

Mental Health Services Agreement
Between
San Mateo Health Commission
And
San Mateo County

This Agreement ("Agreement") is entered into this _____ day of _____, 2003, by and between the County of San Mateo for services provided by the Mental Health Services Division of the Health Services Agency (hereinafter referred to as MHSD), to administer mental health benefits and provide mental health services under HealthWorx, Healthy Families and the Healthy Kids Programs, and the San Mateo Health Commission, doing business as the Health Plan of San Mateo (hereinafter referred to as "PLAN"). The parties agree as follows:

This Mental Health Services Agreement in its entirety is comprised of the following:

Attachment A --	Terms and Conditions
Attachment B --	HealthWorx Evidence of Coverage
Attachment C --	Healthy Families Evidence of Coverage
Attachment D --	Healthy Kids Evidence of Coverage
Attachment E --	Rates of Payment
Attachment F --	Business Associate Agreement

County of San Mateo

Executed by:

Authorized Signature for
County of San Mateo

(Print Name)

Date

Commission

Executed by:

Michael W. Murray
Authorized signature for San Mateo
Health Commission

Michael W. Murray
(Print Name)

JAN. 3, 2003
Date

MENTAL HEALTH SERVICES AGREEMENT

TABLE OF CONTENTS

Attachment A -	Terms and Conditions	1
Section 1 -	Definitions	1
Section 2 -	Provider Qualifications	4
Section 3 -	PLAN/MENTAL HEALTH PLAN Relationship	4
Section 4 -	Services to Be Provided	4
Section 5 -	Exclusions From and Limitations on Covered Mental Health Services	4
Section 6 -	Payments and Claims Processing	5
Section 7 -	Term, Termination, and Amendment	6
Section 8 -	Records, Accounts, Reporting and Recoveries	7
Section 9 -	Insurance and Indemnification	9
Section 10 -	Grievance and Appeals	10
Section 11 -	Coordination of Services	10
Section 12 -	General Provisions	11
Section 13 -	Mutual Hold Harmless.....	12
Section 14 -	Non-Discrimination	12
Section 15 -	Mergers	14
Attachment B -	HealthWorx Evidence of Coverage	
Attachment C -	Healthy Families Evidence of Coverage	
Attachment D -	Healthy Kids Evidence of Coverage	
Attachment E -	Rates of Payment	
Attachment F -	Business Associate Agreement	

ATTACHMENT A
TERMS AND CONDITIONS

Recitals:

- A. In addition to its initial purpose, which was to contract with the State of California for the administration of Medi-Cal services in the County of San Mateo, PLAN has entered into or will enter into and maintain Agreements for the following three health services programs: the San Mateo County Public Authority In Home Support Services (IHSS) to administer HealthWorx program; the California Managed Risk Medical Insurance Board (MRMIB) to administer the Healthy Families Program; and the County of San Mateo, Children and Families First Commission, and Peninsula Community Foundation to administer the Healthy Kids Program.
- B. Individuals who subscribe and are enrolled in these PROGRAMS will receive mental health services hereinafter defined as "Covered Services," for which the PLAN will be financially responsible.
- C. Mental Health Services, as defined below, (with the exception of Emergency Services) shall be delivered only with authorization from the MHSD. In all cases, care is coordinated with PLAN.
- D. MHSD shall provide, either by contract or by direct services, Mental Health Services to Members and shall receive payment from PLAN for the rendering of those Services.

NOW, THEREFORE, it is agreed that the above Recitals are 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 **"Children's Health Initiative (CHI) Coalition"** is the decision-making body established by the San Mateo Board of Supervisors for the planning and development of the Healthy Kids Program.
- 1.2 **"Commission"** shall mean the San Mateo Health Commission.
- 1.3 **"Copayment"** shall mean the portion of covered health care costs for which the Member or Member's family has financial responsibility under the PROGRAMS.
- 1.4 **"Covered Services"** shall mean those health care services that a Member is entitled to receive under the PROGRAMS and which are set forth in the PROGRAMS' Evidences of Coverage in Attachments B, C, and D and in the PLAN's Provider Manual.

- 1.5 **“Emergency Psychiatric Condition”** shall mean a condition that is due to a mental disorder causing the Member to be a danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requiring psychiatric inpatient hospital services. (CCR Title 9 §1820.205 and §1820.225)
- Psychiatric emergency services and care include psychiatric screening, examination, evaluation, and treatment by a Mental Health Provider to the extent permitted by applicable law and within the scope of their licensure and privileges. Coverage is provided for care and treatment necessary to relieve or eliminate the psychiatric emergency condition.
- 1.6 **“Evidence of Coverage”** shall mean the document issued by the PLAN to Members that describes Covered Services and Non-Covered Services in the PROGRAMS.
- 1.7 **“Excluded Services”** shall mean those health care services which are excluded as Non-Covered Services in the PROGRAMS’ Evidences of Coverage (Attachments B, C, and D) or those that are not required by the Knox-Keene Act, for which the PLAN will not provide benefit payments. These services may also be called “Non-Covered Services.”
- 1.8 **“Health Plan of San Mateo” (HPSM)** shall mean the health plan governed by the San Mateo Health Commission.
- 1.9 **“HealthWorx”** shall mean the health insurance program authorized by Section 14087.51 of the California Welfare and Institution Code that is administered by the Health Plan of San Mateo for eligible In-Home Supportive Services (IHSS) workers whose employer of record is the San Mateo County Public Authority.
- 1.10 **“Healthy Families Program”** shall mean the health insurance program created by Title X, Chapter 5.8 of the California Code of Regulations that is administered by the California Managed Risk Medical Insurance Board through its contract with the Health Plan of San Mateo for legal resident children through age 18 in families with incomes between 100% and 250% of the federal poverty level residing in the State of California.
- 1.11 **“Healthy Kids Program”** shall mean the health insurance program created by the Children’s Health Initiative Coalition and administered by the Health Plan of San Mateo for children through age 18 in families with incomes up to 400% of the federal poverty level residing in San Mateo County who are ineligible for Healthy Families and full scope Medi-Cal.
- 1.12 **“Medical Director”** shall mean the PLAN’s Medical Director.
- 1.13 **“Medically Necessary”** shall mean necessary treatment defined by regulations and guidelines set by the state and the State Department of Mental Health for the Medi-Cal Program.
- 1.14 **“Member”** shall mean an individual who is enrolled in good standing with the HealthWorx, Healthy Families, or Healthy Kids Programs.

- 1.15 **“Mental Health Benefit”** shall mean mental health care available to Members as specified in the PROGRAMS’ Evidence of Coverage (Attachments B, C, and D).
- 1.16 **“Mental Health Services Division” (MHSD)** shall mean the mental health plan administered by the San Mateo County Health Services Agency.
- 1.17 **“Mental Health Provider”** shall mean any health professional or institution certified by the Mental Health Plan to render mental health services to Members.
- 1.18 **“Mental Health Services”** shall mean services provided by the MHSD to administer the Mental Health Benefit, as specified in the PROGRAMS’ Evidences of Coverage (Attachments A, B, & C).
- 1.19 **“Participating Mental Health Provider”** shall mean a mental health provider or organization that has entered into an Agreement with the MHSD to provide mental health services to Members.
- 1.20 **“Physician”** shall mean an individual licensed to practice medicine or osteopathy in accordance with applicable California law.
- 1.21 **“PLAN”** shall mean the programs governed by the San Mateo Health Commission which serve San Mateo County Medi-Cal Members and Members of the HealthWorx, Healthy Families, and Healthy Kids Programs. Also called Health Plan of San Mateo.
- 1.22 **“PROGRAM(S)”** shall mean any or all of the PLAN’s HealthWorx, Healthy Families, and Healthy Kids Programs.
- 1.23 **“Quality Assessment”** shall mean those processes and procedures established by the PLAN and designed to review and analyze various aspects of desired health care.
- 1.24 **“Referral /Authorization”** shall mean the process by which the Participating Physicians or Providers direct a Member to seek or obtain Covered Services from a health professional, hospital or any other Provider of Covered Services in accordance with the PLAN’s referral and authorization procedures.
- 1.25 **“San Mateo County”** shall also be referred to as “County”.
- 1.26 **“Utilization Management (UM)”** shall mean those review processes and procedures which are designed to determine whether services are Covered Services or medically necessary and which all Participating Mental Health Providers must follow.

SECTION 2 PROVIDER QUALIFICATIONS

2.1 Referral Mental Health Provider Eligibility

Any Mental Health Provider employed by or contracting with the MHSD may serve Members hereunder if the provider meets the qualifications of the MHSD as required by the State Department of Mental Health and federal and state regulations for participation in federal and state funded programs.

SECTION 3 PLAN/MENTAL HEALTH PLAN RELATIONSHIP

- 3.1 The PLAN shall delegate administration of the PROGRAM'S Mental Health Benefit to the MHSD. The MHSD shall administer the PROGRAM'S Mental Health Benefit in accordance with each PROGRAM'S Evidence of Coverage (Attachments B, C, and D). The Healthy Families mental health benefit for children with Serious Emotional Disturbances (SED) is administered and reimbursed by the State Department of Mental Health through a contract with the MHSD. The services included in the contract between the State and the MHSD are not included in this Agreement but are coordinated by the MHSD and the PLAN through a Healthy Families Memorandum of Understanding (MOU) between the PLAN and the MHSD.

SECTION 4 SERVICES TO BE PROVIDED

- 4.1 The MHSD shall provide Mental Health Benefits in accordance with each PROGRAM'S Evidence of Coverage (Attachments B, C, and D).

SECTION 5 EXCLUSIONS FROM AND LIMITATIONS ON COVERED MENTAL HEALTH SERVICES

5.1 Program Restrictions

- 5.1.1 Services provided shall be subject to the limitations and procedures listed in each PROGRAM'S Evidence of Coverage (Attachments B, C, and D).

5.2 Formulary

Prescriptions payable by PLAN shall be subject to the same prescribing provider criteria used by PLAN except where changes are required by the Evidences of Coverage for the PROGRAMS as stated in the Evidences of Coverage (Attachments B, C, and D) and the PLAN's Provider Manual. Mental Health Providers shall be subject to all policies and procedures set forth by PLAN for the provision of pharmacy services.

SECTION 6 PAYMENTS AND CLAIMS PROCESSING

6.1 Conditions for Payment

The PLAN will make reimbursement to the MHSD for services provided to Members if the following conditions are met:

- 6.1.1 The Member was eligible for the Healthy Families, Healthy Kids, or HealthWorx Program at the time the service was provided by the Provider; and
- 6.1.2 The service was a Covered Service under the PROGRAMS according to regulations and Evidences of Coverage (Attachments B, C, and D) in effect at that time; and
- 6.1.3 Prior or retrospective authorization, if required, was received by the Provider from the MHSD, as appropriate, except for emergency circumstances.

6.2 Billing for Services Provided

The MHP shall complete the billing form(s) specified by the PLAN for all services rendered to Members. Such form(s) shall be submitted with the information and within the time requirements contained in the PLAN Provider Manual.

6.3 Payment for Other Services Providers

Reimbursement for services shall be made according to the Rates of Payment Schedule (Attachment E).

6.4 Copayments

The MHP and Mental Health Providers may collect any copayments from Members as are authorized under the PROGRAMS.

