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

This Group Agreement (Agreement), including the Evidence of Coverage (EOC) document(s) and attachments listed below and incorporated herein by reference, and any amendments to any of them, constitutes the contract between the San Mateo Health Commission, dba Health Plan of San Mateo, (PLAN) and the San Mateo County Public Authority (Contract Holder). This Agreement is effective this 1st day of August, 2002.

Product Name: HealthWorx

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

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

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

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

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

Group Agreement Effective Date: August 1, 2002
Contract Holder Number: 000001

San Mateo County Public Authority	San Mateo Health Commission
_____	_____
Signature	Signature
_____	Richard S. Gordon
Print Name	Print Name
_____	4/16/2003
Date	Date

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ATTACHMENT A
TERMS AND CONDITIONS

Recital:

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

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

SECTION 1
DEFINITIONS

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

1.1 **"Beneficiary"** – shall mean a person designated by an insuring [illegible] eligible to receive insurance benefits.

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

1.3 **"Commission"** shall mean the San Mateo Health Commission.

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

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

1.6 **"Copayment"** - shall mean the portion of health care costs for covered services for which the Member has financial responsibility under the HealthWorx Program.

1.7 **"Covered Services"** shall mean those health care services and supplies which a Member is entitled to receive under the HealthWorx Program and which are set forth in the HealthWorx Program Evidence of Coverage (Attachment A, attached hereto and hereby incorporated by reference).

1.8 **"Evidence of Coverage"** - shall mean the document issued by the PLAN to Members that describes Covered Services and Non-Covered Services in the HealthWorx Program [illegible] reference)

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

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

1.11 **"Hospital"** - shall mean a licensed general acute care hospital.

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

1.13 **"Participating Provider"** - shall mean a Provider who has entered into an Agreement with the PLAN to provide Covered Services to Members. The terms "Participating Provider" and "Contracting Provider" may be used interchangeably.

1.14 **"PLAN"** - shall mean the Health Plan of San Mateo, which is governed by the San Mateo County Health Commission.

1.15 " " - shall mean any health professional or institution certified to render services to Members contracting with the PLAN under the HealthWorx Program.

SECTION II
ENROLLMENT

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

2.1 The Contract Holder or designee shall be responsible for forwarding completed enrollment information on eligible members to the PLAN.

2.2 The Contract Holder or designee shall also be responsible for forwarding enrollment information on HealthWorx Members eligible through COBRA or Cal-COBRA. The Contract Holder will make every effort to ensure that eligibility information is transmitted electronically to the PLAN not later than January 2, 2004.

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

SECTION III
PREMIUMS

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

3.1 Premium Change

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

3.1.2 upon parties agreement to amend Attachment B of this Group Agreement. However, said amendment is contingent upon the approval of the State Department of Health Services; or

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

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

3.2 Premium Payment

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

3.3 Premium due date and grace period

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

3.3.1 Premiums shall be paid in full for Members whose coverage is effective on the P[illegible] whose coverage terminates on the last day of [illegible] period.

3.4 Credit for Member terminations

Contract Holder may receive a maximum of two (2) month's credit for Member terminations which occurred more than thirty-one (31) days prior to the date PLAN was notified of the Member's termination. Retroactive additions will be honored at the discretion of the PLAN base upon the eligibility guidelines described in the EOC and on the Schedule of Benefits. Retroactive additions are subject to payment of applicable premiums.

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

3.5 Non-payment of Premium

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

SECTION IV
TERM AND TERMINATION

4.0 Effective Date

This agreement shall become effective on August 1, 2002.

4.1 Term

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

4.2 Termination on Notice

This Agreement may be terminated by either party as follows:

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

Commission by Certified U.S. Mail, UPS, FedEX, or other traceable mail service, proper postage prepaid and properly addressed to the office of the Commission as provided below:

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

4.2.2 If termination is initiated by Commission, the date of such termination shall be set by consideration for the welfare of Members and necessary allowance for notification of Providers and Members, and Contract Holder shall be notified as hereinafter provided. Commission may terminate this Agreement at any time and for any reason, including, but not limited to, the parties' inability to agree to a rate increase or obtain Department of Health Services (DHS) approval for said rate increase, upon thirty (30) days written notice transmitted by Commission to Contract Holder by Certified U.S. Mail, FedEX, or other traceable mail service, proper postage prepaid and properly addressed to the office of the Contract Holder as provided below.

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

4.3 Termination for nonpayment

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

4.4 Termination due to non-acceptance of amendments

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

4.5 Termination due to non-renewal of Agreement

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

4.6 Termination due to Premium change

The Contract Holder may terminate this Group Agreement as of the date any Premium change would become effective, by providing PLAN with written notice of termination not less than thirty (30) days prior to such effective date based upon inability to perform due to changed legal, contractual or regulatory circumstances.

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

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

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

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

4.7.2 In the event there are (1) changes effected in the PLAN's Medi-Cal contract with the State of California, or (2) changes effected in HealthWorx, or (3) changes in the Federal Medicaid or SCHIP Programs, or (4) changes in the Federal Medicare Program, or (5) substantial changes under other public or private health care insurance programs or policies any of which changes will have a material detrimental financial effect on the operations of the Contract Holder or PLAN, Contract Holder or PLAN may terminate this Group Agreement upon providing the other party with thirty (30) days prior written notice. In any case where such notice is provided, both parties shall negotiate in good faith during such thirty (30) day period in an effort to develop a revised Group Agreement, which, to the extent reasonably practicable, under the circumstances, will adequately protect the interests of both parties in the event the government program or private insurance policy changes which constituted the basis for the exercise of this termination provision.

