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COUNTY OF SAN MATEO
AGING AND ADULT SERVICES
MEMORANDUM

Date: JUL 1 8 2001
Hearing date: JUL 3 1 2001

TO: Honorable Board of Supervisors
Acting as the In-Home Supportive Services Public Authority

FROM: Charlene A. Silva, Director, Aging and Adult Services

SUBJECT: Agreement with the Health Plan of San Mateo for Fiscal Year 2001-02

RECOMMENDATION

Adopt a resolution authorizing the Public Authority of San Mateo to enter into an agreement with the Health Plan of San Mateo to provide health benefits to independent providers of the In-Home Supportive Services Program

Background

In September 1993, your board approved an ordinance establishing a separate Public Authority to administer the provider components of the In-Home Supportive Services Program (IHSS) and designating the San Mateo County Board of Supervisors as the governing Board of the Public Authority.

The goal of IHSS is to assist eligible aged, blind, and disabled individuals to remain in their own homes and avoid institutionalization. Using independent providers, IHSS provides participants with a wide variety of basic services such as meal preparation, feeding and bathing, protective supervision, laundry and shopping, transportation, house cleaning, and certain paramedical services authorized by a physician.

A worker registry and referral system to assist clients in securing qualified workers (independent providers) has been an integral part of the Public Authority's model from the start. The Public Authority recruits, screens, and matches independent providers with clients. Recruitment, training, and retention of service providers have been key to effective service delivery. Furthermore, the creation of the Authority as the "employer of record" has allowed the independent provider work force to engage in collective bargaining. The independent providers are represented by Service Employees International Union (SEIU), and the Public Authority negotiates with the union.

Discussion

In the shared community vision project created by the San Mateo County Board of Supervisors, access to health care and preventive care was identified as one of the major concerns of San Mateo County residents. Similarly, IHSS service providers have voiced a concern over their lack of health benefits. In August 2000, a survey was conducted to determine the number of San Mateo County IHSS independent providers without health care coverage. The survey revealed that approximately 32% did not have any health care coverage. In addition, the state budget for 2000-01 included the provision for

the state to contribute a share of cost up to $0.60 per hour for the health benefits for independent providers, subject to specific state General Fund revenue targets. This contribution would reduce the county's cost for the provision of health benefits to independent providers.

In November 2000, the IHSS Public Authority signed an agreement with SEIU, Local 715, to provide health benefits to the independent providers. In accordance with the agreement between the Public Authority and SEIU, independent providers who are authorized to work a minimum of 35 hours a month will be offered the opportunity to request coverage in the proposed health benefits plan.

Because of the complexity of the issues related to developing a health benefits program, a consultant was hired to conduct a financial feasibility study. The study included an assessment of the population group, financing and general program features, and recommendation of a potential health plan administrator. Based on the results of the study, the Health Plan of San Mateo (HPSM) was recommended as the best alternative to provide health benefits for the independent providers. The selection was based on HPSM's experience providing health benefits to over 38,000 Medi-Cal and Healthy Families members; provision of a fully licensed insurance product with a full scope of services; effectiveness as an organization; experience in dealing with similar populations, including cultural competence in working with diverse populations; and partnership with the County. An amendment to the HPSM's statute that expanded the provision of health care beyond the Medi-Cal and Healthy Families recipients to publicly funded programs was passed by the legislature and became effective on January 1, 2001. A health plan based on the Healthy Families program model was designed specifically for the independent providers. An agreement between the Public Authority and HPSM has been developed to establish HPSM as the administrator of health benefits for the independent providers through this plan.

County Counsel has reviewed and approved this agreement.

Fiscal Impact

The term of the agreement is July 1, 2001 to June 30, 2002. The monthly premium for this health plan is $195, and each provider who is covered is expected to pay $10 per month toward the premium cost. The total cost of this health benefit will be included in the rate for the Public Authority and is eligible for reimbursement from both federal and state sources. In 2001-02 the county cost for independent provider benefits is projected to be $820,000. This amount is made up of $420,000, which is included in the approved IHSS Public Authority budget, and an additional $400,000 that is provided on a one-time basis from funds that were budgeted but not spent on health benefits in 2000-01. An appropriation transfer request will be submitted to your board later this year to cover the $400,000 from departmental reserves. Total cost of the benefits is limited by the amount of funding available from the state and federal governments, which we estimate to be about $1.5 million. The county share of the cost is based on the amount of state funding available. There is no additional impact on the county General Fund as a result of this action.

RECOMMENDED

Marquez Taylor

HEALTH SERVICES DEPARTMENT

RESOLUTION NO. _____

IN-HOME SUPPORTIVE SERVICES PUBLIC AUTHORITY
COUNTY OF SAN MATEO, STATE OF CALIFORNIA

* * * * * * * * * *

RESOLUTION APPROVING AN AGREEMENT WITH THE HEALTH PLAN OF SAN MATEO TO PROVIDE HEALTH BENEFITS TO INDEPENDENT PROVIDERS OF THE IN-HOME SUPPORTIVE SERVICES PROGRAM

RESOLVED, by the In-Home Supportive Services Public Authority of the County of San Mateo, State of California, that;

WHEREAS, the Board of Supervisors of San Mateo has designated itself as the Governing Board of the San Mateo County In-Home Supportive Services Public Authority to carry out programs pursuant to the In-Home Supportive Services Program; and

WHEREAS, there has been presented to this Governing Board for its consideration and acceptance an Agreement, reference to which is hereby made for further particulars, whereby the Health Plan of San Mateo will provide health benefits to independent providers providing In-Home Supportive Services through the Public Authority; and

WHEREAS, this Governing Board has been presented with a form of the Agreement and has examined and approved it as to both form and content and desires to enter into the Agreement:

NOW, THEREFORE, IT IS RESOLVED that this Agreement with the Health Plan of San Mateo is hereby approved and the President of this Governing Board is hereby authorized and directed to execute the aforesaid Agreement for and on behalf of the In-Home Supportive Services Public Authority, and the Clerk of the Board shall attest the President's signature thereto.

GROUP AGREEMENT
Between
San Mateo Health Commission
and
San Mateo County Public Authority

This Group Agreement (Agreement), including the Evidence of Coverage (EOC) document(s) and attachments listed below and incorporated herein by reference, and any amendments to any of them, constitutes the contract between the San Mateo Health Commission, dba Health Plan of San Mateo, (PLAN) and the San Mateo County Public Authority (Contract Holder). This Agreement is effective this _____ day of _____, 2001.

Product Name: HealthWorks

Attachment	A - Terms and Conditions
Attachment	B – Premium Schedule
Attachment	C - COBRA and Cal-COBRA
Attachment	D – Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Attachment	E – Evidence of Coverage (EOC)

Pursuant to this Agreement, PLAN will provide covered services and supplies to Members in accord with the terms, conditions, rights, and privileges as set forth in this Agreement and the EOC.

The PLAN is subject to the requirements of state and federal laws governing health care plans, including the Knox-Keene Act of 1975 and its amendments. Any provisions required to be in this Agreement by either the applicable Statute or Regulations will bind PLAN whether or not expressly stated in this Agreement.

