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.

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.

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 或拨打 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

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 rehord. Para sa karagdagang katanungan at impormasyon, mangyaring tawagan ang Mga Serbisyo para sa mga Miyembro.
NOTICE OF PRIVACY PRACTICES
Effective: April 14, 2003
Revised: May 1, 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Why Am I Receiving this Notice?
Health Plan of San Mateo (HPSM) understands that health information about you is personal. We are committed to protecting your health information. This notice contains a summary of HPSM’s privacy practices and your rights relating to health information. This notice only covers HPSM’s privacy practices. Your doctor may have different policies or notices regarding the use and disclosure of your health information created in the doctor’s office.

We Are Required by Law to:
• Make sure that your health information is kept private
• Give you this notice of our legal duties and privacy practices about your health information
• Follow the terms of the notice that is currently in effect

How We May Use and Share Your Health Information
Your information may be used or shared by HPSM only for treatment, payment and health care operations associated with the particular program you are enrolled in. The information we use and share includes, but is not limited to:
• Your name
• Address
• Personal facts
• Medical care given to you
• The cost of your medical care
• Your medical history
Notice of Privacy Practices (Privacy Notice)

Some Examples of When We May Use or Share Your Health Information

- **For Treatment**: You may need medical treatment that needs to be approved ahead of time. We will share your health information with doctors, hospitals and others in order to get you the care you need.

- **For Payment**: We use your health information to pay doctors, hospitals and others who have provided you medical care. We may also forward bills to other health plans or organizations for payment.

- **For Health Care Operations**: We may use your health information to check the quality of care you receive. We may also use this information in audits, programs to stop fraud and abuse, financial and organizational planning, and general administration.

- **For Business Associates**: We may use or share your health information to an outside company that assists us in operating our health plan.

Other Uses for Your Health Information

- **Health Benefits or Services**: We may use and share health information to tell you about HPSM’s benefits or services that may be of interest to you through HPSM’s Health Education Programs.

- **Payment Decisions**: You or your doctor, hospital, or other health care provider may appeal decisions made about payment for your health care. Your health information may be used to make these appeal decisions.

- **Oversight Activities**: We may share your health information with health oversight agencies for activities authorized by law. These oversight activities may include audits, investigations, inspections, licensure activities, or disciplinary actions. These activities are necessary for the government to monitor HPSM’s compliance with laws and regulations.

- **Individuals Involved in Your Care**: We may share information with people involved in your health care, or with your personal representative.

- **Workers Compensation**: We may share health information about you for Workers Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
Notice of Privacy Practices (Privacy Notice)

- **Coroners, Medical Examiners, and Funeral Directors:** We may share the health information of members who are deceased to coroners, medical examiners or funeral directors to enable them to perform their duties.

- **Organ and Tissue Donations:** We may share your health information with organizations that obtain, bank or transplant organs or tissue donations.

- **Public Health Activities:** We may share your health information for public health activities. These activities may include, but are not limited to the following:
  - To prevent or control disease, injury or disability
  - To report births and deaths
  - To report child abuse or neglect
  - To report problems with medications and other medical products
  - To notify people of recalls of products they may be using
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

- **Law Enforcement or Legal Proceedings:** We may share health information if required to do so by a law enforcement official, in response to a court order or warrant, and if requested by authorized federal officials for national security activities authorized by law. We may also share your health information in response to a subpoena or other lawful process, but only if efforts have been made to notify you of the request or to obtain an order protecting the information requested.

- **50 Years After Death:** We may share the health information of deceased members to any agency if the member has been deceased for more than 50 years.

**When Written Permission is Needed**

If we want to use your health information for any purpose not listed above, we must first get your written permission. If you give us your permission, you may take it back in writing at any time.

**Your Privacy Rights**

You have the following rights regarding your health information that we store:

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on how we use or share your health information. In your request, you must tell us:
  1. What information you want to limit;
Notice of Privacy Practices (Privacy Notice)

2. Whether you want to limit our use of information, sharing of information, or both; and
3. To whom you want the limits to apply.

To request restrictions, you must make your request in writing. See page 6 for instructions regarding where to send such requests.

Note: We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

• Right to Request Confidential Communications: You have the right to request that we contact you privately and with special handling. For example, you can ask that we contact you at a different address, only by telephone, or only while you’re at work.

We will not ask you for the reason for your request. We will make every effort to accommodate reasonable requests. Your request must specify how or where you wish to be contacted. To request special handling in the way you are contacted, you must make your request in writing. See page 6 for instructions regarding where to send such requests.

• Right to Access Your Health Information: You have the right to obtain a copy of certain health information that HPSM maintains in its records. In general, this includes health and billing records. You will have to contact your doctor for a copy of your medical record. You may be charged a fee for the costs of copying and mailing records. To get a copy of health information that we maintain, you must submit your request in writing. See page 6 for instructions regarding where to send such requests.

We may deny your request to obtain a copy in certain cases. If you are denied access to health information, we will tell you the reason why in writing. If denied access, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your original request. We will comply with the outcome of the review.

• Right to an Accounting of Disclosures: You have the right to ask for a list of the times we have shared your health information with other parties. We call this an accounting of disclosures. We will include all disclosures, except for those about treatment, payment, and health care operations. We will also be unable to provide a list of certain other disclosures, such as those made to law enforcement or when we have provided you your own health information after you asked for it. We are only able to
provide you with a list of disclosures going back up to 6 years from the date of your request.

- **Right to Receive a Copy of this Privacy Notice:** You can ask for a paper copy of this notice at any time. This notice is also available on our website at www.hpsm.org

- **Right to Amend Your Health Information:** If you feel that health information we have about you is wrong or incomplete, you may ask us to amend the information. You have the right to request an amendment only on those records we maintain. For example, we cannot amend or change your doctor's records.

  We are not required to amend health information that:
  
  - Was not created by HPSM;
  - Is not part of the information we maintain;
  - Is not part of the information which you would be allowed to obtain a copy of; or
  - Is correct and complete.

  If HPSM denies your request to amend your health information, we will notify you in writing. You will also receive a written explanation of why your request was denied. If we don’t make the changes you request, you may ask that we review our decision. You may also provide a statement saying why you disagree with our records, and your statement will be kept with your records. Please see page 6 for instructions regarding where to send requests for amendment.

- **Right to Receive Notice of a Breach:** A breach occurs when protected health information is obtained, used or revealed in a way that violates relevant privacy laws. HPSM is required to inform you of any such incident within 60 days of discovering that the privacy of your information has been violated. The Secretary of the U.S. Department of Health & Human Services, and in certain circumstances the media, may also have to be notified.

  The notice of the breach that you receive will include a description of what happened, the types of information that were involved in the breach, and the steps that you should take to protect yourself from potential harm. The notice will also tell you what HPSM is doing to investigate the situation and minimize harm to you, and to prevent breaches from occurring again.
Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised notice effective for all health information we already have about you as well as any information we receive in the future. You can find the effective date of the Notice at the top of the first page. In addition, each time there are changes to the notice, we will notify you through the mail within 60 days. We will also post a copy of the current notice on our website at www.hpsm.org.

Contact Us:

If you believe your privacy rights have been violated, you may file a grievance with HPSM. You may also contact the U.S. Department of Health and Human Services to file a complaint.

Health Plan of San Mateo
Attn: Grievance & Appeals Unit
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080
1-888-576-7227 or 650-616-2850

Secretary of the U.S. Department of Health and Human Services
Office for Civil Rights
Attn: Regional Manager
90 7th St., Suite 4-100
San Francisco, CA 94103
1-800-368-1019 or 1-800-537-7697 (TDD)

You will not be penalized for filing a grievance.

For requests pertaining to your rights as listed in this notice, please send written requests to:

Health Plan of San Mateo
Attn: Privacy Officer
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

If you request a copy of your health information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We will notify you of the cost involved and you may choose to withdraw or change your request at that time before it is processed.

If you have questions about this Notice, please contact Member Services. They are available to serve you Monday through Friday, 8:00 a.m. to 6:00 p.m. at 1-800-750-4776 or 650-616-2133. Members with hearing or speech impairments can use the California Relay Service (CRS) at 1-800-735-2929 (TTY) or dial 7-1-1.
Health Plan of San Mateo Nondiscrimination Notice

The Health Plan of San Mateo (HPSM) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPSM does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

HPSM:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services.

If you believe that HPSM has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Member Services  
801 Gateway Blvd., Suite 100  
South San Francisco, CA 94080  
Toll Free: 1-800-750-4776 Local: 650-616-2133  
TTY: 1-800-735-2929  
Fax: 650-616-8581

You can file a grievance in person or by mail, fax, or phone. If you need help filing a grievance, Member Services staff are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)  
ATTENTION: If you speak other languages other than English, language assistance services, free of charge, are available to you. Call 1-800-750-4776 (TTY: 1-800-735-2929).
This page intentionally left blank.

Esta página ha sido dejada en blanco intencionalmente.

此頁有意留為空白。

Ang pahinang ito ay sadyang iniwan na blangko.
Maternity Care ................................................................. 54
Family Planning Services .................................................. 55
Medical Transportation Services ..................................... 55
Emergency Health Care Services ..................................... 56
Mental Health Benefits ...................................................... 56
  Psychiatric Emergency Services ................................... 56
  Mental Health Services Patient Advocate ..................... 56
Inpatient Mental Health Care Services ......................... 57
Outpatient Mental Health Care Services ....................... 57
Inpatient Alcohol/Drug Abuse Treatment ................... 58
Outpatient Alcohol/Drug Abuse Treatment .................. 58
Home Health Care Services ............................................ 58
Skilled Nursing Care ......................................................... 59
Physical, Occupational, and Speech Therapy ................. 59
Acupuncture & Chiropractic Services ............................. 60
Blood and Blood Products ............................................... 60
Health Education ............................................................ 60
Hospice ........................................................................ 61
Organ Transplants ......................................................... 61
Reconstructive Surgery .................................................. 62
Phenylketonuria (PKU) .................................................... 62
Clinical Cancer Trials ..................................................... 62
Annual or Lifetime Benefit Maximums ....................... 63
Coordination of Services ................................................. 63
  California Children’s Services (CCS) ......................... 63
Excluded Benefits .......................................................... 64

Section 8
Covered Vision Services ...................................................... 67
Detailed Description of Benefits, Co-Payments, Conditions, And Exclusions .......... 67
  Low Vision ................................................................ 68

Section 9
Covered Dental Services, Benefits and Co-Payments .............................................. 69
Choosing A Primary Care Dental Provider .................. 69
Scheduling Appointments ............................................ 69
Changing Your Provider ............................................... 69
Continuity of Care For New Members ......................... 69
Continuity Of Care Upon Termination Of Provider ........ 70
Prior Authorization For Services .................................. 70
Referrals To Specialists .................................................. 70
Obtaining A Second Opinion ....................................... 70
Utilization Review ......................................................... 71
Getting Urgent Care ..................................................... 71
Getting Emergency Services ....................................... 71
What To Do If You Are Not Sure If You Have An Emergency ...... 71
Non-Covered Services .................................................... 71
Follow-Up Care ............................................................ 71
Co-payments ................................................................. 72
Member Liabilities .......................................................... 72
Missed or Broken Appointments .................................. 72
Grievances Concerning Dental Services .................... 72
Appeals ....................................................................... 73
Dental Plan Covered Benefits Matrix ................................................................. 74
Deductibles ........................................................................................................... 77
Lifetime Maximum ............................................................................................... 77

Benefits Description ............................................................................................. 78
Diagnostic and Preventive Benefits ..................................................................... 78
Restorative Dentistry ......................................................................................... 78
Oral Surgery ......................................................................................................... 79
Endodontic ........................................................................................................... 80
Periodontics ........................................................................................................ 80
Crown and Fixed Bridge ....................................................................................... 81
Removable Prosthetics ......................................................................................... 82
Other Benefits ...................................................................................................... 83
Orthodontic Benefits ........................................................................................... 84

Section 10
Benefits Changes, Disenrollment, Termination, And Cancellation ..................... 85
Changes in Benefits and Charges ....................................................................... 85
Disenrollment ....................................................................................................... 85
Return of Family Contribution ............................................................................ 86
Individual’s Right of Cancellation ....................................................................... 86
Review By the Department Of Managed Health Care ......................................... 86

Section 11
Grievance and Appeals Process .......................................................................... 87
Grievance ............................................................................................................. 87
Independent Medical Reviews .......................................................................... 87
An IMR is available in the following situations: .................................................. 88
Independent Medical Review for Denials of Experimental / Investigational Therapies ................................................................. 88
Review by the Department of Managed Health Care ........................................... 88
Mediation ............................................................................................................. 89

Section 12
General Information ............................................................................................. 91
Other Health Insurance ....................................................................................... 91
Third Party Recovery Process and Member Responsibilities ............................. 91
Non-Duplication of Benefits with Workers’ Compensation ............................... 91
Coordination of Benefits ................................................................................... 91
Limitations of Other Coverage .......................................................................... 92
Provider Payment ............................................................................................... 92
Reimbursement Provisions—If You Receive a Bill ............................................ 92
Public Participation ............................................................................................ 92
Notifying You of Changes in the Plan ................................................................. 93
Privacy Practices ............................................................................................... 93
Authorization for Release of Information .......................................................... 93
Organ and Tissue Donation .............................................................................. 93
Disclosure

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Health Plan’s policies and coverage under the Healthy Kids HMO Program (HKP).

Regulations require the Health Plan to comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code, section 1340, et seq.), and the Act’s regulations (California Code of Regulations, Title 28). Any provision required to be a benefit of the program by either the Act or the Act’s regulations shall be binding on the Health Plan, even if it is not included in the Evidence of Coverage booklet.
This page intentionally left blank.

Esta página ha sido dejada en blanco intencionalmente.

此頁有意留為空白。

Ang pahinang ito ay sadyang iniwan na blangko.
Introduction

Using This Booklet
This booklet, called the Combined Evidence of Coverage and Disclosure Form or “EOC”, contains detailed information about Healthy Kids HMO Program benefits, how to obtain benefits, and the rights and responsibilities of Healthy Kids HMO Program Members. Please read this booklet carefully and keep it on hand for future reference. If you have special health care needs, please carefully read the sections that apply to you.

Throughout this booklet, “you,” “your,” and “member” refers to the child or children enrolled in the Healthy Kids HMO Program. “We,” “us,” and “our” refers to the Health Plan of San Mateo. “Provider,” “plan provider,” or “participating provider” refers to a licensed physician, hospital, medical group, pharmacy, or other health care provider who is responsible for providing medical services to you.

Welcome!

About the Health Plan
We are very pleased to welcome you to the Health Plan of San Mateo (HPSM). Thank you for choosing us to be your health plan.

The Health Plan of San Mateo is located at 801 Gateway Blvd., Suite 100, South San Francisco, CA 94080. If you need help or want more information, call the Health Plan of San Mateo and speak to a Member Services Representative at 1-800-750-4776 or 650-616-2133. The Member Services staff is available from 8:00 a.m. to 6:00 p.m., Monday through Friday.

Multilingual Services
If you or your representative prefers to speak in any language other than English, call us at 1-800-750-4776 or 650-616-2133. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY 1-800-735-2929 or dial 7-1-1 to speak with a HPSM Member Services Representative. HPSM staff speaks several languages including Spanish, and Tagalog. We offer telephone interpreter services for other languages. Our Member Services staff can help you find a health care provider who speaks your language or who has a regular interpreter available. You do not have to use family Members or friends as interpreters. If you cannot locate a health care provider who meets your language needs, you can request to have an interpreter available for discussions of medical information at no charge.

This EOC booklet, as well as other informational material, has been translated into Spanish. To request translated materials, please call HPSM at 1-800-750-4776 or 650-616-2133. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY 1-800-735-2929 or dial 7-1-1. For California Relay Service in Spanish call 1-800-835-3000.

Member Identification Card
All Members of HPSM are given a member identification (ID) card. This card contains important information regarding your medical benefits. If you have not received a card or if you have lost your Member identification card, please call a Member Services Representative at 1-800-750-4776 or 650-616-2133. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY 1-800-735-2929 or dial 7-1-1. We will send you a new card. Please show your HPSM Member identification card to your provider when you receive medical care or pick up prescriptions at the pharmacy.
Only the Member is authorized to obtain medical services using his or her Member identification card. If a card is used by or for an individual other than the Member, that individual will be billed for the services he or she receives. Additionally, if you let someone else use your Member identification card, HPSM may not be able to keep you in our plan.

**ID #:** This is the number assigned to you by HPSM.

**Eff (Effective) Date:** This date shows when the information on this card becomes effective.

**Name:** This person is eligible to receive benefits under the Healthy Kids HMO Program.

**PCP:** This is your Primary Care Physician.

**DOB:** This is your date of birth.
This page intentionally left blank.

Esta página ha sido dejada en blanco intencionalmente.

此頁有意留為空白。

Ang pahinang ito ay sadyang iniwan na blangko.
Section 1
Definitions

Active Labor
Labor is when there is inadequate time to safely transfer the Member to another hospital prior to delivery or when transferring the Member may pose a threat to the health and safety of the Member or the unborn child.

Acute Condition
A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Appropriately Qualified Health Care Professional
A primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to a particular illness, disease, condition or conditions. Health care professionals for autism or pervasive developmental disorder may be licensed or certified by a national agency, Qualified autism service paraprofessionals are unlicensed and uncertified but have adequate education, training, and experience, are employed and supervised by a qualified autism service provider, and meet all requirements in applicable regulations.

Authorization
The requirement that certain services be approved by HPSM or your Primary Care Provider before being provided in order to be a covered service.

Behavioral Health Treatment
Professional services and treatment programs that develop or restore to the maximum extent practicable, the functioning of an individual with autism or pervasive developmental disorder. The treatment must be prescribed by a licensed physician or surgeon or developed by a licensed psychologist and provided under a treatment plan prescribed by a qualified autism service provider.

Benefits (Covered Services)
Those services, supplies, and drugs that a Member is entitled to receive pursuant to the terms of this Agreement. A service is not a benefit, even if described as a covered service or benefit in this booklet, if it is not medically necessary or if it is not provided by a HPSM provider with authorization as required.

Benefit Year
The twelve (12) month period starting the first day of the month in which health coverage begins.

Complaint
A complaint is also called a grievance or an appeal. Examples of a complaint can be when

- You can’t get a service, treatment or medicine you need.
- Your plan denies a service and says it is not medically necessary.
- You have to wait too long for an appointment.
- You received poor care or were treated rudely
- Your plan does not pay you back for emergency or urgent care that you had to pay for.
- You get a bill that you believe you should not have to pay.

Co-payment
A fee, which the Plan provider may collect directly from a Member, for a particular covered benefit at the time the service is rendered.
Emergency Care
An emergency is a medical or psychiatric condition, including Active Labor or severe pain, manifesting itself by acute symptoms of a sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the Member’s health in serious jeopardy, or
- Causing serious impairment to the Member’s bodily functions, or
- Causing serious dysfunction of any of the Member’s bodily organs or parts.

Exclusion
Any medical, surgical, hospital or other treatment for which the program offers no coverage.

Experimental or Investigational Service
Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional medical standards, or if safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which it is recommended or prescribed.

Evidence of Coverage and Disclosure Form (EOC)
This booklet is the combined Evidence of Coverage and Disclosure Form that describes your coverage and benefits.

Federal Poverty Income Guideline
The federal poverty income guideline is set each year by the U.S. Department of Health and Human Services (HHS). The guidelines are used to determine eligibility for certain programs such as HFP or Medi-Cal. The poverty guidelines are sometimes referred to as the “federal poverty level” (FPL).

Formulary
A list of brand-name and generic prescription drugs approved for coverage and available without prior authorization from HPSM. The presence of a prescription drug on the formulary does not guarantee that it will be prescribed by your doctor for a particular condition.

Grievance
A written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a Member or the Member’s representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Healthy Kids HMO
The health insurance program created by the Children’s Health Initiative Coalition for children up to age 19 in families with incomes up to 400% of the federal poverty level residing in San Mateo County who are ineligible for full scope Medi-Cal.

Hospital
A health care facility licensed by the State of California, and accredited by the Joint Commission on Accreditation of Health Care Organizations, as either:
(a) an acute care hospital;
(b) a psychiatric hospital; or
(c) a hospital operated primarily for the treatment of alcoholism and/or substance abuse.

A facility which is primarily a rest home, nursing home or home for the aged, or a distinct part skilled nursing facility portion of a hospital is not included.
**Family Contribution Premium**
How much you pay for the monthly premium is determined by your income category. The income categories are determined based on the current Federal Poverty Income Guidelines. You may call HPSM to find out whether you fall into Category A, B, C, D or E.

**Inpatient**
An individual who has been admitted to a hospital as a registered bed patient and receives covered services under the direction of a physician.

**Medically Necessary**
Those health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply and level of service which considers the potential risks, benefits and alternatives.

**Member**
A person who joins HPSM to receive his or her health care. In this booklet, a Member is also referred to as "you."

**Member Identification Card**
The identification card provided to Members by HPSM that includes the Member identification number, primary care provider information, and important phone numbers.

**Mental Health Services**
Psychoanalysis, psychotherapy, counseling, medical management or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage and family therapist, for diagnosis or treatment of mental or emotional disorders including autism or pervasive developmental disorder or the mental or emotional problems associated with an illness, injury, or any other condition.

**Non-formulary Drug**
A drug that is not listed on HPSM’s Formulary and requires an authorization from HPSM in order to be covered.

