電話：上午 8:00 至晚上 6:00
辦公室服務時間：上午 8:00 至下午 5:00

大字版需求
若您需要本手冊的大字版，請致電會員服務部

隱私權聲明
聖馬刁健康計劃 (HPSM) 會為您保密病歷資訊。
如有疑問或需要更多資訊，請致電會員服務部

Nuestra Unidad de Servicios al Miembro está disponible para ayudarlo

Llámenos al **1-800-750-4776** (número telefónico gratuito)
o al **650-616-2133**

Miembros con dificultades auditivas:
TTY 1-800-855-3000 o marque el **7-1-1**

De lunes a Viernes:
Por teléfono 8:00am-6:00pm
Horario de oficina 8:00am-5:00pm

Solicitud de impresión en caracteres grandes
Si desea una copia de este manual en letra grande, llame al Departamento de Servicios al Miembro.

Declaración de privacidad
El Health Plan of San Mateo garantiza la privacidad de su registro médico. Si tiene alguna pregunta o desea obtener más información, llame a Servicios al Miembro.

Handa kayong Tulungan ng aming Yunit para sa mga Serbisyo sa mga Miyembro

Tawagan kami sa **1-800-750-4776** (walang bayad)
o sa **650-616-2133**

May Kapansanan sa Pandinig:
TTY **1-800-735-2929** o i-dial ang **7-1-1**

Lunes hanggang Biyernes:
Telepono: 8:00 a.m. hanggang 6:00 p.m.
Mga oras ng opisina: 8:00 a.m. hanggang 5:00 p.m.

Paghiling para sa Pagkakalimbag na may Malalaking Letra
Kung gusto ninyong makakuha ng librong ito na malalaki ang mga letra sa pagkakalimbag, mangyaring tawagan ang mga Serbisyo para sa mga Miyembro

Pahayag tungkol sa pagiging pribado ng impormasyon
Tinitiyak ng Health Plan of San Mateo ang pagiging pribado ng inyong medikal na rekord. Para sa karagdagang katanungan at impormasyon, mangyaring tawagan ang Mga Serbisyo para sa mga Miyembro.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call Member Services at 1-800-750-4776. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-750-4776 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for costs and services this plan covers.
Are there services covered before you meet your deductible?	Yes	This plan does not have a deductible.
Are there other deductibles for specific services?	No	This plan does not have a deductible. But a copayment or coinsurance may apply.
What is the out-of-pocket limit for this plan?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.hpsm.org/docs/default-source/member-manuals/healthworx_provider_directory.pdf or call **1-800-750-4776** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Not Covered	None
	Specialist visit	$5	Not Covered	A referral from primary care physician required. Member will pay for services if not referred.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Preauthorization is required for diagnostic radiology services (CT/PET scans, MRIs).
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hpsm.org/member/healthworx/prescriptions-pharmacies	Generic drugs	$3	Not Covered	Covers up to 90-day supply unless otherwise stated on the Formulary. * See Prescription Drug description in Section 6 (Covered Services, Benefits, and Co-Payments) of the HealthWorx Evidence of Coverage.
	Brand name drugs	$10	Not Covered	
	Specialty drugs	$3 or $10	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	$5 copayment for outpatient physical, occupational, and speech therapy.
	Physician/surgeon fees	No Charge	Not Covered	Preauthorization may be required.
If you need immediate medical attention	Emergency room care	$25	Not Covered	Copayment waived if admitted.
	Emergency medical transportation	No Charge	Not Covered	None
	Urgent care	No Charge	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Except in an emergency, your doctor must tell the plan you are being admitted to the hospital.
	Physician/surgeon fees	No Charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5	Not Covered	Mental and behavioral health services are offered through San Mateo County Behavioral Health and Recovery Services (BHRS). You can call the BHRS ACCESS Call Center at **1-800-686-0101** (TYY: **7-1-1**) for more information. Preauthorization from BHRS is required.
	Inpatient services	No Charge	Not Covered	Mental and behavioral health services are offered through San Mateo County Behavioral Health and Recovery Services (BHRS).
If you are pregnant	Office visits	No Charge	Not Covered	None
	Childbirth/delivery professional services	No Charge	Not Covered	Inpatient care for the member is limited to inpatient care up to 48 hours, or 96 hours after cesarean section.* Inpatient new born hospital care will be provided for up to 48 hours following a normal vaginal delivery and up to 96 hours following delivery by Cesarean Section unless an extended stay is authorized by HPSM.* * See Pregnancy and Maternity Care description in Section 6 (Covered Services, Benefits, and Co-Payments) of the HealthWorx HMO Evidence of Coverage.
	Childbirth/delivery facility services	No Charge	Not Covered	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Referral is required. Preauthorization is required. Custodial care not included
	Rehabilitation services	$5	Not Covered	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Includes outpatient physical, occupational, speech, and respiratory therapy.
	Habilitation services	Excluded	Not Covered	Excluded
	Skilled nursing care	No Charge	Not Covered	Preauthorization is required.
	Durable medical equipment	No Charge	Not Covered	Referral is required. Preauthorization is required.
	Hospice services	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Excluded	Not Covered	Excluded
	Children's glasses	Excluded	Not Covered	
	Children's dental check-up	Excluded	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care (Adult) except for IHSS workers which is covered through SEIU
- Dental Check-up (Child)
- Habilitation Services
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Child)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic Care
- Hearing aids
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is : Health Plan of San Mateo **1-800-750-4776**. You may also contact the California Department of Managed Health Care at **1-888-466-2219**. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call **1-800-318-2596**.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also

provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

Member Services
Health Plan of San Mateo
801 Gateway Boulevard, Suite 100, South San Francisco, CA 94080
Phone: **1-800-750-4776** or **650-616-2133 (**TTY: **1-800-735-2929** or dial **7-1-1**)
Fax: 650-616-8581
www.hpsm.org

Additionally, a consumer program can help you file your appeal. Contact:

California Department of Managed Health Care
California Help Center
980 9th St, Suite 500 Sacramento, CA 95814
Phone: **1-888-466-2219** TDD: **1-877-688-9891**
Fax: 1-916-255-5241
www.dmhc.ca.gov
helpline@dmhc.ca.gov

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-750-4776.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-750-4776.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-750-4776.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-750-4776.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.hpsm.org/member/healthworx/member-resources

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist cost sharing** **$5**
- **Hospital (facility) cost sharing** **0%**
- **Other cost sharing** **0%**

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,600**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$22
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$82**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist cost sharing]** **$5**
- **Hospital (facility) cost sharing** **0%**
- **Other cost sharing** **0%**

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,200**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$182
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$237**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist cost sharing** **$5**
- **Hospital (facility) cost sharing** **0%**
- **Other cost sharing** **0%**

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$15
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$15**

The plan would be responsible for the other costs of these EXAMPLE covered services.


San Mateo County
El Condado de San Mateo
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E
S
Daly City
South
San Francisco
SFO
San Bruno
Pacifica
Millbrae
Burlingame
Montara
Hillsborough
Foster City
San Mateo
Belmont
San Carlos
Moss-Beach
Redwood City
East Palo Alto
Menlo Park
Half Moon Bay
Atherton
Woodside
Portola
Valley
Santa Clara County

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