If any provision of this Agreement is deemed to be invalid or illegal, such provision shall be fully severable and the remaining provisions of this Agreement shall continue in full force and effect.

This Agreement and its attachments have the same meaning given those terms in the EOC.

Group Agreement Effective Date:
Contract Holder Number: 000001

San Mateo County Public Authority	San Mateo Health Commission
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
_____	_____
Date	Date

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ATTACHMENT A
TERMS AND CONDITIONS

Recital:

A. Commission has entered into or will enter into and shall maintain a contract with the San Mateo County Public Authority pursuant to which individuals who subscribe and are enrolled under HealthWorks will receive, through the Commission, health services hereinafter defined as "Covered Services."

NOW, THEREFORE, it is agreed that the above Recital is true and correct and as follows:

SECTION 1
DEFINITIONS

As used in this agreement, the following terms (listed alphabetically) shall have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended.

1.1 **"Agreement"** – see Group Agreement

1.2 **"Beneficiary"** - a person designated by an insuring organization as eligible to receive insurance benefits.

1.3 **"Cal-COBRA"** - a California State law that requires employers to offer continued health insurance coverage under certain circumstances where coverage would otherwise terminate.

1.4 **"Contract Holder"** - refers to the San Mateo County Public Authority (SMCPA), the employer of record for San Mateo County In-Home Supportive Services Workers (IHSS). SMCPA is the entity responsible for purchasing medical coverage on behalf of eligible IHSS workers and authorizing the Group Agreement with the PLAN.

1.5 **"Contracting Provider"** - means a person who holds a degree of Doctor of Medicine or Osteopathy, who is licensed to practice medicine in the State of California, and who has a contract with the Plan to provide medical services to HealthWorks Beneficiaries.

1.6 **"Consolidated Omnibus Budget Reconciliation Act (COBRA)"** - a federal law that, among other things, requires employers to offer continued health insurance coverage to certain employees and their beneficiaries who have had their group health insurance coverage terminated.

1.7 **"Copayment"** - a cost-sharing arrangement in which a plan member pays a specified charge for a specified service, such as $10 for an office visit. The member is usually responsible for payment at the time the health care is rendered.

1.8 **"Evidence of Coverage"** - a description of the benefits included in a health plan. The certificate of coverage is required by state law and represents the coverage provided

under the contract. A copy of the certificate is provided to the member.

1.9 **"Group Agreement"** - the application and addenda signed by both the health plan and the enrolling entity, which constitutes the agreement regarding the benefits, exclusions and other conditions between the health plan and the enrolling unit.

1.10 **"Health Insurance Portability and Accountability Act of 1996 (HIPAA)"** - a federal law that, among other things, provides guaranteed renewability of health care coverage to certain employees who no longer qualify for group health insurance through their employer and have an opportunity to purchase coverage from another insurer.

1.11 **"Hospital"** - a facility, licensed, certified or otherwise authorized by state and federal laws that provides acute inpatient care.

1.12 **"Member"** - shall mean an individual who is enrolled in good standing with HealthWorks.

1.13 **"Participating Provider"** - a provider who has contracted with the health plan to provide medical services to covered persons. The provider may be a hospital, pharmacy, other facility or a physician who has contractually accepted the terms and conditions as set forth by the health plan.

1.14 **"PLAN"** - shall mean the programs governed by the San Mateo Health Commission which serve San Mateo County Medi-Cal Beneficiaries, Members of Healthy Families and Members of HealthWorks. Also called the Health Plan of San Mateo.

1.15 **"Premium"** - the amount paid to the plan for providing coverage under a contract.

SECTION II
ENROLLMENT

2.0 Members may enroll with the PLAN during the Open Enrollment or within sixty-two (62) days from the date the individual becomes eligible for coverage. Member eligibility conditions are described in the EOC. Eligible individuals who do not enroll during the Open Enrollment or within sixty-two (62) days of becoming eligible for coverage may only be enrolled during a subsequent Open Enrollment or upon satisfying special enrollment provisions stated in the EOC. Open Enrollment shall be in compliance with applicable law.

2.1 The Contract Holder shall be responsible for forwarding completed enrollment information on eligible members.

2.2 The Contract Holder shall not change the eligibility requirements used to determine membership in the group during the term of the Group Agreement, unless agreed to in writing by the PLAN.

SECTION III
PREMIUMS

3.0 Premiums for the Covered Benefits under this Group Agreement are set forth in Attachment B, attached hereto, which is fully incorporated herein by reference.

3.1 Premium Change

3.1.1 PLAN may change the Premium with thirty-one (31) days written notice to Contract Holder as follows:

3.1.2 upon the renewal date of this Group Agreement; or

3.1.3 upon the effective date of any applicable law or regulation having a direct and material impact on the cost of providing coverage to Members.

Payment of the applicable Premium on and after that date shall constitute acceptance of those changes by the Contract Holder, individually and on behalf of all Members enrolled under this Group Agreement.

3.2 Premium Payment

Premiums are payable to the PLAN at the PLAN's corporate office by electronic file transfer via ACH, wire transfer or check via mail addressed to: Financial Officer, Health Plan of San Mateo, 701 Gateway Blvd, Ste. 400, South San Francisco, CA 94080.

3.3 Premium due date and grace period

The Premium due date will be the first of the month for which coverage is provided. A five (5) day grace period will allow the Group Agreement to be in force beyond the premium due date. The Contract Holder remains liable for the payment of the Premium for the time coverage was in effect during the grace period and Members will remain liable for Copayments. A check is not a payment until it is cleared by the PLAN's bank.

3.3.1 Premiums shall be paid in full for Members whose coverage is effective on the Premium due date or whose coverage terminates on the last day of the Premium period.

3.4 Credit for Member terminations

Contract Holder may receive a maximum of two (2) month's credit for Member

terminations which occurred more than thirty-one (31) days prior to the date PLAN was notified of the Member's termination. Retroactive additions will be honored at the discretion of the PLAN base upon the eligibility guidelines described in the EOC and on the Schedule of Benefits. Retroactive additions are subject to payment of applicable premiums.

3.4.1 The Contract Holder shall be responsible for any claims paid by PLAN and Member to the extent PLAN relied on the Contract Holder's submitted enrollment to confirm coverage where coverage was not valid.

3.5 Non-payment of Premium

3.5.1 If the Premiums are not paid by the Premium due date, PLAN will require the Contract Holder to pay interest on the overdue amount at 1 1/2% for each month overdue, commencing on the thirty first (31st) day after the Premium due date.

3.5.2 In the event of non-payment of any amount due, PLAN shall be entitled to all remedies provided for in law or in equity, including but not limited to, reasonable attorney's fees (which the parties acknowledge may constitute at least 33 1/3% of the sum sued upon), costs of suit (including but not limited to filing fees and deposition transcript costs), and pre- and post-judgment interest at the rate of 1 1/2% per month.