**Non-Participating Provider**
A provider who is not contracted with HPSM to provide services to Members.

**Orthotic Device**
A support or brace designed for the support of a weak or ineffective joint, muscle, or to improve the function of movable body parts.

**Outpatient**
Services, under the direction of a physician, which do not incur overnight charges at the facility where the services are provided.

**Out-of Area Services**
Emergency care or urgent care provided outside of HPSM’s service area (San Mateo County) which could not be delayed until Member returned to the service area.

**Participating Provider or Plan Provider**
A physician, hospital, skilled nursing facility or other licensed health professional, licensed facility or licensed home health agency who, or which, at the time care is rendered to a member, has a contract in effect with HPSM to provide covered services to its Members.
**Pharmacy Benefits Manager (PBM)**
A third party administrator of a health plan’s prescription drug program that is mainly responsible for authorizing and paying prescription drug claims. PBMs assist the health plan with development and maintenance of drug formularies, contracts with pharmacies, and negotiate discounts and rebates with drug manufacturers.

**Plan or HPSM**
Health Plan of San Mateo

**Plan Physician**
A doctor of medicine or osteopathy rendering a service covered under this EOC, licensed in the state or jurisdiction of practice, and practicing within the scope of his or her license, who has entered into a written agreement with HPSM to provide covered services to Members in accordance with the terms of this agreement.

**Primary Care Provider (PCP)**
A pediatrician, general practitioner, family practitioner, internist, or sometimes an obstetrician/gynecologist, who has contracted with HPSM or works at a clinic contracted with HPSM to provide primary care to Members and to refer, authorize, supervise and coordinate the provision of benefits to Members in accordance with the Evidence of Coverage booklet. Nurse practitioners and physician assistants associated with a contracted primary care provider are available to Members seeking primary care.

**Program**
The Healthy Kids HMO Program.

**Prosthetic Device**
An artificial device used to replace a body part.

**Provider**
A physician, hospital, skilled nursing facility or other licensed health professional, licensed facility or licensed home health agency.

**Provider List**
The directory of all the providers contracted with HPSM to provide services to its Members.

**Psychiatric Emergency Medical Condition**
A mental disorder with acute symptoms of sufficient severity to render either an immediate danger to yourself or others, or you are immediately unable to provide for or use, food, shelter or clothing due to the mental disorder.

**Qualified Autism Service Provider**
A person, entity, or group that is nationally certified to design, supervise, or provide treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group.

A qualified autism service provider can also be a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

**Serious Chronic Condition**
A medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
**Serious Emotional Disturbance (SED)**
SED refers to a diagnosed mental condition in a child that is not a “substance abuse disorder” or “developmental disorder.” A child with SED also behaves in a way that is not appropriate for the child’s age. The San Mateo Behavioral and Recovery Services decides if a child has SED based on California Law (Welfare and Institutions Code Section 5600.3(a)(2)). In making that decision, Behavioral and Recovery Services will consider whether a child has certain problems. These could include trouble taking care of him/herself, problems at school, or problems with family relationships. The child might also have other problems such as being at risk of suicide or violence. Or, the child might meet the state’s Special Education requirements. Behavioral and Recovery Services may also look at whether the child is at risk of being removed from the home and at how long the condition is expected to last.

**Service Area**
The geographic area served by the Health Plan of San Mateo and approved by the State of California Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS). San Mateo County is the designated Service Area of the Health Plan of San Mateo.

**Severe Mental Illness (SMI)**
Includes:
- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa

**Skilled Nursing Facility**
A facility licensed by the California State Department of Health Services as a “Skilled Nursing Facility” to provide a level of inpatient nursing care that is not of the intensity required of a hospital.

**Specialist Physician**
A plan physician who provides services to a Member usually upon referral by a primary care provider within the range of his or her designated specialty area of practice and who is specialty board certified or specialty board eligible in such specialty. Some specialty services do not require a referral, e.g., obstetrical services.

**Terminal Illness**
An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.

**Urgent Care**
Services needed to prevent serious deterioration of a Member’s health resulting from unforeseen illness or injury for which treatment cannot be delayed.
This page intentionally left blank.
Esta página ha sido dejada en blanco intencionalmente.

此頁有意留為空白。
Ang pahinang ito ay sadyang iniwan na blangko.
Section 2

Member Rights and Responsibilities

As an HPSM Member, you have the right to:

• Be treated with respect and dignity.
• Choose your primary care provider from our Provider Directory.
• Get appointments within a reasonable amount of time.
• Participate in candid discussions and decisions about your health care needs, including appropriate or medically necessary treatment options for your condition(s), regardless of cost and regardless of whether the treatment is covered by this health plan.
• Have a confidential relationship with your provider.
• Have your records kept confidential. This means we will not share your health care information without your written approval or unless it is permitted by law.
• Voice your concerns about HPSM, or about health care services you received, to HPSM.
• Receive information about HPSM services, and our providers.
• Make recommendations about your rights and responsibilities.
• See your medical records.
• Get services from providers outside of our network in an emergency.
• Request an interpreter at no charge to you.
• Use interpreters who are not your family members or friends.
• File a Grievance if your linguistic needs are not met.

Your responsibilities are to:

• Give your providers and HPSM correct information.
• Understand your health problem(s) and participate in developing treatment goals, as much as possible, with your provider.
• Always present your HPSM Member Identification Card when getting services.
• Use the emergency room only in cases of an emergency or as directed by your provider.
• Make and keep medical appointments and inform your provider at least 24 hours in advance when an appointment must be cancelled.
• Ask questions about any medical condition and make certain you understand your provider’s explanations and instructions.
• Help HPSM maintain accurate and current medical by providing timely information regarding changes in address, family status, and other health care coverage. Failure to do so may cause early cancelation of benefits.
• Notify HPSM as soon as possible if a provider bills you inappropriately or if you have a complaint.
• Treat all HPSM personnel and health care providers respectfully and courteously.
This page intentionally left blank.

Esta página ha sido dejada en blanco intencionalmente.

此頁有意留為空白。

Ang pahinang ito ay sadyang iniwan na blangko.
Section 3
Accessing Care

Physical Access
HPSM has made every effort to ensure that our offices and the offices and facilities of HPSM providers are accessible to the disabled. If you are not able to locate an accessible provider, please call us toll free at 1-800-750-4776 or 650-616-2133 and we will help you find an alternate provider.

Access for the Hearing Impaired
The hearing impaired may contact us through the California Relay Service at 1-800-735-2929 (TTY) or dial 7-1-1 or for the California Relay Service in Spanish call 1-800-835-3000.

Access for the Vision Impaired
This Evidence of Coverage (EOC) and other important plan materials will be made available in large print for the vision impaired. For alternative formats or for direct help in reading the EOC and other materials, please call us at 1-800-750-4776 or 650-616-2133.

The Americans with Disabilities Act of 1990
HPSM complies with the Americans with Disabilities Act of 1990 (ADA). This Act prohibits discrimination based on disability. The Act protects Members with disabilities from discrimination concerning program services. In addition, section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall be excluded, based on disability, from participation in any program or activity which receives or benefits from federal financial assistance, nor be denied the benefits of, or otherwise be subjected to discrimination under such a program or activity.

Disability Access Grievances
If you believe the plan or its providers have failed to respond to your disability access needs, you may file a grievance with HPSM by calling 1-800-750-4776 or 650-616-2133.

Using The Health Plan
Facilities and Provider Locations
Please read the following information so you will know from whom or what group of providers health care may be obtained.

Choosing a Primary Care Provider
The Health Plan of San Mateo Provider List which you have received along with this Evidence of Coverage, lists the Primary Care Physicians, clinics, hospitals, and other health care providers and facilities available to you. The List also has the doctors’ and other providers’ addresses, telephone numbers, languages spoken and the hospitals they work with. HPSM updates the list every three (3) months and shows which doctors are not accepting new patients. You can write or call the Member Services Department at 1-800-750-4776 or 650-616-2133 to request a Provider List or ask for specific information about a doctor, including board education, board certification, or specialty training.

Your PCP is your main doctor and will take care of most of your health care needs. A Primary Care Physician may be a Pediatrician, a General Practitioner, a Family Practitioner, an Internist, or in some cases an OB/GYN doctor. If you want to choose a specific nurse practitioner or physician assistant, select the primary care facility where he or she works.

If you have not yet selected your doctor, here are some ideas to help you choose a Primary Care Physician.
How to Choose or Change Your Primary Care Physician

• You may choose the doctor you already use if you see the name on the list.

OR

• You may choose a new doctor. You will find helpful information about each doctor and the clinics where they work in the Provider List.

Before you choose a doctor you may want to think about these questions:

• Does the doctor take care of children?
• Does the doctor work at a clinic I like to use?
• Is the office close to my home, work or school?
• Is it easy to get to by public transportation?
• Do the doctors and/or office staff speak my language?
• Does the doctor work with a hospital that I like?
• Do they provide the services I may need?
• What are the doctor’s office hours?

Some doctors and hospitals do not provide one or more of the following services that you may need:

• Family Planning
• Contraceptive services, including emergency contraception
• Sterilization, including tubal ligation at the time of labor and delivery
• Infertility treatments
• Abortion

You and your PCP are a team working to keep you healthy. It is best to stay with the same doctor, so she or he can get to know your health care needs. If you change doctors often, your health care may not be as good as it could be. The PCP whom you choose will provide, authorize and coordinate your health care, except for emergency and out of area urgent care services. He or she will see you for most of your health care service needs, including preventive services.

If you do not choose a Primary Care Physician when you enroll in the Healthy Kids HMO Program, HPSM’s Member Services staff will contact you to help you choose one. If we are not able to reach you, or you do not wish to choose a doctor, we will assign you to a doctor based on your address, age and other available information to help us make a good choice for you.

Working with your PCP is the key to your health care. Your PCP may refer you to Specialists when needed. Your PCP may want to see you at his/her office before authorizing your visit to a Specialist.

To receive more information before you select a PCP, you can call the doctor’s office. The HPSM Member Services Department can also give you information to help you make a good choice for you.

Timely Access to Non-Emergency Health Care Services

Sometimes it’s hard to know what kind of care your child needs. Your doctor or a nurse will be ready to help you by phone 24 hours a day, seven days a week. This is known as “triage.” Here are some of the ways that triage can help you.

• They can answer your questions about a health worry, and teach you about self-care at home if needed.
• They can guide you about whether you should get health care, and how and where to get care. If you are not sure whether your child’s health issue is an Emergency health issue, they can help you
decide whether you need Emergency Health Care Services or Urgent Care, and how and where to get that care.)

- They can tell you what to do if your child needs care and your provider’s office is closed.

HPSM providers will make sure that you speak with a doctor or nurse over the phone within a time span that is right for your child’s health issue. The waiting time to get a call back from a doctor or nurse will not be longer than 30 minutes.

HPSM will make sure that all contracted health providers also have an answering service, or answering machine, available during non-business hours that can give tips about how to seek urgent or emergency service.

Please call your PCP at the number on your HPSM Member ID Card to use phone triage or screening services, 24 hours a day, 7 days a week.

If you cannot reach your doctor, a nurse from Nurse Advice Line can triage your health issues and answer some health care questions. You can call the Nurse Advice Line 24 hours per day, 7 days per week. Call the Nurse Advice Line at 1-833-846-8773. TTY users call 1-800-735-2929 or dial 7-1-1. This call is free.

You have the right to interpreter services to help in getting services. Interpreter services are available by phone free of charge 24 hours per day at service sites, such as your doctor’s office. You do not have to use family members, friends, or children as interpreters.

If you have any questions, please call HPSM Member Services at 1-800-750-4776, Monday through Friday, 8:00 a.m. to 6:00 p.m. TTY users may call 1-800-735-2929 (California Relay Service) or dial 7-1-1.

**Making Appointments**

When you get your child’s ID card you need to call his or her main doctor, also called the primary care provider (PCP) and make an appointment. The best time to get to know your child’s PCP is not when your child is sick, but when he or she is well. As a new Member your child should have a firstwell exam within four (4) months of being an HPSM Member. During their first well exam, your doctor will record your child’s whole health history and give your child a physical exam. This first well exam assesses your child’s health status and health risk.

To make an appointment with your child’s PCP, call the PCP’s phone number on your HPSM ID Card. You can ask the office staff how to make appointments, rules about appointments, and directions to the office. We suggest that you go to your doctor’s office about 15 minutes before your appointment. **It is very important to keep your appointments.** This is a key way for you and your PCP to get to know each other and your child’s health care needs. You will need to show your child’s HPSM ID Card. For urgent or routine care, always call your PCP.

When your child is sick, call your doctor’s office for an appointment. The doctor’s office staff will talk to you about seeing the doctor. They will tell you what to do and where to go. By calling your doctor early, you may be able to avoid a trip to the hospital emergency room.

HPSM has to make sure that your doctors give your child an appointment that is right for their health care needs. Based on the type of appointment your child needs, this table shows how long you should wait to get an appointment to see their doctor:
<table>
<thead>
<tr>
<th>Type of Visit</th>
<th>Waiting time to get an appointment from the day you call for an appointment.</th>
<th>Type of Provider/Approval</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>Within 2 days (48 hours)</td>
<td>If HPSM doesn’t need to approve the service</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 4 days (96 Hours)</td>
<td>If HPSM needs to approve the service</td>
<td></td>
</tr>
<tr>
<td>Non-Urgent Care</td>
<td>Within 2 weeks (10 business days)</td>
<td>Primary Care Provider</td>
<td>Primary Care Provider</td>
</tr>
<tr>
<td>Non-Urgent Care</td>
<td>Within 3 weeks (15 business days)</td>
<td>Specialist Physician</td>
<td>Eye, Ear-Nose-Throat, Orthopedists</td>
</tr>
<tr>
<td>Non-Urgent Care</td>
<td>Within 2 weeks (10 business days)</td>
<td>Non-Physician Mental Health Care Provider</td>
<td>Psychologist, Marriage Family Therapist</td>
</tr>
</tbody>
</table>

**Initial Health Exam**

All new Members are encouraged to see their primary care provider for an initial health examination when they join the Healthy Kids HMO Program. The first meeting with your new doctor is important. It’s a time to get to know each other and review your health status. Your doctor will help you understand your medical needs and advise you about staying healthy. Call your doctor’s office for an appointment today. You may want to complete a Staying Healthy Assessment Tool to bring to your PCP. You can call a Member Services Representative at **1-800-750-4776** or **650-616-2133** or go to [www.hpsm.org](http://www.hpsm.org) to get the form. The form asks questions about your lifestyle, behavior, environment and cultural and linguistic needs. Filling out the form and taking it to your first appointment will help your PCP to get to know you better. If you do not complete the form, your PCP may ask you to complete it when you come for your appointment.

**Changing Your Primary Care Provider**

If you and your doctor are not able to establish a good relationship, either of you has the right to ask for a change. For example, if you miss many appointments, do not follow your PCP’s medical advice, or are disruptive or abusive, your PCP may request that you select a new PCP. If you are not satisfied with the treatment or service of your PCP, you may select a new doctor. The Member Services Representative may ask the reason for your change. This information helps HPSM be sure our Providers meet the needs of our Members.

If you decide to choose a different PCP, we will do our best to meet your request. A PCP selection or choice may not be granted, in the following situations:

1. the PCP is accepting established patients only (EPO) and the Member has not seen the PCP before;
2. the provider’s practice is full;
3. you have been removed from the PCP’s practice in the past; or
4. you select a PCP who does not see Members in your age group.

If you change PCPs, the change will be effective the first day of the following month.

We will send you a new HPSM ID Card. Your new ID card will have the name and phone number of your new PCP. Your new ID Card will also show the date your PCP change is effective. Please continue to see the PCP listed on your current ID Card for all of your health care needs, until the effective date of the change. If you do not receive a new ID Card within fourteen (14) days or have questions about the effective date of change, please call HPSM and speak to a Member Services Representative at **1-800-750-4776** or **650-616-2133**.
Continuity of Care for New Members

Under some circumstances, HPSM will provide continuity of care for new Members who are receiving medical services from a non-participating provider, such as a doctor or hospital, when HPSM determines that continuing treatment with a non-participating provider is medically appropriate. If you are a new Member, you may request permission to continue receiving medical services from a non-participating provider if you were receiving this care before enrolling in HPSM and if you have one of the following conditions:

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.

- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by HPSM in consultation with you and the non-participating provider, and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with HPSM.

- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.

- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time you enroll with HPSM.

- The care of a newborn child between birth and age thirty-six (36) months.

- Completion of covered services shall not exceed twelve (12) months from the time you enroll with HPSM.

- Performance of a surgery or other procedure that your previous plan authorized as part of a documented course of treatment and that has been recommended and documented by the non-participating provider to occur within 180 days of the time you enroll with HPSM.

Please contact Member Services at 1-800-750-4776 or 650-616-2133 to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. If your request is approved, you will be financially responsible only for applicable co-payments under this plan.

We will request that the non-participating provider agree to the same contractual terms and conditions that are accepted by participating providers providing similar services, including payment terms. If the non-participating provider does not accept the terms and conditions, HPSM is not required to continue that provider's services. HPSM is not required to provide continuity of care as described in this section to a newly covered Member who was covered under an individual subscriber agreement and undergoing a treatment on the effective date of his or her Healthy Kids HMO coverage. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement.

A Member Services Representative will notify you of HPSM’s decision. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see HPSM’s Grievance and Appeals Process on page 85.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 1-888-HMO-2219; or at the TDD number for the hearing impaired, 1-877-688-9891; or online at www.hmohelp.ca.gov.

Continuity of Care Upon Termination of Provider

If your primary care provider or other health care provider stops working with HPSM, we will make every attempt to let you know by mail 60 days before the contract termination date.
HPSM will provide continuity of care for covered services rendered to you by a provider whose participation has terminated, if you were receiving this care from this provider prior to termination and you have one of the following conditions:

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by HPSM in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the provider’s contract termination date.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time the provider stops contracting with HPSM.
- The care of a newborn child between birth and age thirty-six (36) months.
- Completion of covered services shall not exceed twelve (12) months from the provider’s contract termination date.
- Performance of a surgery or other procedure that HPSM had authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the provider’s contract termination date.

Continuity of care will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions, including reimbursement rates, of his or her agreement with HPSM prior to termination.

If the provider does not agree with these contractual terms and conditions and reimbursement rates, we are not required to continue the provider’s services beyond the contract termination date.

Please contact Member Services at 1-800-750-4776 or 650-616-2133 to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement. If your request is approved, you will be financially responsible only for applicable co-payments under this plan.

A Member Services Representative will notify you of HPSM’s decision. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see HPSM’s Grievance and Appeals Process on page 85.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 1-888-HMO-2219; or at the TDD number for the hearing impaired, 1-877-688-9891; or online at www.hmohelp.ca.gov.

**Prior Authorization for Services**

Your primary care provider will coordinate your health care needs and, when necessary, will arrange specialty services for you. In some cases, HPSM must authorize the specialty services before you receive the services. Your primary care provider will obtain the necessary referrals and authorizations for you. Some specialty services, such as OB/GYN services, do not require prior authorization before you receive the services.
If you see a specialist or receive specialty services before you receive the required authorization, you may be responsible to pay for the cost of the treatment. If HPSM denies a request for specialty services, HPSM will send you a letter explaining the reason for the denial and how you can appeal the decision if you do not agree with the denial.

**Referrals to Specialty Physicians**
Your primary care provider may decide to refer you to a physician who is a specialist to receive care for a specific medical condition. A written referral authorized by HPSM is currently not required if the service is provided by an HPSM contracted provider. In consultation with you, your primary care provider will choose a participating specialist physician, participating hospital, or other participating provider from whom you may receive services. For a list of specialists, call Member Services at **1-800-750-4776** or **650-616-2133**. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY **1-800-735-2929** or dial **7-1-1**.

In the event that there is no participating provider available to perform the needed service, your primary care provider will refer you to a non-participating provider for the services, after obtaining authorization from HPSM.

**Standing Referrals to Non-HPSM Providers**
If you have a condition or disease that requires specialized medical care over a prolonged period of time, you may need a standing referral to a specialist in order receive continuing specialized care. If you receive a standing referral to a specialist, you will not need to get authorization every time you see that specialist. Additionally, if your condition or disease is life threatening, degenerative, or disabling, you may need to receive a standing referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate your health care. To get a standing referral, call your primary care provider. If you have any difficulty getting a standing referral, call Member Services at **1-800-750-4776** or **650-616-2133**. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY **1-800-735-2929** or dial **7-1-1**. If, after calling the Plan, you feel your needs have not been met, please refer to HPSM’s Grievance and Appeals Process on page 85.

If you see a specialist or receive specialty services before you receive the required referral, you may be responsible to pay for the cost of the treatment. If HPSM denies a request for specialty services, HPSM will send you a letter explaining the reason for the denial and how you can appeal the decision if you do not agree with the denial.

This is a summary of HPSM’s specialist referral policy. To obtain a copy of our policy, please contact us at **1-800-750-4776** or **650-616-2133** and ask to speak to a Member Services Representative.

At some time in the future, HPSM may change its policy on whether or not HPSM approval is needed for PCP referrals to see specialists. If we do, we will give you advance notice of the effective date of any change to the referral process. After the effective date of the change, you may be required to have HPSM approve a written referral from your PCP before you can see a specialist. If you do not have an approved written referral before you obtain services, you may have to pay for these services yourself.