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

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

4.9 Termination for cause

PLAN may terminate this Group Agreement if the Contract Holder:

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

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

becomes insolvent;

files a petition in bankruptcy;

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

has begun any voluntary or involuntary liquidation process;

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

Termination [illegible] following the date PLAN gives the Contract Holder written notice of termination.

4.10 Effect of [illegible]

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

SECTION V
MEMBER NOTIFICATION OF TERMINATION

5.0 It is the responsibility of the Contract Holder or designee to notify the Members of the termination of the Group Agreement in compliance with all applicable laws. However, PLAN reserves the right to notify Members' of termination of the Group Agreement for any reason, including non-payment of Premium. When PLAN delivers a notice of

cancellation or termination to Contract Holder, Contract Holder or designee will mail a legible, true copy to each Member under this Group Agreement at the Members' current address.

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

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

SECTION VI
OBLIGATIONS UNDER COBRA AND CAL-COBRA

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

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

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

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

SECTION VIII
INDEPENDENT CONTRACTOR RELATIONSHIPS

8.0 Between Participating Providers and PLAN.

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

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

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

8.1 Between the Contract Holder and PLAN.

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

SECTION IX
ADMINISTRATION OF THE AGREEMENT

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

9.0 Entire Agreement

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

9.1 Amendments

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

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

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

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

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

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

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

9.2 Forms

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

9.3 Records

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

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

9.4 Clerical Errors

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

9.5 Claim Determinations

PLAN has complete authority to review all claims for Covered Benefits under this Group Agreement. In exercising such responsibility, PLAN shall have discretionary authority to

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

9.6. [illegible]

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

9.7 Assignability

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

9.8 Waiver

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

9.9 Notices

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

9.10 Third Parties

This Group Agreement shall not confer any [illegible] specifically provided herein.

9.11 [illegible]

9.11.1 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.

9.11.2 Both parties 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. Contract Holder's equal employment policies shall be made available to County of San Mateo upon request.

9.11.3 With respect to the provision of employee benefits, Contractor shall comply with the 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.

9.11.4 Both parties 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 contract.

9.12 [illegible] to Arrange Services

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

9.13 [illegible]

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

9.14 Workers' Compensation

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

ATTACHMENT B

PREMIUM SCHEDULE FOR 2002
(AUGUST 1, 2002 – JULY 31, 2005)

Premium .....$195.31/per member/per month

ATTACHMENT C

CONTRACT HOLDER'S OBLIGATIONS UNDER COBRA AND CAL-COBRA

A. All parties will comply with applicable federal law, regulations and requirements regarding continuation of benefits .

B. All parties will comply with applicable state law, regulations and requirements regarding continuation benefits.

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

D. Contract Holder will administer or contract for the administration of coverage under COBRA and Cal-COBRA.

E. Contract Holder must provide written notice to PLAN within thirty (30) days of the date the Contract Holder becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S. C. Section 1 161 et seq.

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

G. If Contract Holder fails to meet these obligations, PLAN will not provide continuation coverage to qualified Beneficiaries under COBRA or Cal-COBRA. Contract Holder hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to COBRA or Cal-COBRA continuation coverage

ATTACHMENT D

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

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

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

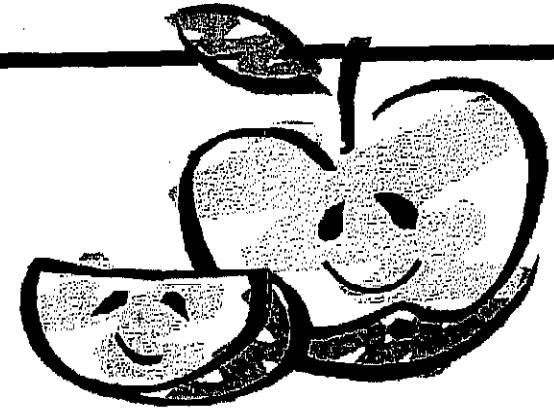
C. Contract Holder or designee also agrees to forward to PLAN in a timely manner copies of any and all notices provided to Members regarding HIPAA.

HealthWorx

Healthcare for Caregivers

Evidence of Coverage and Member Handbook

2002/2003



Providing Publicly Funded Health Care for San Mateo County
A Product of the Health Plan of San Mateo

701 Gateway Blvd., Suite 400
South San Francisco, CA 94080
650-616-0050 ** 1-800-750-4776

ATTACHMENT E

We Speak Your Language!

Member Services 1-800-750-4776 or 650-616-0050
Hearing Impaired (TDD) 650-616-8037

If you would like a large print copy of this book, please call the HPSM Member Services Department.

Si usted necesita una copia en español, favor de llamar al Departamento de Servicios para Miembros.

Kung hindi ninyo maintindihan o hindi mabasa ito, tumawag lamang sa Health Plan of San Mateo Member Services Department.

如果您不明白或不會看此信，請電
Health Plan of San Mateo 會員部門

Если Вы не можете прочитать или
разобраться в данной информации,
пожалуйста, позвоните в План Здоровья
Сан Матео области Health Plan of San Mateo,
в отдел Member Services Department.

The Health Plan of San Mateo ensures the privacy of your medical record. For more information, contact Member Services.

Table of Contents

The Health Plan of San Mateo
HealthWorx Program

Member Handbook and Evidence of Coverage

Introduction

WELCOME

We are very pleased to welcome you to HealthWorx and the Health Plan of San Mateo (HPSM).