SECTION IV
TERM AND TERMINATION

4.0 Effective Date

This agreement shall become effective on the date specified on the HealthWorks Group Agreement, or on the date for which the Commission first assumes responsibility for Members under HealthWorks, whichever is later.

4.1 Term

4.1.1 The term of the Group Agreement shall begin with the effective date of the Agreement and last for one year or shall coincides with the term of the contract between San Mateo County Public Authority and Local 715 SEIU, IHSS workers, whichever occurs first. This Agreement does not automatically renew.

4.2 Termination on Notice

This Agreement may be terminated by either party as follows:

4.2.1 If terminated by Contract Holder, termination will require forty-five (45) days advance written notice of intent to terminate, transmitted by Contract Holder to

Commission by Certified U.S. Mail, Return Receipt Requested, addressed to the office of the Commission as provided below:

Health Plan of San Mateo
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080

4.2.2 If termination is initiated by Commission, the date of such termination shall be set by consideration for the welfare of Members and necessary allowance for notification of Providers and Members, and Contract Holder shall be notified as hereinafter provided. Commission may terminate this Agreement at any time and for any reason upon thirty (30) days written notice transmitted by Commission to Contract Holder by Certified U.S. Mail, Return Receipt Requested, addressed to the office of the Contract Holder as provided below.

San Mateo County Public Authority
225 – 37th Avenue
San Mateo, CA 94403

4.3 Termination for nonpayment

If Contract Holder fails to make any past-due payment within fifteen (15) days after PLAN's initial written notice to Contract Holder of amount payable, PLAN may terminate this Agreement immediately by giving written notice to Contract Holder and Contract Holder is liable for all unpaid Premiums through the termination date.

4.4 Termination due to non-acceptance of amendments

All amendments are deemed accepted by Contract Holder unless Contract Holder gives PLAN written notice of non-acceptance at least thirty (30) days before the effective date of the amendment and remits all amount payable related to this Agreement, including Premiums, for the period prior to the amendment effective date. The Contract Holder notifies the Commission in writing of termination within sixty (60) days of notice of said Amendment.

4.5 Termination due to non-renewal of Agreement

The Contract Holder may terminate this Group Agreement as of its renewal date, by providing PLAN written notice of non-renewal not less than thirty (30) days prior to the renewal date.

4.6 Termination due to Premium change

The Contract Holder may terminate this Group Agreement as of the date any Premium change would become effective, by providing PLAN with written notice of termination not less than thirty (30) days prior to such effective date.

4.7 Termination for discontinuance of a product or all products within a market

4.7.1 PLAN may terminate a particular product offered as permitted by the Health Insurance Portability and Accountability Act (HIPPA) if;

4.7.1.1 for any reason, PLAN is unable to enter into or maintain service contracts with sufficient numbers of providers, (hospitals and physicians) to assure adequate Member access to needed Covered Services, the PLAN may terminate this Agreement upon thirty (30) days written notice to the Contract Holder; or

4.7.1.2 if, the qualification of PLAN under the Federal Social Security Act is terminated or ceases for any reason or if the PLAN's contract with the State of California is terminated or ceases for any reason, Plan shall give Contract Holder immediate written notice of the foregoing termination(s) and this Agreement shall terminate in accordance with the terms of Section 4.7.2 of this Agreement.

4.7.2 In the event there are (1) changes effected in the PLAN's contract with the State of California, or (2) changes effected in HealthWorks, or (3) changes in the Federal Medicare Program and/or substantial changes under other public or private health and/or hospital care insurance programs or policies which will have a material detrimental financial effect on the operations of the Contract Holder or PLAN, Contract Holder or PLAN may terminate this Group Agreement upon providing the other party with thirty (30) days prior written notice. In any case where such notice is provided, both parties shall negotiate in good faith during such thirty (30) day period in an effort to develop a revised Group Agreement, which, to the extent reasonably practicable, under the circumstances, will adequately protect the interests of both parties in light of the governmental program or private insurance policy changes which constituted the basis for the exercise of this termination provision.

4.8 Termination for fraud or intentionally furnishing incorrect or incomplete inform Information

PLAN may terminate this Agreement upon fifteen (15) days prior written notice to Contract Holder, if Contract Holder commits fraud or intentionally furnishes incorrect or incomplete material information to PLAN.

4.9 Termination for cause

PLAN may terminate this Group Agreement if the Contract Holder:

4.9.1 Admits in writing its inability to pay debts as they come due;

4.9.2 consents to the appointment of a trustee or receiver, or if a trustee or receiver is appointed for the Contract Holder or for all or a substantial part of its properties or business;

becomes insolvent;

files a petition in bankruptcy;

files a petition seeking any reorganization, arrangement, composition or similar relief under any federal or state law regarding insolvency or relief for debtors; or

has begun any voluntary or involuntary liquidation process;

changes eligibility requirements, employer (employer of record) contribution or other material information stated in the Contract Holder's application or Service Agreement, without PLAN's prior written approval.

Termination will be effective immediately following the date PLAN gives the Contract Holder written notice of termination.

4.10 Effect of Termination

As of the date of termination pursuant to any provision of this Agreement, this Agreement shall be of no further force or effect whatsoever, and each of the parties hereto shall be relieved and discharged herefrom, except that the PLAN shall remain liable for all Benefits rendered to Members up to the date of termination and for any Benefits rendered hereunder after such date until such time as appropriate transfer (or other medically acceptable disposition) of Members receiving inpatient services as of the date of termination is achieved.

SECTION V
MEMBER NOTIFICATION OF TERMINATION

5.0 It is the responsibility of the Contract Holder to notify the **Members** of the termination of

the Group Agreement in compliance with all applicable laws. However, PLAN reserves the right to notify **Members'** of termination of the Group Agreement for any reason, including non-payment of Premium. When PLAN delivers a notice of cancellation or termination to Contract Holder, Contract Holder will promptly mail a legible, true copy to each **Member** under this Group Agreement at the **Members'** current address.

5.1. In accordance with the EOC, the Contract Holder shall also provide written notice to Members of Member's continuation and conversion rights upon termination of coverage.

5.2 Termination shall not relieve the Contract Holder or PLAN from any obligation incurred prior to the date of termination of this Group Agreement.

SECTION VI
OBLIGATIONS UNDER COBRA AND CAL-COBRA

6.0 The Contract Holder is subject to the requirements of state and federal law governing continuation of health care coverage for Members. The federal law is the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). The California state law is the California Continuation Benefits Replacement Act ("Cal-COBRA"). Obligations of the Contract Holder under COBRA and Cal-COBRA are summarized in ATTACHMENT C. Any provisions required to be in this Group Agreement by either the applicable Code or Regulation governing COBRA or Cal-COBRA will bind the Contract Holder whether or not expressly stated in the Group Agreement or any Attachments.
Contract Holder hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to COBRA and/or Cal-COBRA continuation coverage.