**Obtaining a Second Opinion**
Sometimes you may have questions about your illness or your primary care provider’s recommended treatment plan. You may want to get a second opinion. You may request a second opinion for any reason, including the following:

- You question the reasonableness or necessity of a recommended surgical procedure.
- You have questions about a diagnosis or a treatment plan for a chronic condition or a condition that could cause loss of life, loss of limb, loss of bodily function, or substantial impairment.
• Your provider’s advice is not clear, or it is complex and confusing.
• Your provider is unable to diagnose the condition or the diagnosis is in doubt due to conflicting test results.
• The treatment plan in progress has not improved your medical condition within an appropriate period of time.
• You have attempted to follow the treatment plan or consulted with your initial provider regarding your concerns about the diagnosis or the treatment plan.

You should speak to your primary care provider if you want a second opinion.

If your request to obtain a second opinion about care, you will receive a second opinion from an appropriately qualified health care professional of your choice from any appropriate doctor in HPSM’s network. If there is no appropriately qualified health care professional within HPSM’s network, HPSM will authorize a second opinion from an appropriately qualified non-participating health care professional. In this case, a written referral authorized by HPSM is required. You will be responsible for paying all co-payments for the second opinion.

If your request to obtain a second opinion is denied and you would like to appeal our decision, please refer to HPSM’s Grievance and Appeals Process on page 85.

This is a summary of HPSM’s policy regarding second opinions. To obtain a copy of our policy, please contact us at 1-800-750-4776 or 650-616-2850.

Utilization Review

Treatment Authorization Request (TAR)
Some medical services and some medications need prior authorization from HPSM. Prior authorization means HPSM and your doctor agree that the services that are needed are medically necessary for your treatment. To receive these services, your doctor will send a form called a Treatment Authorization Request (TAR) to HPSM. This is a request for a service/treatment that needs prior authorization from HPSM. When HPSM receives the TAR, it is reviewed by our medical staff (doctor, nurse, and pharmacy staff) for approval. When we review the TARs we use current clinical guidelines that meet state and national standards to help make the decision.

Most TARs are approved but in some cases they may be denied or deferred. When a TAR is denied, that means it has not been approved for the service/treatment that your doctor requested. If your TAR is not approved, you and your doctor will get a letter explaining why it was denied. The letter will also explain your right to appeal the decision and how to appeal the decision.

If a TAR is deferred, that means we need more information from your doctor in order to decide if the service/treatment your doctor is requesting can be approved. You will receive a notice of action letter, if a TAR is deferred to let you know that we have requested additional information from the provider in order to approve the TAR. If we do not receive the requested information from the provider within 30 calendar days, we will send a final reminder letter to the provider again requesting the additional information. If after 10 more business days, we still do not receive the requested information, we will deny the TAR for administrative reasons.

We respond to all TARs sent to HPSM within five (5) working days. If a TAR is urgent we will respond to it within 72 hours. Requested services are reviewed for medical necessity, level of care, appropriateness of site and length of time (e.g., for a hospitalization). Criteria and guidelines used to review TARs are developed with input from practicing health care providers and national guidelines and are consistent with sound clinical principles and processes. Criteria and guidelines are evaluated at least annually and updated as necessary. HPSM can provide you with guidelines or criteria used
for a TAR decision. Please remember that these are specific to the treatment or service requested, the benefits covered under the Healthy Kids HMO Program and individual need. HPSM's policies and procedures for making TAR decisions are available upon request.

**Services That Do Not Need Prior Authorization**

Some services do not require prior authorization or a referral from your primary care provider (main doctor). You may go straight to the health care provider for the services listed below. Some of these services are limited. Please see the benefits section for more information.

1. Emergency and out of area urgent services.
2. Primary and Preventive Care Services—to your primary care provider (main doctor)PCP, who must be an HPSM provider.
3. Family Planning/STD and Private HIV/AIDS Testing:
   These are services that relate to the prevention, care or planning of pregnancy, including birth control, emergency birth control services, pregnancy tests, prenatal care, abortion, and abortion-related procedures. This also includes the screening, prevention, testing, diagnosis, and care of sexually transmitted infections (STIs), sexually transmitted diseases (STDs), and HIV/AIDS. This also includes services for the diagnosis and care of sexual assault or rape, as well as the collection of medical proof for the sexual assault or rape. You can get these services from your primary care provider (main doctor), a participating family planning office, OB/GYN, or any trained provider who provides these services. See page 20 for more information.

   Family Planning services are provided to Members of child bearing age to help you decide when you want to have children. They will also help you if you want to protect yourself from having children until you are ready. These services include all methods of birth control approved by the Federal Food and Drug Administration. HPSM’s Member Services staff can help you find a family planning clinic, or you can call the California Office of Family Planning’s Information & Referral Service toll-free number at 1-800-942-1054.

4. Women’s Services:
   Female Members have unlimited, direct access to OB/GYN services. Members may choose to have these services provided by their primary care provider (main doctor) or Members may self-refer to any OB/GYN or primary care provider within HPSM’s network for these services.

5. Acupuncture and Chiropractic services are provided as a self-referral benefit up to a maximum of twenty (20) visits each per benefit year. Treatment authorization is needed for children under 16 years of age. Be sure that the provider that you choose for non-emergency services is an HPSM network provider. If not, you could be responsible for the bill. There are some exceptions. Call Member Services if you have any questions.

6. Indian Health Services:
   If you are an American Indian or Alaskan Native and a Member of HPSM, as provided under federal law, you may choose any available Indian Health Service Provider. The provider does not have to be an HPSM network provider and HPSM will make arrangements to arrange services for you.
This page intentionally left blank.

Esta página ha sido dejada en blanco intencionalmente.

此頁有意留為空白。

Ang pahinang ito ay sadyang iniwan na blangko.
Section 4
Getting Pharmacy Benefits

Prescriptions
One of your benefits as an HPSM Member is getting prescription medications you need as a part of your medical care. You may go to any of the pharmacies in the HPSM Provider List to get your prescription medicine. When you get a prescription filled, show your HPSM ID Card to the pharmacist. Your prescription may be written by your PCP, your Specialist, or other doctor or dentist.

Refills
If you take medications on a regular basis, never wait until your medication is gone before getting a refill. Some medications may need a new prescription from your doctor before it can be refilled. Do not go to the emergency room to refill your medication.

Over-The-Counter/Non-Prescription Drugs
Some over-the-counter medications may be covered by HPSM if you have a doctor’s prescription and they are medically necessary. Remember to talk with your doctor about any over-the-counter drugs you may be using.

The Health Plan of San Mateo Drug Formulary
HPSM has a list of medications that are covered by your pharmacy benefit. This list is called a drug Formulary. Medications are added to the Formulary by HPSM’s Pharmacy Review Committee. This committee has pharmacists and doctors who decide what medications are included on the Formulary. If you would like to know which medications are on the formulary visit our website at www.hpsm.org or call a Member Services Representative at 1-800-750-4776 or 650-616-2133 for a copy.

The HPSM Formulary lists all covered medication by either the generic name or brand name (if one exists). Please note that the presence of a medication on HPSM’s Formulary does not guarantee that you will be prescribed the medication by your PCP or a Specialist.

Generic Equivalent Drugs
HPSM’s pharmacy benefit covers generic medications when they are available instead of brand name medications. Generics work the same as the brand name medication. Generic medications are approved by the Federal Drug Administration in the same way as the brand name medication. The HPSM Formulary lists available generic medications that are covered by HPSM.

Brand Name Medications Requested by Your Doctor
If your doctor believes a brand name medication must be provided, he or she may write “Dispense as Written” (DAW) or “Do Not Substitute” on the prescription. The pharmacist will then contact HPSM to see if a Prior Authorization Form (PA) is required. If an PA is required, the pharmacist will submit a request by fax to HPSM’s Pharmacy Services at 650-829-2045.

Brand Name Medications Requested by the Member
If you prefer a brand name medication, there must be a medical reason for using it rather than the generic medication which would normally be covered. The pharmacist must contact the doctor to determine if there is medical necessity for using the brand name drug. After receiving more information from the doctor, the pharmacist will submit an MRF to HPSM asking for approval of the brand name medication. A brand name drug will also be prescribed if there is no generic medication available or if a medication has a narrow therapeutic index. In the latter case, although a generic
medication may be available, you will be provided the brand name medication as written by the provider. A narrow therapeutic index means that very small changes in the dosage level of the drug could cause toxic results. To receive a list of medications that are called “Narrow Therapeutic Index” medications, you can contact Member Services at 1-800-750-4776 or 650-616-2133. Members with hearing and speech impairments can use the California Relay Service (CRS) at TTY 1-800-735-2929 or dial 7-1-1.

**Non-Formulary Drugs**
HPSM’s participating doctors and pharmacies are responsible for using the Formulary. If a drug is prescribed that is not on the Formulary, the pharmacist will call the doctor to request a change to a Formulary medication. If the substitution of a Formulary medication is not approved by the requesting doctor, the pharmacist or doctor must submit an MRF form to HPSM for the Non-Formulary medication with medical justification. The pharmacist or doctor may phone or fax an MRF to HPSM. If the MRF is approved based on criteria developed by HPSM staff pharmacists and Medical Director, then the Non-Formulary medication will be dispensed as written.

The average time to process a request for a Non-Formulary medication MRF is one (1) working day. More time may be needed to process the request if the MRF is incomplete or more information is needed from your doctor. If you have any questions about a request for a Non-Formulary medication, please talk to your doctor.

**Availability of Drugs for Off-Label Usage**
All medications covered by your HPSM Pharmacy benefit must be approved by the U.S. Food and Drug Administration (FDA). The FDA decides how the medication can be used. A drug company must prove to the FDA that the medication is safe and effective in treating specific conditions, and the conditions must be clearly listed on the medication label.

However, there may be a need for you to use a medication for a condition that is not on the medication label. This is called off-label usage. HPMS allows doctors to prescribe medication for off-label use if you have a life threatening condition, or if you have a condition that is chronic and likely to cause serious long-term problems. The medication can only be used when there is enough information to support using the medication for the off-label condition. In addition, medication prescribed for off-label use may require an MRF for reimbursement.

If you have any questions about being treated with an off-label drug, please talk to your doctor.

**Evening, Weekend or Holiday Prior Authorization Submissions**
HPSM reviews MRF’s on business days only. In urgent situations that arise on weekends or holidays, while waiting for a review decision, members may be given up to a three-day supply of medication to allow time for the pharmacy to receive HPMS’s decision on the next business day. The pharmacist can call the pharmacy call center at HPSM’s pharmacy benefits manager (PBM), Argus, at 1-888-635-8362, for an emergency override. A one-time fill may be authorized.

**Changes in Formulary Medications**
If you are taking a medication and HPSM drops the medication from its Formulary, and your doctor chooses to continue to prescribe the medication, HPMS will provide coverage for the medication for up to 90 days. An approved MRF will be required for continued use of non-formulary drugs beyond 90 days.

**Deferred, Modified or Denied MRF’s**
If your request for a medication is deferred, modified, or denied, a “Notice of Action” letter will be sent to you. The Notice of Action letter will explain the reason it was deferred, modified, or denied and provide information on how you may file an appeal with HPMS about the decision.
Section 5
Urgent and Emergency Care

Getting Urgent Care
Urgent care services are services needed to prevent serious deterioration of your health resulting from an unforeseen illness, an injury, prolonged pain, or a complication of an existing condition, including pregnancy, for which treatment cannot be delayed. HPSM covers urgent care services any time you are outside our service area or on nights and weekends when you are inside our service area. To be covered, the urgent care service must be needed because the illness or injury will become much more serious if you wait for a regular doctor’s appointment. On your first visit, talk to your primary care provider about what he or she wants you to do when the office is closed and you feel urgent care may be needed.

To obtain urgent care when you are inside HPSM’s service area on nights and weekends, if you have an urgent medical problem, call your Primary Care Physician’s office even during the hours that your PCP’s office is normally closed. Your PCP or a doctor on call will always be available to tell you how to handle the problem at home or if you should go to an urgent care center or a hospital emergency room.

Problems that may be urgent but not medical emergencies are problems that can usually wait for treatment without getting worse such as:

- An earache
- A mild cough or cold
- A small cut or scrape
- Mild fever or rash
- Mild diarrhea
- A sprain or strain
- Throwing up (once or twice)
- Medicine refill

To obtain urgent care when you are outside HPSM’s service area, try to call your PCP. If you cannot reach your PCP, go to the nearest medical facility. Always show your HPSM ID card when seeking medical care.

Emergency Health Care Services
An emergency is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of a sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the Member’s health in serious jeopardy, or
- Causing serious impairment to the Member’s bodily functions, or
- Causing serious dysfunction of any of the Member’s bodily organs or parts.

Examples include:
- Broken bones
- Chest pain
- Severe burns
○ Fainting
○ Drug overdose
○ Paralysis
○ Severe cuts that won’t stop bleeding
○ Psychiatric emergency conditions

If you have a medical emergency, call 9-1-1 or go to the nearest emergency room. Emergency services are covered inside and outside of HPSM’s service area and in and out of HPSM’s participating facilities. When you have a Medical Emergency, call 9-1-1 or go to the closest emergency room for help. You do not have to go to the hospital where your PCP works if you have a Medical Emergency.

Please note: If you also receive restricted benefits under Medi-Cal (i.e. for emergency and/or pregnancy-related services only) and do not have a share of cost, your emergency and/or pregnancy-related services will be covered by State Medi-Cal, not by Healthy Kids HMO. Your provider will need to bill State Medi-Cal for these services. For more information, please contact a Health Plan of San Mateo Member Services Representative at 1-800-750-4776 or 650-616-2133.

What to Do If You Are Not Sure If You Have an Emergency
If you are not sure whether you have an emergency or require urgent care, contact your PCP for advice.

Post Stabilization and Follow-up Care After an Emergency
Once your child’s emergency medical condition has been treated at a hospital and an emergency no longer exists because your child’s condition is stabilized, the doctor who is treating your child may want your child to stay in the hospital for a while longer before your child can safely leave the hospital. The services your child receives after an emergency condition is stabilized are called “post-stabilization services.”

If the hospital where your child received emergency services is not part of HPSM’s contracted network (non-contracted hospital), the non-contracted hospital will contact HPSM to get approval for your child to stay in the non-contracted hospital.

If HPSM approves your child’s continued stay in the non-contracted hospital, you will not have to pay for services except for any co-payments normally required by HPSM.

If HPSM has notified the non-contracting hospital that your child can safely be moved to one of the plan’s contracted hospitals, HPSM will arrange and pay for your child to be moved from the non-contracted hospital to a contracted hospital.

If HPSM determines that your child can be safely transferred to a contracted hospital, and you or your spouse or legal guardian do not agree to your child being transferred, the non-contracted hospital must give you or your spouse or legal guardian a written notice stating that you will have to pay for all of the cost for post-stabilization services provided to your child at the non-contracted hospital after your child’s emergency condition is stabilized.

Also, you may have to pay for services if the non-contracted hospital cannot find out what your name is and cannot get contact information at the plan to ask for approval to provide services once your child(ren) are stable.

If you feel that you were improperly billed for post-stabilization services that your child received from a non-contracted hospital, please contact HPSM Member Services at:
Non-Covered Services
HPSM does not cover medical services that are received in an emergency or urgent care setting for conditions that are not emergencies or urgent if you reasonably should have known that an emergency or urgent care situation did not exist. You may be responsible for all charges related to these services.
This page intentionally left blank.

Esta página ha sido dejada en blanco intencionalmente.

此頁有意留為空白。

Ang pahinang ito ay sadyang iniwan na blangko.
Section 6
Member Financial Responsibilities
Quarterly Family Contributions

Quarterly Family Contributions
The quarterly Family Contribution is set by the Children’s Health Initiative (CHI) Coalition and determined by family size and income. Co-payment responsibilities are set for Healthy Kids HMO by the CHI Coalition. Under Healthy Kids HMO, you pay a quarterly Family Contribution per child depending on family income and the Federal Poverty Guidelines. If an applicant chooses to pay nine (9) months of Family Contribution at the time of enrollment or redetermination, this will result in a free 10th, 11th, and 12th month.

The amount you need to pay for your quarterly family contribution depends on the Income Category you fall into. If you do not know what Income Category you are in, please call HPSM to find out if you are in Category A, B, C, D or E. The quarterly payments per child are listed below:

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category A</td>
<td>$0</td>
</tr>
<tr>
<td>Category B</td>
<td>$12</td>
</tr>
<tr>
<td>Category C</td>
<td>$39</td>
</tr>
<tr>
<td>Category D</td>
<td>$63</td>
</tr>
<tr>
<td>Category E</td>
<td>$150</td>
</tr>
</tbody>
</table>

HPSM will mail you a bill for quarterly payments. Payments must be sent to:

Healthy Kids HMO Finance
Health Plan of San Mateo
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

Use one of the following methods to pay:
- Personal check
- Money order
- Cashier’s check

The CHI Coalition will not increase the amount of the Family Contribution unless the Applicant is given thirty (30) days’ written notice sent by postage prepaid, regular U.S. mail to the Applicant’s most current address of record with HPSM. If you experience hardship paying your family contribution, contact the Health Coverage Unit at 650-616-2002.

Co-payments
You will be required to pay a small amount of money for some services. This is called a co-payment.

If you are in Income Category A, B, C or D, the maximum amount of money you are required to pay out in one benefit year per household is $250.

If you are in Income Category E, the maximum amount of money you are required to pay out in one benefit year per household is $1,000.
All co-payments paid for Healthy Kids HMO Members in your household apply to the annual maximum. If you do not know which Income Category you fall into, please call HPSM to find out. Make sure that you keep all receipts from your doctors’ visits and prescriptions for all family Members enrolled in the Healthy Kids HMO Program. HPSM will send you a letter to inform you when your family has paid the maximum amount for that year. Please take this letter with you to all appointments so that you won’t be asked to pay any more co-payments.

No co-payment will be charged for routine examinations and preventive care. Additionally, no co-payment will be charged to Members who are 24 months of age and younger for well baby care, health examinations and office visits. There are no co-payments for Members who are determined to be American Indians or Alaskan Natives.

HPSM is also working with our Providers to help you if you cannot pay all your co-payments. If you have to pay more than $25 in co-payments in one month, many Providers will allow you to make the payment within 30 or 60 days rather than at the time of the appointment. If paying the co-payments becomes a problem for you, please talk with your doctor or other Provider.

**Member Liabilities**
Generally, the only amount a member pays for covered services is the required co-payment.

You may have to pay for services you receive that are NOT covered services, such as:
- non-emergency services received in the emergency room;
- non-emergency or non-urgent services received outside of HPSM’s service area if you did not get authorization from HPSM before receiving such services;
- specialty services you receive if you did not get a required referral or authorization from HPSM before receiving such services (see page 18 and 19, Prior Authorization for Services);
- services from a non-participating provider, unless the services are for situations allowed in this Evidence of Coverage booklet (for example, emergency services, urgent services outside of the plan’s service area, or specialty services approved by the plan (see page 18 and 19, Standing Referrals to Non-HPSM Providers); or
- services you received that are greater than the limits described in this Evidence of Coverage booklet unless authorized by HPSM.

HPSM is responsible to pay for all covered services including emergency services. You are not responsible to pay a provider for any amount owed by the health plan for any covered service.

If HPSM does not pay a non-participating provider for covered services, you do not have to pay the non-participating provider for the cost of the covered services. Covered services are those services that are provided according to this Evidence of Coverage booklet. The non-participating provider must bill HPSM, not you, for any covered service. But remember, services from a non-participating provider are not “covered services” unless they fall within the situations allowed by this Evidence of Coverage booklet.