It is important to us that you understand how the Health Plan of San Mateo (HPSM) works so you get the health care you need. This *Handbook and Evidence of Coverage* has important information about your benefits, how to get care, and how to get answers to question you may have.

The Health Plan of San Mateo is located at 701 Gateway Blvd., Suite 400, South San Francisco, CA 94080. If you need assistance or would like more information regarding the HealthWorx Program, call a Health Plan of San Mateo Member Services Representative. Members' toll free number for questions, problems or help in choosing a doctor is **1-800-750-4776**. Members may also reach HPSM at **650-616-0050**.

ABOUT THE HEALTH PLAN OF SAN MATEO

The Health Plan of San Mateo is a Managed Care Plan which contracts with the San Mateo County Public Authority to manage the health care of those who are eligible for HealthWorx. Getting your health care from a Managed Care Plan may be new to you, so it is very important that you READ the *Member Handbook and Evidence of Coverage*, and any riders, inserts, or attachments CAREFULLY. You will learn:

- How to choose a doctor or change your doctor;
- How to receive care;
- What your benefits are; and,
- What to do if you have a question or a problem.

The Health Plan of San Mateo makes personal, cost effective, and convenient health care available for you. HPSM works to meet your health care needs through a network of qualified medical groups, clinics, hospitals, pharmacies, and other health care providers located throughout San Mateo County.

As a Health Plan of San Mateo Member, your health care needs will be managed by the Primary Care Physician you select from among the many physicians who are part of the Health Plan. Your Primary Care Physician will take care of most of your health care needs, including preventive care such as checkups, immunizations, and PAP smears for women. Your Primary Care Physician will refer you to Specialists when necessary and will make arrangements for hospitalization when required.

Each Eligible Person may choose his or her own Primary Care Physician. The name and telephone number of your Primary Care Physician will be listed on your Health Plan of San Mateo Identification (ID) Card.

If you need to go to a hospital, you will usually be admitted to the hospital where your Primary Care Physician is on staff or has arrangements to admit you. The hospitals where HPSM doctors work are listed in your Provider List.

PREMIUMS, ELIGIBILITY, ENROLLMENT, AND TERMINATION OF COVERAGE

Premium Contributions

Members are entitled to health care coverage only for the period for which the Health Plan of San Mateo has received the appropriate Premiums from the San Mateo County Public Authority. You are responsible for a monthly premium contribution. The San Mateo County Public Authority will tell you the amount and arrange for you to pay your contribution through a payroll deduction.

Who is Eligible?

The San Mateo County Public Authority (SMCPA) is required to inform you of their eligibility requirements. To enroll, you must meet SMCPA requirements that HPSM has approved, and the subscriber must live or work in our Service Area. The Service Area is described in the "Definitions" section of the HealthWorx Member Handbook and Evidence of Coverage. In addition, you must meet the Subscriber eligibility requirements below.
You must be eligible to enroll as a Subscriber if you are:

1. An In-Home Supportive services Worker under the San Mateo County Public Authority (SMCPA) who works a specified number of hours as determined by SMCPA and the Service Employees International Union (SEIU), Local 715 and;

2. SMCPA has openings available to add subscribers to the HealthWorx Program.

Members with Medicare and Retirees

This plan is not intended for most Medicare beneficiaries and SMCPA does not offer coverage to retirees. If, during the term of this EOC, you are or become eligible for Medicare or you retire, you should contact HPSM Member Services at **1-800-750-4776** for assistance.

Enrollment and Effective Date of Coverage

After SMCPA has confirmed that you are eligible to enroll, enrollment is permitted as follows and membership begins at 12:01 a.m. on the effective date indicated on your Identification Card.

New Employees

Once SMCPA informs you that you are eligible to enroll as a Subscriber, you may enroll yourself by submitting a Health Plan-approved enrollment application to SEIU, Local 715 within 31 days.

The effective date of coverage for new employees is the first day of the second month following the date that an enrollment or change of enrollment application is signed.

Special Enrollment Due to Loss of Other Coverage
An employee may enroll within 90 days of losing other coverage by submitting to SEIU, Local 715 an enrollment or change of enrollment application in a form agreed upon by SEIU and HPSM. The employee requesting enrollment must have previously waived coverage for self when originally eligible because of the other coverage, continuation of other coverage has expired, or the other employer has ceased making contributions toward the other coverage and the loss of coverage is not due to non-payment or cause.The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the second month following the date that an enrollment or change of enrollment application is signed.

Open Enrollment

You may enroll yourself by submitting a Health Plan-approved enrollment application to the Service Employees International Union, Local 715 during the open enrollment period. SEIU will let you know when the open enrollment period begins and ends and the effecitve date of coverage.

If you have questions on these topics or would like another copy of these materials, please contact the HealthWorx Program at:

Service Employees International Union, Local 715
891 Marshall Street
Redwood City, CA 94063
650-365-8715 ext. 16

Termination of Coverage

A Member's coverage will be terminated if the Public Authority fails to pay the Member's premium in accordance with the Group agreement. The Public Authority will provide written notification to the Member no less than thirty (30) days prior to the effective date of termination. The notice will be in writing and sent by regular U.S. Mail to the Member's address on file with the Public Authority. The notice will clearly indicate the last day of coverage.

CUSTOMER SERVICE

For Help In Other Languages, Call 1-800-750-4776.