SECTION VII
THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

7.0 The Contract Holder is subject to the requirements of state and federal law governing the portability of health care coverage for Members ("creditable coverage"). The federal law is the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Obligations of the Contract Holder under HIPAA are summarized in ATTACHMENT D. Any provisions required to be in this Group Agreement by either the applicable Statute or Regulation governing HIPAA will bind the Contract Holder whether or not expressly stated in the Group Agreement or any Attachments.

Contract Holder hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to HIPAA continuation coverage.

SECTION VIII
INDEPENDENT CONTRACTOR RELATIONSHIPS

8.0 Between Participating Providers and PLAN.

The relationship between PLAN and Participating Providers is a contractual relationship among independent contractors. Participating Providers are not agents or employees of PLAN nor is PLAN an agent or employee of any Participating Provider.

Participating Providers maintain the provider-patient relationship with Members and are solely responsible to their Member patients for any health services rendered to their Member patients. PLAN makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any Physician, Hospital or other Participating Provider. In no event will PLAN be liable for the negligence, wrongful acts, or omissions in a Participating Provider's delivery of services regardless of whether such services are or would be covered under this Group Agreement, nor will PLAN be liable for services or facilities which for any reason beyond its control are unavailable to the Member.

A Contracting Provider's participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**.

8.1 Between the Contract Holder and PLAN.

The relationship between PLAN and the Contract Holder is limited to a contractual relationship between independent contractors. Neither party is an agent nor employee of the other in performing its obligations pursuant to this Group Agreement.

SECTION IX
ADMINISTRATION OF THE AGREEMENT

PLAN may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Group Agreement.

9.0 Entire Agreement

This Group Agreement, including the Group Application, Evidence of Coverage, Schedule of Benefits, any amendments, endorsements, insets or attachments, constitutes the entire Group Agreement between the Contract Holder and PLAN, and on the Effective Date of Coverage, supersedes all other prior an contemporaneous arrangements, understandings, agreements, negotiations and discussions between the parties, whether written or oral, previously issues by PLAN for Covered Benefits provided by this Group Agreement.

9.1 Amendments

9.1.1 This Group Agreement may be amended at any time upon written agreement of PLAN and Contract . **Holder**. Upon 30 days prior written notice to Contract Holder, Plan may extend the term of this Agreement and/or make other changes by amending this Agreement. Extending the term of this Agreement will be contingent upon Contract Holder's acceptance of all amendments, including Premiums and benefits, as described under "Acceptance of Amendments" below.

9.1.2 This Group Agreement may be amended by the PLAN upon thirty (30) days written notice to the Contract Holder. If the Contract Holder does not give written notice of termination within thirty (30) days, Contract Holder agrees that any such amendment by the PLAN shall be part of the Group Agreement.

9.1.3 The terms of the Group Agreement shall be subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), as amended , and the regulations promulgated thereunder (the "Regulations"), to the extent applicable hereto, and any provision required to be in this Agreement by either the Act or Regulations shall bind PLAN and the PCP as appropriate, whether or not provided herein. If the Director of the Department of Managed Health Care or his/her successor requires further amendments to this Group Agreement, PLAN shall notify Contract Holder in writing of such amendments. The Contract Holder will have thirty (30) days from the date of PLAN's notice to reject the proposed amendments by written notice of rejection to PLAN. If PLAN does not receive such written notice of rejection within the thirty (30) day period, the amendments shall be deemed accepted by and binding upon the Contract Holder. Amendments for this purpose shall include, but not be limited to, material changes to PLAN's Utilization Management, Quality Assessment and Improvement and Complaint and Grievance programs and procedures and to the health care services covered by this Group Agreement. Without limiting the foregoing, the validity and enforceability of this Agreement, as well as the rights and duties of the parties herein shall be governed by California law.

9.1.4 Formal acceptance of an amendment to this Group Agreement by the Contract Holder shall not be required if:

9.1.4.1 the change was requested by either the Contract Holder or PLAN and is agreed to in writing by the other; or

9.1.4.2 the change is required to bring the Group Agreement into conformance with any applicable federal or state law or regulation, or ruling of the jurisdiction in which the Group Agreement is delivered; or

9.1.4.3 the Contract Holder makes payment of any applicable Premium on and after the effective date of such amendment.

9.2 Forms

PLAN shall supply the Contract Holder with a reasonable supply of its forms and descriptive literature. The Contract Holder shall distribute PLAN's forms and descriptive literature to any eligible individual who becomes eligible for coverage. The Contract Holder shall, within sixty-two (62) days of receipt from an eligible individual, forward all applicable forms and other required information to PLAN.

9.3 Records

The PLAN maintains records and information to allow the administration of a Member's coverage. The Contract Holder shall provide the PLAN information to allow for the administration of a Member's benefits. This includes information on enrollment, continued eligibility, and termination of eligibility. The PLAN shall not be obligated to provide coverage prior to receipt of information needed to administer the benefits or confirm eligibility in a form satisfactory to the PLAN.

The Contract Holder shall make payroll and other records directly related to Member's coverage under this Group Agreement available to PLAN for inspection, at PLAN's expense, at the Contract Holder's office, during regular business hours, upon reasonable advance request from PLAN. This provision shall survive the termination of this Group Agreement as necessary to resolve outstanding financial or administrative issues pursuant to this Group Agreement. PLAN's performance of any obligation that depends on information to be furnished by Contract Holder or Member will not arise prior to receipt of that information in the form requested by PLAN. Nor will PLAN be liable for any obligation due to information incorrectly supplied by Contract Holder or Member. All records of Contract Holder that have a bearing on coverage shall be open for inspection by PLAN at any reasonable time.

9.4 Clerical Errors

Incorrect information furnished to PLAN may be corrected, provided that PLAN has not acted to its prejudice in reliance thereon. Clerical errors or delays in keeping or reporting data relative to coverage will neither invalidate coverage which would otherwise be in force, continue coverage which would otherwise be validly terminated if PLAN, in its sole discretion, determines that a clerical error has been made, nor grant additional benefits to Members. Upon discovery of such errors or delay, an adjustment of Premiums shall be made. In no case will adjustments in coverage or Premiums be made effective more than two (2) Premium due dates prior to the date PLAN is notified in writing, on a form satisfactory to PLAN, of the requested addition, deletion, or change in coverage.

9.5 Claim Determinations

PLAN has complete authority to review all claims for Covered Benefits under this Group

Agreement. In exercising such responsibility, PLAN shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and construe any disputed or doubtful terms under this Group Agreement. PLAN shall be deemed to have properly exercised such authority unless **PLAN** abuses its discretion by acting arbitrarily and capriciously.

9.6. Fraudulent or Material Misstatements

If any relevant fact as to a Member is found to have been misstated, an equitable adjustment of Premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is to remain in force

9.7 Assignability

No rights or benefits under this Group Agreement are assignable by the Contract Holder to any other party unless approved by PLAN.

9.8 Waiver

PLAN's failure to implement, or insist upon compliance with, any provision of this Group Agreement or the terms of the EOC incorporated hereunder, at any given time or times, shall not constitute a waiver of PLAN's right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of Premiums or benefits. This applies whether or not the circumstances are the same.