6.5 No Reimbursement from State or Others

The MHSD agrees that neither Mental Health Services or its contract providers from whom it requests services shall claim or otherwise seek reimbursement or any form of payment whatsoever from the PLAN's Medi-Cal funds, the State of California, MRMIB, the San Mateo County Public Authority, Children and Families First, the Peninsula Community Foundation, or Members for services provided under this agreement in the event the PLAN cannot or will not pay for services performed by the MHSD and its Providers pursuant to the terms of the Agreement, except for those services covered by the State Department of Mental Health for the Healthy Families program for serious emotional disturbances (SED) of children and the Department of Health Services for the Medi-Cal Program.

6.6 Member Liability

Other than copayments, the MHSD and its Providers shall look only to PLAN for compensation for Covered Services and shall at no time seek compensation from Members for Covered Services, including but not limited to, nonpayment by PLAN, PLAN's insolvency, dissolution, bankruptcy or breach of this Agreement. The MHSD and its Providers shall not bill, charge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any action or have any recourse against, or make any surcharge upon any Member or other persons acting on a Member's behalf for Covered Services payable by PLAN. If PLAN receives notice of any surcharges upon any Member, it shall be empowered to take appropriate action. This provision shall not prohibit billing and collecting from Members for services that are not Covered Services. The MHSD or its Providers shall supply to the Members prior to treatment of a non-covered service, a written note informing them of their financial responsibility for such services.

The obligations set forth in this section shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of Members, and the provisions of this section shall supersede any oral or written Agreement to the contrary now existing or hereafter entered into between the MHSD and/or its Providers and the Member or any persons acting on their behalf.

SECTION 7 TERM, TERMINATION, AND AMENDMENT

7.1 Effective Date

This Agreement shall become effective on the later of January 1, 2003 or the date is first fully executed by both parties.

7.2 Term

This Agreement shall be for a term of eighteen (18) months from the date it becomes effective. This Agreement may be terminated or amended as hereinafter provided.

7.3 Termination

This Agreement may be terminated by either party as follows:

7.3.1 Either party may terminate this agreement for good cause only, upon 120 days written notice of intent to terminate, transmitted by the terminating party to the other party as provided in Section 12.4.1.

- 7.3.2 The MHDS may terminate this Agreement upon less than one hundred twenty (120) days written notice if it is in response to an Agreement amendment proposed by the PLAN according to the provision of Section 7.5.2.
- 7.3.3 In the event of the termination of the PLAN's underlying agreement with the Contract Holder of any of its product lines (i.e., San Mateo County Public Authority, for HealthWorx; MRMIB for Healthy Families; and the County of San Mateo, Children and Families First, and the Peninsula Community Foundation for Healthy Kids), the provisions of this Agreement pertaining to the terminated product line shall term automatically. PLAN shall notify MHSD as soon as receiving or sending such notice of termination and no later than the first of the month following notification or the actual date of termination, whichever is earlier but not less than thirty (30) days. Upon receiving notification, MHSD will prepare and implement a transition plan for Members. PLAN will be responsible for payment for services provided up to the date of termination.
- 7.3.3.1 This Agreement shall terminate effective immediately if, for any reason, the MHSD or the Health Plan of San Mateo ceases to operate.

7.4 Assignment

This Agreement shall not be transferred or assigned to any other entity unless prior approval of the other contracting party is obtained.

7.5 Amendments

7.5.1 Amendment by Mutual Agreement

This Agreement may be amended at any time upon written agreement of both parties subject to section 12.8.

7.5.2 Amendment by the PLAN

This Agreement may be amended by the PLAN upon forty-five (45) business days written notice to MHSD. MHSD has the right to negotiate and agree to the change. If the PLAN and MHSD cannot agree to the Amendment, MHSD has the right to terminate the contract prior to the effective date of the Amendment. MHSD is expected to provide written notice to the PLAN with as much advance warning as possible.

This Agreement may be amended by the PLAN upon less than forty-five (45) business days written notice to MHSD if a change in state or federal law or regulation or any accreditation requirements of a private sector accreditation organization require a shorter timeframe for compliance.

None of the provisions in this section shall be construed to prevent the parties from mutually agreeing to waive the forty-five (45) business day notice

requirement nor to mutually agree to proposed changes at any time after MHSD has received notice of the Amendment.

7.5.3 Knox-Keene Amendments

The terms of this Agreement shall be subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene"), as amended, and the regulations of the Department of Managed Health Care (DMHC) promulgated thereunder, to the extent applicable hereto, and any provision required to be in this Agreement by either the Knox-Keene Act or Regulations shall bind PLAN and the MHSD as appropriate, whether or not provided herein.

If the DMHC requires further amendments to this Agreement, upon notification PLAN shall notify MHSD in writing of such amendments. The MHSD shall exercise best efforts to process said amendments in a timely fashion.

7.6 Continuity of Care

Upon termination of this Agreement for any reason, MHP shall ensure an orderly transition of care for Members under treatment, including but not limited to the transfer of Member medical records.

SECTION 8 RECORDS, ACCOUNTS, REPORTING AND RECOVERIES

8.1 Medical Records

MHSD shall require that each Mental Health Provider who provides services under this agreement shall maintain for each Member who has received Mental Health Benefits under this agreement a legible medical record, kept in detail consistent with appropriate medical and professional practice, which permits effective internal professional review and external medical audit process and which facilitates an adequate system for follow-up treatment. MHP and its Providers shall maintain such records for at least five (5) years from the close of the State's fiscal year in which this Agreement was in effect.

8.2 Inspection Rights

MHP and its Providers shall make all of their books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination or copying to the extent allowable under applicable federal and state statutes and regulations.

8.2.1 By the PLAN, the State Department of Health Services, the Department of Managed Health Care, the Managed Risk Medical Insurance Board and the United States Department of Health and Human Services.

8.2.2 At all reasonable times at the MHSD's and/or MHSD Provider's place of business or at such other mutually agreeable location in California.

8.2.3 In a form maintained in accordance with the general standards applicable to such book or record keeping.

8.2.4 For a term of at least five (5) years from the close of the State's fiscal year in which this Agreement was in effect.

8.3 Member Eligibility

The MHSD shall verify a Member's eligibility with PLAN prior to Authorizing/arranging services.

8.4 Confidentiality of Member Information

For the purpose of this Agreement, all information, records, data and data elements collected and maintained for the operation of this Agreement and pertaining to Members shall be protected by the MHSD and MHSD Providers and his/her staff from unauthorized disclosure as required by federal and state statutes and regulations.

MHSD shall only share relevant information regarding the Member's medical and mental condition, including current medications prescribed with those parties who are permitted to receive such information under applicable federal and state confidentiality and privacy statutes and regulations. (See Attachment F.)

8.5 Subcontracts

The MHSD shall maintain and make available to the PLAN, and all applicable State and Federal agencies, regulatory agencies and the Department of Managed Health Care all subcontracts upon request and shall ensure that all subcontracts are in writing and require that the subcontractor:

- Make all books and records pertaining to the goods and services furnished under the terms of the Agreement available at all reasonable times for inspection, examination, or copying by all applicable State and Federal agencies, regulatory agencies, the Department of Managed Health Care or the PLAN; and
- Retain such books and records for a term of at least five (5) years from the close of the State's fiscal year in which the subcontract is in effect.
- Subcontractors shall comply with all substantive requirements of this Agreement.

8.6 Other Insurance Coverage

8.6.1 Health Insurance Other Than Medicare

MHSD Providers shall be required in their contract to bill third party insurance if available prior to billing MHSD. MHSD shall notify PLAN that health insurance or another health program other than Medicare, Medi-Cal, or Healthy Families may cover any Covered Services provided by MHSD whenever MHSD discovers

this potential coverage. MHSD also shall cooperate with and assist PLAN in obtaining such recoveries.

8.6.2 Other Insurance Recoveries

The PLAN's Provider Manual specifies that certain other health insurance programs (including Medicare) for Members must be billed and recoveries made prior to billing PLAN. The PLAN shall return claims to MHSD Provider if he/she has failed to first make recoveries from these other programs.

8.7 Member's Potential Tort, Casualty, or Workers' Compensation Awards

MHSD Providers shall notify MHSD that a potential tort, casualty insurance, or Worker's Compensation award may be required to be used to reimburse any provider for any Covered Services provided by MHSD Provider whenever the provider discovers such potential awards.

SECTION 9 INSURANCE AND INDEMNIFICATION

9.1 Insurance

Each participating MHSD Provider covered by this Agreement shall carry professional liability insurance of at least ONE MILLION DOLLARS (\$1,000,000) per person per occurrence, insuring against professional errors and omissions (medical malpractice) in providing medical services under the terms of this Agreement.

Each MHSD Provider shall carry at least ONE HUNDRED THOUSAND DOLLARS (\$100,000) per person per occurrence general liability insurance to include premises liability, employer's liability in the amount of ONE HUNDRED THOUSAND DOLLARS (\$100,000), and Worker's Compensation to the extent said Worker's Compensation is required by law.

9.2 Certificates of Insurance

The MHSD will require any provider who provides services under this agreement or sub-contract to provide to the MHSD certificates of insurance or verification of required coverages, and shall inform the MHSD of any notice of cancellation for any and all coverages required by this Agreement, and for subsequent renewals of all required coverages.

9.3 Automatic Notice of Termination

The MHSD will require that any provider who provides services under this agreement or sub-contract shall direct the provider's insurance carrier to have automatic notification of insurance coverage termination given to MHSD.

SECTION 10 GRIEVANCE AND APPEALS

10.1 Grievances and Appeals

It is understood that MHSD Providers and clients may have Grievances. These shall be resolved through the Complaint and Grievance procedures of the MHSD that comply with relevant state statutes and regulations.

SECTION 11 COORDINATION OF SERVICES

11.1 Responsibility

The PLAN's Executive Director has primary responsibility for maintenance, review, formulation of policy changes, and procedural improvements. The Executive Director shall be assisted by the Director of Planning and Evaluation Services.

The San Mateo County Mental Health Division's Deputy Director of Operations has primary responsibility for maintenance, review, formulation of policy changes, and procedural improvements. The Deputy Director shall be assisted by the Quality Improvement Manager.

Medical Directors of PLAN and MHSD shall coordinate and meet as necessary to resolve specific care problems and coordination of services.

The PLAN and MHSD shall meet on a biannual basis to inform staff of changes in policies and procedures. Coordination of Care meetings will be held quarterly. Attendees at these meetings will include the PLAN's Director of Planning & Evaluation Services, the MHSD's Deputy Director of Operations, Medical Directors, clinical managers or supervisors, and quality management, pharmacy, and claims staff as necessary. In addition,

SECTION 12 GENERAL PROVISIONS

- 12.1 In the event any part of this Agreement is found to be unlawful or Legislation modifies the entitlement of Members or other provision hereunder, the Agreement shall automatically and without prior notice be modified to reflect that which is lawful and all other provisions shall remain in full force and effect.

- 12.2 The waiver by the PLAN of any one or more defaults, if any, on the part of the MHSD hereunder, shall not be construed to operate as a waiver by the PLAN of any other or future default in the same obligation in this Agreement.
- 12.3 Unless specifically excepted by the PLAN in this Agreement, in amendments to this Agreement, the MHSD shall follow the terms of its Agreement with the state for its Medi-Cal Program.
- 12.4 Whenever either party amends or terminates this Agreement, notice shall be given in writing and shall be served by Registered or Certified Mail, Return Receipt Requested, UPS, FedEx, or other traceable mail service addressed as follows:

12.4.1 If served on the PLAN, it shall be addressed to:

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

12.4.2 If served on MHSD, it shall be addressed to:

Deputy Director of Operations
Mental Health Services Division
225 – 37th Avenue, 3rd Floor
San Mateo, CA 94403

12.4.3 If served on MHSD Provider, it shall be addressed to the MHSD Provider at the address that appears on the MHSD Provider's Agreement with the MHSD.