If you do not speak or read English well, you may get help in the following ways:

- HPSM staff speak several languages, including Spanish, Tagalog, and Chinese. The Member Services staff is available from 8:00 a.m. to 6:00 p.m. Monday through Friday at **1-800-750-4776** to answer questions, solve problems or help you choose a doctor.
- You can see doctors who speak your language. The HealthWorx' Provider List has information about languages spoken in each office, office locations and hours available for appointments, including evening and weekend hours. The Member Services staff can help you choose doctors if you need help or have questions.
- Translation services are available by phone , or through use of Language Line Services.
- You can request HealthWorx documents in other languages.

PHYSICAL ACCESS

The Health Plan of San Mateo has made every effort to ensure that our offices and the offices and facilities of HPSM providers are accessible to the disabled. If you are not able to locate an accessible provider, please call our toll free customer service number at **1-800-750-4776** and a customer service representative will help you find an alternate provider.

ACCESS FOR THE HEARING IMPAIRED (TDD)

The hearing impaired may contact our customer services representative through our TDD number at **650-616-8037**.

ACCESS FOR THE VISION IMPAIRED

This *Member Handbook and Evidence of Coverage* (EOC) and other important HealthWorx materials will be made available in alternate formats for the vision impaired. Large print and enlarged computer disk formats are available. For alternate formats, or for direct help in reading the Member Handbook and EOC and other materials, please call a Member Services Representative at **1-800-750-4776**.

HOW TO USE THIS EVIDENCE OF COVERAGE

Please read the entire *Member Handbook and Evidence of Coverage*. Many of the sections go together; so, if you read just one or two sections, you may not have complete information about HealthWorx.

Many words used in the *Member Handbook and Evidence of Coverage* have special meanings. These words are defined in Section 1, Definitions, and appear in this booklet with capital first letters. Refer to the Definitions to help you understand a Member's benefits, rights and responsibilities under the Health Plan of San Mateo, HealthWorx Program. From time to time, the Health Plan's Contract with the San Mateo County Public Authority may be changed. If that happens, a new *Evidence of Coverage* or an Amendment of this *Evidence of Coverage* will be sent to you. Please keep your copy of the most current *Evidence of Coverage* in a safe place.

IF YOU HAVE QUESTIONS

The information in your HealthWorx' *Member Handbook and Evidence of Coverage* and New Member Packet should answer most of your questions about your health care benefits. If you have other questions about the Health Plan of San Mateo or about your benefits or your rights with HPSM, always feel free to contact a Member Services Representative at **1-800-750-4776.**

Section 1 / DEFINITIONS

Amendment means a written description of any changes to the HealthWorx contract which the Health Plan of San Mateo (HPSM) will send to Members when such changes impact the *Evidence of Coverage*. These changes should be read and then be attached to your *Evidence of Coverage*.

Anniversary Date means the date each year that is the same as the day and month a Subscriber's HealthWorx coverage began.

Applicant means a person applying for HealthWorx coverage for himself or herself.

Authorization means approval granted by the Primary Care Physician or HPSM usually in advance of the rendering of a service to a Member.

Benefits or ***Coverage*** or ***Covered Service(s)*** means the health care services provided to HealthWorx Members, subject to the terms, conditions, limitations and exclusions of the HealthWorx Contract and as shown in the Member's *Evidence of Coverage* and its Amendments.

Benefit Year means a twelve (12) month period starting January 1 of each year at 12:01 a.m.

California Children's Services (CCS) is a case management and insurance program for children with certain disabling medical conditions.

Clinic is a place where a team of doctors, nurses and other providers treat patients on an outpatient basis.

Copayment means an amount a Member must pay for certain Benefits, usually at the time of a medical appointment.

Coverage Decision means the approval, modification, or denial of health care services by HPSM or its contracting providers based on a finding that a particular service is included or excluded as a covered benefit under the terms and conditions of the benefit plan.

DMHC means the Department of Managed Health Care.

Disputed Health Care Service means any health care service eligible for coverage and payment that has been denied, modified, or delayed based on a decision by HPSM or its contracting providers that the service is not medically necessary.

Emergency Medical Care means those services required to relieve a medical condition that causes severe pain, or 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:

i) placing the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

ii) serious impairment of bodily functions, or

iii) serious dysfunction of any bodily 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.

Emergency services are provided both in and out of HPSM's services area and in and out of HPSM's participating facilities.

Grievance means a statement filed by a Member or Provider with HPSM's Grievance Coordinator expressing dissatisfaction with the delivery of health care services which must be resolved by the Health Plan.

Health Plan or ***HPSM*** mean the Health Plan of San Mateo.

HealthWorx Program means the health insurance program under 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.

Identification Card means the card issued by the Health Plan to each Member. This card should be presented to all Participating Providers whenever the Member needs care.

Investigational Services means those drugs, equipment, and procedures that were experimental at one time, but are now tested in humans. Investigational services may be covered if the following conditions are met:

- You have a life-threatening or seriously debilitating condition, and
- Standard therapies have not been effective, or are not appropriate, or there is no standard therapy covered by HPSM that is more beneficial than the therapy being proposed.

Life Threatening means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

Medical Emergency *[See Emergency Medical Care].*

Medical Group means a group of professionals including physicians, clinics, hospitals, and other health care professionals under contract with the Health Plan of San Mateo and HealthWorx to arrange for and provide health care services to Members.