9.9 Notices

Any notice required or permitted under this Group Agreement shall be in writing and shall be deemed to have been given on the date when delivered in person, or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the offices of the PLAN.

9.10 Third Parties

This Group Agreement shall not confer any rights or obligations on third parties except as specifically provided herein.

9.11 Non-Discrimination

The Contract Holder shall not discriminate on the basis of sex, race, creed, color,

ancestry, religious creed, national origin, physical disability including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, age, medical condition or mental status. In addition all Primary Care Providers shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment.

9.12 Inability to Arrange Services

In the event that due to circumstances not within the reasonable control of PLAN, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of PLAN's Participating Providers or entities with whom PLAN has arranged for services under this Group Agreement, or similar causes, the rendition of medical or Hospital benefits or other services provided under this Group Agreement is delayed or rendered impractical, PLAN shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid Premiums held by PLAN on the date such event occurs. PLAN is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

9.13 Use of the HealthWorks Name and all Symbols, Trademarks, and Service Marks

PLAN reserves the right to control the use of its name and all symbols, trademarks, and service marks presently existing or hereinafter established with respect to it. The Contract Holder agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without prior written consent of PLAN and will cease any and all usage immediately upon request of PLAN or upon termination of this Group Agreement.

9.14 Workers' Compensation

9.14.1 The Contract Holder is responsible for protecting PLAN's interests in any worker's compensation claims or settlements with any eligible individual. PLAN shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

9.14.2 At the signing of this Group Agreement and upon renewal, the Contract Holder shall submit proof of their worker's compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Worker's Compensation. The Contract Holder is also required to submit a monthly report to PLAN listing all workers' compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individual.

ATTACHMENT B

PREMIUM SCHEDULE FOR 2001
(FEBRUARY 1, 2001 – December 31, 2001)

Premium .....$195.31/per month

ATTACHMENT C

CONTRACT HOLDER'S OBLIGATIONS UNDER COBRA AND CAL-COBRA

A. Contract Holder is obligated under both federal and state law with regard to the continuation of health coverage for Members under certain circumstances where coverage would otherwise terminate ("continuation coverage"). The federal law is the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to employers (employer of record) with twenty (20) or more eligible employees. The California state law is the California Continuation Benefits Replacement Act ("Cal-COBRA"). Cal-COBRA applies to employers (employer of record) with fewer than twenty (20) eligible employees. Many of the provisions of COBRA and Cal-COBRA are the same, however some differences do exist. The obligations of Contract Holder under COBRA and CAL-COBRA are summarized below. However, Contract Holder should review the **EOC** for an explanation of the eligibility requirements and limitations associated with COBRA and Cal-COBRA.

B. Contract Holder Obligations Under COBRA. Under federal law, the employer (employer of record) who employs twenty (20) or more employees on a typical business day during the prior calendar year must provide Members with the opportunity to elect COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. Such Contract Holders and their group health plan's administrators (in certain cases, the employer (employer of record) may be the plan administrator) have the obligation to: (1) provide Members with notice of the opportunity to elect continuation coverage; and (2) administer the continuation coverage. The obligation to provide notice includes both general notification to Members of their right to elect continuation coverage and specific notification of the right to continuation coverage within a specific time period after the occurrence of the event which triggers the continuation coverage option.

C. Contract Holder also agrees to forward to PLAN in a timely manner copies of any and all notices provided to Members regarding COBRA continuation coverage.

D. Contract Holder Obligations Under Cal-COBRA. Under California law, a health care service plan that contracts with employers (employer of record) who employ two (2) through nineteen (19) eligible employees on a typical business day during the prior calendar year is required to provide Members with the opportunity to elect Cal-COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. PLAN will administer or contract for the administration of continuation coverage under Cal-COBRA. Nonetheless, Contract Holder must provide certain notices to PLAN and to Members as described below.

E. Contract Holder must notify PLAN in writing of any employee who has a qualifying event defined in section A, "Continued Group Coverage (COBRA and Cal-COBRA)" of

the EOC within thirty (30) days of the qualifying event. Such notice must be separate from other communications from Contract Holder and must specifically reference Cal-COBRA. Notations of additions and/or deletions on monthly invoices will not constitute sufficient notice. Contract Holder must further provide written notice to PLAN within thirty (30) days of the date the Contract Holder becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S. C. Section 1 161 et seq.

F. Contract Holder must also notify qualified beneficiaries of the ability to continue coverage prior to terminating a group agreement (such as this Group Agreement) under which a qualified beneficiary is receiving continuation coverage. This notification shall be provided either thirty (30) days prior to the agreement termination or when all other enrolled employees are notified, whichever is greater. Contract Holder must notify any successor PLAN in writing of the qualified beneficiaries currently receiving continuation coverage to enable the successor PLAN, contracting employer (employer of record), or administrator to provide such qualified beneficiaries with the premium information, enrollment forms, and disclosures necessary to allow the qualified beneficiaries to continue coverage under other available group plans.

G. If Contract Holder fails to meet these obligations, PLAN will not provide continuation coverage to qualified beneficiaries under Cal-COBRA. Contract Holder hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to Cal-COBRA continuation coverage. Contract Holder also agrees to forward to PLAN in a timely manner copies of any notice provided to Members regarding Cal-COBRA continuation coverage.

ATTACHMENT D

CONTRACT HOLDER'S OBLIGATIONS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

A. Contract Holder is obligated under both federal and state law with regard to the renewablility of health care coverage for Members under certain circumstances where coverage would otherwise terminate ("creditable coverage"). The federal law is the Health Insurance Portability and Accountability Act (HIPAA). The guaranteed renewability provision of HIPAA entitles a Member, who is disenrolled or terminated from employment an opportunity to purchase a health insurance plan that provides the same scope of benefits that the Member received through the Contract Holder program.

B. Contract Holder Obligations Under HIPAA. Under federal law, an employer (employer of record) must notify Members of their entitlement under HIPAA within ten (10) days of disenrollment or termination of employment. Contract Holders and their group health plan's administrators (in certain cases, the employer (employer of record) may be the plan administrator) have the obligation to: (1) provide Members with notice of the opportunity to pursue other coverage without exclusions or waiting periods; and (2) provide a certificate of "creditable coverage" which details the scope of benefits and the length of enrollment in the Contract Holders program. The obligation to provide notice includes both general notification to Members of their right to purchase renewable coverage and specific notification of the right to renewable coverage within a specific time period after the occurrence of the event which triggers the coverage option.

C. Contract Holder also agrees to forward to PLAN in a timely manner copies of any and all notices provided to Members regarding HIPAA.