Any such notice so mailed shall be deemed to have been served upon and received by the addressee forty-eight (48) hours after the same has been deposited in Registered, Certified United States mail, Return Receipt Requested, UPS, or FedEx, or other traceable mail service. Either party shall have the right to change the place to which notice is to be sent by giving forty-eight (48) hours written notice to the other of any change of address.

- 12.5 This Agreement shall not be modified, altered or changed in any manner, except as provided in Section 7.
- 12.6 This Agreement is not intended to create, and shall not be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, the employer or the representative of the other.
- 12.7 Throughout this Agreement the singular shall include the plural, and the plural the singular; the masculine shall include the neuter and feminine, and the neuter the masculine and the feminine.
- 12.8 This Agreement and any amendment to it shall become effective only after approval by the Department of Managed Health Care as required by California law.

SECTION 13 MUTUAL HOLD HARMLESS

- 13.1 It is agreed that the MHSD shall defend, save harmless and indemnify PLAN, its officers and employees from any and all claims which arise out of the terms and conditions of this Agreement and which result from the negligent acts or omissions of MHSD, its officers and/or employees.
- 13.2 It is agreed that PLAN shall defend, save harmless, and indemnify the MHSD, its officers and employees from any and all claims for injuries or damage to persons and/or property which arise out of the terms and conditions of this Agreement and which result from the negligent acts or omissions of PLAN, its officers and/or employees.
- 13.3 In the event of concurrent negligence of PLAN, its officers and/or employees, and the MHSD, its officers and/or employees, then the liability for any and all claims for injuries or damage to persons and/or property which arise out of terms and conditions of this Agreement shall be apportioned according to the California theory of comparative negligence.

SECTION 14 NON-DISCRIMINATION

14.1 Section 504

The MHSD shall comply with §504 of the Rehabilitation Act of 1973, which provides that no otherwise qualified handicapped individual shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of this Agreement.

14.2 General Non-Discrimination

No person shall, on the grounds of race, color, religion, ancestry, gender, age (over 40), national origin, medical condition (cancer), physical or mental disability, sexual orientation, pregnancy, childbirth or related medical condition, marital status, or political affiliation be denied any benefits or subject to discrimination under this Agreement.

14.3 Equal employment opportunity

The MHSD shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this agreement. The MHSD's equal employment policies shall be made available to PLAN upon request.

14.4 Violation of Non-discrimination provisions

Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject the MHSD to penalties, to be determined by the PLAN, including but not limited to:

- termination of this Agreement;
- disqualification of the MHSD from bidding on or being awarded a PLAN contract for a period of up to 3 years;
- liquidated damages of \$2,500 per violation;
- imposition of other appropriate contractual and civil remedies and sanctions, as determined by PLAN.

14.5 To effectuate the provisions of this section, PLAN shall have the authority to:

- examine MHSD's employment records with respect to compliance with this paragraph;
- set off all or any portion of the amount described in this paragraph against amounts due to MHSD under this Agreement or any other Contractor between MHSD and PLAN.

14.6 MHSD shall report to the PLAN the filing by any person in any court of any complaint of discrimination or the filing by any person of any and all charges with the Equal Employment Opportunity Commission, the Fair Employment and Housing Commission or any other entity charged with the investigation of allegations within 30 days of such filing, provided that within such 30 days such entity has not notified MHSD that such charges are dismissed or otherwise unfounded. Such notification shall include the name of the complainant, a copy of such complaint and a description of the circumstance. MHSD shall provide PLAN with a copy of their response to the Complaint when filed.

14.7 Compliance with Equal Benefits Ordinance

With respect to the provision of employee benefits, MHSD shall comply with County Ordinance which prohibits contractors from discriminating in the provision of employee benefits between an employee with a domestic partner and an employee with a spouse.

SECTION 15 MERGERS

This Agreement, including the Exhibits hereto, is entire and contains all the terms and conditions agreed upon by the parties. No alteration or variation shall be valid unless made in writing and signed by the parties hereto, and no oral understanding or agreement shall be binding on the parties hereto.

ATTACHMENT B
HEALTHWORX
EVIDENCE OF COVERAGE

ATTACHMENT B

HEALTHWORX - EVIDENCE OF COVERAGE

Detailed Description of Benefits, Copayments, Conditions and Exclusions

PREVENTIVE HEALTH SERVICES

- Cost to Member:** ■ No copayment for preventive services
- Description:** ■ Periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current recommendations of the U.S. Public Health Service
- The frequency of such examinations will not be increased for reasons which are unrelated to the medical needs of the Subscriber, including a Subscriber's desire for physical examinations or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance
- Preventive services, including services for the detection of asymptomatic diseases, including the following:
- (1) periodic health examinations (including well baby care during the first 30 days of life)
 - (2) a variety of voluntary family planning services
 - (3) prenatal care
 - (4) vision and hearing testing
 - (5) immunizations
 - (6) venereal disease tests, including confidential HIV/AIDS counseling and testing
 - (7) Annual cervical cancer screening including the conventional Pap smear exam and the option of any cervical cancer screening test approved by the Federal Food and Drug Administration
 - (8) generally medically accepted cancer screening tests
 - (9) screening and diagnosis of breast cancer consistent with generally accepted medical practice and scientific evidence, upon referral of the subscriber's physician
 - (10) effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the Plan

- Immunizations for newborns during the first thirty (30) days of life consistent with the most current recommendations for preventive pediatric health care, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians
- Age appropriate immunizations as recommended by the U.S. Public Health Service

PHYSICIAN AND PROFESSIONAL SERVICES

- | | |
|-----------------------|---|
| Description | <ul style="list-style-type: none"> ■ Medically necessary professional services and consultations by a Physician or other licensed health care provider acting within the scope of his or her license. Including: <ul style="list-style-type: none"> ◆ 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 |
| Cost to Member | <ul style="list-style-type: none"> ■ \$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 |

PREGNANCY AND MATERNITY CARE

- | | |
|--------------------|--|
| Description | <ul style="list-style-type: none"> ■ Medically necessary professional and hospital services relating to maternity care are covered including: <ul style="list-style-type: none"> ◆ 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 HPSM. 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
 - ◆ 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 a medical condition that causes severe pain, or a serious illness or injury which a prudent lay person (a careful or cautious non-medical person) believes could reasonably expect without speedy medical care to result in:
 - ◆ Placing their health or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious danger, or
 - ◆ Serious harm to the way your body works, or
 - ◆ Serious damage of any body organ or part.
 - Emergency Services and care include psychiatric screening, examination, evaluation, and treatment by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and privileges
 - Coverage is coordinated with the San Mateo County Mental Health Plan to provide care and treatment necessary to relieve or eliminate the psychiatric emergency within the capability of a facility
 - Coverage is provided both in and out of the HPSM service area and in and out of HPSM 's participating facilities.
- Cost to Member**
- \$25 copayment per visit

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

- Description**
- Emergency ambulance transportation ("911" service) provided to a Member as a result of a "911" emergency response system request for assistance, is covered to the first hospital or urgent care center that accepts the Member for emergency care, where the Member reasonably believes an emergency existed, even if it is later discovered that an emergency did not in fact exist
 - Emergency transportation is covered for a medical condition that causes severe pain, a serious illness or injury, or a psychiatric emergency which a prudent lay person (a careful or cautious non-medical member) believes is an emergency condition that requires ambulance transport, even if it is later determined that an emergency did not exist

- 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 HPSM

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, needles, and syringes necessary for the administration of the covered injectable medication
- ◆ Insulin, Glucagon, and prescriptive medications for the treatment of diabetes
- ◆ Medically necessary 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 a prescription:
 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 devices to prevent or treat diabetes-related complications
 8. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
- ◆ 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. HealthWorx 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 HPSM as covered or preferred (on the Plan's Formulary) are medically appropriate, the provider must contact HPSM 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. HPSM 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 prescription (except insulin)
 - 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/or food supplements
- Drugs or medications for cosmetic purposes
- Experimental or investigational drugs

OUTPATIENT HOSPITAL SERVICES

Description	<ul style="list-style-type: none"> ■ Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility including: <ul style="list-style-type: none"> ◆ 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 ◆ HPSM will coordinate such services with the Member's dental plan, if any
Cost to Member	<ul style="list-style-type: none"> ■ No copayment, except for the following: <ul style="list-style-type: none"> ◆ \$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	<ul style="list-style-type: none"> ■ Services of a dentist or oral surgeon for dental procedures (except medically necessary surgical procedures for conditions affecting the upper and lower jawbone or associated bone joints) ■ Dental appliances or prosthetics

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. HPSM will coordinate such services with the Member's dental plan, if any.
- 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
 - Services of a dentist or oral surgeon are excluded for dental procedures (except medically necessary surgical procedures for conditions affecting the upper and lower jawbone or associate bone joints)

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
- ◆ Emergency contraception when provided by a HPSM pharmacist or a non-HPSM pharmacist in a medical emergency

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 HPSM or care organizations affiliated with the Health 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
- ◆ HPSM 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
 ■ 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, unless medically necessary

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 HPSM, and dispensed by a Participating Provider. Repair is provided unless necessitated by misuse or loss. HPSM, 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 services when authorized by the San Mateo County Mental Health Plan and performed by a participating mental health provider.
 - ◆ Mental health will be provided on the same basis as any other illness including treatment of a Severe Mental Illness and Serious Emotional Disturbances (SED). Medically necessary benefits include the following:
 1. Outpatient services
 2. Inpatient services
 3. Partial hospital services
 4. Prescription drugs
 - ◆ Family members may be involved in the treatment to the extent the Health Plan determines it is necessary for the health and recovery of the Member.
 - ◆ There are no visit limits for treatment of severe mental illnesses and SED. Severe mental illnesses include, but are not limited to the following:
 1. Schizophrenia
 2. Schizoaffective disorder
 3. Bipolar disorder (manic depressive illness)
 4. Major depressive disorder
 5. Panic disorder
 6. Obsessive-compulsive disorder
 7. Pervasive developmental disorder or autism
 8. Anorexia nervosa
 9. Bulimia nervosa
- Up to twenty (20) visits per year for illnesses that do not meet the criteria for severe mental illness or Serious Emotional Disturbance of a child.
- Cost to Member** ■ \$5 copayment per outpatient mental health visit

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.
- No day limitations for severe mental illnesses or SED. Severe mental illnesses 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. Pervasive developmental disorder or autism
 8. Anorexia nervosa
 9. Bulimia nervosa
- Thirty (30) days per benefit year for those with illnesses that do not meet the criteria for severe mental illnesses nor the criteria for SED .
- 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 HealthWorx 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 HPSM
- Health services provided in the home by health care personnel, e.g., visits by RNs, LVNs, and home health aides
- Medically necessary 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 HPSM
- 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 HPSM to choose the setting for providing the care. HPSM 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
■ Physical therapy and rehabilitation which are not medically necessary

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 HPSM. The hospice benefit includes:
- ◆ Development and maintenance of an appropriate plan of care
 - ◆ Skilled nursing services
 - ◆ Certified home health aide services
 - ◆ Homemaker services
 - ◆ Bereavement Services
 - ◆ Social services/counseling services
 - ◆ Dietary counseling
 - ◆ Physician services
 - ◆ Volunteer services by trained hospice volunteers
 - ◆ Short-term inpatient care
 - ◆ Physical therapy, occupational therapy, and speech therapy for symptom control or to maintain activities of daily living
 - ◆ Pharmaceuticals, medical equipment and supplies to the extent reasonable and necessary for the palliation and management of terminal illness

Hospice care is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of one year or less and who elect hospice care for such illness instead of the traditional services covered by the Health Plan. The hospice election may be revoked at any time. Hospice services include the provision of palliative medical treatment of pain and other symptoms associated with a terminal disease, but do not provide for efforts to cure the disease.