If you receive a bill for a covered service from any provider or from an out-of-network provider at an in-hospital or in-network facility that was authorized by HPSM, whether participating or non-participating, contact the HSPM Member Services department at **1-800-750-4776** or **650-616-2133**.
### Health Plan Covered Benefits Matrix

This Matrix is intended to be used to help you compare covered benefits and is a summary only. The Detailed Benefit Descriptions Section should be consulted for a detailed description of covered benefits and limitations. Members in all income categories will pay the co-payments specified below. You may call HPSM to find out whether you fall into Category A, B, C, D, or E.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Services</th>
<th>Categories A &amp; B: Cost to Member (Co-payment)</th>
<th>Categories C &amp; D: Cost to Member (Co-payment)</th>
<th>Category E: Cost to Member (Co-payment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services</td>
<td>Room and board, nursing care, and all medically necessary ancillary services.</td>
<td>No-copayment</td>
<td>No-copayment</td>
<td>$200 per visit</td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td>Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility.</td>
<td>No co-payment except • $5 per visit for physical, occupational and speech therapy performed on an outpatient basis. • $5 per visit for emergency health care services (waived if the member is hospitalized)</td>
<td>No co-payment except • $10 per visit for physical, occupational and speech therapy performed on an outpatient basis. • $15 per visit for emergency health care services (waived if the member is hospitalized)</td>
<td>No co-payment except • $15 per visit for physical, occupational and speech therapy performed on an outpatient basis. • $40 per visit for urgent care services and $75 per visit for emergency health care services (waived if the member is hospitalized)</td>
</tr>
<tr>
<td>Primary Care Services</td>
<td>Services and consultations by a primary care physician or other appropriately qualified health care provider.</td>
<td>$5 per office or home visit except • No co-payment for members 24 months of age and younger</td>
<td>$10 per office or home visit except • No co-payment for members 24 months of age and younger</td>
<td>$15 per office or home visit except • No co-payment for members 24 months of age and younger</td>
</tr>
<tr>
<td>Benefits</td>
<td>Services</td>
<td>Categories A &amp; B: Cost to Member (Co-payment)</td>
<td>Categories C &amp; D: Cost to Member (Co-payment)</td>
<td>Category E: Cost to Member (Co-payment)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Specialty Care Physician Services</td>
<td>Services and consultations by a physician specializing in a particular area of medical care.</td>
<td>$5 per office or home visit except • No co-payment for hospital inpatient professional services • No co-payment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments • No co-payment for members 24 months of age and younger • No co-payment for vision or hearing testing, or for hearing aids</td>
<td>$10 per office or home visit except • No co-payment for hospital inpatient professional services • No co-payment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments • No co-payment for members 24 months of age and younger • No co-payment for vision or hearing testing, or for hearing aids</td>
<td>$20 per office or home visit except • No co-payment for hospital inpatient professional services • No co-payment for anesthesia, or radiation, chemotherapy, or dialysis treatments • No co-payment for members 24 months of age and younger • No co-payment for vision or hearing testing, or for hearing aids</td>
</tr>
<tr>
<td>Preventive Health Care Services</td>
<td>Periodic health examinations, Well Baby Care, routine diagnostic testing and laboratory services, immunizations, and services for the detection of asymptomatic diseases.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Benefits</td>
<td>Services</td>
<td>Categories A &amp; B: Cost to Member (Co-payment)</td>
<td>Categories C &amp; D: Cost to Member (Co-payment)</td>
<td>Category E: Cost to Member (Co-payment)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Diagnostic, X-Ray and Laboratory Services **</td>
<td>Laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, and treat Members.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>• $15 per laboratory service</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• $25 per X-ray</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• $50 per CT Scan (Computerized Tomography)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• $150 per MRI (Magnetic Resonance Imaging)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• No co-payment for other diagnostic services</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>Surgery performed in an outpatient setting.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>$50 per surgery</td>
</tr>
<tr>
<td>Diabetic Care **</td>
<td>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.</td>
<td>$5 per office visit Co-payment for prescriptions as described in the “Prescription Drug Program” Section</td>
<td>$10 per office visit Co-payment for prescriptions as described in the “Prescription Drug Program” Section</td>
<td>$10 per office visit Co-payment for prescriptions as described in the “Prescription Drug Program” Section</td>
</tr>
<tr>
<td>Prescription Drug Program **</td>
<td>Drugs prescribed by a licensed practitioner.</td>
<td>$5 per prescription for a up to 30 day supply of generic or brand name drugs.</td>
<td>$10 per prescription for a up to 30 day supply of generic drugs.</td>
<td>10 per prescription for a up to 30 day supply of generic drugs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$5 per prescription for a up to 90 day supply of maintenance generic or brand name drugs.</td>
<td>$15 for up to 30 day supply for brand name drugs unless there is no generic equivalent or if the use of a brand name drug</td>
<td>$15 for up to 30 day supply for brand name drugs unless there is no generic equivalent or if the use of a brand name drug</td>
</tr>
<tr>
<td>Benefits</td>
<td>Services</td>
<td>Categories A &amp; B: Cost to Member (Co-payment)</td>
<td>Categories C &amp; D: Cost to Member (Co-payment)</td>
<td>Category E: Cost to Member (Co-payment)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Prescription Drug Program ** (continued) | • No co-payment for prescription drugs provided in an inpatient setting.  
• No co-payment for drugs administered in the doctor’s office or in an outpatient facility.  
• No co-payment for all FDA-approved contraceptive drugs, devices and products | • is medically necessary, then $10 co-payment applies.  
• $10 per prescription for a up to 90 day supply of maintenance generic drugs  
• $15 per prescription for up to 90 day supply of maintenance brand drugs unless there is no generic equivalent or the brand name drug is medically necessary, then $10 co-payment applies.  
• No co-payment for prescription drugs provided in an inpatient setting.  
• No co-payment for drugs administered in the doctor’s office or in an outpatient facility.  
• No co-payment for all FDA-approved contraceptive drugs, devices and products | • $10 per prescription for a up to 90 day supply of maintenance generic drugs  
• $15 per prescription for up to 90 day supply of maintenance brand drugs unless there is no generic equivalent or the brand name drug is medically necessary, then $10 co-payment applies.  
• No co-payment for prescription drugs provided in an inpatient setting.  
• No co-payment for drugs administered in the doctor’s office or in an outpatient facility.  
• No co-payment for all FDA-approved contraceptive drugs, devices and products | • is medically necessary, then $10 co-payment applies.  
• $10 per prescription for a up to 90 day supply of maintenance generic drugs  
• $15 per prescription for up to 90 day supply of maintenance brand drugs unless there is no generic equivalent or the brand name drug is medically necessary, then $10 co-payment applies.  
• No co-payment for prescription drugs provided in an inpatient setting.  
• No co-payment for drugs administered in the doctor’s office or in an outpatient facility.  
• No co-payment for all FDA-approved contraceptive drugs, devices and products |
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Services</th>
<th>Categories A &amp; B: Cost to Member (Co-payment)</th>
<th>Categories C &amp; D: Cost to Member (Co-payment)</th>
<th>Category E: Cost to Member (Co-payment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment **</td>
<td>Medical equipment appropriate for use in the home which 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.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>For items costing $100 or less, co-payment is $10. If item costs less than $10, co-payment is the cost of the item. For items costing more than $100, co-payment is $20.</td>
</tr>
<tr>
<td>Orthotics and Prosthetics **</td>
<td>Original and replacement devices as prescribed by a licensed practitioner.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Cataract Spectacles and Lenses **</td>
<td>Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>Professional and hospital services relating to maternity care.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Voluntary family planning services</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Medical Transportation Services **</td>
<td>Emergency ambulance transportation and non-emergency transportation to transfer a Member from a hospital to another hospital or facility, or facility to home.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Benefits</td>
<td>Services</td>
<td>Categories A &amp; B: Cost to Member (Co-payment)</td>
<td>Categories C &amp; D: Cost to Member (Co-payment)</td>
<td>Category E: Cost to Member (Co-payment)</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Emergency Health Care Services **</td>
<td>Emergency services are covered both in and out of the plan’s service area and in and out of the plan’s participating facilities.</td>
<td>$5 per visit (waived if the member is admitted to the hospital.)</td>
<td>$15 per visit (waived if the member is admitted to the hospital.)</td>
<td>$40 per visit if services are provided in an Urgent Care facility. (waived if the member is admitted to the hospital.) $75 per visit if services are provided in an Emergency Room. (waived if the member is admitted to the hospital.)</td>
</tr>
<tr>
<td>Inpatient Mental Health Care Services</td>
<td>Services are arranged and managed by San Mateo Behavioral and Recovery Services. The Health Plan of San Mateo provides all mental health care services through San Mateo Behavioral and Recovery Services including medically necessary services to treat severe mental illness and serious emotional disturbance. The Health Plan of San Mateo shall provide all medically necessary covered services until the San Mateo Behavioral and Recovery Services establishes eligibility for a member with serious emotional disturbance and severe mental illness and provides the medically necessary</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>$200 per hospitalization</td>
</tr>
<tr>
<td>Benefits</td>
<td>Services</td>
<td>Categories A &amp; B: Cost to Member (Co-payment)</td>
<td>Categories C &amp; D: Cost to Member (Co-payment)</td>
<td>Category E: Cost to Member (Co-payment)</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
</tbody>
</table>
| Inpatient Mental Health Care Services (continued) | services to treat the serious emotional disturbance or severe mental illness. 

The member will remain enrolled in the Healthy Kids HMO program and will continue to receive primary care, specialty care, and all other services for medical care. | $5 per visit 
The co-payment amount does not change according to the time the provider spends with the member. Per visit means each visit not how long the visit takes. | $10 per visit 
The co-payment amount does not change according to the time the provider spends with the member. Per visit means each visit not how long the visit takes. | $15 per visit 
The co-payment amount does not change according to the time the provider spends with the member. Per visit means each visit not how long the visit takes. |
| Outpatient Mental Health Care Services | Services are arranged and managed by the San Mateo Behavioral and Recovery Services. 

The Health Plan of San Mateo provides all mental health care services through San Mateo Behavioral and Recovery Services including medically necessary services to treat severe mental illness and serious emotional disturbance. The Health Plan of San Mateo shall provide all medically necessary covered services until the San Mateo Behavioral and Recovery Services establishes eligibility for a member with serious emotional disturbance or severe mental illness and provides the medically necessary services to treat the serious emotional disturbance or severe mental illness. | $5 per visit 
The co-payment amount does not change according to the time the provider spends with the member. Per visit means each visit not how long the visit takes. | $10 per visit 
The co-payment amount does not change according to the time the provider spends with the member. Per visit means each visit not how long the visit takes. | $15 per visit 
The co-payment amount does not change according to the time the provider spends with the member. Per visit means each visit not how long the visit takes. |
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Services</th>
<th>Categories A &amp; B: Cost to Member (Co-payment)</th>
<th>Categories C &amp; D: Cost to Member (Co-payment)</th>
<th>Category E: Cost to Member (Co-payment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Mental Health Care Services (continued)</td>
<td>The services include, but are not limited to, the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement. It also includes pervasive developmental disorder or autism. Family members may be involved in the treatment when medically necessary for the health and recovery of the child. Unlimited outpatient days.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Alcohol/ Drug Abuse Treatment</td>
<td>Hospitalization to remove toxic substances from the system. Unlimited inpatient days.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>$200 per hospitalization</td>
</tr>
<tr>
<td>Outpatient Alcohol/ Drug Abuse Treatment</td>
<td>Crisis intervention and treatment of alcoholism or drug abuse. Unlimited outpatient days.</td>
<td>$5 per visit</td>
<td>$10 per visit</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Benefits</td>
<td>Services</td>
<td>Categories A &amp; B: Cost to Member (Co-payment)</td>
<td>Categories C &amp; D: Cost to Member (Co-payment)</td>
<td>Category E: Cost to Member (Co-payment)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>Services provided at the home by health care personnel.</td>
<td>No co-payment, except $5 per visit for physical, occupational, and speech therapy</td>
<td>No co-payment, except $10 per visit for physical, occupational, and speech therapy</td>
<td>No co-payment, except $15 per visit for physical, occupational, and speech therapy</td>
</tr>
<tr>
<td>Skilled Nursing Care</td>
<td>Services provided in a licensed skilled nursing facility.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td></td>
<td>Benefit is limited to a maximum of 100 days per benefit year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational, and Speech Therapy**</td>
<td>Therapy may be provided in a medical office or other appropriate outpatient setting.</td>
<td>$5 per visit when performed in an outpatient setting</td>
<td>$10 per visit when performed in an outpatient setting</td>
<td>$15 per visit when performed in an outpatient setting</td>
</tr>
<tr>
<td></td>
<td>No co-payment for inpatient therapy</td>
<td>No co-payment for inpatient therapy</td>
<td>No co-payment for inpatient therapy</td>
<td>No co-payment for inpatient therapy</td>
</tr>
<tr>
<td>Acupuncture &amp; Chiropractic Services</td>
<td>Does not require referral from the member’s provider but services must be obtained from a plan provider.</td>
<td>$5 per visit</td>
<td>$10 per visit</td>
<td>$15 per visit</td>
</tr>
<tr>
<td></td>
<td>Services for children under 16 years require approval of a treatment authorization request.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefit is limited to 20 visits per benefit year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood and Blood Products **</td>
<td>Includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Benefits</td>
<td>Services</td>
<td>Categories A &amp; B: Cost to Member (Co-payment)</td>
<td>Categories C &amp; D: Cost to Member (Co-payment)</td>
<td>Category E: Cost to Member (Co-payment)</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Health Education</td>
<td>Includes education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Hospice</td>
<td>For members who are diagnosed with a terminal illness and who elect hospice care instead of traditional health care services.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Organ Transplants **</td>
<td>Coverage for organ transplants and bone marrow transplants which are not experimental or investigational.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>$200 per hospitalization</td>
</tr>
<tr>
<td>Reconstructive Surgery **</td>
<td>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.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>$200 per hospitalization</td>
</tr>
<tr>
<td>Phenylketonuria (PKU)</td>
<td>Testing and treatment of PKU, including those prescribed formulas and special food products that are part of a diet that is deemed medically necessary.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Clinical Cancer Trials</td>
<td>For Members participating in a clinical cancer trial, phase I through IV, when participation is recommended by the Member's physician and the Member meets certain criteria.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
</tbody>
</table>
Benefits Services Categories A & B: Cost to Member (Co-payment) Categories C & D: Cost to Member (Co-payment) Category E: Cost to Member (Co-payment)

California Children’s Services Program (CCS) CCS is a California medical program that treats children who have certain physically handicapping conditions and who need specialized medical care. Services provided through the CCS Program are coordinated by the county CCS office.

If the member’s condition is determined to be eligible for CCS services, the member remains enrolled in the Healthy Kids HMO Program and continues to receive medical care from plan providers for services not related to the CCS eligible condition. The member will receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers.

No co-payment No co-payment No co-payment

**Deductibles**
No deductibles will be charged for covered benefits.

**Lifetime Maximums**
No lifetime maximum limits on benefits apply under this plan.

* Benefits are provided only for services which are medically necessary.

** These services may be covered and paid for by the California Children’s Services (CCS) program, if the Member is found to be eligible for CCS services.
Inpatient Hospital Services

Cost to Member

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost to Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>E</td>
<td>$200 per visit</td>
</tr>
</tbody>
</table>

Description
General hospital services received in a room of two or more individuals containing customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. Benefit includes all medically necessary ancillary services, including, but not limited to:

- Use of operating room and related facilities
- Intensive care unit and services
- Drugs, medications, and biologicals
- Anesthesia and oxygen
- Diagnostic, laboratory, and x-ray services
- Special duty nursing
- Physical, occupational, and speech therapy
- Respiratory therapy
- Administration of blood and blood products
- Other diagnostic, therapeutic, and rehabilitative services
- Coordinated discharge planning, including the planning of such continuing care as may be necessary

Includes coverage for general anesthesia and associated facility charges in connection with dental procedures, when hospitalization is necessary because of an underlying medical condition or clinical status, or because of the severity of the dental procedure. This benefit is only available to Members under seven (7) years of age; the developmentally disabled, regardless of age; and Members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. HPSM will coordinate the services with the Member’s dental plan.

Exclusions
Personal or comfort items or a private room in a hospital are excluded unless medically necessary. Services of dentists or oral surgeons are excluded for dental procedures.

Outpatient Hospital Services

Cost to Member
No co-payment, except:

Physical, occupational and speech therapy performed on an outpatient basis:

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost to Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>E</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>
**Emergency health care services:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Fee Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Category E</td>
<td>$40 per visit for services provided in an Urgent Care setting, $75 per visit for services provided in an Emergency Room</td>
</tr>
</tbody>
</table>

For all categories, the co-payment for emergency services is waived if the Member is hospitalized. The co-payment amount does not change according to the time the provider spends with the member. Per visit means each visit and not how long the visit takes.

**Please note:** If you also receive restricted benefits under Medi-Cal (i.e. emergency or pregnancy-related services only) and do not have a share of cost, your emergency and/or pregnancy-related services will be covered by State Medi-Cal, not by Healthy Kids HMO. Your provider will need to bill State Medi-Cal for these services. For more information, please contact a Health Plan of San Mateo Member Services Representative at 1-800-750-4776 or 650-616-2133.

**Description**
Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility including:
- Physical, speech, and occupational therapy as appropriate
- Hospital services which can reasonably be provided on an ambulatory basis
- Related services and supplies in connection with outpatient services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the Member’s stay at the facility

General anesthesia and associated facility charges and outpatient services in connection with dental procedures when the use of a hospital or surgery center is required because of an underlying medical condition or clinical status, or because of the severity of the dental procedure. This benefit is only available to Members under seven (7) years of age; the developmentally disabled, regardless of age; and Members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. HPSM will coordinate the services with the Member’s participating dental plan.

**Exclusions**
Services of dentists or oral surgeons are excluded for dental procedures.

**Primary Care Services**

**Cost to Member**

<table>
<thead>
<tr>
<th>Category</th>
<th>Fee Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Category E</td>
<td>$15 per visit $50 per surgery</td>
</tr>
</tbody>
</table>

**Except:**
- No co-payment for Members 24 months of age or younger

**Description**
Medically necessary professional services and consultations by a primary care physician or other licensed or unlicensed health care provider acting within the scope of his or her license or other qualification. Primary care services include:
- Office visits to a primary care provider other than an annual check-up.
- Home visits by a primary care provider when medically necessary.
**Specialty Care Physician Services**

**Cost to Member**

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost per Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Category E</td>
<td>$20 per visit</td>
</tr>
</tbody>
</table>

**Description**

Medically necessary professional services and consultations by a physician or other licensed health care provider specializing in a field of medicine. The provider must be acting within the scope of his or her license or other qualification. Specialty care services include:

- Professional office visits to a physician or other health care provider specializing in a field of medicine. This includes visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment.
- Home visits when medically necessary
- Surgery, assistant surgery, and anesthesia (inpatient or outpatient)
- Inpatient hospital and skilled nursing facility visits
- Eye examinations including eye refractions to determine the need for corrective lenses and dilated retinal eye exams
- Hearing tests, hearing aids and related services including 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
- Hearing aid(s): Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. There is no charge for visits for fitting, counseling, adjustments, repairs, etc., for a one-year period following receipt of a covered hearing aid.
- Treatment for pervasive developmental disorder or autism according to a treatment plan prescribed by a qualified autism service provider.

**Exclusions**

Purchase of batteries or other ancillary equipment for hearing aids, except those covered under the initial hearing aid purchase, and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss

- Replacement parts for hearing aids or repair of hearing aid after the covered one-year warranty period
- Replacement of a hearing aid more than once in any period of thirty-six months
- Surgically implanted hearing devices

**Preventive Health Services**

**Cost to Member**

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost / No co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Category E</td>
<td>No co-payment</td>
</tr>
</tbody>
</table>

**Description**

Periodic health examinations, including annual child and adolescent examinations and all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics; and age appropriate immunizations, including immunizations required for travel,
consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, as adopted by the Advisory Committee on Immunization Practices.

Preventive services also include services for the detection of asymptomatic diseases, including, but not limited to:

- Well-baby care during the first two (2) years of life, including newborn hospital visits, health examinations, and other office visits
- A variety of voluntary family planning services
- Contraceptive services
- Prenatal care
- Vision and hearing testing
- Sexually transmitted disease (STD) testing
- Human Immunodeficiency Virus (HIV) testing
- Cytology examinations on a reasonable periodic basis
- Yearly exams (pelvic exam, Pap smear, and breast exam) and any other gynecological service from your primary care provider or an OB/GYN provider in our plan (primary care provider approval not required).
- Medically accepted cancer screening tests including, but not limited to breast, prostate, and cervical cancer screening
- Health education services, including education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services affiliated with the plan

Limitations
The frequency of periodic health examinations will not be increased for reasons which are unrelated to the Member’s medical needs, including a Member’s desire for additional physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

Immunizations are available to protect your child from the dangerous diseases listed below:

- Chickenpox (also called Varicella) is a common childhood disease. It is usually mild, but it can be serious, especially in young infants and adults. Getting a chickenpox vaccine is much safer than getting the chickenpox disease. The chickenpox virus can be spread from person to person through the air, or by contact with fluid from chickenpox blisters. It causes a rash, itching, fever, and tiredness. It can lead to severe skin infections, scars, pneumonia, brain damage, or death. A person who has had chickenpox can get a painful rash called shingles (also called herpes zoster) years later.
- Diphtheria is a disease caused by bacteria. The disease causes a thick covering in the back of the throat. It can lead to breathing problems, paralysis, heart failure, and even death. The bacteria can spread from person to person through close contact.
- Haemophilus influenzae type b (HIB) disease is a serious disease caused by bacteria. The disease is a leading cause of serious illness in children under 5 years old. It can lead to meningitis, pneumonia, and a severe throat infection that can cause choking. It can spread from person to person through close contact.
- Hepatitis A is a virus that causes jaundice, tiredness, stomach pain, loss of appetite, vomiting, diarrhea, and fever. Hepatitis A is spread from person to person by putting something in the mouth that has been contaminated with the stool of a person infected with Hepatitis A.
- Hepatitis B is a serious disease caused by a virus that attacks the liver. The virus which is called hepatitis B virus (HBV), can cause lifelong infection, scarring of the liver, liver cancer, liver failure and death. The disease can cause jaundice (yellow skin or eyes), vomiting, loss of appetite, joint
pain, tiredness and stomach pain. The virus can be spread through blood or body fluids from someone who has the disease. Everyone under 18 years of age should get the vaccine to prevent the disease.

- Influenza (Flu) is caused by a virus that spreads from infected persons to the nose or throat of others. Influenza can cause fever, sore throat, chills, cough, headache, and muscle aches. Many get much sicker and may need to be hospitalized. The Influenza (flu) vaccine is recommended once a year for children 6 months or older with high risk conditions such as heart conditions, asthma, diabetes, and others. It is also encouraged for healthy children between 6-23 months of age and their caregivers to get a “flu shot” once a year and may be indicated for older children. Please talk to your doctor about the need for your child to get a flu shot.