Medically Necessary Services means those health services which are necessary to meet the basic health needs of an individual. Determination of medical necessity is done on a case-by-case basis and considers several factors, including but not limited to, the standards of the medical community. The fact that a Physician has performed, prescribed or recommended a procedure or treatment does not mean that it is medically necessary. In addition, the service must (1) be consistent with the diagnosis of, and prescribed course of treatment for the patient's condition, or be generally accepted by the medical community as a preventive health service, (2) be required for reasons other than the convenience of the patient or his or her Physician, or not be required solely for custodial, comfort, or maintenance reasons, and could not have been omitted without adversely affecting the Member's condition or the quality of medical care rendered, (3) be performed in the most cost-efficient type of setting appropriate for the condition, and (4) be rendered at a frequency which is accepted by the medical community as medically appropriate. Final determination of what is medically necessary will be made by the HPSM's Medical Director.

Member means a person determined eligible for HealthWorx Coverage who enrolls in the Health Plan of San Mateo.

Participating Hospital means a licensed hospital that is a Participating Provider.

Participating Provider means a physician, clinic, hospital, hospice, or other health care professional or facility under contract with the Health Plan of San Mateo to arrange for and provide health care services to Members.

Premium means the monthly contribution made by Applicants to the San Mateo County Public Authority for a HealthWorx Subscriber.

Primary Care Physician or **PCP** is the doctor you select or are assigned to who provides all your basic care at the time you join the Health Plan of San Mateo. Your Primary Care Physician is your regular doctor and is always the first doctor you see. Your PCP is responsible for setting up referrals for specialist care if you need it, and for knowing about your health situation.

Provider List is a list of Participating Providers including doctors, clinics, hospitals, and other specialty providers.

Referral means that when you need special kinds of care, your Primary Care Physician will refer, or send you, to a Specialist who is a Participating Provider.

San Mateo County Public Authority (SMCPA) Contract means the agreement signed by the Health Plan of San Mateo and the San Mateo County Public Authority which sets forth the benefits, exclusions, payments, administration and other conditions under which HPSM will provide HealthWorx services to Members of the Health Plan of San Mateo.

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

Seriously Debilitating means diseases or conditions that may cause morbidity.

Specialist or ***Referral Provider*** means a doctor who only treats certain kinds of problems like broken bones or heart trouble. Your regular doctor will tell you if you need special care and will authorize the visit.

State means the State of California.

Subscriber means a person determined eligible for HealthWorx Coverage.

Terminal Illness is a condition that has a high probability of causing death within one year or less.

Urgent Care means services: 1) provided in response to a Member's need for quick diagnosis and/or treatment of a medical or mental disorder that could become an emergency if not diagnosed and/or treated in a timely manner.

Section 2 / MEMBER RIGHTS AND RESPONSIBILITIES

As a Member of the Health Plan of San Mateo (HPSM) you have the right to:

Dignified, courteous, and considerate treatment regardless of race, religion, age, gender, national origin, disability, sexual identity or orientation, family composition or size, medical condition or stage of illness.

Have your confidential medical records protected, except when disclosure is required by law or permitted by you. With adequate notice, you have the right to review your records with your Primary Care Physician (PCP) and add a statement if you disagree with any information in your medical record.

Access information and services in a way which respects your language and cultural needs.

Get up-to-date information about the physicians and hospitals who participate in the Health Plan.

Obtain primary and preventive care from the Primary Care Physician (PCP) you have chosen from the HPSM network.

Change from the Primary Care Physician (PCP) you selected to another available Primary Care Physician (PCP) who participates in the HPSM network.

Receive information on how to schedule appointments and get health care during and after office hours.

Obtain necessary care from participating specialists, hospitals and other providers.

Call 911 if you have an emergency.

Know and understand your medical problem and your physician's treatment plan.

Participate actively in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse or discontinue treatment.

Obtain a second opinion from another provider.

Receive a prompt reply when you ask HPSM questions or request information.

Be fully informed about HPSM's Grievance procedure without fear of interruption of health care services.

Free interpreter services in the event that a Grievance Hearing is held, or notice

As a Member of the Health Plan of San Mateo (HPSM) you have the responsibility to:

Carefully read all HPSM Member materials so you understand how to use your benefits and what procedures to follow when you need care.

Do your best to keep appointments; if you need to cancel or reschedule an appointment, call the provider or clinic as soon as possible.

Show your ID card or remember to tell your Provider you are a HealthWorx Member before receiving care.

Follow the treatment plan you and your provider have agreed upon.

Provide accurate and complete information about your health care needs when you see your provider. Let your provider know if you have a medical condition.

Ask your doctor questions if you do not understand something or are unsure about the advice you are given.

See the specialists to whom your Primary Care Physician (PCP) refers you.

Actively participate in health care programs that keep you well.

Work with your provider in building and maintaining a good working relationship.

Be sure to follow-up with your Primary Care Physician (PCP) after getting care at an emergency facility.

Report lost or stolen ID cards to the Health Plan of San Mateo's Member Services Department and do not let anyone else use your card.

Contact the Health Plan of San Mateo's Member Services Department if you do not understand how to use your benefits or have any problems with the services provided.

Promptly follow the HPSM Grievance procedure if you believe you need to submit a Grievance.

Section 3 / CHOICE OF PHYSICIANS AND FACILITIES

The HealthWorx Provider List, which you received along with this *Member Handbook and Evidence of Coverage*, lists the Primary Care Physicians, clinics, hospitals, and other health care professionals and facilities available to you. It also lists where doctors and other practitioners, and clinics are located, their telephone numbers, what languages they speak, the hospitals they work with, and other useful information. The list is updated every three (3) months and indicates which providers are accepting new patients. You can request a new list or if you would like more information about a particular provider including education, board certification or specialty training, please call a Member Services Representative at **1-800-750-4776.**

A Primary Care Physician may be a Pediatrician, a General Practitioner, a Family Practitioner, an Internist, or in some cases an OB/GYN doctor. If you wish to choose a specific nurse practitioner or physician assistant, select the primary care facility where he or she works.