CLINICAL CANCER TRIALS

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
- Trial must meet following requirements:
 - ◆ Trials have a therapeutic intent with documentation provided by the treating physician
 - ◆ Treatment provided must be approved by one of the following: 1) the National Institute of Health, the Federal Food and Drug Administration, the U.S. Veterans Administration, or 2) involve a drug that is exempt under the federal regulations from a new drug application
- These services may be covered and paid for by the California Children's Services (CCS) program, if the Member is found to be eligible. The Health Plan of San Mateo will coordinate these services with CCS for the Member.
- Charges for routine patient care costs of a Member. These are costs associated with the provision of health care services, 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 service 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.
- Member may request an Independent Medical Review (IMR) of HPSM's coverage decisions. Information on how to request an IMR is on page 69.

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

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 nationally recognized standards of practice
- 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 for a Member

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

ATTACHMENT C

**HEALTHY FAMILIES
EVIDENCE OF COVERAGE**

ATTACHMENT C

HEALTHY FAMILIES - EVIDENCE OF COVERAGE

Detailed Description of Benefits, Copayments, Conditions and Exclusions

PREVENTIVE HEALTH SERVICES

Cost to Member: ■ No Copayment for preventive services for subscriber children.
\$5 copayment for subscriber parents for preventive services.

Description: ■ Periodic health examinations for subscriber children, including 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.

■ Periodic health examinations for subscriber parents, including all routine diagnostic testing and laboratory services appropriate for such examinations.

Recommended Schedule of Preventive Pediatric Health Care Visits

During Infancy

Newborn
2-4 days
1 month
2 months
4 months
6 months
9 months
12 months

During Early Childhood

15 months
18 months
2 years
3 years
4 years

During Middle Childhood

5 years
6 years
8 years
10 years

During Adolescence

Once yearly starting at age 11 through age 21

■ The frequency of such examinations will not be increased for reasons which are unrelated to the medical needs of the Subscriber, including a Subscriber's desire for physical examinations or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

- Preventive services, including services for the detection of asymptomatic diseases, including the following:
 - (1) periodic health examinations (including well baby care during the first two years of life including newborn hospital visits, health examinations, and other office visits)
 - (2) a variety of voluntary family planning services
 - (3) prenatal care
 - (4) vision and hearing testing
 - (5) immunizations
 - (6) venereal disease tests, including confidential HIV/AIDS counseling and testing
 - (7) Annual cervical cancer screening test including the conventional Pap smear exam and the option of any cervical cancer screening test approved by the Federal Food and Drug Administration
 - (8) generally medically accepted cancer screening tests
 - (9) screening and diagnosis of breast cancer consistent with generally accepted medical practice and scientific evidence, upon referral of the subscriber's physician
 - (10) coverage for the screening and diagnosis of prostate cancer including, but not limited to, prostate-specific antigen testing and digital rectal examination when medically necessary and consistent with good medical practice.
 - (11) effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the Plan
- Immunizations consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices (ACIP). Immunizations required for travel as recommended by the ACIP and other age appropriate immunizations as recommended by the ACIP.
- Immunizations for subscriber parents as recommended by the ACIP. Immunizations required for travel as recommended by the ACIP. Immunizations such as Hepatitis B for individuals at occupational risk and other age appropriate immunizations as recommended by the ACIP.

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

- **POLIO** is caused by a virus that attacks the nerves which control muscles. It can leave people crippled or paralyzed, and it is sometimes fatal.
- **HAEMOPHILUS INFLUENZAE TYPE B (Hib)** affects the brain and spinal cord. It can cause serious diseases such as bacterial meningitis, pneumonia and infections throughout the body. One out of 20 children who contracts Hib Meningitis dies, and one out of four suffers permanent brain damage.
- **DIPHTHERIA, TETANUS, PERTUSSIS (DTaP/DTP)**
Diphtheria is a bacteria that can lead to heart failure, breathing problems, paralysis and death. One out of ten people who gets Diphtheria dies.
Tetanus causes serious, painful spasms of all muscles. It can "lock" the jaw so the person cannot open his or her mouth or swallow. Three out of ten people who get tetanus die.
Pertussis (Whooping Cough) causes severe coughing, making it hard to breathe, eat or drink. Serious cases can lead to convulsions (strong, uncontrollable body shaking), lung collapse, pneumonia, brain damage and death.
- **MEASLES, MUMPS, RUBELLA (MMR)**
Measles can cause ear infections, pneumonia, seizures, hearing loss and brain damage. In a nationwide epidemic between 1989-91, 134 people died from measles.
Mumps can cause glands to swell and can spread to the brain and spinal cord.

Recommended Childhood Immunization Schedule

Hepatitis B*

First Dose: Between birth and 2 months
Second Dose: Between 1 and 4 months
Third Dose: Between 6 and 18 months

Diphtheria, Tetanus, Pertussis (DtaP)

First Dose: 2 months
Second Dose: 4 months
Third Dose: 6 months
Fourth Dose: Between 15 and 18 months
Fifth Dose: Between 4-6 years

H. influenzae type b (Hib)

First Dose: 2 months
Second Dose: 4 months
Third Dose: 6 months
Fourth Dose: Between 15 and 18 months

Polio

First Dose: 2 months
Second Dose: 4 months
Third Dose: Between 15 and 18 months
Fourth Dose: Between 4 and 6 years

Measles, Mumps, Rubella (MMR)

First Dose: Between 12 and 15 months
Second Dose: Between 4 and 6 years

Varicella

One Dose: Between 12 and 18 months

Preteen Vaccines

Make sure 11-12 year old adolescents are protected.
Hep B, MMR, Td and chicken pox vaccine may be needed.

*** The second dose of Hepatitis B should be given at least 1 month after the first dose. The third dose should be given at least 4 months after the first dose and at least 2 months after the second dose.**

Preventive Screening and Immunization Recommendations for Healthy Individuals*

HEALTH PLAN OF SAN MATEO

Clinical Practice Guidelines

The following chart lists the recommended preventive services for adults. The chart lists how often you should consider getting specific services based on your age. You and your doctor should decide how often you should get each service.

Service	18-24	25-34	35-44	45-54	55-64
Physical Exam A Health Assessment including History and Physical Examination is recommended within 120 days of enrollment with your Primary Care Physician	H&P - 1 to 3 yrs Ht & Wt - 1 to 3 yrs Blood Pressure Screening - Min. 1 to 2 yrs	H&P - 1 to 3 yrs Ht & Wt - 1 to 3 yrs Blood Pressure Screening - Min. 1 to 2 yrs	H&P - 1 to 3 yrs Ht & Wt - 1 to 3 yrs Blood Pressure Screening - Min. 1 to 2 yrs	H&P - 1 to 3 yrs Ht & Wt - 1 to 3 yrs Blood Pressure Screening - Min. 1 to 2 yrs	H&P, Ht, Wt, Vision, Hearing - Yearly Blood Pressure Screening - Min. 1 to 2 yrs
Mammogram/Mammogram with annual clinical breast exam - Women	1 to 2 yrs Discuss with Physician	1 to 2 yrs Discuss with Physician	1 to 2 yrs	1 to 2 yrs	1 to 2 yrs (75+ Physician Discretion)
Cervical Cancer Screening - Pap Test/Pelvic Exam -- Women (Annual for 3 consecutive years: begin at 19 or when sexually active.)	1 to 3 yrs	1 to 3 yrs	1 to 3 yrs	1 to 3 yrs	1 to 3 yrs
Chlamydia Screening -- Women • Under 25 • Over 25	Regularly Periodically/If High Risk	Periodically/If High Risk	Physician Discretion	Physician Discretion	Physician Discretion
Prostate Cancer Screening/Prostate Exam - Men PSA per Physician Discretion		2 to 3 yrs	2 yrs	2 yrs	Yearly
Colon Cancer Screening • Occult Blood Testing • Flexible sigmoidoscopy			1 to 2 yrs 5 yrs	1 to 2 yrs 5 yrs	Yearly 3 to 5 yrs
Cholesterol <i>If Normal Cholesterol</i>	Men 35+ Every 5 yrs	Women 45+ Every 5 yrs	Every 5 yrs	Every 5 yrs	Every 5 yrs
Eye Exam/Screening (Glaucoma, Retinopathy)		Physician Discretion Every 2 yrs	Physician Discretion Every 2 yrs	Physician Discretion Every 2 yrs	Physician Discretion Every 2 yrs
T.B. Screening	If High Risk	If High Risk	If High Risk	If High Risk	If High Risk
Diphtheria - Tetanus Booster -- (TD)	Every 10 yrs	Every 10 yrs	Every 10 yrs	Every 10 yrs	Every 10 yrs
Hepatitis B Vaccine (High Risk) Hepatitis A Vaccine (High Risk) <i>Over 18 years of age -- 2 doses</i>	Current visit, then at 1 & 6 months	Current visit, then at 1 & 6 months	Current visit, then at 1 & 6 months	Current visit, then at 1 & 6 months	Current visit, then at 1 & 6 months
Influenza Vaccine (Flu Shot)	Yearly-If High Risk	Yearly-If High Risk	Yearly-If High Risk	Yearly-If High Risk	Yearly
Pneumovax (Pneumonia Shot)					Once (Booster may be needed)
MMR (measles, mumps, rubella) Vaccination for those without proof of immunity <i>Rubella Serology or Vaccination (women of childbearing age without proof of immunity)</i>	Once	Once	Once	Once	
Varicella (Chicken Pox Vaccination) -- <i>No history of Varicella infection or previous vaccination</i>	2 doses 4-8 weeks apart	2 doses 4-8 weeks apart	2 doses 4-8 weeks apart	2 doses 4-8 weeks apart	
Counseling and Health Education • Staying Healthy Assessment Tool (SHAT) • Age specific counseling should include but not be limited to: > Counseling for menopausal women > Self breast exam for women > Self testicular exam for men (These are minimum recommendations. If you have questions, ask your physician.)	Ask Your Doctor for an Assessment	Ask Your Doctor for an Assessment	Ask Your Doctor for an Assessment	Ask Your Doctor for an Assessment	Ask Your Doctor for an Assessment

- (1) **Exception:** If past medical records are adequate to assess health status. Initial visit to include medical history, weight, height, BP & pertinent preventive health screens & tests.
- (2) The Peer Review Committee recognizes that controversy exists over the frequency of pap smears for females over the age of 65 who have had regular and consistently normal pap smears.
- (3) High risk includes, but is not limited to, children of mothers infected with HBV, sex partners of HBV carriers, IV drug users, health profession students, firefighters, paramedics, law enforcement and public works personnel, health care providers, etc.

***NOTE:** Recommended screening guidelines for healthy adults. Guidelines should be modified for patients with chronic diseases, a high risk medical history, and/or at physician discretion.

Based on U.S.P.S.T.F. recommendations (1996), and C.A.H.P. recommendations for Preventive Screening, Immunizations, and Counseling, November 2000, which were adopted by HPSPM as Preventive Health Guidelines.