- Measles virus causes fever, rash, cough, runny nose and watery eyes. It can also cause ear infections and pneumonia. Measles can also lead to more serious problems, such as brain damage, seizures and even death. The virus can be spread from person to person through the air.

- Meningitis is a serious infection of the fluid around the brain that can lead to serious disabilities or death. The meningitis vaccine helps prevent this infection in 90% of the people who get the shot. Because this disease is especially common in teenagers and young adults, it is now recommended that children ages 11 to 12 receive the vaccine at their usual check-up, and any teens who have never received it should also get the vaccine at their next check-up.

- Mumps virus causes fever, headache, and swollen glands. It can lead to deafness, meningitis, painful swelling of the testicles or ovaries, and rarely, death. The virus can spread from person to person through the air.

- Pertussis (Whooping Cough) causes coughing spells so bad that it is hard for infants to eat, drink or breathe. These severe coughs can last for weeks. It can lead to pneumonia, seizures (jerking and staring spells), brain damage and death. The bacteria can spread from person to person.

- Pneumococcal infection causes severe disease in children under five years old including meningitis, blood infections, and ear infections. It can lead to other health problems including pneumonia, deafness, and brain damage. Children under two years old are at highest risk for serious disease. The bacteria are spread from person to person through close contact. Infection with the bacteria that causes this infection can lead to serious illness and death. It is the leading cause of bacterial Meningitis in children. Meningitis is an infection of the brain and spinal cord covering.

- Pneumonia is an infection of the lungs, causing problems breathing. The germ that most commonly causes pneumonia in children also causes ear infections, blood infections and other illnesses. Children under age two are especially at risk. The pneumonia vaccine helps prevent these serious problems. That is why children should get this vaccine. It is recommended at the baby’s two month, four month and six month check-ups, and then at the 12-15 month visit. If older children have never had the vaccine, they can also get this to help prevent this disease.

- Polio is a disease caused by a virus. It enters the body through the mouth. It can cause paralysis (can’t move arm or leg). It can kill people who get it by paralyzing the muscles that help them breathe.

- Rubella (German Measles) virus causes rash, mild fever, and swelling of the glands in the neck. Rubella can also cause brain swelling or a problem with bleeding. If a pregnant woman gets rubella, she could have a miscarriage or her baby could be born with serious birth defects. The virus is spread from person to person through the air.

- Tetanus (Lockjaw) is a serious disease caused by bacteria that enters the body through an opening in the skin like a cut or wound. Children can also get the disease after a severe burn, ear infections, tooth infections, or animal bites. Tetanus causes serious, painful spasms of all muscles and can lead to “locking” of the jaw so the patient cannot open his or her mouth or swallow.

- Tdap vaccine: In the past, children would get the last vaccine that included protection against pertussis (whooping cough – a serious lung infection) before they entered kindergarten or first grade. After that time, if a child or teen needed a tetanus booster they got one that did not contain
the vaccine against pertussis, because it was thought that the disease was not that common in older children, teens or adults. However, we now know that people older than age 5 can get very sick from pertussis. That is why the tetanus booster now includes an ingredient to help fight pertussis. Instead of the Td booster, older children, teens and adults should get a tdap booster to help fight this serious infection. This is recommended every 10 years for life.

### 2017 Recommended Immunizations for Children from Birth Through 6 Years Old

<table>
<thead>
<tr>
<th>Age</th>
<th>HepB</th>
<th>DTaP</th>
<th>IPV</th>
<th>PCV</th>
<th>Hib</th>
<th>RV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>HepB</td>
<td>DTaP</td>
<td>IPV</td>
<td>PCV</td>
<td>Hib</td>
<td>RV</td>
</tr>
<tr>
<td>1 month</td>
<td>HepB</td>
<td>DTaP</td>
<td>IPV</td>
<td>PCV</td>
<td>Hib</td>
<td>RV</td>
</tr>
<tr>
<td>2 months</td>
<td></td>
<td>DTaP</td>
<td>IPV</td>
<td>PCV</td>
<td>Hib</td>
<td>RV</td>
</tr>
<tr>
<td>4 months</td>
<td></td>
<td>DTaP</td>
<td>IPV</td>
<td>PCV</td>
<td>Hib</td>
<td>RV</td>
</tr>
<tr>
<td>6 months</td>
<td></td>
<td>DTaP</td>
<td>IPV</td>
<td>PCV</td>
<td>Hib</td>
<td>RV</td>
</tr>
<tr>
<td>12 months</td>
<td></td>
<td>DTaP</td>
<td>IPV</td>
<td>PCV</td>
<td>Hib</td>
<td>RV</td>
</tr>
<tr>
<td>15 months</td>
<td></td>
<td>DTaP</td>
<td>IPV</td>
<td>PCV</td>
<td>Hib</td>
<td>RV</td>
</tr>
<tr>
<td>18 months</td>
<td></td>
<td>DTaP</td>
<td>IPV</td>
<td>PCV</td>
<td>Hib</td>
<td>RV</td>
</tr>
<tr>
<td>19-23 months</td>
<td></td>
<td>DTaP</td>
<td>IPV</td>
<td>PCV</td>
<td>Hib</td>
<td>RV</td>
</tr>
<tr>
<td>2-3 years</td>
<td></td>
<td>DTaP</td>
<td>IPV</td>
<td>PCV</td>
<td>Hib</td>
<td>RV</td>
</tr>
<tr>
<td>4-6 years</td>
<td></td>
<td>DTaP</td>
<td>IPV</td>
<td>PCV</td>
<td>Hib</td>
<td>RV</td>
</tr>
</tbody>
</table>

**FOOTNOTES:**
- Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and/or some other children in this age group.
- Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 to 18 months later. HepA vaccination may be given to any child 12 months and older to protect against HepA. Children and adolescents who did not receive the HepA vaccine and are at high-risk, should be vaccinated against HepA.
- If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your doctor for more details.

**NOTE:**
- If your child misses a shot, you don’t need to start over, just go back to your child’s doctor for the next shot.
- Talk with your child’s doctor about additional vaccines that he may need.
- If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your doctor for more details.

### INFORMATION FOR PARENTS

Talk to your child’s doctor or nurse about the vaccines recommended for their age.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Flu Influenza</th>
<th>Tdap</th>
<th>HPV</th>
<th>MenACWY</th>
<th>MenB</th>
<th>Pneumococcal</th>
<th>Hepatitis B</th>
<th>Hepatitis A</th>
<th>Inactivated Polio</th>
<th>MMR</th>
<th>Meningococcal Vaccine (MenACWY)</th>
<th>Varicella</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-8 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-10 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-12 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-15 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-18 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Get more information at www.cdc.gov/vaccines/parents or visit 1-800-CDC-INFO for more information.

For more information, call toll free 1-800-CDC-INFO (1-800-232-4636).
The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child’s age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

### Children age 4 months through 6 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
<th>Minimum Interval Between Doses</th>
<th>Minimum Interval Between Doses</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>Birth</td>
<td>4 weeks</td>
<td>8 weeks</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>8 weeks</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Diphtheria, tetanus, and acellular pertussis</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Haemophilus influenza type b</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Inactivated poliovirus</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Measles, mumps, rubella</td>
<td>12 months</td>
<td>4 weeks</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Varicella</td>
<td>12 months</td>
<td>3 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>12 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Meningococcal (Hib-MenCY ≥6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)</td>
<td>6 weeks</td>
<td>8 weeks</td>
<td>8 weeks</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Measles, mumps, rubella</td>
<td>12 months</td>
<td>3 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Varicella</td>
<td>12 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Meningococcal (MenACWY ≥9 mos; MenACWY-CRM ≥2 mos)</td>
<td>Not Applicable</td>
<td>8 weeks</td>
<td>8 weeks</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Human papillomavirus</td>
<td>9 years</td>
<td>4 weeks</td>
<td>6 weeks</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>N/A</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>N/A</td>
<td>4 weeks</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Inactivated poliovirus</td>
<td>N/A</td>
<td>4 weeks</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Measles, mumps, rubella</td>
<td>N/A</td>
<td>4 weeks</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Varicella</td>
<td>N/A</td>
<td>3 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
</tbody>
</table>

### Children and adolescents age 7 through 18 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
<th>Minimum Interval Between Doses</th>
<th>Minimum Interval Between Doses</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)</td>
<td>Not Applicable</td>
<td>8 weeks</td>
<td>8 weeks</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Tetanus, diphtheria, tetanus, diphtheria, and acellular pertussis</td>
<td>7 years</td>
<td>4 weeks</td>
<td>6 weeks</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Human papillomavirus</td>
<td>9 years</td>
<td>4 weeks</td>
<td>6 weeks</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>N/A</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>N/A</td>
<td>4 weeks</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Inactivated poliovirus</td>
<td>N/A</td>
<td>4 weeks</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Measles, mumps, rubella</td>
<td>N/A</td>
<td>4 weeks</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Varicella</td>
<td>N/A</td>
<td>3 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
</tbody>
</table>

NOTE: The above recommendations must be read along with the footnotes of this schedule.
Figure 1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2017.

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded in gray.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>9 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>19-23 mos</th>
<th>2-3 yrs</th>
<th>4-6 yrs</th>
<th>7-10 yrs</th>
<th>11-12 yrs</th>
<th>13-15 yrs</th>
<th>16 yrs</th>
<th>17-18 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus (RV) (RV1 (2-dose series); RV5 (3-dose series)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td>4th dose</td>
<td>5th dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, tetanus, &amp; acellular pertussis (DTaP)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenzae type b (Hib)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td>4th dose</td>
<td>5th dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal conjugate (PCV13)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td>4th dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated poliovirus (IPV: &lt;18 yrs)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza (IIV)</td>
<td>Annual vaccination (IIV) or 2 doses</td>
<td>Annual vaccination (IIV) 1 dose only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)</td>
<td>See footnote 8</td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (VAR)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A (HepA)</td>
<td>2-dose series, See footnote 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal C (Hib-MNC, Mnc2; MenACWY-D ≥ 2 mos)</td>
<td>See footnote 11</td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, &amp; acellular pertussis (Tdap)</td>
<td>See footnote 11</td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV)</td>
<td>See footnote 13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal C (Hib-MNC, Mnc2; MenACWY-D ≥ 2 mos)</td>
<td>See footnote 11</td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (PPSV23)</td>
<td>See footnote 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: The above recommendations must be read along with the footnotes of this schedule.
Diagnostic X-Ray and Laboratory Services

Cost to Member

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Category E</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$15 per laboratory service</td>
</tr>
<tr>
<td></td>
<td>$25 per X-ray</td>
</tr>
<tr>
<td></td>
<td>$50 per CT Scan (Computerized Tomography)</td>
</tr>
<tr>
<td></td>
<td>$150 per MRI (Magnetic Resonance Imaging)</td>
</tr>
</tbody>
</table>

No co-payment for other diagnostic services

Description
Diagnostic laboratory services, diagnostic imaging and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat and follow-up on the care of Members. Benefit includes other diagnostic services, including, but not limited to:

- Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes
- Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (Glycohemoglobin)

Outpatient Surgery

Cost to Member

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Category E</td>
<td>$50 per surgery</td>
</tr>
</tbody>
</table>

Description
Surgery that is performed in a doctor’s office, an outpatient surgery center, or a hospital, but for which the member is not admitted to the hospital and does not stay overnight.

Diabetic Care

Cost to Member

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Category E</td>
<td>$10 per visit</td>
</tr>
</tbody>
</table>

Co-payments for prescriptions as described in the “Prescription Drug Program” Section below.

Description
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, including:

1. Blood glucose monitors and blood glucose testing strips
2. Blood glucose monitors designed to assist the visually impaired
3. Insulin pumps and all related necessary supplies
4. Ketone urine testing strips
5. Lancets and lancet puncture devices
6. Pen delivery systems for the administration of insulin
7. Podiatric services to prevent or treat diabetes-related complications
8. Insulin syringes
9. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
10. Insulin
11. Prescriptive medications for the treatment of diabetes
12. Glucagon

Coverage also includes outpatient self-management training, education, and medical nutrition therapy necessary to enable a Member to properly use the equipment, supplies, and medications and as prescribed by the Member’s HPSM provider.

**Prescription Drug Program**

**Cost to Member**

<table>
<thead>
<tr>
<th></th>
<th>Categories A &amp; B</th>
<th>Categories C &amp; D</th>
<th>Category E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 30 day supply for generic drugs</td>
<td>$5 per prescription</td>
<td>$10 per prescription</td>
<td>$10 per prescription</td>
</tr>
<tr>
<td>Up to 30 day supply for brand name drugs unless there is no generic equivalent or if the use of a brand name drug is medically necessary</td>
<td>$5 per prescription</td>
<td>$10 per prescription</td>
<td>$15 per prescription</td>
</tr>
<tr>
<td>Up to 90 day supply for maintenance* generic drugs purchased either through a participating pharmacy.</td>
<td>$5 per prescription</td>
<td>$10 per prescription</td>
<td>$10 per prescription</td>
</tr>
<tr>
<td>Up to 90 day supply for maintenance* brand drugs purchased through a participating pharmacy</td>
<td>$5 per prescription</td>
<td>$15 per prescription, unless there is no generic equivalent or if the use of a brand name drug is medically necessary, then $10 co-payment applies.</td>
<td>$15 per prescription, unless there is no generic equivalent or if the use of a brand name drug is medically necessary, then $10 co-payment applies.</td>
</tr>
</tbody>
</table>

- No co-payment for prescription drugs provided in an inpatient setting
- No co-payment for drugs administered in the doctor’s office or in an outpatient facility setting during the Member’s stay at the facility
- No co-payment for FDA-approved contraceptive drugs, devices and products

*Maintenance drugs are drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.*
**Description**
Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes, but is not limited to:

- Injectable medication, and needles and syringes necessary for the administration of the covered injectable medication
- Insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin
- Blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent, and gestational diabetes
- Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription
- Medically necessary drugs administered while a Member is a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan-designated pharmacy
- Disposable devices that are necessary for the administration of covered drugs, such as spacers and inhalers for the administration of aerosol prescription drugs and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes. The term “disposable” includes devices that may be used more than once before disposal.
- One cycle or course of treatment of tobacco cessation drugs per benefit year. The Member must attend tobacco cessation classes or programs in conjunction with the use of tobacco cessation drugs
- All FDA-approved contraceptive drugs, devices and products for women, including all FDA-approved over the counter drugs, devices and products with a prescription are covered, including internally implanted time-release contraceptives For information concerning HPSM’s prescription drug coverage, please refer to “Getting Pharmacy Benefits” on page 21 of this booklet.

**Exclusions**

- Drugs or medications prescribed solely for cosmetic purposes
- Patent or over-the-counter medicines—even if prescribed by your doctor, except as noted above
- Medicines not requiring a written prescription (except insulin and smoking cessation drugs as previously described)
- Dietary supplements (except for formulas or special food products, when medically necessary, including for phenylketonuria or PKU), appetite suppressants, or any other diet drugs or medications, unless medically necessary for the treatment of morbid obesity
- Experimental or investigational drugs.

If HPSM denies your request for prescription drugs based on a determination that the drug is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to HPSM’s Grievance and Appeals Process on page 85.

**Durable Medical Equipment**

<table>
<thead>
<tr>
<th>Cost to Member</th>
<th>Categories A &amp; B</th>
<th>Categories C &amp; D</th>
<th>Category E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>For items costing $100 or less, co-payment is $10. If item costs less than $10, co-payment is the cost of the item. For items costing more than $100, co-payment is $20.</td>
</tr>
</tbody>
</table>
**Description**

Medical equipment appropriate for use in the home which
1. Primarily serves a medical purpose,
2. Is intended for repeated use, and
3. Is generally not useful to a person in the absence of illness or injury

HPSM may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Durable medical equipment includes, but is not limited to:

- Oxygen and oxygen equipment
- Blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes
- Insulin pumps and all related necessary supplies
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
- Apnea monitors
- Podiatric devices to prevent or treat diabetes complications
- Pulmoaides and related supplies
- Nebulizer machines, face masks, tubing, related supplies, spacer devices for metered dose inhalers, and peak flow meters
- Ostomy bags and urinary catheters and supplies

**Exclusions**

- Comfort or convenience items
- Disposable supplies, except ostomy bags, urinary catheters, and supplies consistent with Medicare coverage guidelines
- Exercise and hygiene equipment
- Experimental or research equipment
- Devices not medical in nature, such as sauna baths and elevators, or modifications to the home or automobile
- Deluxe equipment
- More than one piece of equipment that serves the same function

**Orthotics and Prosthetics**

**Cost to Member**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>E</td>
<td>No co-payment</td>
</tr>
</tbody>
</table>

**Description**

Orthotics and prosthetics benefits include original and replacement devices, including, but not limited to:

- Medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her license
- Medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her license
• Initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy
• Therapeutic footwear for diabetics
• Prosthetic devices to restore and achieve symmetry incident to mastectomy

Covered items must be prescribed by a physician, authorized by HPSM, and dispensed by a plan provider. Repairs are provided unless necessitated by misuse or loss. HPSM, at its option, may replace or repair an item.

Exclusion
• Corrective shoes, shoe inserts, and arch supports, except for therapeutic footwear and inserts for individuals with diabetes
• Non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts
• Dental appliances
• Electronic voice producing machines
• More than one device for the same part of the body
• Eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery)

Cataract Spectacles and Lenses

Cost to Member
No co-payment

Description
Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Benefits also include one pair of conventional eyeglasses or conventional contact lenses, if necessary, after cataract surgery with insertion of an intraocular lens.

Maternity Care

Cost to Member

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost to Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Category E</td>
<td>No co-payment</td>
</tr>
</tbody>
</table>

Description
Medically necessary professional and hospital services relating to maternity care are covered including:
• Prenatal and postpartum care, including complications of pregnancy
• Newborn examinations and nursery care while the mother is hospitalized
• Coverage includes participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program
• Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy
• Counseling for nutrition, health education and social support needs
• Labor and delivery care, including midwifery services
Inpatient hospital care will be provided for 48 hours following a normal vaginal delivery and 96 hours following delivery by cesarean section, unless an extended stay is authorized by the HPSM. You do not need specific authorization to stay in the hospital 48 hours after a vaginal delivery or 96 hours after a C-section and you may remain in the hospital for these time periods unless you and your doctor decide otherwise. If, after consulting with you, your doctor decides to discharge you before the 48– or 96–hour time period, HPSM will cover a post-discharge follow-up visit within 48 hours of discharge when prescribed by your doctor. The visit includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The doctor and you will decide whether the post-discharge visit will occur in the home, at the hospital, or at the doctor’s office depending on the best solution for you.

**Family Planning Services**

**Cost to Member**

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost to Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>E</td>
<td>No co-payment</td>
</tr>
</tbody>
</table>

**Description**

Voluntary family planning services are covered, including:

- Counseling and surgical procedures for sterilization, as permitted by state and federal law
- Contraceptive (birth control) methods, including all FDA-approved contraceptive drugs, devices and products prescribed by your provider. This includes the insertion or removal of IUD and Norplant, diaphragms, or other FDA approved birth control methods.
  - You must have a prescription from your provider in order for your birth control to be covered by HPSM. Birth control bought over-the-counter (without a prescription) is not covered.
  - You can get a 12 month supply of FDA-approved hormonal birth control at one time from a network pharmacy. This only applies to birth control that you give yourself (self-administered), such as birth control pills, patches, and vaginal rings.
- Voluntary Termination of Pregnancy

**Note:** Some hospitals and other providers do not provide one or more of the following services: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. Call your prospective doctor, medical group, independent practice association, clinic, or HPSM at 1-800-750-4776 or 650-616-2133 to ensure that you can obtain the health care services that you need. Members with hearing or speech impairment can use the California Relay Service (CRS) at TTY 1-800-735-2929.

**Medical Transportation Services**

**Cost to Member**

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost to Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>E</td>
<td>No co-payment</td>
</tr>
</tbody>
</table>

**Description**

Emergency ambulance transportation to the first hospital which actually accepts the Member for emergency care is covered in connection with emergency services. Benefit includes ambulance and ambulance transport services provided through the “9-1-1” emergency response system. Also includes, non-emergency transportation for the transfer of a Member from a hospital to another hospital or facility, or facility to home when the transportation is:
Exclusion
Coverage for public transportation including by airplane, passenger car, taxi, or other forms of public conveyance.

Emergency Health Care Services

Cost to Member

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Category E</td>
<td>$75 per visit if services are provided in an Emergency Room. $40 per visit if services are provided in an Urgent Care facility.</td>
</tr>
</tbody>
</table>

Co-payment will be waived if the Member is admitted to the hospital.

Description
Twenty-four hour care is covered for an emergency medical condition. An emergency medical condition is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the Member's health in serious jeopardy, or
- Causing serious impairment to the Member's bodily functions, or
- Causing serious dysfunction of any of the Member's bodily organs or parts.

Coverage is provided both inside and outside of HPSM's service area, and in participating and non-participating facilities.

Mental Health Benefits

Mental health services are provided by the San Mateo County Behavioral and Recovery Services. Members utilizing mental health services must comply with the Behavioral and Recovery Services’ Authorization requirements. For information about mental health providers and access to care, Members should call the Behavioral and Recovery Services at 1-800-686-0101.

Mental health benefits will be provided on the same basis as any other illness including treatment of severe mental illness at any age and for serious emotional disturbance in children.

Mental Health Access Team
1-800-686-0101
Monday through Friday, 8:00 a.m. to 5:00 p.m.

Psychiatric Emergency Services
In a psychiatric emergency, please call 9-1-1 or go directly to the closest Emergency Room for help.