HealthWorks Evidence of Coverage

Detailed Description of Benefits, Copayments, Conditions and Exclusions

PHYSICIAN AND PROFESSIONAL SERVICES

Description

- Medically Necessary Professional Services and consultations by a Physician or other licensed health care provider acting within the scope of his or her license. Includes:
  - Surgeon, assistant surgeon, and anesthesiologist (inpatient or outpatient)
  - Inpatient hospital and skilled nursing facility visits
  - Professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, dialysis treatment, and sexually transmitted infection care
  - Home visits when Medically Necessary
  - Hearing tests and eye examinations including eye refractions to determine the need for corrective lenses and dilated retinal eye exams
  - Well baby care for the first thirty (30) days of life which includes newborn hospital visits, health examinations, and other office visits

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Cost to Member

- $5 copayment per office or home visit
- No copayment for hospital inpatient professional services
- No copayment for surgery or anesthesia, radiation, chemotherapy, or dialysis treatment

PREVENTIVE HEALTH SERVICES

Description

- Periodic health examinations including all routine diagnostic testing and laboratory services
- Immunizations for newborns during the first thirty (30) days of life consistent with the most current recommendations for preventive pediatric health care, as adopted by the American Academy of Pediatrics, and the most current version of Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices and recommended by the U.S. Public Health Service. Age appropriate immunizations as recommended by the U.S. Public Health Service

Cost to Member

- No copayment for preventive services

PREGNANCY AND MATERNITY CARE

Description

- Medically Necessary professional and hospital services relating to maternity care are covered including:
  - Prenatal and postnatal care and complications of pregnancy
  - Diagnostic and genetic testing
  - Counseling for nutrition, health education, and social support needs
  - Labor and delivery care including midwifery services
  - Newborn examinations within the first thirty (30) days of life and nursery care while the mother is hospitalized
- Inpatient hospital care will be provided for up to 48 hours following a normal vaginal delivery and up to 96 hours following delivery by Cesarean Section unless an extended stay is authorized by HealthWorks. Members do not have to leave the hospital before 48 hours after a vaginal delivery or 96 hours after a Cesarean Section unless the member and doctor decide this together. If members leave the hospital before 48 or 96 hours, the doctor may prescribe a follow-up visit within 48 hours of discharge. The follow-up visit shall include parent education, assistance and training in breast or bottle feeding, and any necessary physical assessment of the mother or baby. The mother and doctor together shall decide whether the follow-up visit shall be at home, the hospital, or the doctor's office depending on the family's transportation needs and environmental and social risks

Cost to Member

- No copayment

DIAGNOSTIC X-RAY AND LABORATORY SERVICES

Description

- Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services which will include, but not be limited to, the following:
  - Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes
  - Other services necessary to appropriately evaluate, diagnose, treat, and follow-up care
  - Laboratory tests appropriate for the management of diabetes including, at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (Glycohemoglobin)
  - All generally medically accepted cancer screening tests subject to physician prescription and utilization review

Cost to Member

- No copayment

EMERGENCY SERVICES AND CARE (INCLUDING "911 SERVICES")

Description

- Twenty-four hour Emergency Services and Care are covered for alleviation of sudden, serious, and unexpected illness or a condition requiring immediate diagnosis and treatment both in and out of the HealthWorks Service Area

Cost to Member

- $25 copayment per visit

EMERGENCY ("911") AND NON-EMERGENCY TRANSPORTATION SERVICES

Description

- Emergency ambulance transportation "911" service in connection with life-threatening emergency services to the first hospital or urgent care center which accepts the Member for emergency care
- Non-emergency transportation for the transfer of a Member from a hospital to another hospital or facility, or facility to home when:
  1. Medically Necessary
  2. Requested by Participating Provider
  3. Authorized in advance by HealthWorks

Cost to Member

- No copayment

DIABETES SELF-MANAGEMENT

Description

- Diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable a Member to properly use covered equipment, supplies, medications and additional diabetes outpatient self-management training, education, and medical nutrition therapy upon direction or prescription of those services by a Member's Participating Provider

Cost to Member

- No copayment

PRESCRIPTION DRUGS

Description

- Medically Necessary drugs when prescribed by a participating licensed practitioner acting within the scope of his or her license in accordance with accepted standards of the medical community including:
  - Injectable medication (including insulin), needles, and syringes necessary for the administration of the covered injectable medication
  - Glucometer, lancets, blood glucose testing strips in Medically Necessary quantities for the monitoring and treatment of insulin dependent, non-insulin dependent, and gestational diabetes
  - Ketone urine testing strips for Type 1 diabetes and lancets
  - Prenatal vitamins and fluoride supplements, included with vitamins or independent of vitamins, which require a prescription
  - Medically Necessary prescription drugs administered while a Member is a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when provided through a participating plan pharmacy
  - One cycle or course of treatment of prescription tobacco cessation drugs per Benefit Year. HealthWorks requires the Member to attend tobacco cessation classes or programs in conjunction with the use of prescription tobacco cessation drugs
  - Prescription Contraceptive Drugs and Devices: all FDA-approved oral and injectable contraceptive drugs and devices including internally implanted time-release contraceptives such as Norplant. If a Member's Participating Provider determines that none of the methods designated by HealthWorks as covered or preferred (on the Plan's Formulary) are medically appropriate, the provider must contact HealthWorks in advance for authorization to prescribe a non-Formulary contraceptive drug or device

Cost to Member

- No copayment for prescription drugs provided in an inpatient setting, for drugs administered in the doctor's office or in an outpatient facility, or for FDA-approved contraceptive drugs and devices
- $5 per prescription for up to a 32-day supply for brand name or generic drugs including prescription tobacco use cessation drugs

- Maintenance Drugs: $5 per prescription for up to a 100-day supply. Maintenance Drugs are drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions such as heart disease, diabetes, or hypertension. HealthWorks may dispense available generic equivalent prescription drugs provided that no medical contraindications exist. NOTE: When purchasing diabetic supplies (including insulin), one (1) $5 copayment will apply at the time of each purchase

Exclusions

- Over-the-counter medicines including non-prescription contraceptive drugs and devices such as contraceptive jellies, ointments, foams, condoms, etc.
- Medicines not requiring a written prescription
- Dietary supplements, appetite suppressants, or any other diet drugs or medications
- Over-the-counter devices or medications not requiring a prescription
- Over-the-counter vitamins unless they are prescribed prenatal vitamins, minerals, and food supplements
- Drugs or medications for cosmetic purposes

OUTPATIENT HOSPITAL SERVICES

Description

- Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility including:
  - Physical, occupational, and speech therapy as Medically Necessary
  - Hospital services which can reasonably be provided on an ambulatory basis
  - Related services and supplies in connection with these 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
  - Outpatient services in connection with dental procedures when the use of a hospital or outpatient facility is required because of an underlying medical condition, clinical status, or because of the severity of the dental procedure
  - HealthWorks will coordinate such services with the Member's participating dental plan

Cost to Member

- No copayment, except for the following:
  - $5 copayment per visit for physical, occupational, and speech therapy performed on an outpatient basis
  - $25 copayment per visit for emergency services and care

Exclusions

- Services of a dentist or oral surgeon for dental procedures

INPATIENT HOSPITAL SERVICES

Description

- General hospital services in a room of two or more with customary furnishings and equipment, meals (including special diets as Medically Necessary), and general nursing care. Includes all Medically Necessary ancillary services such as:
  - 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 as Medically Necessary
  - Physical, occupational, and speech therapy
  - Respiratory therapy
  - Administration of blood and blood products
  - Other diagnostic, therapeutic, and rehabilitative services as Medically Necessary
  - Coordinate discharge planning including the planning of continuing care as Medically Necessary
- Includes inpatient hospital services in connection with dental procedures when hospitalization is required because of an underlying medical condition, clinical status, or because of the severity of the dental procedure. HealthWorks will coordinate such services with the Member's dental plan, if any. Services of a dentist or oral surgeon are excluded for dental procedures.