PHYSICIAN SERVICES

- Cost to Member:**
- \$5 per office or home visit
 - No Copayment for vision testing for subscriber children
 - No Copayment for hospital inpatient professional services
 - No Copayment for surgery or anesthesia, radiation, chemotherapy, or dialysis treatments
 - No Copayment for Subscribers under 24 months of age for well baby care, health exams, and other office visits

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:

- Surgery, assistant surgery and anesthesia (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
- Eye examinations, including eye refractions to determine the need for corrective lenses, limited to one visit per year for subscriber parents, and dilated retinal eye exams
- Well baby care for the first two years of life which includes newborn hospital visits, health examinations, and other office visits

INPATIENT HOSPITAL SERVICES

Cost to member: No Copayment, except \$5 per visit for emergency health care 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 appropriate
- Coordinated discharge planning, including the planning of such continuing care as may be necessary

Includes inpatient hospital services, 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 subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. The Health Plan of San Mateo will coordinate such services with the Subscriber's participating dental plan.

Exclusions:

Personal or comfort items or a private room in a hospital unless medically necessary. The services of the dentist or oral surgeon are excluded for dental procedures (except medically necessary surgical procedures for conditions affecting the upper and lower jawbone or associated bone joints).

OUTPATIENT HOSPITAL SERVICES

Cost to member: No Copayment, except for the following:

- \$5 per visit for physical, occupational, speech and respiratory therapy performed on an outpatient basis;
- \$5 per visit for emergency health care services.

Description:

Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility, including:

- Physical, speech, occupational and respiratory 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 Subscriber's stay at the facility

Includes general anesthesia and associated facility charges, and outpatient services in connection with dental procedures when the use of a hospital or surgery center 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 subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. The Health Plan of San Mateo will coordinate such services with the Subscriber's participating dental plan.

Exclusions: Services of dentist or oral surgeon for dental procedures (except medically necessary surgical procedures for conditions affecting the upper and lower jawbone or associated bone joints).

EMERGENCY HEALTH CARE SERVICES

Cost to Member: \$5 per visit
The copayment is waived if the subscriber is hospitalized.

Description: ■ Twenty-four hour Emergency Care for a medical condition that causes severe pain, or a serious illness or injury which a prudent lay person (a careful or cautious non-medical person) believes could reasonably expect without speedy medical care to result in:

- ◆ Placing their health or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious danger, or
- ◆ Serious harm to the way your body works, or
- ◆ Serious damage of any body organ or part.

■ Emergency Services and care include psychiatric screening, examination, evaluation, and treatment by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and privileges

■ Coverage is coordinated with the San Mateo County Mental Health Plan to provide care and treatment necessary to relieve or eliminate the psychiatric emergency within the capability of a facility

■ Coverage is provided both in and out of the HPSM service area and in and out of HPSM's participating facilities

PRESCRIPTION DRUG PROGRAM

Cost to member: ■ No Copayment for prescription drugs provided in an inpatient setting, or for drugs administered in the doctor's office or in an outpatient facility setting during the Subscriber's stay at the

- facility. For subscriber children, no copayment for FDA approved contraceptive drugs or devices, including norplant.
- For subscriber parents, \$5.00 copayment for 90 day supply of FDA approved oral and injectable contraceptives and contraceptive devices. No refund if the medication is removed.
- \$5 per prescription for up to a 30-34 day supply for brand name or generic drugs, including prescription drugs to stop smoking
- \$5 per prescription for up to a 90-100 day supply for maintenance drugs. Maintenance drugs are drugs that are prescribed for 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, including:

- ◆ Injectable medication, 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
- ◆ Medically necessary 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 a prescription:
 1. Blood glucose monitors and blood glucose testing strips
 2. Blood glucose minitors 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 devices to prevent or treat diabetes-related complications
 8. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
- ◆ Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription
- ◆ Medically necessary drugs administered while a Subscriber 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

- ◆ One cycle or course of treatment per benefit year of prescription drugs to stop smoking that must be supported by Smoking Cessation classes provided through HPSM's Health Promotion Department
- ◆ Contraceptive Drugs and Devices. All FDA-approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered, including internally implanted time release contraceptives such as Norplant

The Health Plan of San Mateo may dispense available generic equivalent prescription drugs, provided that no medical contraindications exist.

Exclusions:

- Experimental or investigational drugs, unless accepted for use by the standards of the medical community.
- Drugs or medications for cosmetic purposes
- Patent or over-the-counter medicines, including nonprescription contraceptive jellies, ointments, foams, condoms, etc.
- Medicines not requiring a prescription order (except insulin and smoking cessation drugs as previously described)
- Appetite suppressants, or any other diet drugs or medications
- Dietary supplements (except for formulas or special food products to treat phenylketonuria or PKU)

INPATIENT MENTAL HEALTH SERVICES

- Inpatient mental health services are authorized, arranged and provided by the San Mateo County Mental Health Plan.

Cost to Member: No Copayment

Description:

- Mental health care when ordered and performed by a San Mateo County Mental Health Plan Provider for the treatment of a mental health condition during a certified confinement in a San Mateo County Mental Health Plan hospital
- For children who meet the criteria for Serious Emotional Disturbances (SED) thirty (30) days per benefit year. Continued treatment provided by San Mateo County Mental Health Department.

- For children and parents: No visit limitations for severe mental illnesses which include:
 1. Schizophrenia
 2. Schizoaffective disorder
 3. Bipolar disorder (manic-depressive illness)
 4. Major depressive disorders
 5. Panic disorder
 6. Obsessive-compulsive disorder
 7. Pervasive developmental disorder or autism
 8. Anorexia nervosa
 9. Bulimia nervosa
- Children and parents with illnesses that do not meet the criteria for severe mental illnesses nor the criteria for SED of a child, thirty (30) days per benefit year.
- With the agreement of the Subscriber or Applicant or other responsible adult if appropriate, 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); or
 - Four (4) outpatient visits

OUTPATIENT MENTAL HEALTH SERVICES

- Outpatient mental health services are authorized, arranged and provided by the San Mateo County Mental Health Plan.

Cost to Member: \$5 per visit.

- Description:** ■ Mental health services when authorized by the San Mateo County Mental Health Plan Provider
- Mental health benefits will be provided on the same basis as any other illness including treatment of a Severe Mental Illness. Medically necessary benefits include the following:
 1. Outpatient services
 2. Inpatient services
 3. Partial hospital services
 4. Prescription drugs

- Family members may be involved in the treatment to the extent the Mental Health Plan determines it is appropriate for the health and recovery of a child
- There are no visit limits for treatment of severe mental illnesses (SMI) These conditions include, but are not limited to the following:
 1. Schizophrenia
 2. Schizoaffective disorder
 3. Bipolar disorder (manic-depressive illness)
 4. Major depressive disorders
 5. Panic disorder
 6. Obsessive-compulsive disorder
 7. Pervasive developmental disorder or autism
 8. Anorexia nervosa
 9. Bulimia nervosa
- Up to 20 visits per benefit year for illnesses that do not meet the criteria for severe mental illness or Serious Emotional Disorder of a child.
- Children with Severe Emotional Disorders (SED) are provided care through San Mateo County.

FAMILY PLANNING SERVICES

Cost to Member: No Copayment for subscriber children.
\$5 copayment per visit and \$5 copayment per device for subscriber parents.

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 pursuant to the prescription drug benefit, including insertion or removal of IUD and Norplant, diaphragms, or other FDA approved devices
- Office visits for family planning
- Lab and x-rays
- Pregnancy tests
- Treatment for problems resulting from family planning care
- Elective pregnancy terminations
- Emergency contraception when provided by an HPSM pharmacist or a non-HPSM pharmacist in a medical emergency

MATERNITY

Cost to Member: No Copayment

Description: Medically necessary professional and hospital services relating to maternity care including:

- Pre-natal and post-natal care and complications of pregnancy
- Newborn examinations and nursery care while the mother is hospitalized
- Diagnostic and genetic testing
- Counseling for nutrition, health education and social support needs
- Labor and delivery care, including midwifery service
- Participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program

Members do not have to leave the hospital before 48 hours after a vaginal delivery or 96 hours after a C-section unless the Member and doctor decide this together. If a Member leaves 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.

INPATIENT ALCOHOL/DRUG ABUSE SERVICE

Cost to Member: No Copayment

Description: Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system

OUTPATIENT ALCOHOL/DRUG ABUSE SERVICES

Cost to Member: \$5 per visit

Description: ■ Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate

- Standard benefit of 20 visits per benefit year. Additional visits may be covered if approved and authorized by the Health Plan of San Mateo

DIAGNOSTIC X-RAY AND LABORATORY SERVICES

Cost to Member: No Copayment

Description: Diagnostic laboratory services, diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat, and follow-up on the care of subscribers. Other diagnostic services, which will include, but not be limited to, the following:

- Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes
- Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, micro albuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin)
- All generally medically accepted cancer screening tests including mammograms subject to physician prescription and utilization review

DURABLE MEDICAL EQUIPMENT

Cost to Member: No Copayment

- 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
- The Health Plan of San Mateo may determine whether to rent or purchase standard equipment
 - Repair or replacement is covered unless necessitated by misuse or loss
 - 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
 - Apnea monitors
 - Pulmoaides and related supplies
 - Nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers
 - Ostomy bags, and urinary catheters and supplies
 - Insulin pumps and all related supplies
 - Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin, and apnea monitors
 - Podiatric devices to prevent or treat diabetes complicatio

Exclusions:

- Comfort and convenience items
- Disposable supplies, except ostomy bags and 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, unless medically necessary

ORTHOTICS AND PROSTHETICS

Cost to Member: No Copayment

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 licensure
- 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 physician prescribed, custom-fitted standard orthotic or prosthetic devices, authorized by the Health Plan of San Mateo and dispensed by a Plan Provider. Repair is provided unless necessitated by misuse or loss. The Health Plan of San Mateo, at its option, may replace or repair an item.

Exclusions:

- Over the counter items
- Corrective shoes, shoe inserts 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
- More than one device for the same part of the body, unless medically necessary
- Eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery)

CATARACT SPECTACLE AND LENSES

Cost to Member: No Copayment

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

MEDICAL TRANSPORTATION SERVICES

Cost to Member: No Copayment

- Description:** ■ Emergency ambulance services and transportation ("911" service) provided to a Member as a result of a "911" emergency response system request for assistance, is covered to the first hospital that accepts the Member for emergency care, where the Member reasonably believes an emergency existed, even if it is later discovered that an emergency did not in fact exist
- Emergency transportation is covered for a medical condition that causes severe pain, a serious illness or injury, or a psychiatric emergency which a prudent lay person (a careful or cautious non-medical member) believes is an emergency condition that requires ambulance transport, even if it is later determined that an emergency did not exist
 - 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 a Plan provider, and
 3. authorized in advance by the Health Plan of San Mateo.

Exclusions: Coverage for transportation by airplane, passenger car, taxi, or other form of public conveyance

HOME HEALTH CARE SERVICES

Cost to Member: No Copayment except for \$5 per visit for physical, occupational, respiratory and speech therapy performed in the home or other outpatient setting

- Description:** ■ Those services that are prescribed or directed by attending Plan physician or other appropriate authority designated by the Health Plan of San Mateo
- Health services provided at the home by health care personnel, e.g., visits by RNs, LVNS, and home health aides
 - Medically necessary physical therapy, occupational therapy, speech therapy, and respiratory therapy when prescribed by a licensed plan practitioner acting within the scope of his or her licensure

If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the Health Plan of San Mateo to choose the setting for providing the care. The Plan exercises prudent medical case management to ensure that appropriate 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 appropriate alternative services or settings.