HOW TO CHOOSE OR CHANGE YOUR PRIMARY CARE PHYSICIAN

You will need to choose a personal Primary Care Physician from the Provider List. The Primary Care Physician whom you choose will provide, authorize and coordinate all of your health care. He or she will see you for most of your health care service needs, including preventive services.

- You may choose the doctor you already use if you see his or her name on the list.

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

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

- Does the doctor work at a clinic I like to use?
- Is the office close to my home, work or school?
- Is it easy to get to by public transportation?
- Do the doctors and nurses speak my language?
- Does the doctor work with a hospital that I like?
- Do they provide the services I may need?

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

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

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

If your Primary Care Physician cannot take care of your problem, he or she will refer you to a Specialist. If you need to go to the hospital, your Primary Care Physician will make all of the arrangements. The hospital to which you would be admitted will be determined by your choice of Primary Care Physician or Specialist.

You and your Primary Care Physician are a team, working to keep you healthy. It is best to stay with the same doctor so he or she can get to know your health care needs. If you change doctors often, your health care may not be as good as it could be.

To obtain more information before you select a PCP, you can call the doctor's office or call the HPSM Member Services Department at **1-800-750-4776** to ensure that you can obtain the health care services that you need.

If you and your Primary Care Physician are not able to establish a good relationship, either of you have the right to request a different assignment. For example, if you fail to keep appointments, do not follow your Primary Care Physician's medical advice, or are disruptive or abusive, your Primary Care Physician may request that you select a new Primary Care Physician. If you are not satisfied with the treatment or service of your Primary Care Physician, you may also select a new PCP. If you decide to choose a different Primary Care Physician, we will do our best to meet your request. To select another Primary Care Physician, you may choose another doctor by calling a Member Services Representative at **1-800-750-4776** or **650-616-0050.** The Member Services Representative may ask the reason for your Primary Care Physician change. This information helps HPSM ensure the quality of care provided by our doctors. It also helps us to be sure our provider network meets the needs of our Members.

If a request to change is processed before the 20th day of the month, it will become effective on the first day of the following month. If it is processed after the 20th, it will become effective on the first day of the month after that. (i.e., a change processed on May 25th will become effective on July 1st). If the Primary Care Physician that you choose is unavailable for some reason, we will contact you by phone or in writing. The sooner you contact us to change your Primary Care Physician, the better.

Please note: A **new** Member ID Card will be mailed to you with the name of your new Primary Care Physician. Your new ID Card will show the date your Primary Care Physician change is effective. Please continue to see the Primary Care Physician listed on your current ID Card for all of your health care needs, until the effective date of change. If you do not receive a new ID Card within ten (10) days or have questions about the effective date of change, please call the Member Services Department at **1-800-750-4776** or **650-616-0050**.

Continuation of Services

If your PCP or specialist stops being a HPSM provider, you may, in some cases, be able to continue to receive care from that provider. If you are being treated for certain conditions you may be able to continue care with your current physician for 90 days, or longer if necessary, while you find another physician. This includes, for example, women who are pregnant and in their second or third trimester, or Members with chronic conditions. If you feel you are in this situation, please call a Member Services Representative for assistance at **1-800-750-4776**.

Indian Health Services

Native Americans who are Members of HealthWorx, as provided under Federal law, may choose any Indian Health Service Provider available. The provider does not have to be a HealthWorx network provider and HPSM will make arrangements to coordinate appropriate services for these Members.

HealthWorx Service Area

The HealthWorx service area includes all Zip Codes in San Mateo County.

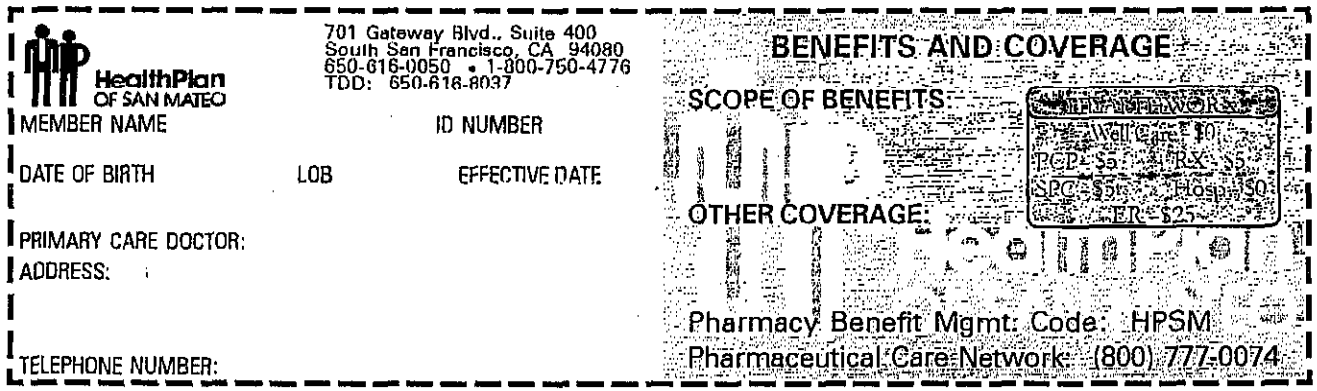
Section 4 / PROCEDURES FOR OBTAINING HEALTH CARE SERVICES WITHIN THE HEALTH PLAN OF SAN MATEO

Remember Your Member Identification Card

Each member who is covered under the HealthWorx Program will receive his or her own HPSM Identification (ID) Card. Always carry your current Member Identification Card with you and show your Identification Card every time you seek health care services. The people providing care need to know that you are a Member of HPSM .