Cost to Member

- No copayment, except $25 per visit for emergency services and care

Exclusions

- Personal or comfort items or a private room in a hospital unless Medically Necessary. The services of a dentist or oral surgeon are excluded for dental procedures

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FAMILY PLANNING SERVICES

Description

- Voluntary family planning services are covered including the following:
  - Counseling and surgical procedures for sterilization as permitted by State and Federal law
  - Contraceptive drugs and devices pursuant to the prescription drug benefit including insertion or removal of IUD and Norplant
  - Office visits for family planning
    - Lab and x-rays
    - Pregnancy test
  - Treatment for problems resulting from family planning care
  - Elective pregnancy terminations

Cost to Member

- No copayment

Exclusions

- Infertility treatment

HEALTH EDUCATION

Description

- Effective health education services including tobacco cessation classes, information regarding personal health behavior and care, and recommendations regarding the optimal use of health services provided by HealthWorks or care organizations affiliated with the plan

Cost to Member

- No copayment

DURABLE MEDICAL EQUIPMENT

Description

- Medical equipment necessary for use in the home which:
  - Primarily serves a medical purpose
  - Is intended for repeated use
  - Is generally not useful to a person in the absence of illness or injury
- HealthWorks may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Durable Medical Equipment that is covered includes:
  - Oxygen and oxygen equipment
  - Blood glucose monitors and apnea monitors
  - Pulmoaides and related supplies
  - Nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers
  - Insulin pumps and related necessary supplies
  - Ostomy bags and urinary catheters and supplies

Cost to Member

- No copayment

Exclusions

- Comfort and 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, elevators, or modifications to the home or automobile
- Deluxe equipment
- More than one piece of equipment that serves the same function

ORTHOTICS AND PROSTHETICS

Description

- Orthotics and prosthetics are covered as follows:
  - 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 incidental to a laryngectomy
  - Therapeutic footwear for diabetics
  - Prosthetic device or reconstructive surgery incidental to mastectomy
- Covered items must be Physician-prescribed, custom-fitted, standard orthotic or prosthetic devices, authorized by HealthWorks, and dispensed by a Participating Provider. Repair is provided unless necessitated by misuse or loss. HealthWorks, at its option, may replace or repair an item.

Cost to Member

- No copayment

OUTPATIENT MENTAL HEALTH SERVICES

Description

- Outpatient mental health services are authorized, arranged, and provided by the San Mateo County Mental Health Plan.
  - Mental health care when ordered and performed by San Mateo County Mental Health Plan
  - Mental health services are limited to the evaluation, crisis intervention, and treatment of conditions which are subject to significant improvement through relatively short term therapy. This includes treatment for family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, divorce, or bereavement
  - Family members may be involved in the treatment to the extent the Plan determines it is necessary for the health and recovery of the member
  - There is a maximum of twenty (20) outpatient visits per Benefit Year, except as substituted for inpatient days. The treatment of a Serious Emotional Disturbance and Severe Mental Illness includes, but is not limited to:
    1. Schizophrenia
    2. Schizoaffective disorder
    3. Bipolar disorder (manic depressive illness)
    4. Major depressive disorder
    5. Panic disorder
    6. Obsessive-compulsive disorder
    7. Anorexia nervosa
    8. Bulimia nervosa

Cost to Member

- $5 copayment per outpatient mental health visit

Exclusions

- Services for conditions not subject to significant improvement through relatively short term therapy

INPATIENT MENTAL HEALTH SERVICES

Description

- Inpatient mental health care and partial hospitalization when authorized by the San Mateo County Mental Health Plan and performed by a participating mental health provider for the treatment of an acute phase of a mental health condition during a certified confinement in a San Mateo County Mental Health Plan participating hospital
- Limit of thirty (30) days per Benefit Year, except for the treatment of a Serious Emotional Disturbance and Severe Mental Illness which are not limited. These conditions include, but are not limited to:
    1. Schizophrenia
    2. Schizoaffective disorder
    3. Bipolar disorder (manic depressive illness)
    4. Major depressive disorder
    5. Panic disorder
    6. Obsessive-compulsive disorder
    7. Anorexia nervosa
    8. Bulimia nervosa
- With the agreement of the Member, if necessary, each day of inpatient hospitalization may be substituted for any of the following outpatient mental health services:
    - Two (2) days of residential treatment
    - Three (3) days of day care treatment (care in which patients participate during the day, returning to their home or other community placement during the evening and night)
    - Four (4) outpatient visits

Cost to Member

- No copayment

OUTPATIENT ALCOHOL AND DRUG ABUSE SERVICES

Description

- Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as Medically Necessary
- Standard benefits of twenty (20) visits per Benefit Year. Additional visits may be covered by HealthWorks if Medically Necessary

Cost to Member

- $5 copayment per visit

INPATIENT ALCOHOL AND DRUG ABUSE SERVICES

Description

- Hospitalization for alcoholism or drug abuse as Medically Necessary to remove toxic substances from the system

Cost to Member

- No copayment

HOME HEALTH CARE SERVICES

Description

- Those services that are prescribed or directed by a Participating Provider or other appropriate authority designated by HealthWorks
- Health services provided at the home by health care personnel, e.g., visits by RNs, LVNs, and home health aides
- Medically Necessary short term physical therapy, occupational therapy, speech therapy, and respiratory therapy when prescribed by a licensed Participating Provider acting within the scope of his or her license
- Home Health Services are only those services that are prescribed or directed by a Participating Provider or other appropriate authority designated by HealthWorks
- If a basic health service can be provided in more than one Medically Necessary setting, it is within the discretion of the Participating Provider or other appropriate authority designated by HealthWorks to choose the setting for providing the care. HealthWorks exercises prudent medical case management to ensure that Medically Necessary care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost-effective when there is a choice among several Medically Necessary alternative services or settings

Cost to Member

- No copayment, except for $5 per visit for physical, occupational, and speech therapy performed in the home

Exclusions

- Custodial care and long term physical therapy and rehabilitation

SKILLED NURSING CARE

Description

- Services prescribed by a Participating Provider or nurse practitioner and provided in a licensed skilled nursing facility when Medically Necessary. Includes:
  - Skilled nursing on a 24-hour per days basis
  - Bed and board
  - X-ray and laboratory procedures
  - Respiratory therapy
  - Physical, occupational, and speech therapy
  - Medical social services
  - Prescribed drugs and medications
  - Medical supplies
  - Appliances and equipment ordinarily furnished by the skilled nursing facility
  - Maximum of one hundred (100) days per Benefit Year