Exclusions: Custodial care, physical therapy and rehabilitation which are not medically necessary

SKILLED NURSING CARE

Cost to Member: No Copayment, including physical, occupational, respiratory or speech therapy performed on an inpatient basis.

Description: Services prescribed by a Plan Physician or nurse practitioner and provided in a licensed skilled nursing facility when medically necessary. 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
- Maximum of 100 days per benefit year

Exclusions: Custodial care

PHYSICAL, OCCUPATIONAL, RESPIRATORY AND SPEECH THERAPY

Cost to Member: No Copayment for inpatient therapy. \$5 per visit copayment for outpatient services.

Description: ■ 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, which is medically necessary, is provided

ACUPUNCTURE

Cost to member: \$5 per visit

Description: ■ Acupuncture services are provided as a self-referral benefit and do not require referral from a primary care or other physician or health professional
■ Limited to a maximum of 20 visits per Benefit Year

BIOFEEDBACK

Cost to member: \$5 per visit

Description: ■ Biofeedback services are provided as a self-referral benefit and do not require referral from a primary care or other physician or health professional
■ Limited to a maximum of 20 visits per Benefit Year

CHIROPRACTIC SERVICES

Cost to member: \$5 per visit

Description: ■ Chiropractic services are provided as a self-referral benefit and do not require referral from a primary care or other physician or health professional
■ Limited to a maximum of 20 visits each per Benefit Year

HEARING TESTS, HEARING AIDS AND SERVICES

Cost to member: No Copayment for subscriber children
\$5 copayment per visit for subscriber parents

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
- Hearing tests, hearing aids and services: Audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.
- Hearing aid: Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Visits for fitting, counseling, adjustments, repairs, etc., at no charge for a one-year period following the provisions of a covered hearing aid.
- Limitation: for subscriber parents, this benefit is limited to a maximum of \$1000 per member every thirty-six months for the hearing aid instrument and ancillary equipment.

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 hearing aids after the covered one year warranty period
- Replacement of a hearing aid more than once in any 36-month period
- Surgically implanted hearing devices

BLOOD AND BLOOD PRODUCTS

Cost to Member: No Copayment

Description: ■ Processing, storage and administration of blood and blood products in inpatient and outpatient settings

- Includes the collection and storage of autologous blood when medically indicated

DIABETES TREATMENT

Cost to Member: \$5 per visit
\$5 per prescription for up to a 30-34 day supply for brand name or generic drugs
\$5 per prescription for up to a 90-100 day supply for maintenance drugs
No copayment for durable medical equipment

Description:

- Outpatient self-management education training
- Blood glucose monitor including those for the visually impaired
- Blood glucose testing strips
- Insulin pumps and all related necessary supplies
- Ketone urine testing strips
- Pen delivery systems for administration of insulin
- Podiatric devices to prevent or treat diabetes-related complications
- Insulin syringes
- Insulin
- Prescriptive medicine for the treatment of diabetes
- Glucagon

HEALTH EDUCATION

Cost to Member: No Copayment for subscriber children
For subscriber parents, up to \$5 copayment for diabetes outpatient self-management training, education, and medical nutrition therapy services. Charges may vary for other education services.

Description: Effective health education services, including information 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: No Copayment

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 Health Plan of San Mateo

The hospice benefit includes:

- Development and maintenance of an appropriate plan of care
- Skilled nursing services
- Certified home health aide services
- Homemaker services
- Bereavement Services
- Social services/counseling services
- Dietary counseling
- Physician services
- Volunteer services by trained hospice volunteers
- Short-term inpatient care
- Physical therapy, occupational therapy, and speech therapy for symptom control or to maintain activities of daily living
- Pharmaceuticals, medical equipment and supplies to the extent reasonable and necessary for the palliation and management of terminal illness

Hospice care is limited to those individuals who are diagnosed with a Terminal Illness with a life expectancy of one year or less and who elect hospice care for such illness instead of the traditional services covered by the Plan. The hospice election may be revoked at any time. Hospice services include the provision of palliative medical treatment of pain and other symptoms associated with a terminal disease, but do not provide for efforts to cure the disease.

RECONSTRUCTIVE SURGERY

Cost to Member : No Copayment

Description: Reconstructive surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

- Improve function
- Create a normal appearance to the extent possible

Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy

Exclusions: Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance

ORGAN TRANSPLANTS

Cost to Member: No Copayment

- Description:**
- Coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational in nature
 - These services may be covered and paid for by the California Children's Services (CCS) program, if the Member is found to be eligible. The Health Plan of San Mateo will coordinate these services with CCS for the Member
 - 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 Subscriber
 - Charges for testing of relatives for matching bone marrow transplants are covered
 - 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 are covered if the expenses are directly related to the anticipated transplant of a Subscriber

CLINICAL CANCER TRIALS

Cost to Member: No Copayment

- 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
 - Trial must meet the following requirements:
 - ◆ Trials must have a therapeutic intent with documentation provided by the treating physician
 - ◆ Treatment provided must be approved by one of the following: 1) the National Institute of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Veterans Administration, or 2) involve a drug that is exempt under the federal regulations from a new drug application
 - These services may be covered and paid for by the California Children's Services (CCS) program, if the Member is found to be eligible. The Health Plan of San Mateo will coordinate these services with CCS for the Member

- Charges for routine patient care costs of a Member. These are costs associated with the provision of health care services, 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.
- Members may request an Independent Medical Review (IMR) of HPSM's coverage decisions.

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

PHENYLKETONURIA (PKU)

Cost to Member: \$5 for 90-100 day supply

- Description:** ■ Coverage for formulas and special food products, used in place of normal food such as grocery store food, that are part of diet prescribed by a physician
- Excludes food that is naturally low in protein, may include food that is specially formulated
 - Includes food used in place of normal food products, such as grocery store foods

ATTACHMENT D

HEALTHY KIDS
EVIDENCE OF COVERAGE

ATTACHMENT D

HEALTHY KIDS - EVIDENCE OF COVERAGE

Detailed Description of Benefits, Copayments, Conditions and Exclusions

Preventive Health Services

- Cost to Member:** ■ No Copayment for preventive services.
- Description:** ■ Periodic health examinations for subscriber children, including 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.

Recommended Schedule of Preventive Pediatric Health Care Visits

<u>During Infancy</u>	<u>During Early Childhood</u>
Newborn	15 months
2-4 days	18 months
1 month	2 years
2 months	3 years
4 months	4 years
6 months	
9 months	
12 months	
<u>During Middle Childhood</u>	<u>During Adolescence</u>
5 years	Once yearly starting at
6 years	age 11 through age 21
8 years	
10 years	

- The frequency of such examinations will not be increased for reasons which are unrelated to the medical needs of the Subscriber, including a Subscriber's desire for physical examinations or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.
- Preventive services, including services for the detection of asymptomatic diseases, including the following:
- (1) periodic health examinations (including well baby care during the first two years of life including newborn hospital visits, health examinations, and other office visits)
 - (2) a variety of voluntary family planning services
 - (3) prenatal care

- (4) vision and hearing testing
- (5) immunizations
- (6) venereal disease tests, including confidential HIV/AIDS counseling and testing
- (7) annual cervical cancer screening test including the conventional Pap smear exam and the option of any cervical cancer screening test approved by the Federal Food and Drug Administration
- (8) generally medically accepted cancer screening tests
- (9) screening and diagnosis of breast cancer consistent with generally accepted medical practice and scientific evidence, upon referral of the subscriber's physician
- (10) coverage for the screening and diagnosis of prostate cancer including, but not limited to, prostate-specific antigen testing and digital rectal examination when medically necessary and consistent with good medical practice.
- (11) effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the Plan

- Immunizations consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices (ACIP). Immunizations required for travel as recommended by the ACIP and other age appropriate immunizations as recommended by the ACIP.

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

- **POLIO** is caused by a virus that attacks the nerves which control muscles. It can leave people crippled or paralyzed, and it is sometimes fatal.
- **HAEMOPHILUS INFLUENZAE TYPE B (Hib)** affects the brain and spinal cord. It can cause serious diseases such as bacterial meningitis, pneumonia and infections throughout the body. One out of 20 children who contracts Hib Meningitis dies, and one out of four suffers permanent brain damage.
- **DIPHTHERIA, TETANUS, PERTUSSIS (DTaP/DTP)**
Diphtheria is a bacteria that can lead to heart failure, breathing problems, paralysis and death. One out of ten people who gets Diphtheria dies.
Tetanus causes serious, painful spasms of all muscles. It can "lock" the jaw so the person cannot open his or her mouth or swallow. Three out of ten people who get tetanus die.
Pertussis (Whooping Cough) causes severe coughing, making it hard to breathe, eat or drink. Serious cases can lead to convulsions (strong, uncontrollable body shaking), lung collapse, pneumonia, brain damage and death.
- **MEASLES, MUMPS, RUBELLA (MMR)**
Measles can cause ear infections, pneumonia, seizures, hearing loss and brain damage. In a nationwide epidemic between 1989-91, 134 people died from measles.
Mumps can cause glands to swell and can spread to the brain and spinal cord.
- **VARICELLA**
Varicella (Chickenpox) is a common viral infection that causes a rash which can turn into blisters. It is usually not a serious illness in healthy children, but can be serious for infants, teens, and adults, especially those with impaired immune systems or chronic lung disease. Chickenpox vaccine is recommended for everyone 12 months of age or older who has not already been vaccinated and who has not had Chickenpox.

Recommended Childhood Immunization Schedule

Hepatitis B*

First Dose: Between birth and 2 months
Second Dose: Between 1 and 4 months
Third Dose: Between 6 and 18 months

Diphtheria, Tetanus, Pertussis (DtaP)

First Dose: 2 months
Second Dose: 4 months
Third Dose: 6 months
Fourth Dose: Between 15 and 18 months
Fifth Dose: Between 4-6 years

H. influenzae type b (Hib)

First Dose: 2 months
Second Dose: 4 months
Third Dose: 6 months
Fourth Dose: Between 15 and 18 months

Polio

First Dose: 2 months
Second Dose: 4 months
Third Dose: Between 15 and 18 months
Fourth Dose: Between 4 and 6 years

Measles, Mumps, Rubella (MMR)

First Dose: Between 12 and 15 months
Second Dose: Between 4 and 6 years

Varicella

One Dose: Between 12 and 18 months

Preteen Vaccines

Make sure 11-12 year old adolescents are protected.
Hep B, MMR, Td and chicken pox vaccine may be needed.

*** The second dose of Hepatitis B should be given at least 1 month after the first dose. The third dose should be given at least 4 months after the first dose and at least 2 months after the second dose.**

Physician Services

- Cost to Member:**
- \$5 per office or home visit
 - No Copayment for vision testing for Members
 - No Copayment for hospital inpatient professional services
 - No Copayment for surgery or anesthesia, radiation, chemotherapy, or dialysis treatments
 - No Copayment for Subscribers under 24 months of age for well baby care, health exams, and other office visits

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:

- Surgery, assistant surgery and anesthesia (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
- Well baby care for the first two years of life which includes newborn hospital visits, health examinations, and other office visits

Inpatient Hospital Services

Cost to member: No Copayment, except \$5 per visit for emergency health care 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 appropriate
- Coordinated discharge planning, including the planning of such continuing care as may be necessary

Includes inpatient hospital services, 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 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. The Health Plan of San Mateo will coordinate such services with the Healthy Kids participating dental plan.

Exclusions: Personal or comfort items or a private room in a hospital unless medically necessary.