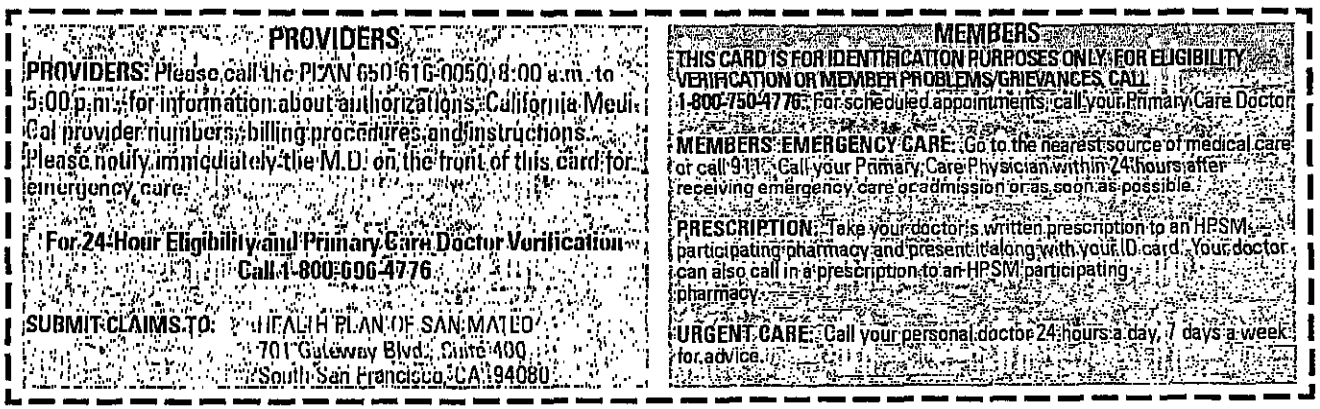
A picture of the Member Identification Card is shown below.

Front side of card



Back side of card

This side describes how you use the card



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

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

Name: This person is eligible to receive benefits under the HealthWorx Program.

PCP: This is your Primary Care Physician.

DOB: This is your date of birth.

Copayment: This is the amount that you will need to pay for certain benefits, usually at the time of an appointment. There is no copayment required for well care visits (Well Care) or for authorized inpatient hospital stays (HOSP). There is a $5 charge for all other appointments that you have with a PCP or specialty care provider (SCP), and for each prescription (Rx) that you have filled. There is a $25 charge for emergency room care and services.

Scheduling Appointments

Call your Primary Care Physician and make an appointment. Your Primary Care Physician's phone number and address is listed on your Member ID Card. If you find that you need to change the appointment, let the doctor's office know as soon as you can and make a new appointment for a better time.

If your Primary Care Physician believes that you should see a Specialist, he or she will refer you. Members should not refer themselves to Specialists without Authorization from their Primary Care Physician.

Women's Services

Female Members have unlimited, direct access to OB/GYN services. Members may choose to have these services provided by any qualfied Primary Care Physician, including Familiy Practitioners, Internists and General Practitioners qualified to provide OB/GYN services and minor surgery. Members may self-refer to any contracted OB/GYN or Primary Care Physician within the HPSM network.

Referral Authorization Form (RAF)

Your Primary Care Physician may decide that you need to see a Specialist for consultation, treatment, laboratory work, x-rays or other specialty care. The Primary Care Physician will send a Referral Authorization Form (RAF) to the Specialist authorizing one or more than one visit (Standing Referral). Members who have a life-threatening, degenerative or disabling condition or disease, including HIV or AIDS, which requires specialized medical care over a prolonged period of time, can receive a standing referral to a Specialist, or a specialty care center, that has expertise in treating the condition or disease.

HealthWorx furnishes Members and Providers with a Provider List listing Board Certified Specialists accredited by the American Board of Medical Specialists. Specialty referrals are determined by your PCP. If you would like another copy of the HealthWorx Provider List, please call Member Services at **1-800-750-4776**.

Treatment Authorization Request (TAR)

Some medical services and some medications require prior authorization. Your provider will send a Treatment Authorization Request (TAR) to HPSM to request a service/treatment that requires prior authorization. HPSM uses the same TAR requirements as those currently used by the California State Department of Health Services, unless specifically excepted by the Health Plan.

Utilization review criteria and guidelines used by HPSM or any entities with which the health plan contracts for services, that include utilization review or utilization management functions, to determine whether to authorize, modify, defer, or deny health care services are:

1. Developed with involvement from actively practicing health care providers;

2. Consistent with sound clinical principles and processes;

3. Evaluated, and updated at least annually, if necessary;

4. Are disclosed to the provider and the member in the specified case;

5. Disclosure of Policies and Procedures and a description of the process used by HPSM, its contracting provider groups, or any entity with which HPSM contracts for service is available to members and the public upon request. HPSM is only required to disclose the criteria or guidelines for the specific procedures or conditions requested.