Cost to Member

- No copayment, including physical, occupational, or speech therapy performed on an inpatient basis

Exclusions

- Custodial care

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY

Description

- Medically Necessary therapy may be provided by a Participating Provider in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home

Cost to Member

- No copayment for inpatient therapy
- $5 copayment per visit when provided on an outpatient basis

CATARACT SPECTACLES AND LENSES

Description

- Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery
- One pair of conventional eyeglasses or conventional contact lenses, if necessary, after cataract surgery with insertion of an intraocular lens

Cost to Member

- No copayment

HEARING AIDS AND SERVICES

Description

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

Cost to Member

- No copayment

Exclusions

- Purchase of batteries or other ancillary equipment except those covered under the terms of 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 and repair of a hearing aid after the covered one-year warranty period
- Replacement of a hearing aid more than once in any 36-month period
- Surgically implanted hearing devices

ACUPUNCTURE

Description

- Acupuncture services are provided as a self-referral benefit to Participating Providers
- Limited to a maximum of 20 visits per Benefit Year

Cost to Member

- $5 copayment per visit

CHIROPRACTIC

Description

- Chiropractic services are provided as a self-referral benefit to Participating Providers
- Limited to a maximum of 20 visits per Benefit Year

Cost to Member

- $5 copayment per visit

HOSPICE SERVICES

Description

- Hospice means care and services provided in a home by a licensed or certified provider that are: (a) designed to provide palliative and supportive care to individuals who have received a diagnosis of a terminal illness, (b) directed and coordinated by medical professionals, and (c) with prior authorization by the HealthWorks. The hospice benefit includes:
  - Nursing care
  - Medical social services
  - Home health aide services
  - Physician services, drugs, medical supplies and appliances, and counseling and bereavement services as necessary
  - Physical therapy, occupational therapy, speech therapy
  - Short term inpatient care for pain control and symptom management
  - Homemaker services and short term inpatient respite care
- Hospice care is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of six months or less and who elect hospice care for such illness instead of the restorative services covered by the Plan. Individuals 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. The hospice election may be revoked at any time.

Cost to Member

- No copayment

OUTPATIENT ALCOHOL AND DRUG ABUSE SERVICES

Description

- Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as Medically Necessary
- Standard benefits of twenty (20) visits per Benefit Year. Additional visits may be covered by HealthWorks if Medically Necessary

Cost to Member

- $5 copayment per visit

INPATIENT ALCOHOL AND DRUG ABUSE SERVICES

Description

- Hospitalization for alcoholism or drug abuse as Medically Necessary to remove toxic substances from the system

Cost to Member

- No copayment

HOME HEALTH CARE SERVICES

Description

- Those services that are prescribed or directed by a Participating Provider or other appropriate authority designated by HealthWorks
- Health services provided at the home by health care personnel, e.g., visits by RNs, LVNs, and home health aides
- Medically Necessary short term physical therapy, occupational therapy, speech therapy, and respiratory therapy when prescribed by a licensed Participating Provider acting within the scope of his or her license
- Home Health Services are only those services that are prescribed or directed by a Participating Provider or other appropriate authority designated by HealthWorks
- If a basic health service can be provided in more than one Medically Necessary setting, it is within the discretion of the Participating Provider or other appropriate authority designated by HealthWorks to choose the setting for providing the care. HealthWorks exercises prudent medical case management to ensure that Medically Necessary care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost-effective when there is a choice among several Medically Necessary alternative services or settings

Cost to Member

- No copayment, except for $5 per visit for physical, occupational, and speech therapy performed in the home

Exclusions

- Custodial care and long term physical therapy and rehabilitation

SKILLED NURSING CARE

Description

- Services prescribed by a Participating Provider or nurse practitioner and provided in a licensed skilled nursing facility when Medically Necessary. Includes:
  - Skilled nursing on a 24-hour per days basis
  - Bed and board
  - X-ray and laboratory procedures
  - Respiratory therapy
  - Physical, occupational, and speech therapy
  - Medical social services
  - Prescribed drugs and medications
  - Medical supplies
  - Appliances and equipment ordinarily furnished by the skilled nursing facility
  - Maximum of one hundred (100) days per Benefit Year

Cost to Member

- No copayment, including physical, occupational, or speech therapy performed on an inpatient basis

Exclusions

- Custodial care

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY

Description

- Medically Necessary therapy may be provided by a Participating Provider in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home

Cost to Member

- No copayment for inpatient therapy
- $5 copayment per visit when provided on an outpatient basis

CATARACT SPECTACLES AND LENSES

Description

- Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery
- One pair of conventional eyeglasses or conventional contact lenses, if necessary, after cataract surgery with insertion of an intraocular lens

Cost to Member

- No copayment

HEARING AIDS AND SERVICES

Description

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

Cost to Member

- No copayment

Exclusions

- Purchase of batteries or other ancillary equipment except those covered under the terms of 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 and repair of a hearing aid after the covered one-year warranty period
- Replacement of a hearing aid more than once in any 36-month period
- Surgically implanted hearing devices

ACUPUNCTURE

Description

- Acupuncture services are provided as a self-referral benefit to Participating Providers
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Cost to Member

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CHIROPRACTIC

Description

- Chiropractic services are provided as a self-referral benefit to Participating Providers
- Limited to a maximum of 20 visits per Benefit Year

Cost to Member

- $5 copayment per visit

HOSPICE SERVICES

Description

- Hospice means care and services provided in a home by a licensed or certified provider that are: (a) designed to provide palliative and supportive care to individuals who have received a diagnosis of a terminal illness, (b) directed and coordinated by medical professionals, and (c) with prior authorization by the HealthWorks. The hospice benefit includes:
  - Nursing care
  - Medical social services
  - Home health aide services
  - Physician services, drugs, medical supplies and appliances, and counseling and bereavement services as necessary
  - Physical therapy, occupational therapy, speech therapy
  - Short term inpatient care for pain control and symptom management
  - Homemaker services and short term inpatient respite care
- Hospice care is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of six months or less and who elect hospice care for such illness instead of the restorative services covered by the Plan. Individuals 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. The hospice election may be revoked at any time.

Cost to Member

- No copayment

ORGAN TRANSPLANTS

Description

- Coverage for Medically Necessary organ transplants and bone marrow transplants prescribed by a Participating Provider in accordance with the community standard of care
- Reasonable 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
- Charges for testing of relatives for matching bone marrow transplants
- Charges associated with the search and testing of unrelated bone marrow donors through a recognized donor registry and charges associated with the procurement of donor organs through a recognized donor transplant bank, if the expenses are directly related to the anticipated transplant of a Member

Cost to Member

- No copayment

BLOOD AND BLOOD PRODUCTS

Description

- Processing, storage, and administration of blood and blood products in outpatient settings
- Includes the collection of autologous blood when Medically Necessary

Cost to Member

- No copayment