Outpatient Hospital Services

Cost to member: No Copayment, except for the following:

- \$5 per visit for physical, occupational, speech and respiratory therapy performed on an outpatient basis
- \$5 per visit for emergency health care services

Description: Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility, including:

- Physical, speech, occupational and respiratory 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 Subscriber's stay at the facility

This includes general anesthesia and associated facility charges, and outpatient services in connection with dental procedures when the use of a hospital or surgery center 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 subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. The Health Plan of San Mateo will coordinate such services with the Healthy Kids participating dental plan.

Emergency Health Care Services

Cost to Member: \$5 per visit

The copayment is waived if the subscriber is hospitalized.

Description:

- Twenty-four hour Emergency Care for a medical condition that causes severe pain, or a serious illness or injury which a prudent lay person (a careful or cautious non-medical person) believes could reasonably expect without speedy medical care to result in:
 - ◆ Placing their health or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious danger, or
 - ◆ Serious harm to the way your body works, or
 - ◆ Serious damage of any body organ or part.
- Emergency Services and care include psychiatric screening, examination, evaluation, and treatment by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and privileges
- Coverage is coordinated with the San Mateo County Mental Health Plan to provide care and treatment necessary to relieve or eliminate the psychiatric emergency within the capability of a facility
- Coverage is provided both in and out of the HPSM Service Area and in and out of HPSM's participating facilities

Prescription Drug Program

- Cost to member:**
- No Copayment for prescription drugs provided in an inpatient setting, or for drugs administered in the doctor's office or in an outpatient facility setting during the Subscriber's stay at the facility. No copayment for FDA approved contraceptive drugs or devices, including Norplant.
 - \$5 per prescription for up to a 30-34 day supply for brand name or generic drugs, including prescription drugs to stop smoking
 - \$5 per prescription for up to a 90-100 day supply for maintenance drugs. Maintenance drugs are drugs that are prescribed for 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, including:
 - ◆ Injectable medication, 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
 - ◆ Medically necessary 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 a prescription:
 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 devices to prevent or treat diabetes-related complications
 8. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
 - ◆ Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription
 - ◆ Medically necessary drugs administered while a Subscriber 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
 - ◆ One cycle or course of treatment per Benefit Year of prescription drugs to stop smoking that must be supported by Smoking Cessation classes provided through HPSM's Health Promotion Department
 - ◆ Contraceptive Drugs and Devices. All FDA-approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered, including internally implanted time release contraceptives such as Norplant

The Health Plan of San Mateo may dispense available generic equivalent prescription drugs, provided that no medical contraindications exist.

Exclusions:

- Experimental or investigational drugs, unless accepted for use by the standards of the medical community
- Drugs or medications for cosmetic purposes
- Patent or over-the-counter medicines, including nonprescription contraceptive jellies, ointments, foams, condoms, etc.
- Medicines not requiring a prescription order (except insulin and smoking cessation drugs as previously described)
- Appetite suppressants, or any other diet drugs or medications
- Dietary supplements (except for formulas or special food products to treat phenylketonuria or PKU)

Mental Health Benefits

Mental health services are provided by the San Mateo County Managed Mental Health Plan. Members utilizing mental health services must comply with the Mental Health Plan's Authorization requirements. For information about mental health providers and access to care, Members should call the Mental Health Plan 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 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 Services**

- Inpatient mental health services are authorized, arranged and provided by the San Mateo County Mental Health Plan.

Cost to Member: No Copayment**Description:**

- Mental health care when ordered and performed by a San Mateo County Mental Health Plan Provider for the treatment of a mental health condition during a certified confinement in a San Mateo County Mental Health Plan hospital

- No visit limitations for Serious Emotional Disturbances (SED) of a child or for severe mental illnesses which include:
 1. Schizophrenia
 2. Schizoaffective disorder
 3. Bipolar disorder (manic-depressive illness)
 4. Major depressive disorders
 5. Panic disorder
 6. Obsessive-compulsive disorder
 7. Pervasive developmental disorder or autism
 8. Anorexia nervosa
 9. Bulimia nervosa
- Children with illnesses that do not meet the criteria for severe mental illnesses nor the criteria for SED of a child, thirty (30) days per benefit year.
- With the agreement of the Subscriber or Applicant or other responsible adult if appropriate, 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); or
 - Four (4) outpatient visits

Outpatient Mental Health Services

- Outpatient mental health services are authorized, arranged and provided by the San Mateo County Mental Health Plan.

Cost to Member: \$5 per visit.

Description:

- Mental health services when authorized by the San Mateo County Mental Health Plan Provider
- Mental health benefits will be provided on the same basis as any other illness including treatment of Serious Emotional Disturbances (SED) of a child and Severe Mental Illness. Medically necessary benefits include the following:
 1. Outpatient services
 2. Inpatient services
 3. Partial hospital services
 4. Prescription drugs

- Family members may be involved in the treatment to the extent the Mental Health Plan determines it is appropriate for the health and recovery of a child
- There are no visit limits for treatment of SED, and severe mental illnesses (SMI). Severe mental illnesses include, but are not limited to the following:
 1. Schizophrenia
 2. Schizoaffective disorder
 3. Bipolar disorder (manic-depressive illness)
 4. Major depressive disorders
 5. Panic disorder
 6. Obsessive-compulsive disorder
 7. Pervasive developmental disorder or autism
 8. Anorexia nervosa
 9. Bulimia nervosa
- Up to 20 visits per benefit year for illnesses that do not meet the criteria for severe mental illness or Serious Emotional Disorder of a child.

Family Planning Services

Cost to Member: No Copayment

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 pursuant to the prescription drug benefit, including insertion or removal of IUD and Norplant, diaphragms, or other FDA approved devices
- Office visits for family planning
- Lab and x-rays
- Pregnancy tests
- Treatment for problems resulting from family planning care
- Elective pregnancy terminations
- Emergency contraception when provided by an HPSM pharmacist or a non-HPSM pharmacist in a medical emergency

Maternity

Cost to Member: No Copayment

Description: Medically necessary professional and hospital services relating to maternity care including:

- Pre-natal and post-natal care and complications of pregnancy
- Newborn examinations and nursery care while the mother is hospitalized
- Diagnostic and genetic testing
- Counseling for nutrition, health education and social support needs
- Labor and delivery care, including midwifery service
- Participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program

Members do not have to leave the hospital before 48 hours after a vaginal delivery or 96 hours after a C-section unless the Member and doctor decide this together. If a Member leaves 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.

Inpatient Alcohol/Drug Abuse Services

Cost to Member: No Copayment

Description: Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system

Outpatient Alcohol/Drug Abuse Services

Cost to Member: \$5 per visit

Description:

- Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate
- Standard benefit of 20 visits per benefit year. Additional visits may be covered if approved and authorized by the Health Plan of San Mateo.

Diagnostic X-ray and Laboratory Services

Cost to Member: No Copayment

Description: Diagnostic laboratory services, diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat, and follow-up on the care of Members. Other diagnostic services, which will include, but not be limited to, the following:

- Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes
- Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, micro albuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin)
- All generally medically accepted cancer screening tests including mammograms subject to physician prescription and utilization review

Durable Medical Equipment

Cost to Member: No Copayment

- 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
 - The Health Plan of San Mateo may determine whether to rent or purchase standard equipment
 - Repair or replacement is covered unless necessitated by misuse or loss
 - 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
 - Apnea monitors
 - Pulmoaides and related supplies
 - Nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers
 - Ostomy bags, and urinary catheters and supplies
 - Insulin pumps and all related supplies
 - Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin, and apnea monitors
 - Podiatric devices to prevent or treat diabetes complication

Exclusions:

- Comfort and convenience items
- Disposable supplies, except ostomy bags and 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, unless medically necessary

Orthotics and Prosthetics

Cost to Member: No Copayment

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 licensure
- 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 physician prescribed, custom-fitted standard orthotic or prosthetic devices, authorized by the Health Plan of San Mateo and dispensed by a Plan Provider. Repair is provided unless necessitated by misuse or loss. The Health Plan of San Mateo, at its option, may replace or repair an item.

Exclusions:

- Over the counter items
- Corrective shoes, shoe inserts 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
- More than one device for the same part of the body, unless medically necessary

Cataract Spectacle and Lenses

Cost to Member: No Copayment

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

Medical Transportation Services

Cost to Member: No Copayment

- Description:**
- Emergency ambulance services and transportation ("911" service) provided to a Member as a result of a "911" emergency response system request for assistance, are covered to the first hospital that accepts the Member for emergency care, where the Member reasonably believes an emergency existed, even if it is later discovered that an emergency did not in fact exist
 - Emergency transportation is covered for a medical condition that causes severe pain, a serious illness or injury, or a psychiatric emergency which a prudent lay person (a careful or cautious non-medical person) believes is an emergency condition that requires ambulance transport, even if it is later determined that an emergency did not exist
 - 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 a Plan provider, and
 3. authorized in advance by the Health Plan of San Mateo.

Exclusions: Coverage for transportation by airplane, passenger car, taxi, or other form of public conveyance

Home Health Care Services

Cost to Member: No Copayment except for \$5 per visit for physical, occupational, respiratory and speech therapy performed in the home or other outpatient setting

Description:

- Those services that are prescribed or directed by attending Plan physician or other appropriate authority designated by the Health Plan of San Mateo
- Health services provided at the home by health care personnel, e.g., visits by RNs, LVNS, and home health aides
- Medically necessary physical therapy, occupational therapy, speech therapy, and respiratory therapy when prescribed by a licensed Plan practitioner acting within the scope of his or her licensure

If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the Health Plan of San Mateo to choose the setting for providing the care. The Plan exercises prudent medical case management to ensure that appropriate 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 appropriate alternative services or settings.

Exclusions: Custodial care, physical therapy and rehabilitation which are not medically necessary

Skilled Nursing Care

Cost to Member: No Copayment, including physical, occupational, respiratory or speech therapy performed on an inpatient basis.

Description: Services prescribed by a Plan Physician or nurse practitioner and provided in a licensed skilled nursing facility when medically necessary. 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
- Maximum of 100 days per benefit year

Exclusions: Custodial care

Physical, Occupational, Repiratory and Speech Therapy

Cost to Member: No Copayment for inpatient therapy. \$5 per visit copayment for outpatient services.