Mental Health Services Patient Advocate
Children and Adolescents 650-655-6276
### Inpatient Mental Health Care Services

**Cost to Member**

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Category E</td>
<td>$200 per hospitalization</td>
</tr>
</tbody>
</table>

**Description**

Mental health care during a certified confinement in a participating hospital when ordered and performed by San Mateo Behavioral and Recovery Services for the treatment of a mental health condition.

**Limitations**

Unlimited inpatient days.

Inpatient mental health care days for the treatment of serious emotional disturbance (SED) or severe mental illness (SMI) of a child is not limited.

HPSM will provide all medically necessary covered services until Behavioral and Recovery Services establishes eligibility for a member with SED or SMI and provides the medically necessary services to treat the SED or SMI.

HPSM and Behavioral and Recovery Services will coordinate services to ensure that medically necessary services and treatment are provided to a member with SED or SMI.

The member will remain enrolled in the Healthy Kids HMO program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED or SMI from HPSM.

### Outpatient Mental Health Care Services

**Cost to Member**

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Category E</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>

Please note that the co-payment amount does not change according to the time the provider spends with the member. Per visit means each visit not how long the visit takes.

**Description**

Mental health care services are authorized, arranged and provided by San Mateo Behavioral and Recovery Services.

**Outpatient mental health care benefits include:**

- Treatment for members who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, divorce, or bereavement.
- Involvement of family members in the treatment to the extent the provider determines it is appropriate for the health and recovery of the Member
- Treatment of serious emotional disturbance (SED) or severe mental illness (SMI) of a child
- Behavioral health treatment for pervasive developmental disorder or autism
  - Services are arranged and managed by San Mateo Behavioral and Recovery Services. The Health Plan of San Mateo provides all mental health care services through San Mateo
Behavioral and Recovery Services including medically necessary services to treat severe mental illness or serious emotional disturbance and behavioral health treatment for autism.

- HPSM will provide all medically necessary covered services until Behavioral and Recovery Services establishes eligibility for a member with SED or SMI and provides the medically necessary services to treat the SED or SMI.
- HPSM and Behavioral and Recovery Services will coordinate services to ensure that medically necessary services and treatment are provided to a member with SED or SMI.
- The member will remain enrolled in the Healthy Kids HMO program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED or SMI from HPSM.

**Limitations**
Unlimited outpatient days

### Inpatient Alcohol/Drug Abuse Treatment

**Cost to Member**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>E</td>
<td>$200 per hospitalization</td>
</tr>
</tbody>
</table>

**Description**
Hospitalization for alcoholism or drug abuse as medically necessary to remove toxic substances from the system. Unlimited inpatient days.

### Outpatient Alcohol/Drug Abuse Treatment

**Cost to Member**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>E</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>

**Description**
Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically necessary.

**Limitation**
Unlimited outpatient visits

### Home Health Care Services

**Cost to Member**
No co-payment for all Income Categories, except for physical, occupational, and speech therapy; and for Behavioral Health Treatment performed in the home:

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>E</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>

**Description**
Health services provided at home by health care personnel. Benefit includes:
• Visits by RNs, LVNs, home health aides and qualifies autism service providers.
• Physical therapy, occupational therapy, and speech therapy
• Respiratory therapy when prescribed by a licensed plan provider acting within the scope of his or her licensure
• Behavioral Health Treatment (BHT) for pervasive developmental disorders or autism

Limitations
• Home health care services are limited to those services that are prescribed or directed by the Member’s primary care provider or another appropriate authority designated by HPSM
• If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the Member’s primary care provider or other appropriate authority designated by HPSM to choose the setting for providing the care
• HPSM will exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting

Exclusion
Custodial care

Skilled Nursing Care

Cost to Member

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost to Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>E</td>
<td>No co-payment</td>
</tr>
</tbody>
</table>

Description
Medically necessary services prescribed by a plan provider and provided in a licensed skilled nursing facility. Benefit includes:
• Skilled nursing on a 24-hour per day basis
• Bed and board
• X-ray and laboratory procedures
• Respiratory therapy
• Physical, speech, and occupational therapy
• Medical social services
• Prescribed drugs and medications
• Medical supplies
• Appliances and equipment ordinarily furnished by the skilled nursing facility

Limitation
This benefit is limited to a maximum of one hundred (100) days per benefit year

Exclusion
Custodial care

Physical, Occupational, and Speech Therapy

Cost to Member
No co-payment for inpatient therapy, including services received in a skilled nursing facility. When performed in the home or other outpatient setting, the following co-payments apply:
Categories A & B | $5 per visit  
Categories C & D | $10 per visit  
Category E | $15 per visit

**Description**
Therapy must be medically necessary. Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home. HPSM may require periodic evaluations as long as therapy is provided.

**Acupuncture & Chiropractic Services**

**Cost to Member**

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Category E</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>

**Description**
Acupuncture and chiropractic services do not require a referral from the Member’s primary care provider or other health care provider. Services must be obtained from a participating provider.

**Limitation**
- Treatment is limited to a maximum of twenty (20) visits per benefit year.
- Services must be obtained from a plan provider.
- Service authorization is required for children under 16 years.

**Blood and Blood Products**

**Cost to Member**

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Category E</td>
<td>No co-payment</td>
</tr>
</tbody>
</table>

**Description**
Benefit includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Also includes the collection and storage of autologous blood when medically indicated.

**Health Education**

**Cost to Member**

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Category E</td>
<td>No co-payment</td>
</tr>
</tbody>
</table>

**Description**
Benefit includes health education services, including education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.
Hospice

Cost to Member

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>E</td>
<td>No co-payment</td>
</tr>
</tbody>
</table>

Description
The hospice benefit is provided to Members who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services covered by the plan. The hospice benefit includes:

- Nursing care
- Medical social services
- Home health aide services
- Physician services, drugs, medical supplies and appliances
- Counseling and bereavement services
- Physical, occupational, and speech therapy
- Short-term inpatient care
- Pain control and symptom management
- Homemaker services, services of volunteers, and short-term inpatient respite care

The hospice election may be revoked at any time.

Limitation
Members who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect.

Organ Transplants

Cost to Member

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>E</td>
<td>$200 per hospitalization</td>
</tr>
</tbody>
</table>

Description
Benefits include coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational. The benefit includes payment for:

- Medically necessary medical and hospital expenses of a donor or an individual identified as a prospective donor, if these expenses are directly related to the transplant for a Member
- Testing Member’s relatives for matching bone marrow transplants
- Searching for and testing unrelated bone marrow donors through a recognized Donor Registry
- Charges associated with procuring donor organs through a recognized Donor Transplant Bank are covered if the expenses are directly related to the anticipated transplant of the Member

These services may be covered and paid for by the California Children's Services (CCS) program, instead of by HPSM, if the Member is found to be eligible for CCS services. HPSM will coordinate these services with CCS for the Member. For more information about the CCS program, see “Coordination of Services” on page 63.
If HPSM denies your organ transplant request based on a determination that the service is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to HPSM’s Grievance and Appeals Process on page 85.

**Reconstructive Surgery**

<table>
<thead>
<tr>
<th>Cost to Member</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Category E</td>
<td>$200 per hospitalization</td>
</tr>
</tbody>
</table>

**Description**

Medically necessary reconstructive surgical services 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 to the extent possible. This benefit includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

**Phenylketonuria (PKU)**

<table>
<thead>
<tr>
<th>Cost to Member</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Category E</td>
<td>No co-payment</td>
</tr>
</tbody>
</table>

**Description**

Testing and treatment of PKU, including those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the plan, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

**Clinical Cancer Trials**

<table>
<thead>
<tr>
<th>Cost to Member</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Category E</td>
<td>No co-payment</td>
</tr>
</tbody>
</table>

- Co-payment for prescriptions as described in the “Prescription Drug Program” Section.

**Description**

- 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 the following requirements:
  - Member must be diagnosed with cancer
  - Member must be accepted into a phase I, phase II, Phase III, or phase IV clinical trial for cancer
  - Member’s treating physician, who is providing covered services, must recommend participation in the clinical trial after determining that participation will have a meaningful potential to the Member, and
  - The trial must meet the following requirements:
1. Trials must have a therapeutic intent with documentation provided by the treating physician, and
2. Treatment provided must be approved by one of the following:
   a) the National Institute of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs, or
   b) involve a drug that is exempt under the federal regulations from a new drug application.

Benefits include the payment of costs associated with the provision of routine patient care, including drugs, items, devices and services that would otherwise be covered if they were not provided in connection with an approved clinical trial program. Routine patient costs for cancer clinical trials include:
- Health care services required for the provision of the investigational drug, item, device or service
- Health care services required for the clinically appropriate monitoring of the investigational drug, item, device, or service
- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service

Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis or treatment of complications.

Exclusions
- Provision of non-FDA-approved drugs or devices that are the subject of the trial
- Services other than health care services, such as travel, housing, and other non-clinical expenses that a Member may incur due to participation in the trial
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient
- Health care services that are otherwise not a benefit (other than those excluded on the basis that they are investigational or experimental)
- Health care services that are customarily provided by the research sponsors free of charge for any enrollee in the trial
- Coverage for clinical trials may be restricted to participating hospitals and physicians in California, unless the protocol for the trial is not provided in California

Annual or Lifetime Benefit Maximums
There shall be no lifetime financial benefit maximums in any of the coverages under the program.

Coordination of Services

California Children’s Services (CCS)
As part of the services provided through the Healthy Kids HMO Program, members needing specialized medical care may be eligible for services through the California Children’s Services (CCS) program.

CCS is a California medical program that treats children who have certain physically handicapping conditions and who need specialized medical care. This program is available to all children in California whose families meet certain medical, financial and residential eligibility requirements. All children enrolled in the Healthy Kids HMO Program are deemed to have met the financial eligibility requirements of the CCS Program. Services provided through the CCS Program are coordinated by the county CCS office.

If a member’s primary care provider suspects or identifies a possible CCS eligible condition, he or she must refer the member to the local CCS program. Health Plan of San Mateo can assist with this referral. Health Plan of San Mateo will also make a referral to CCS when the plan identifies a possible CCS eligible condition. The CCS program will determine whether the member’s condition is eligible for CCS services.
If the CSS program determines that the condition is a CSS eligible condition, the member will remain enrolled in the Healthy Kids HMO Program. He or she will be referred to, and should receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers. These CCS providers and specialty centers are highly trained to treat CCS eligible conditions. CCS services must be received from CCS paneled providers. Payment for CCS eligible services obtained from non-CCS paneled provider will be the responsibility of the member’s legal guardian.

Health Plan of San Mateo will continue to provide primary care, prevention services, and any other services that are not related to the CCS eligible condition, as described in this booklet. Health Plan of San Mateo will also work with the CCS program and providers to coordinate care provided by both the CCS program and Health Plan of San Mateo. If a condition is determined not to be eligible for CCS program services, the member will continue to receive all medically necessary services from Health Plan of San Mateo. In addition, Health Plan of San Mateo is responsible for all covered services if CCS does not authorize or does not actually provide those specific services.

If CCS authorizes services for a CCS condition, but the services are not or cannot be provided in a timely manner or within the geographic area, Health Plan of San Mateo will provide the services in the health plan’s network to the extent that they are Covered Services. Although all children enrolled in the Healthy Kids HMO Program are determined to be financially eligible for the CCS program, the CCS office must verify residential status for each child in the CCS program. If a member is referred to the CCS program, the member’s parents or legal guardian will be asked to complete a short application to verify residential status and ensure coordination of the member’s care after the referral has been made.

Additional information about the CCS program can be obtained by calling Health Plan of San Mateo’s Member Services at 1-800-750-4776 or 650-616-2133 or by calling the San Mateo County CCS program at 650-616-2500.

**Excluded Benefits**

The following health benefits are excluded under the Health Plan:

1. Any services or items specifically excluded in the Benefits Description section.
2. Any benefits in excess of limits specified in the Benefits Description section.
3. Services, supplies, items, procedures, or equipment which are not medically necessary, unless otherwise specified in the Benefits Description section.
4. Any services which were received prior to the Member’s effective date of coverage. This exclusion does not apply to covered services to treat complications arising from services received prior to the Member’s effective date.
5. Any services which are received subsequent to the time coverage ends.
6. Experimental or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards or for which the safety and efficacy have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed.
7. Medical services that are received in an emergency care setting for conditions that are not emergencies if you reasonably should have known that an emergency care situation did not exist.
8. Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery which are covered under the “Cataract Spectacles and Lenses” benefit.
9. The diagnosis and treatment of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.
10. Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except when HPSM determines they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to “Skilled Nursing Care” and “Hospice” benefits.

11. Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any worker’s compensation benefit plan. HPSM shall provide services at the time of need, and the Member or Member’s legal guardian shall cooperate to assure that HPSM is reimbursed for such benefits.

12. Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. HPSM shall provide services at the time of need, and the Member or Member’s legal guardian will cooperate to assure that HPSM is reimbursed for such benefits.

13. Cosmetic surgery that is solely performed to alter or reshape normal structure of the body in order to improve appearance.

14. Personal or comfort items such as telephones, TVs, guest trays, personal hygiene items, disposable supplies (except ostomy bags or urinary catheters) and other supplies.

15. Services for the dentist or oral surgeon for inpatient dental procedures (this does not exclude coverage for any surgical procedure directly affecting the upper or lower jawbone or associated bone joints). See Section 9 of this document for more information on dental benefits.

16. Drugs or medications for cosmetic use.

17. Exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment; or more than one piece of equipment that serves the same function, unless medically necessary.

18. A private room in a hospital unless medically necessary, as determined by HPSM.

19. Corrective shoes and arch supports, (except for therapeutic footwear for diabetics); non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts, dental appliances, electronic voice producing machines; except as medically necessary.

20. Coverage for transportation by airplane, passenger car, taxi or other form of public transportation.

21. Home Health custodial care and physical therapy and rehabilitation which are not medically necessary.

22. Skilled nursing custodial care provided by skilled nurses or skilled nursing facility.

23. Replacement parts for hearing aids, repair of a hearing aid after the covered one year warranty period, replacement of a hearing aid more than once in a thirty six (36) month period, and surgically implanted hearing devices. The purchase of batteries or other ancillary equipment, (except those covered under the terms of the first hearing aid purchase) and any charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss.
This page intentionally left blank.

Esta página ha sido dejada en blanco intencionalmente.

此頁有意留為空白。

Ang pahinang ito ay sadyang iniwan na blangko.
**Section 8**

**Covered Vision Services**

**Detailed Description of Benefits, Co-Payments, Conditions, And Exclusions**

Vision benefits are provided through HPSM's network of Providers who provide professional vision care to Members. You can select a Provider for vision care from those listed in HPSM’s Provider List. You can request a new List by writing or calling a Member Service Representative at **1-800-750-4776** or **650-616-2133**.

Remember to bring your Healthy Kids HMO identification card to your appointment. If you obtain services from an out-of-network Provider, you are responsible for payment in full to the Provider.

**Cost to Member**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Co-payment per examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; B</td>
<td>$5</td>
</tr>
<tr>
<td>C &amp; D</td>
<td>$10</td>
</tr>
<tr>
<td>E</td>
<td>$10</td>
</tr>
</tbody>
</table>

- For all Income Categories: Frames and Lenses - A frame allowance of $75. If Member chooses a frame that exceeds the plan allowance, the Member will pay the difference.
- Elective Contact Lenses - An allowance of $110 towards the cost of exam, contact lens evaluation, fitting costs, and materials. The Member is responsible for any costs exceeding this allowance.
- Necessary Contact Lenses - No co-payment
- Low vision benefits - Supplemental testing: no co-payment.
- Supplemental care: $5 co-payment

**Description**

**Examinations**

You are entitled to a comprehensive vision examination, including a complete analysis of the eyes and related structures as appropriate, to determine the presence of vision problems or other abnormalities as follows:

- Case History: Review of Member's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.
- Evaluation of the health status of the visual system including:
  1. external and internal examination, including that of direct and/or indirect ophthalmoscopy
  2. assessment of neurological integrity, including that of papillary reflexes and extraocular muscles
  3. biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes
  4. screening of gross visual fields
  5. pressure testing through tonometry
- Evaluation of refractive status including:
  1. evaluation of visual acuity
  2. evaluation of subjective, refractive, and accommodative function
  3. objective testing of a Member's prescription through retinoscopy
- binocular function test
- diagnosis and treatment plan, if needed
- examinations are limited to once each twelve (12) month period, which begins with the date of the last exam.

**Lenses**

Your Provider will order the proper lenses necessary for the Member’s visual welfare. Lenses are limited to once each twelve (12) month period, which begins with the date of the last exam.
Frames
Frames are limited to once every twelve (12) month period, which begins with the date that the last eyeglasses were received.

Medically Necessary Contact Lenses
Medically necessary contact lenses may be prescribed for certain conditions with prior authorization from HPSM, such as:
1) following cataract surgery,
2) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
3) certain conditions of Anisometropia; and
4) keratoconus.

With approval, contact lenses are provided in lieu of covered benefits for that eligibility period. Contact lenses are limited to once each twelve (12) month period, which begins with the date of the last exam.

Elective Contact Lenses (instead of corrective lenses and a frame):
Limited to once each twelve (12) month period, which begins with the date of the last exam.

Low Vision
A low vision benefit is provided to Members with severe visual problems that are not correctable with regular lenses. This benefit requires prior authorization from HPSM. With authorization, supplemental testing and supplemental care, including low vision therapy as visually necessary or appropriate, will be provided.

Exclusions
Any cost associated with the selection of the items listed below will be your financial responsibility.

- Benefits which are neither necessary nor appropriate
- Benefits which are not obtained in compliance with the rules and policies of HPSM’s Vision Plan for Healthy Kids HMO
- Vision training
- Aniseikonic lenses
- Plano lenses
- Two pairs of glasses in lieu of bifocals, unless medically necessary and with prior authorization.
- Replacement or repair of lost or broken lenses or frames prior to being eligible for services
- Medical or surgical treatment of the eyes
- Services or materials for which the Member is covered under a Worker’s Compensation policy
- Eye examinations or any corrective eyeware required as a condition of employment.
- Services or materials provided by any other group benefit providing vision care

There is no benefit for professional services or materials connected with:

- Blended lenses (bifocals which do not have a visible dividing line)
- Contact lenses, except as specified above
- Oversized lenses (larger than standard lens blank to accommodate prescriptions)
- Progressive multifocus lenses
- Coated or laminated lenses
- UV protected lenses
- Other optional cosmetic processes
- Photocromic or tinted lenses

There are no out-of-network benefits.
Section 9
Covered Dental Services, Benefits and Co-Payments

Dental benefits are provided through the Delta Dental Plan of California. Your eligibility for dental benefits begins the same day as your medical benefits.

The Provider List gives you information about office facilities including wheelchair accessibility and languages spoken within the office. You can select any dentist listed on the Provider List. If you need help finding a dentist in your area, or if you have special health care needs and require assistance in finding a dentist who can best meet your needs (for example, wheelchair accessibility or translation services) contact Delta’s Customer Service department toll-free at 1-866-527-9564, Monday through Friday, 8:00 a.m. to 5:00 p.m. When you call, please refer to the Group Number SM60. If you need Emergency Services call Delta’s Customer Service Department. They are available 24 hours a day, seven (7) days a week. When you call, please refer to Group Number SM60.

Choosing A Primary Care Dental Provider
You can choose any participating dentist for your primary dental care. You must go to a participating dentist because only the services by a participating dentist are covered. If you go to a dentist who is not a Participating Provider, you must pay all of the cost of treatment, except in the case of an emergency.

Scheduling Appointments
After you have selected a participating dentist, call the dentist’s office to schedule an appointment. Tell the dentist you are covered by Healthy Kids HMO and ask the dentist to confirm that he or she is a participating Provider for Healthy Kids HMO.

Changing Your Provider
You can choose any participating dentist at any time. If you wish to change dentists, simply review the Provider List for dentists and call to schedule an appointment. Delta’s Customer Service department is available to assist you in choosing a new dentist. You may also review the list of dentists by going to www.deltadentalca.org/gov.

Continuity of Care For New Members
Under some circumstances, Delta will provide continuity of care for new Members who are receiving dental services from a Non-Participating dental Provider when Delta determines that continuing treatment with a Non-Participating Provider is medically appropriate. If you are a new Member, you may request permission to continue receiving dental services from a Non-Participating Provider if you were receiving this care before enrolling in Healthy Kids HMO. You may request authorization for continuity of care by contacting Delta’s Customer Service Department toll-free at 1-866-527-9564.

The hearing impaired may contact Delta Dental through Delta’s TDD/TTY number at 1-800-735-2922. If Delta approves the continued treatment from a Non-Participating Provider, Delta Dental will give you a written authorization. If we determine that you do not meet the criteria for continuity of care and you disagree with Delta’s determination, you may file a grievance with Delta Dental (see page 70) or with HPSM (see page 85).

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 1-888-HMO-2219; or at the TDD number for the hearing impaired, 1-877-688-9891; or online at www.hmohelp.ca.gov.
Continuity Of Care Upon Termination Of Provider
If your dental care Provider stops working with Delta Dental, Delta will let you know by mail.

Prior Authorization For Services
Your participating Provider will coordinate your dental care needs and, when necessary, will arrange specialty services for you. In some cases, Delta must authorize the specialty services before you receive the services. Your primary care dentist will obtain the necessary referrals and authorizations for you. Some specialty services, such as Emergency Care, do not require prior authorization before you receive the services.