- Description:**
- 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, which is medically necessary, is provided

Acupuncture

Cost to member: \$5 per visit

- Description:**
- Acupuncture services are provided as a self-referral benefit and do not require referral from a primary care or other physician or health professional
 - Limited to a maximum of 20 visits per Benefit Year

Biofeedback

Cost to member: \$5 per visit

- Description:**
- Biofeedback services are provided as a self-referral benefit and do not require referral from a primary care or other physician or health professional
 - Limited to a maximum of 20 visits per Benefit Year

Chiropractic Services

Cost to member: \$5 per visit

- Description:**
- Chiropractic services are provided as a self-referral benefit and do not require referral from a primary care or other physician or health professional
 - Limited to a maximum of 20 visits each per Benefit Year

Hearing Tests, Hearing Aids and Services

Cost to member: No Copayment

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

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 hearing aids after the covered one year warranty period
- Replacement of a hearing aid more than once in any 36-month period
- Surgically implanted hearing devices

Blood and Blood Products

Cost to Member: No Copayment

- Description:**
- Processing, storage and administration of blood and blood products in inpatient and outpatient settings
 - Includes the collection and storage of autologous blood when medically indicated

Diabetes Treatment

Cost to Member: \$5 per visit
\$5 per prescription for up to a 30-34 day supply for brand name or generic drugs
\$5 per prescription for up to a 90-100 day supply for maintenance drugs
No copayment for durable medical equipment

Description:

- Outpatient self-management education training
- Blood glucose monitor including those for the visually impaired
- Blood glucose testing strips
- Insulin pumps and all related necessary supplies
- Ketone urine testing strips
- Pen delivery systems for administration of insulin
- Podiatric devices to prevent or treat diabetes related complications
- Insulin syringes
- Insulin
- Prescriptive medicine for the treatment of diabetes
- Glucagon

Health Education

Cost to Member: No Copayment

Description: Effective health education services, including information 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: No Copayment

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 Health Plan of San Mateo

The hospice benefit includes:

- Development and maintenance of an appropriate plan of care
- Skilled nursing services

- Certified home health aide services
- Homemaker services
- Bereavement services
- Social services/counseling services
- Dietary counseling
- Physician services
- Volunteer services by trained hospice volunteers
- Short-term inpatient care
- Physical therapy, occupational therapy, and speech therapy for symptom control or to maintain activities of daily living
- Pharmaceuticals, medical equipment and supplies to the extent reasonable and necessary for the palliation and management of terminal illness

Hospice care is limited to those individuals who are diagnosed with a Terminal Illness with a life expectancy of one year or less and who elect hospice care for such illness instead of the traditional services covered by the Plan. The hospice election may be revoked at any time. Hospice services include the provision of palliative medical treatment of pain and other symptoms associated with a terminal disease, but do not provide for efforts to cure the disease.

Reconstructive Surgery

Cost to Member : No Copayment

Description: Reconstructive surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

- Improve function
- Create a normal appearance to the extent possible

Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy

Exclusions: Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance

Organ Transplants

Cost to Member: No Copayment

- Description:**
- Coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational in nature
 - These services may be covered and paid for by the California Children's Services (CCS) program, if the Member is found to be eligible. The Health Plan of San Mateo will coordinate these services with CCS for the Member (see page **23**)
 - 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 Subscriber
 - Charges for testing of relatives for matching bone marrow transplants are covered
 - 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 are covered if the expenses are directly related to the anticipated transplant of a Member

Clinical Cancer Trials

Cost to Member: No Copayment

- 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
 - Trial must meet the following requirements:
 - ◆ Trials must have a therapeutic intent with documentation provided by the treating physician

- ◆ Treatment provided must be approved by one of the following: 1) the National Institute of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Veterans Administration, or 2) involve a drug that is exempt under the federal regulations from a new drug application
- These services may be covered and paid for by the California Children's Services (CCS) program, if the Member is found to be eligible. The Health Plan of San Mateo will coordinate these services with CCS for the Member (see page **23**)
- Charges for routine patient care costs of a Member. These are costs associated with the provision of health care services, 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.
- Members may request an Independent Medical Review (IMR) of HPSM's coverage decisions.

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

Phenylketonuria (PKU)

Cost to Member: No copayment

Description: Testing and treatment of PKU is covered. Additionally, “formula”, as defined below and certain “special food products”, as defined below, which may be prescribed for the treatment of PKU are covered. Formula and special food products are covered to the extent that the Member’s costs for such items exceed the cost of a normal diet. The formula and/or special food product must also be prescribed by a physician or nurse practitioner, or ordered by a registered dietician upon referral by a participating provider who is authorized to prescribe dietary supplements, as medically necessary, for the treatment of PKU.

- “Formula” means enteral product or enteral products for use at home.
- “Special food product: means a food product that is both of the following:
 - Prescribed by a physician or nurse practitioner for the treatment of PKU and is consistent with the recommendations and best practices of a qualified health professional with expertise and experience in the treatment and care of PKU. It does not include food that is naturally low in protein, but may include food that is specially formulated to have less than one gram of protein per serving, and
 - used in place of normal food products, such as foods found in retail establishments, and used by the general population.

California Children’s Services (CCS)

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

CCS is a California medical program that treats those under 21 with certain physically handicapping conditions and who need specialized medical care. This program is available to those in California whose families meet certain medical, financial and residential eligibility requirements. Services provided through the CCS Program are coordinated by the local county CCS office.

If a Healthy Kids Program Member's Primary Care Physician (PCP) suspects or identifies a possible CCS eligible condition, he/she must refer the member to the local county CCS Program. The CCS Program (local or the CCS Regional Office) will determine if the Member's condition is eligible for CCS services. If referred to the CCS Program, you will be asked to complete a short application to verify residential and financial status and ensure coordination of care after the referral has been made. If determined to be eligible for CCS services, a Healthy Kids Member continues to stay enrolled in the Healthy Kids Program. He or she will be referred and must 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. The Health Plan of San Mateo will continue to provide primary care and prevention services that are not related to the CCS eligible condition, as described in this document, and will also work with the CCS Program to coordinate care provided by both the CCS Program and HPSM.

Additional information about the CCS Program can be obtained by calling CCS at **(650) 573-2755**.

ATTACHMENT E **RATES OF PAYMENT**

PLAN shall pay MHSD the following rates beginning on or after January 1, 2003:

Service	Mental Health Therapist	CPT Code	Proposed Rate
Case Management		TBD	\$106.00
Collateral Assessment	Social worker, PhD, MD, RN	90887	\$ 66.00
Assessment	Social worker, PhD, MD, RN	90801	\$127.20
In-Patient Assessment	MD (0 – 50 minutes)	99222	\$ 72.00
In-Patient Assessment	MD, PhD (51 – 70 minutes)	99223	\$127.00
Individual Therapy	Social worker (0 – 40 minutes)	90804	\$ 60.00
Individual Therapy	Social worker (41 – 70 minutes)	90806	\$105.00
Individual Therapy	Social worker (> 70 minutes)	90808	\$135.00
Individual Therapy	MD, PhD, nurse (0 – 40 minutes)	90805	\$ 85.00
Individual Therapy	MD, PhD, nurse (41 – 70 minutes)	90807	\$135.00
Individual Therapy	MD, PhD, nurse (> 70 minutes)	90809	\$170.00
In-Patient Therapy	MD (0 – 25 minutes)	99232	\$ 38.00
In-Patient Therapy	MD, PhD (26 – 35 minutes)	99233	\$ 72.00
Group Therapy	Social Worker (15 minutes)	90853	\$ 17.00
Group Therapy	MD, PhD, nurse (15 minutes)	90853	\$ 28.00
Medication	MD, nurse (0 – 30 minutes)	M0064	\$100.00
Medication	MD, nurse (> 30 minutes)	90862	\$237.00
Injection		90782	\$ 90.00
Crisis	MD, PhD, Nurse, Social Worker	90899	\$229.00
Day Treatment Intensive Full Day			\$ 83.00
Day Treatment Intensive Half Day			Actual*
Day Treatment Rehabilitative Half Day			Actual*
Day Treatment Rehabilitative Full Day			Actual*
Residential			Actual*
Hospital In-Patient			Actual*
Hospital Administrative Day			\$288.00

* Not to exceed State Department of Mental Health maximum rate.

ATTACHMENT F
BUSINESS
ASSOCIATE AGREEMENT

ATTACHMENT F
Health Insurance Portability and Accountability Act (HIPAA)

Business Associate Requirements

Definitions

Terms used, but not otherwise defined, in this Schedule shall have the same meaning as those terms are defined in 45 Code of Federal Regulations section 160.103 and 164.501. (All regulatory references in this Schedule are to Title 45 of the Code of Federal Regulations unless otherwise specified.)

- (a) *Designated Record Set*. "Designated Record Set" shall have the same meaning as the term "designated record set" in Section 164.501.
- (b) *Individual*. "Individual" shall have the same meaning as the term "individual" in Section 164.501 and shall include a person who qualifies as a person representative in accordance with Section 164.502(g).
- (c) *Privacy Rule*. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Part 160 and Part 164, Subparts A and E.
- (d) *Protected Health Information*. "Protected Health Information" shall have the same meaning as the term "protected health information" in Section 164.501 and is limited to the information created or received by MHS from or on behalf of the PLAN.
- (e) *Required By Law*. "Required by law" shall have the same meaning as the term "required by law" in Section 164.501.
- (f) *Secretary*. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his or her designee.

Obligations and Activities of Contractor

- (a) MHS agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as required by law.
- (b) MHS agrees to use appropriate safeguards to prevent the use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- (c) MHS agrees to mitigate, to the extent practicable, any harmful effect that is known to MHS of a use or disclosure of Protected Health Information by MHS in violation of the requirements of this Agreement.
- (d) MHS agrees to report to the PLAN any use or disclosure of the Protected Health Information not provided for by this Agreement.
- (e) MHS agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by MHS on behalf of the PLAN, agrees to the

same restrictions and conditions that apply through this Agreement to MHS with respect to such information.

- (f) If MHS has protected health information in a designated record set, MHS agrees to provide access, at the request of the PLAN, and in the time and manner designated by the PLAN, to Protected Health Information in a Designated Record Set, to the PLAN or, as directed by the PLAN, to an Individual in order to meet the requirements under Section 164.524.
- (g) If MHS has protected health information in a designated record set, MHS agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the PLAN directs or agrees to make pursuant to Section 164.526 at the request of the PLAN or an Individual, and in the time and manner designed by the PLAN.
- (h) MHS agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by MHS on behalf of, the PLAN available to the PLAN, or at the request of the PLAN to the Secretary, in a time and manner designated by the PLAN or the Secretary, for purposes of the Secretary determining the PLAN's compliance with the Privacy Rule.
- (i) MHS agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for the PLAN to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.
- (j) MHS agrees to provide to the PLAN or an Individual in the time and manner designed by the PLAN, information collected in accordance with Section (i) of this Schedule, to permit the PLAN to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.

Permitted Uses and Disclosures by MHS

Except as otherwise limited in this Schedule, MHS may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the PLAN as specified in the Agreement; provided that such use or disclosure would not violate the Privacy Rule if done by the PLAN.

Obligations of the PLAN

- (a) The PLAN shall provide MHS with the notice of privacy practices that the PLAN produces in accordance with Section 164.520, as well as any changes to such notice.

- (b) The PLAN shall provide MHS with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect MHS's permitted or required uses and disclosures.
- (c) The PLAN shall notify MHS of any restriction to the use or disclosure of Protected Health Information that the PLAN has agreed to in accordance with Section 164.522.

Permissible Requests by the PLAN

The PLAN shall not request MHS to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by the PLAN, unless the MHS will use or disclose Protected Health Information for, and if the Agreement provides for, data aggregation or management and administrative activities of MHS.

Duties Upon Termination of Agreement

- (a) Upon termination of the Agreement, for any reason, MHS shall return or destroy all Protected Health Information received from the PLAN, or created or received by MHS on behalf of the PLAN. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of MHS. MHS shall retain no copies of the Protected Health Information.
- (b) In the event that MHS determines that returning or destroying Protected Health Information is infeasible, MHS shall provide to the PLAN notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, MHS shall extend the protections of the Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as MHS maintains such Protected Health Information.

Miscellaneous

- (a) *Regulatory References.* A reference in this Schedule to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required.
- (b) *Amendment.* The Parties agree to take such action as is necessary to amend this Schedule from time to time as is necessary for the PLAN to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.

- (c) *Survival.* The respective rights and obligations of MHS under this Schedule shall survive the termination of the Agreement.
- (d) *Interpretation.* Any ambiguity in this Schedule shall be resolved in favor of a meaning that permits the PLAN to comply with the Privacy Rule.