If you see a specialist or receive specialty services before you receive the required authorization, you will be responsible to pay for the cost of the treatment. If Delta denies a request for specialty services, Delta will send you a letter explaining the reason for the denial and how you can appeal the decision if you do not agree with the denial.

Referrals To Specialists
Your Participating Provider may refer you to another dentist for consultation or specialized treatment. In consultation with you, your dentist will choose a specialist dentist from whom you may receive services. In the event that there is no Participating Provider available to perform the needed service, you or your Provider may contact Delta’s Customer Service Department toll-free at 1-866-527-9564 for help in locating a specialist.

Obtaining A Second Opinion
Sometimes you may have questions about your condition or your primary care dentist’s recommended treatment plan. You may want to get a second opinion. You may request a second opinion for any reason, including the following:

- You question the reasonableness or necessity of a recommended procedure;
- You have questions about a diagnosis or a treatment plan for a chronic condition or a condition that could cause loss of life, loss of limb, loss of bodily function, or substantial impairment.
- Your Provider’s advice is not clear, or it is complex and confusing,
- Your Provider is unable to diagnose the condition or the diagnosis is in doubt due to conflicting test results,
- The treatment plan in progress has not improved your dental condition within an appropriate period of time;
- You have attempted to follow the treatment plan or consulted with your initial Provider regarding your concerns about the diagnosis or the treatment plan.

If you wish a second opinion for any reason you may contact any network dentist to schedule an exam at no cost to you. If you need assistance in locating another network dentist, you may contact Delta’s Customer Service Department at 1-866-527-9564. A Customer Service Telephone Representative will take your request for the second opinion and will assist you in selecting another dentist. If your request for a second opinion is an emergency situation, the customer service representative will immediately route the information to a Customer Relations Analyst for processing.

A second opinion may also be requested by Delta prior to authorizing treatment when it is necessary to make a benefit determination. Both you and the treating dentist will be notified when a second opinion is necessary and appropriate. When a second opinion is requested by Delta, the Program will pay all charges.
Utilization Review
The goal of Delta's Utilization Management (UM) Program is to ensure that dental services provided to you are necessary and appropriate, the services are provided in an appropriate setting, the services are delivered in a timely manner and the services are provided in accordance with the scope of benefits of Healthy Kids HMO. The Delta Dental Utilization Review (UR) system includes an automated information processing system, employees who use that system, and policies and procedures that govern that usage.

Delta’s UR system identifies Providers who have unusual treatment patterns, which require corrective action. Treatment patterns are accumulated through claim and encounter information submitted by Providers, focus studies, dental facility reviews, dental chart reviews and Member calls and grievances. The data are then analyzed to determine if any Providers have unusual treatment patterns. If necessary, corrective action may include Provider education, sanctions or even termination of a Provider from our network.

Members may obtain information regarding Delta’s UM/UR Program by contacting Delta’s Customer Service Department at 1-866-527-9564.

Getting Urgent Care
Urgent Care services are services needed to prevent serious deterioration of your health resulting from an unforeseen illness or injury for which treatment cannot be delayed. Delta covers Urgent Care services any time you are outside our service area or on nights and weekends when you are inside our service area. To be covered, the Urgent Care service must be needed because the illness or injury will become much more serious, if you wait for a regular dentist’s appointment. On your first visit, talk to your primary care dentist about what he or she wants you to do when the office is closed and you feel Urgent Care may be needed.

Getting Emergency Services
Emergency dental care services are available to you twenty-four (24) hours a day, both inside and outside our service area. If you have a dental emergency, you should call your regular network dentist or any other network dentist. If you need additional assistance call Delta’s Customer Service Department toll-free at 1-866-527-9564. The hearing impaired may contact the customer service department through the TDD/TTY number at 1-800-735-2922.

If you are outside of California, you can get emergency dental services from any licensed dentist without prior approval from Delta. All emergency services by out-of-state dentists are paid at the allowable rate by Delta for emergency treatment. The treating dentist should call 1-800-838-4337 for payment and benefits information.

What To Do If You Are Not Sure If You Have An Emergency
If you are not sure whether you have an emergency or require Urgent Care you may contact your Participating dental Provider or call Delta’s Customer Service Department toll-free at 1-866-527-9564.

Non-Covered Services
Delta does not cover dental services that are received in an emergency or Urgent Care setting for conditions that are not emergencies or urgent if you reasonably should have known that an emergency or Urgent Care situation did not exist. You will be responsible for all charges related to these services.

Follow-Up Care
After receiving any emergency or Urgent Care services, you will need to call your Participating Provider for any necessary follow-up care. If you don’t have a regular Participating Provider, you may select one from the Delta Provider Directory. If you need help selecting a Provider, contact Delta’s Customer Service Department toll-free at 1-866-527-9564.
Co-payments
You will be required to pay a Co-payment. You are responsible to pay the Co-payment to the dental Provider at the time services are provided. There are no Co-payments for the preventive and diagnostic services listed in the Benefits section of this EOC. Additionally, there are no Co-payments for Members who are American Indians or Alaska Natives.

No deductibles are charged for dental benefits.

Member Liabilities
In addition to the Co-payments for selected services, you must pay for any non-covered or optional dental services that you choose to have done. Often there are several choices or different approaches that a dentist may take to treat dental conditions. This Program is designed to cover dental treatment using the most cost effective option that is consistent with good professional practice. Your covered dental benefits are limited to the benefit level for the least costly, appropriate alternative. If you choose a more costly or an optional alternative, you will be responsible for all charges in excess of the covered dental benefit.

You will also be financially responsible for services that require a referral or prior authorization if you obtain these services prior to receiving the required referral or authorization, even if the services were necessary. You may also be responsible for services you receive that are not covered benefits as listed in this EOC and services received that are greater than the limits specified in this EOC.

Missed or Broken Appointments
Your dentist may charge you a $10.00 fee if you fail to cancel an appointment at least 24 hours prior to the appointment. This fee will be waived if it was not reasonably possible for you to cancel your appointment.

In the event Delta does not pay a Participating Provider for covered services, you will not be liable to the Provider for any money owed by Delta. In the event that Delta fails to pay a Non-Participating Provider, you may be liable to the Non-Participating Provider for the costs of services rendered.

Grievances Concerning Dental Services
If you have questions about the services you receive from a network dentist, first discuss the matter with your dentist. If you continue to have concerns or complaints, call Delta Dental’s Customer Service Department at 1-866-527-9564, Monday through Friday from 8:00 a.m. through 5:00 p.m.

If appropriate, an arrangement can be made for you to be examined by another dentist in your area. If the dentist recommends that the work be replaced or corrected, Delta Dental will intervene with the original dentist to either have the service replaced or corrected at no additional cost to you. In the latter case, you are free to choose another network dentist to receive your full benefit.

The Customer Service Representative will try to resolve the problem immediately. However, sometimes more than one day is needed to investigate and gather information. In this case, the representative will contact you within 30 days to tell you of the results of the review.

To file a Grievance, take one of the following actions:

• Call a Delta Dental Customer Service Representative at 1-866-527-9564, and ask to file a Grievance. The Customer Service Representative will fully explain the Grievance process to you. You can file a Grievance with the Customer Service Representative by telephone.

• Visit your network dentist’s office, and request a Grievance form in person. The dental office staff will assist you in filling out the form, but we strongly encourage you to contact a Delta Dental Customer Service Representative to ensure that the form is accurately completed and submitted to Delta Dental.
If you file a Grievance in writing, include the group name (San Mateo Healthy Kids HMO) and number (SM60), the Member’s name, Member identification number, and a telephone number on all correspondence. You should also include a copy of the treatment form (available from your dentist) and any other relevant information. Delta Dental’s address and telephone number are as follows:

Delta Dental - Healthy Kids HMO
HMO P. O. Box 537010
Sacramento, CA 95853-7010
1-866-527-9564

Delta Dental will acknowledge receipt of the Grievance form within five (5) business days of its receipt. Resolution will occur within 30 days of Delta Dental’s receipt of the Grievance. You will receive a letter from Delta Dental concerning the disposition of the Grievance.

If your Grievance involves a serious and imminent threat to your health, please call Delta Dental’s Customer Service Department, and state you want to file an urgent Grievance. Your urgent Grievance will be assigned highest priority and will be resolved within three (3) business days from receipt of the Grievance.

Members who have a Grievance involving the services received from Delta Dental may also contact HPSM’s Member Services Department at 1-800-750-4776 or 650-616-2133.

**Appeals**

If you are not satisfied with the response you receive on your Grievance, you can appeal by requesting a hearing before Delta Dental’s Grievance Committee. Delta Dental’s Grievance Committee handles Members’ appeals and reviews Grievance activity. Delta Dental’s Committee will review the records and contact you to hear your statement. Afterwards you will be notified of the Committee’s decision and sent a letter explaining the findings of Delta Dental’s Committee. To obtain a hearing, submit a written request to Customer Service, and include a copy of the letter you received.

All levels of appeal, whether through Delta Dental or HPSM, must be completed within thirty (30) days of receipt of the original Grievance.

Include the group name (San Mateo Healthy Kids HMO) and number (SM60), Member’s name and client identification number and a telephone number on all correspondence. You should also include a copy of the treatment form, if possible (available from your dentist) and any other relevant information. Send a copy of your appeal to Delta Dental at the address listed on this page.

If you have a Grievance involving dental services, you should first contact Delta Dental toll free at 1-866-527-9564 and use Delta Dental’s Grievance process. However, if within 30 days after filing your Grievance you need help, a Grievance has not been satisfactorily resolved by Delta Dental, or you are not satisfied with the result of Delta Dental’s Grievance process, you have the Option to contact the Department of Managed Health Care as described in Section 11 of this Combined Member Handbook and Evidence of Coverage, or you may use the Grievance process administered by HPSM (see page 85).
## Dental Plan Covered Benefits Matrix

This matrix is intended to be used to help you compare covered benefits and is a summary only. The benefit description section should be consulted for a detailed description of covered benefits and limitations. Members in all income categories will pay the co-payments specified below. You may call HPSM to find out whether you fall into Category A, B, C, D, or E.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Services</th>
<th>Categories A &amp; B: Cost to Member (Co-payment)</th>
<th>Categories C &amp; D: Cost to Member (Co-payment)</th>
<th>Category E: Cost to Member (Co-payment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and Preventive Care</td>
<td>Initial and periodic oral examinations, Consultations, including specialist consultations, Topical fluoride treatment, Preventive dental education and oral hygiene instruction, Roentgenology (x-rays), Prophylaxis services (cleanings), Space Maintainers, Dental sealant treatments.</td>
<td>No-copayment</td>
<td>No-copayment</td>
<td>No-copayment</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restorative Dentistry (Fillings)</td>
<td>Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries, Micro filled resin restorations which are noncosmetic, Replacement of a restoration, Use of pins and pin build-up in conjunction with a restoration, Sedative base and sedative fillings.</td>
<td>No-copayment</td>
<td>No-copayment</td>
<td>No-copayment</td>
</tr>
</tbody>
</table>
| Oral Surgery                     | Extractions, including surgical extractions, Removal of impacted teeth, Biopsy of oral tissues, Alveolecostomies, Excision of cysts and neoplasms, Treatment of palatal torus, Treatment of mandibular torus, Frenectomy, Incision and drainage of abscesses, Post-operative services, including exams, suture removal and treatment of complications, Root recovery (separate procedure). | • $5 co-payment for the removal of impacted teeth for a bony impaction  
• $5 co-payment per root recovery | • $10 co-payment for the removal of impacted teeth for a bony impaction  
• $10 co-payment per root recovery | • $10 co-payment for the removal of impacted teeth for a bony impaction  
• $10 co-payment per root recovery |
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Services</th>
<th>Categories A &amp; B: Cost to Member (Co-payment)</th>
<th>Categories C &amp; D: Cost to Member (Co-payment)</th>
<th>Category E: Cost to Member (Co-payment)</th>
</tr>
</thead>
</table>
| Endodontic     | Direct pulp capping, Pulpotomy and vital pulpotomy, Apexification filling with calcium hydroxide, Root amputation, Root canal therapy, including culture canal, Retreatment of previous root canal therapy, Apicoectomy, Vitality tests. | • $5 co-payment per canal for root canal therapy or retreatment of previous root canal therapy  
• $5 co-payment per root for an apicoectomy | • $10 co-payment per canal for root canal therapy or retreatment of previous root canal therapy  
• $10 co-payment per root for an apicoectomy | • $10 co-payment per canal for root canal therapy or retreatment of previous root canal therapy  
• $10 co-payment per root for an apicoectomy |
| Periodontics   | Emergency treatment, including treatment for periodontal abscess and acute periodontitis, Periodontal scaling and root planing, and subgingival curettage, Gingivectomy, Osseous or muco-gingival surgery. | • $5 co-payment per quadrant for osseous or muco-gingival surgery | • $10 co-payment per quadrant for osseous or muco-gingival surgery | • $10 co-payment per quadrant for osseous or muco-gingival surgery |
| Crown and Fixed Bridge | Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel, Related dowel pins and pin build-up, Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, Recementation of crowns, bridges, inlays and onlays, Cast post and core, including cast retention under crowns, Repair or replacement of crowns, abutments or pontics. | • $5 co-payment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns.  
• $5 co-payment per pontic. | • $10 co-payment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns.  
• $10 co-payment per pontic. | • $10 co-payment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns.  
• $10 co-payment per pontic. |
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Services</th>
<th>Categories A &amp; B: Cost to Member (Co-payment)</th>
<th>Categories C &amp; D: Cost to Member (Co-payment)</th>
<th>Category E: Cost to Member (Co-payment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crown and Fixed Bridge (continued)</td>
<td>• The co-payment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.</td>
<td>• The co-payment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.</td>
<td>• The co-payment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.</td>
<td>• The co-payment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.</td>
</tr>
<tr>
<td>Movable Prosthetics</td>
<td>Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, Office or laboratory relines or rebases, Denture repair, Denture adjustment, Tissue conditioning, Denture duplication, Stayplates.</td>
<td>• $5 co-payment for a complete maxillary or mandibular denture</td>
<td>• $10 co-payment for partial acrylic upper or lower denture with clasps</td>
<td>• $10 co-payment for removable unilateral partial denture</td>
</tr>
<tr>
<td></td>
<td>• $5 co-payment for partial acrylic upper or lower denture with clasps</td>
<td>• $10 co-payment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles</td>
<td>• $10 co-payment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles</td>
<td>• $10 co-payment for removable unilateral partial denture</td>
</tr>
<tr>
<td></td>
<td>• $5 co-payment for removable unilateral partial denture</td>
<td>• $10 co-payment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles</td>
<td>• $10 co-payment for removable unilateral partial denture</td>
<td>• $10 co-payment for removable unilateral partial denture</td>
</tr>
<tr>
<td>Benefits</td>
<td>Services</td>
<td>Categories A &amp; B: Cost to Member (Co-payment)</td>
<td>Categories C &amp; D: Cost to Member (Co-payment)</td>
<td>Category E: Cost to Member (Co-payment)</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Movable Prosthetics (continued)</td>
<td></td>
<td>• $5 co-payment for reline of upper, lower or partial denture when performed by a Laboratory</td>
<td>• $10 co-payment for reline of upper, lower or partial denture when performed by a Laboratory</td>
<td>• $10 co-payment for reline of upper, lower or partial denture when performed by a Laboratory</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $5 co-payment for denture duplication</td>
<td>• $10 co-payment for denture duplication</td>
<td></td>
</tr>
<tr>
<td>Other Benefits</td>
<td>Local anesthetics, Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of licensure, Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of licensure, Emergency treatment, palliative treatment, Coordination of benefits with member’s health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.</td>
<td>No co-payment</td>
<td>No co-payment</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Orthodontia Services</td>
<td>Not a Healthy Kids HMO Program covered benefit. Services are provided to members under the age of 19 through the California Children’s Services Program (CCS) when condition meets the CCS program criteria.</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

For all Income Categories:

**Deductibles**
No deductibles will be charged for covered benefits.

**Lifetime Maximum**
No lifetime maximum limits on benefits apply under this plan.
Benefits Description

This section lists the dental benefits and services you are allowed to obtain through Healthy Kids HMO when the services are necessary for your dental health consistent with professionally recognized standards of practice, subject to the exception and limitations listed here and in the Exclusions section of this EOC.

Diagnostic and Preventive Benefits

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost to Member</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>No co-payment</td>
<td>Benefit includes:</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>No co-payment</td>
<td>• Initial and periodic oral examinations</td>
</tr>
<tr>
<td>Category E</td>
<td>No co-payment</td>
<td>• Consultations, including specialist consultations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Topical fluoride treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Preventive dental education and oral hygiene instruction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Roentgenology (x-rays)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prophylaxis services (cleanings)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Dental sealant treatments</td>
</tr>
</tbody>
</table>

Limitations
Roentgenology (x-rays) is limited as follows:

• Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
• Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.
• Panoramic film x-rays are limited to once every 24 consecutive months.
• Prophylaxis services (cleanings) are limited to two in a 12-month period.
• Dental sealant treatments are limited to permanent first and second molars only.

Restorative Dentistry

Cost to Member

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost to Member</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>No co-payment</td>
<td>Restorations include:</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>No co-payment</td>
<td>• Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries</td>
</tr>
<tr>
<td>Category E</td>
<td>No co-payment</td>
<td>• Micro filled resin restorations which are noncosmetic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Replacement of a restoration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use of pins and pin build-up in conjunction with a restoration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sedative base and sedative fillings</td>
</tr>
</tbody>
</table>
Limitations
Restorations are limited to the following:

• For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations; any other restoration such as a crown or jacket is considered optional.
• Composite resin or acrylic restorations in posterior teeth are optional.

Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

Oral Surgery

Cost to Member
No Co-payment, except:

<table>
<thead>
<tr>
<th>Categories</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>$5 co-payment for the removal of impacted teeth for a bony impaction</td>
</tr>
<tr>
<td></td>
<td>$5 co-payment per root recovery</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>$10 co-payment for the removal of impacted teeth for a bony impaction</td>
</tr>
<tr>
<td></td>
<td>$10 co-payment per root recovery</td>
</tr>
<tr>
<td>Category E</td>
<td>$10 co-payment for the removal of impacted teeth for a bony impaction</td>
</tr>
<tr>
<td></td>
<td>$10 co-payment per root recovery</td>
</tr>
</tbody>
</table>

Description

• Oral surgery includes:
• Extractions, including surgical extractions
• Removal of impacted teeth
• Biopsy of oral tissues
• Alveolectomies
• Excision of cysts and neoplasms
• Treatment of palatal torus
• Treatment of mandibular torus
• Frenectomy
• Incision and drainage of abscesses
• Post-operative services, including exams, suture removal and treatment of complications
• Root recovery (separate procedure)

Limitations
The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
### Endodontic

**Cost to Member**
No Co-payment, except

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>$5 co-payment per canal for root canal therapy or retreatment of previous root canal therapy $5 co-payment per root for an apicoectomy</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>$10 co-payment per canal for root canal therapy or retreatment of previous root canal therapy $10 co-payment per root for an apicoectomy</td>
</tr>
<tr>
<td>Category E</td>
<td>$10 co-payment per canal for root canal therapy or retreatment of previous root canal therapy $10 co-payment per root for an apicoectomy</td>
</tr>
</tbody>
</table>

**Description**
Endodontics benefits include:
- Direct pulp capping
- Pulpotomy and vital pulpotomy
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy, including culture canal and limited retreatment of previous root canal therapy as specified below
- Apicoectomy
- Vitality tests

**Limitations**
Root canal therapy, including culture canal, is limited as follows:
- Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

### Periodontics

**Cost to Member**
No Co-payment, except

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>$5 co-payment per quadrant for osseous or muco-gingival surgery</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>$10 co-payment per quadrant for osseous or muco-gingival surgery</td>
</tr>
<tr>
<td>Category E</td>
<td>$10 co-payment per quadrant for osseous or muco-gingival surgery</td>
</tr>
</tbody>
</table>

**Description**
Periodontics benefits include:
- Emergency treatment, including treatment for periodontal abscess and acute periodontitis
- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy
- Osseous or muco-gingival surgery
Limitations
Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any 12 consecutive months.

Crown and Fixed Bridge

Cost to Member
No Co-payment, except

<table>
<thead>
<tr>
<th>Categories</th>
<th>Cost Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories A &amp; B</td>
<td>$5 co-payment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns. $5 co-payment per pontic.</td>
</tr>
<tr>
<td>Categories C &amp; D</td>
<td>$10 co-payment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns. $10 co-payment per pontic.</td>
</tr>
<tr>
<td>Category E</td>
<td>$10 co-payment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns. $10 co-payment per pontic.</td>
</tr>
</tbody>
</table>

- For all Income Categories, the co-payment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.

Description
Crown and fixed bridge benefits include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel
- Related dowel pins and pin build-up
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold
- Recementation of crowns, bridges, inlays and onlays
- Cast post and core, including cast retention under crowns
- Repair or replacement of crowns, abutments or pontics

Limitations
The crown benefit is limited as follows:

- Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the dental plan.
- Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

The fixed bridge benefit is limited as follows:

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient’s oral health and general dental condition permits.
For children under the age of 16, it is considered optional dental treatment. If performed on a Member under the age of 16, the Applicant must pay the difference in cost between the fixed bridge and a space maintainer.

- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair. The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.

**Removable Prosthetics**

**Cost to Member**
No Co-payment, except:

<table>
<thead>
<tr>
<th>Categories</th>
<th>Description</th>
</tr>
</thead>
</table>
| A & B      | $5 co-payment for a complete maxillary or mandibular denture  
$5 co-payment for partial acrylic upper or lower denture with clasps  
$5 co-payment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles  
$5 co-payment for removable unilateral partial denture  
$5 co-payment for reline of upper, lower or partial denture when performed by a Laboratory  
$5 co-payment for denture duplication |
| C & D      | $10 co-payment for a complete maxillary or mandibular denture  
$10 co-payment for partial acrylic upper or lower denture with clasps  
$10 co-payment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles  
$10 co-payment for removable unilateral partial denture  
$10 co-payment for reline of upper, lower or partial denture when performed by a Laboratory  
$10 co-payment for denture duplication |
| E          | $10 co-payment for a complete maxillary or mandibular denture  
$10 co-payment for partial acrylic upper or lower denture with clasps  
$10 co-payment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles  
$10 co-payment for removable unilateral partial denture  
$10 co-payment for reline of upper, lower or partial denture when performed by a Laboratory  
$10 co-payment for denture duplication |

**Description**
The removable prosthetics benefit includes:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers
- Office or laboratory relines or rebases
- Denture repair
- Denture adjustment
• Tissue conditioning
• Denture duplication
• Space maintainer
• Stayplates

**Limitations**
The removable prosthetics benefit is limited as follows:

- Partial dentures will not be replaced within 36 consecutive months, unless:
  - It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
  - The denture is unsatisfactory and cannot be made satisfactory.
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist that is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.
- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
- Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
- Office or laboratory relines or rebases are limited to one (1) per arch in any 12 consecutive months.
- Tissue conditioning is limited to two per denture.
- Implants are considered an optional benefit.
- Stayplates are a benefit only when used as anterior space maintainers for children.

**Other Benefits**

**Cost to Member**

<table>
<thead>
<tr>
<th>Categories A &amp; B</th>
<th>No co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories C &amp; D</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Category E</td>
<td>No co-payment</td>
</tr>
</tbody>
</table>

**Description**
Other dental benefits include:

- Local anesthetics
- Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of his/her license
- Emergency and palliative treatment
- Coordination of benefits with Member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services
Orthodontic Benefits
Orthodontic treatment is not a benefit of this dental plan. However, orthodontic treatment may be provided by the California Children's Services (CCS) program if the Member meets the eligibility requirements for medically necessary orthodontia coverage under the CCS program. For more information about the CCS program, see page 63.

Excluded Benefits
The following dental benefits are excluded under the Plan:

1. Services which, in the opinion of the attending dentist, are not necessary to the Member's dental health.
2. Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
4. General anesthesia or intravenous/conscious sedation.
5. Experimental procedures.
6. Services that are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. Delta shall provide services at the time of need, and the Member or Member’s legal guardian will cooperate to assure that Delta is reimbursed for such benefits.
7. Services that are provided without cost to the Member by State government or an agency thereof, or any municipality, county or other subdivisions.
8. Hospital charges of any kind.
10. Loss or theft of dentures or bridgework.
11. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
12. Any service that is not specifically listed as a covered benefit.
15. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist’s office due to the general health and physical limitations of the Member.
16. The cost of precious metals used in any form of dental benefits.
17. The removal of implants.
18. Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by his or her panel Provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her panel Provider is a pedodontist/pediatric dentist. Note: There is a $10.00 Co-payment for children under six years of age who are unable to be treated by their panel Provider and who have been referred to a pedodontist/pediatric dentist.
19. Services which are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, or dental plan. The participating dental plan shall provide the services at the time of need, and the Member shall cooperate to assure that the participating dental plan is reimbursed for such benefits.
Section 10
Benefits Changes, Disenrollment, Termination, And Cancellation

Changes in Benefits and Charges
The Children’s Health Initiative reserves the right to change the benefits and charges of this Program. Members will be given at least thirty (30) days’ notice before any changes are made in the benefits or charges.

Disenrollment
A Member shall be disenrolled if any of the following occur:

1. The Member does not meet eligibility requirements during the annual eligibility review.
2. The Member turns age 19. Disenrollment will be on the last day of the month that the Member turns 19.
3. The required family contribution is not paid for the Member for two (2) consecutive calendar months. Disenrollment for this reason will be effective the last day of the second month for which the family contribution was not paid. The Member or responsible individual may be financially responsible for any service provided after the effective date that coverage was terminated.
4. The responsible individual will receive an invoice for the Member’s family contribution. If payment is not received by HPSM, a final notice is sent notifying the responsible individual that the Member’s health coverage will end if payment is not received. The notice states the effective date that coverage will end and is sent at least fifteen (15) days prior to that date.
5. The Member or his/her legal representative requests so in writing. Disenrollment for this reason will be effective at the end of the month for which the request was made. HPSM may also accept a Member’s request that is made over the phone.
6. The applicant or Member has intentionally made false statements in order to establish Program eligibility for any person or has obtained or attempted to obtain services or benefits by means of false, materially misleading, or fraudulent information, acts or omissions. [The Member will be provided at least fifteen (15) days notice prior to termination of coverage.]
7. The Member, or applicant on behalf of the Member, fails to provide the necessary information to be requalified. Disenrollment for this reason shall be effective after one year of coverage.
8. Death of a Member. Disenrollment for this reason shall be effective the day following the date of death.
9. HPSM terminates the program. Disenrollment for this reason shall be effective no sooner than ninety (90) days after the day of mailing the notice to Members of termination of the Program.
10. The Member or applicant has allowed a Non-Member to use a Member Identification Card to obtain services and benefits or otherwise permits another person to fraudulently or deceptively use HPSM services or facilities. The Member will be provided at least fifteen (15) days notice prior to termination of coverage.
11. The Member moves out of San Mateo County. Residence in San Mateo County is a criteria for Healthy Kids HMO eligibility. It is a Member’s responsibility to report a change of address. Disenrollment for this reason will be effective at the end of the month in which the address change will be effective. In cases where the Member does not report a change of address directly to HPSM, the Member will be provided at least fifteen (15) days notice prior to termination of coverage. Returned mail will be evidence of failure to notify HPSM of a change of address (as indicated in Rights and Declarations you signed upon enrollment). You may be able to get low cost health insurance through a similar program in your new county of residence.
12. Member is covered by other health insurance. To qualify for Healthy Kids HMO, a Member must have no other health insurance. It is a Member’s responsibility to report changes in health insurance status. Disenrollment for this reason will be effective at the end of the month in which the other health insurance becomes effective. In cases where the Member does not report a change in insurance status directly to HPSM, the Member will be provided at least fifteen (15) days notice prior to termination of coverage.

Return of Family Contribution
In the event of disenrollment for the reasons identified in subsections (4), (7), (10), and (11), above, HPSM will return to the Applicant the prorated portion of the Family Contribution paid to HPSM which corresponds to any unexpired period for which payment had been received by HPSM.

When a Member is disenrolled, the Member will be notified in writing, sent by regular U.S. mail to the Applicant’s current address on file with HPSM.

A Member who is disenrolled for failure to pay family contribution cannot participate in the Program unless family contribution owed is paid in full unless:
- the Applicant, Member, or other Family member lost employment; or
- the Applicant or other Family member has suffered a catastrophic illness that resulted in the Applicant being unable to work for more than two (2) weeks.

Individual’s Right of Cancellation
Healthy Kids HMO Applicants can cancel at any time with thirty-one (31) days’ written notice.

Review By the Department Of Managed Health Care
The California Department of Managed Health Care is responsible for regulating health care service plans, including HPSM’s enrollment and disenrollment decisions. An Applicant or Member who alleges that an enrollment has been cancelled or not renewed because of the Member’s health status or requirements for health care services may request a review by the Department. The Department of Managed Health Care has a toll-free telephone number, 1-888-HMO-2219, to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Services’ toll-free telephone numbers, 1-800-735-2929 (TTY) or 1-888-875-5378 (TTY), to contact the Department. The Department’s Web site (http://www.hmohelp.ca.gov) has complaint forms and instructions online.
Section 11
Grievance and Appeals Process

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by plan providers to the courtesy extended to you by our Member Services representatives. If you have questions about the services you receive from a plan provider, we recommend that you first discuss the matter with your provider.

If you continue to have a concern regarding any service you received, call HPSM’s Member Services at 1-800-750-4776 or 650-616-2133. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY 1-800-735-2929 or dial 7-1-1.

Appeal
If you think that HPSM has denied your request for a service or other benefit incorrectly, you can request an appeal of HPSM’s decision. You can file an appeal with HPSM within 180 calendar days from the date of HPSM’s original decision. Appeals can be filed with either a Member Services Representative by calling 1-800-750-4776 or 650-616-2133 or by speaking with a Grievance and Appeals Coordinator at 1-888-576-7227 or 650-616-2850. You can obtain a copy of HPSM’s Grievance and Appeals Policy and Procedure by calling our Member Services Department.

Grievance
If you have any other type of complaint against HPSM or a provider, you can file a grievance. You can file a grievance with HPSM within 180 calendar days from the date of the incident. Grievances can be filed with either a Member Services Representative by calling 1-800-750-4776 or 650-616-2133 or by speaking with a Grievance and Appeals Coordinator at 1-888-576-7227 or 650-616-2850. You can obtain a copy of HPSM’s Grievance and Appeals Policy and Procedure by calling our Member Services Department.

How to Submit a Grievance or Appeal
To begin the Grievance or Appeal process, you can call, write, or fax the plan at:

Grievance and Appeals Unit
Health Plan of San Mateo
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

Phone: 1-800-750-4776 or 650-616-2133
Fax: 650-829-2002
Website: www.hpsm.org

You may also submit your grievance through the internet by going to HPSM’s website and completing the online complaint form on the Healthy Kids HMO Member Grievances page.

HPSM will acknowledge receipt of your grievance within five (5) days and will resolve your grievance within thirty (30) days. If your grievance involves an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function; you or your provider may request that HPSM expedite its grievance review. HPSM will evaluate your request for an expedited review and, if your grievance qualifies as an urgent grievance, we will resolve your grievance within three (3) days from receipt of your request.

You are not required to file a grievance with HPSM before asking the Department of Managed Health Care to review your case on an expedited review basis. If you decide to file a grievance with HPSM in which you ask for an expedited review, HPSM will immediately notify you in writing that:

1. You have the right to notify the Department of Managed Health Care about your grievance involving an imminent and serious threat to health, and

2. We will respond to you and the Department of Managed Health Care with a written statement on the pending status or disposition of the grievance no later than 72 hours from receipt of your request to expedite review of your grievance.
Independent Medical Reviews
If medical care that is requested for you is denied, delayed or modified by HPSM or a plan provider, you may be eligible for an Independent Medical Review (IMR). If your case is eligible and you submit a request for an IMR to the Department of Managed Health Care (DMHC), information about your case will be submitted to a medical specialist who will review the information provided and make an independent determination on your case. You will receive a copy of the determination. If the IMR specialist so determines, HPSM will provide coverage for the health care services.

An IMR is available in the following situations:
1. (a) Your provider has recommended a health care service as medically necessary, or
   (b) You have received urgent care or emergency services that a provider determined was medically necessary, or
   (c) You have been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which you seek independent review; and
2. The disputed health care service has been denied, modified, or delayed by HPSM or one of its plan providers, based in whole or in part on a decision that the health care service is not medically necessary; and
3. You have filed a grievance with HPSM and the disputed decision was upheld or the grievance remains unresolved after 30 calendar days.

If your grievance qualifies for expedited review, you are not required to file a grievance with HPSM prior to requesting an IMR. Also, the DMHC may waive the requirement that you follow HPSM’s grievance process in extraordinary and compelling cases.

For cases that are not urgent, the IMR organization designated by DMHC will provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function; the IMR organization will provide its determination within three (3) business days. At the request of the experts, the deadline can be extended by up to three (3) days if there is a delay in obtaining all necessary documents.

The IMR process is in addition to any other procedures or remedies that may be available to you. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the plan regarding the care that was requested. You pay no application or processing fees for an IMR. You have the right to provide information in support of your request for IMR. For more information regarding the IMR process or to request an application form, please call HPSM’s Member Services at 1-800-750-4776 or 650-616-2133. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY 1-800-735-2929 or dial 7-1-1.

Independent Medical Review for Denials of Experimental / Investigational Therapies
You may also be entitled to an Independent Medical Review, through the Department of Managed Health Care, when we deny coverage for treatment we have determined to be experimental or investigational.

- We will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an experimental/ investigational therapy within five (5) business days of the decision to deny coverage.
- You are not required to participate in HPSM’s grievance process prior to seeking an Independent Medical Review of our decision to deny coverage of an experimental/investigational therapy.
- If a physician indicates that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.
**Review by the Department of Managed Health Care**

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against HPSM, you should first telephone HPSM at **1-800-750-4776** or **650-616-2133** and use HPSM's grievance process before contacting the department. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY **1-800-735-2929** or dial **7-1-1**. Using this grievance procedure does not prohibit any legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by HPSM, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial view of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency and urgent medical services. The Department of Managed Health Care has a toll-free telephone number, **1-888-HMO-2219**, to receive complaints regarding health plans. The hearing and speech impaired may use the department’s TDD line (**1-877-688-9891**) number, to contact the department. The Department's Internet website (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.

HPSM's grievance process and DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

**Mediation**

You or your authorized representative can request voluntary mediation with HPSM. You need not participate in mediation for more than thirty (30) days before being able to submit a Grievance to the Department of Managed Health Care. You can still submit a Grievance with the Department after completing mediation. You and HPSM will share the cost of mediation.
This page intentionally left blank.

Esta página ha sido dejada en blanco intencionalmente.

此頁有意留為空白。

Ang pahinang ito ay sadyang iniwan na blangko.
Other Health Insurance
Healthy Kids members usually do not have other health insurance. It is to your advantage to let your network provider know if you have medical coverage in addition to this program. Most carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both programs.

Coverage provided under this program is secondary to all other coverage, except Medi-Cal. Benefits paid under this program are determined after benefits have been paid by any other health care program in which the Member is enrolled. If you receive restricted benefits under Medi-Cal (i.e. for emergency and/or pregnancy-related services only) and do not have a share of cost, your emergency and/or pregnancy-related services will be covered by State Medi-Cal, not by Healthy Kids. Your provider will need to bill State Medi-Cal for these services. For more information, please contact a Health Plan of San Mateo Member Services Representative at 1-800-750-4776 or 650-616-2133.

Be sure to advise your provider of all programs under which you have coverage so that you will receive all benefits to which you are entitled. For further information, contact HPSM’s Member Service department.

Third Party Recovery Process and Member Responsibilities
The Member agrees that, if benefits of this Agreement are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, provided that the Member is made whole for all other damages resulting from the wrongful act or omission before HPSM is entitled to reimbursement, Member shall:

• Reimburse HPSM for the reasonable cost of services paid by HPSM to the extent permitted by California Civil Code section 3040 immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
• Fully cooperate with HPSM’s effectuation of its lien rights for the reasonable value of services provided by the HPSM to the extent permitted under California Civil Code section 3040. HPSM’s lien may be filed with the person whose act caused the injuries, his or her agent or the court.

HPSM shall be entitled to payment, reimbursement, and subrogation in third party recoveries and Member shall cooperate to fully and completely effectuate and protect the rights of HPSM including prompt notification of a case involving possible recovery from a third party.

Non-Duplication of Benefits with Workers’ Compensation
If, pursuant to any Workers’ Compensation or Employer’s Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of medical services provided by HPSM, we will provide the benefits of this Agreement at the time of need. The Member will agree to provide HPSM with a lien on such Workers’ Compensation medical benefits to the extent of the reasonable value of the services provided by the HPSM. The lien may be filed with the responsible third party, his or her agent, or the court. For purposes of this subsection, reasonable value will be determined to be the usual, customary, or reasonable charge for services in the geographic area where the services are rendered. By accepting coverage under this Agreement, Members agree to cooperate in protecting the interest of HPSM under this provision and to execute and to deliver to HPSM or its nominee any and all assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of HPSM or its nominee.

Coordination of Benefits
By enrolling in HPSM each Member agrees to complete and submit to HPSM such consents, releases, assignments and any other document reasonably requested by HPSM in order to assure and obtain
reimbursement and to coordinate coverage with other health benefit plans or insurance policies. The payable benefits will be reduced when benefits are available to a Member under such other plan or policy whether or not claim is made for the same.

The fact that a Member has double coverage under HPSM will in no way reduce Member's obligation to make all required co-payments.

**Limitations of Other Coverage**

This health plan coverage is not designed to duplicate any benefits to which Members are entitled under government programs, including CHAMPUS/TRICARE, Medi-Cal or Workers’ Compensation. By executing an enrollment application, a Member agrees to complete and submit to HPSM such consents, releases, assignments, and other documents reasonably requested by HPSM or order to obtain or assure CHAMPUS/TRICARE or Medi-Cal reimbursement or reimbursement under the Workers’ Compensation Law.

**Provider Payment**

HPSM pays doctors and healthcare providers on a fee-for-service basis. This means that the doctors provide healthcare services to Members and then send a bill to HPSM. Hospitals, Skilled Nursing Facilities and Hospices are paid on a daily rate. There are no risk-sharing provisions in these payment arrangements, and no financial penalties designed to limit health care. In fact, there are incentives for many of our providers to provide the appropriate levels and types of health care to our Members.

**Reimbursement Provisions—If You Receive a Bill**

To make sure your doctor knows how to bill for your care, please tell the doctor’s office staff that you are an HPSM Member. Always show your ID card when you get services.

You should not be billed for services except in certain cases:

- If you asked for and received services that aren’t covered, such as cosmetic surgery.
- If you go to an out-of-network doctor for non-emergency services.
- If you didn’t pay your co-payment at the time of your visit.

If you receive a bill for these services you are responsible to pay.

If you receive a bill for a service that is a benefit or from an out-of-network provider at an in-hospital or in-network facility that was authorized by HPSM, **please do not pay the bill.** Call the provider’s office immediately and ask them to bill HPSM. The provider can call HPSM and we can explain to them how to bill us. The number for a provider to call is on your ID card. If you are unsure what to do, you can call Member Services.

Please do not ignore bills from providers. If you end up being sent to Collections for a bill, we may not be able to help you as easily. You may end up being responsible for part or all of the bill.

If you have already paid a bill for services, for example for emergency services, we will work with the provider to get you a refund. You will have to submit a copy of the bill with your name, ID number (on your Member ID card), your phone number, and date and reason for the bill. You must also submit proof of payment. Send the bill to:

Member Services Department  
Health Plan of San Mateo  
801 Gateway Blvd., Suite 100  
South San Francisco, CA 94080

Your written request should be mailed to HPSM within 3 months from the date you received services, or as soon as reasonably possible, but in no event later than 12 months after receiving the care.
Public Participation
The Consumer Advisory Committee, which is made up of HPSM Members and community advocates that work on behalf of HPSM’s members, is a standing advisory group of the San Mateo Health Commission, which is responsible for the Health Plan of San Mateo. The committee advises the Commission on how the Health Plan can best serve Members. It also reviews policy issues which the Commission will decide so that the Members can participate before final decisions are made. A Member of the Consumer Advisory Committee represents Health Plan Members on the Health Plan’s Quality Assessment and Improvement Committee.

If you would like to apply for membership on the Consumer Advisory Committee, please contact Member Services at 1-800-750-4776 or 650-616-2133.

Notifying You of Changes in the Plan
Throughout the year we may send you updates about changes to the Healthy Kids HMO program. This can include updates for the Provider Directory, Handbook, and Evidence of Coverage. We will keep you informed and are available to answer any questions you may have. Call Member Services at 1-800-750-4776 or 650-616-2133 if you have any questions about changes in the plan.

Privacy Practices
HPSM will protect the privacy of Member’s health information. Contracted providers are also required to protect your health information. Protected health information includes your name, social security number, and other information that reveals who you are. You have the right, with certain exceptions, to see and receive copies of your health information that HPSM maintains, correct or update your health information, and ask us for an accounting of certain disclosures of your health information.

HPSM may use or disclose your health information for treatment, payment and health care operations, including measuring the quality of care and services that you receive. We are sometimes required by law to give protected health information to government agencies or in judicial actions. In addition, we will not use or disclose your health information for any other purpose without your (or your representative’s) written authorization, except as described in our Notice of Privacy Practices.

Contact HPSM’s Member Services Department at 1-800-750-4776 or 650-616-2133 for a copy of HPSM’s Notice of Privacy Practices. Our Notice of Privacy Practices is also on our website at www.hpsm.org and at the beginning of this booklet.

Authorization for Release of Information
The Health Plan of San Mateo will not release individually identifiable medical or personal information without obtaining authorization from the Member or the Member’s designee, except as allowed in statute. HPSM may release information that is not individually identifiable. In order to release medical information for purposes not related to treatment, payment, or health care operations, or as required by law (including any release of individually specific genetic testing information), HPSM will seek authorization from the Member or the Member’s designee.

Organ and Tissue Donation
Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities. The Department of Health and Human Services’ Internet website (www.organdonor.gov) has additional information on donating your organs and tissues.
This page intentionally left blank.

Esta página ha sido dejada en blanco intencionalmente.

此頁有意留為空白。

Ang pahinang ito ay sadyang iniwan na blangko.
Healthy is for everyone.