HPSM may charge a reasonable fee to cover administrative expenses related to disclosed criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. HPSM may also make the criteria or guidelines available through electronic communication. The disclosure required by this paragraph shall be accompanied by the following notice: "The materials provided to you are the guidelines used by this plan to authorize, modify, defer or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and benefits covered under your contract."

6. The criteria used as guidelines by HPSM include but are not limited to:

   a. Manual of criteria for Medi-Cal authorization (State of California Department of Health Service)
   b. Milliman & Robertson, Inc., Health Care Management Guidelines
   c. The Severity of Illness/Intensity of Service Criteria (SI/IS) published by Interqual, Inc.
   d. Medi-Cal Medical, Allied Health and Inpatient/Outpatient Provider Manuals
   e. Other nationally accepted criteria as appropriate for the review process

7. Requested services are reviewed and assessed for medical necessity, level of care, appropriateness of site and duration, benefit determination, and delays in the provision of health care services.

Services Excluded from Prior Authorization

Some services do not require an authorization or referral from your Primary Care Physician. You may go directly to the medical provider for the services listed below.

1. Emergency Services

2. Primary and Preventive Care Services

3. Family Planning/Sexually Transmitted Disease and Confidential HIV/AIDS Testing - These are services that relate to pregnancy planning, birth control, prevention of sexually transmitted disease, confidential testing for venereal disease and HIV/AIDS counseling and testing. These services are available from the member's PCP, participating family planning agency, or participating obstetrician.

   Family Planning services are provided to Members of child bearing age to help you decide when you want to have children. They will also help you if you want to protect yourself from having children until you are ready. These services

include all methods of birth control approved by the Federal Food and Drug Administration. HPSM's Member Services staff can provide referrals to family planning clinics if you want some help, or you can contact the California Office of Family Planning's Information & Referral Service toll-free number at **1-800-942-1054**.

4. Women's Services - Female members have unlimited, direct access to OB/GYN services. Members may choose to have these services provided by any qualified Primary Care Physician, including Family Practitioners, Internists and General Practitioners qualified to provide OB/GYN services. Members may self-refer to any contracted OB/GYN or Primary Care Physician within the HPSM network. You can get these services from your Primary Care Physician or any other qualified HPSM network provider who provides these services. **Your doctor does not have to refer you or authorize this care.**

5. The following services are provided as a self-referral benefit and do not require referral from a Primary Care Physician, other physician or health professional. These services are limited to a maximum of 20 visits per Benefit Year.

   a. Acupuncture
   b. Chiropractic Services

6. Indian Health Services - Native Americans who are HPSM Members, as provided under federal law, may choose any Indian Health Service Provider available. The provider does not have to be a HPSM network provider and HPSM will make arrangements to coordinate appropriate services for these members.

Medications

Medically necessary prescription drugs are a HealthWorx benefit. In certain circumstances, some drugs may be covered even if they are not part of the HPSM formulary. When you get a prescription filled, you show your HPSM Member ID card or tell the pharmacist you are a Member of HPSM . Your prescription may be from your PCP, your referral doctor, or any other licensed doctor or dentist. HealthWorx routinely covers generic drugs. Some prescriptions require a Treatment Authorization Request (TAR).

Refills

Never wait until your medication is gone before getting a refill. Some medications may require a new prescription before they can be refilled. Talk with your doctor and go to your pharmacy early enough to allow for this possibility. Do not go to the emergency room for prescription refills.

Over-The-Counter /Non-Prescription Drugs

Some over-the-counter medications may be covered by HealthWorx if you have a doctor's prescription and they are medically necessary. Remember to talk with your doctor about any over-the-counter drugs you may be using.

HPSM Drug Formulary

The HPSM Drug Formulary is a comprehensive list of medication which is approved for use and/or coverage by HealthWorx. Drugs are dispensed through participating pharmacies to HealthWorx Members. HealthWorx uses the State of California Medi-Cal Formulary and additional drugs are selected by the HPSM Pharmacy Review.Committee, which is comprised of HPSM pharmacists and physicians representing various medical, surgical and psychiatric specialties. This committee reviews new drugs quarterly and updates the formulary as appropriate. The HPSM Member Services Representatives have been trained to be able to inform Members whether or not a particular drug is on the formulary. For questions regarding the HPSM Formulary or to obtain a copy of the formulary, contact the Member Services Department at **1-800-750-4776**. The HPSM Formulary lists all covered drugs by either the chemical name, brand name (if one exists), and/or the name of the generic equivalent.

Please note that the presence of a drug on the HPSM Formulary does not guarantee that a Member will be prescribed the drug by the Member's prescribing provider.

Generic Equivalent Drugs

Generic equivalent drugs are pharmaceutical equivalents of one or more brand name drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drugs.

The HPSM Formulary lists available generic equivalents that will be dispensed, with the following exceptions:

Physician Requested Brand Name Drugs

If the physician believes a generic equivalent must not be dispensed, he or she may write "Dispense as Written" (DAW) or "Do Not Substitute" on the prescription. The pharmacist will then contact HPSM to see if a Treatment Authorization Request (TAR) is required. If a TAR is required, the pharmacist will submit a request by phone or by fax to HPSM.

Member Requested Brand Name Drugs

The Member may prefer a brand name drug rather than the generic equivalent, which would normally be dispensed. The pharmacist must then contact the prescribing provider to determine the medical necessity for using a brand name. After obtaining additional information from the prescribing provider, the pharmacist will submit a Treatment Authorization Request (TAR) to HPSM asking for approval of the brand name drug.

Non-Formulary Drugs

HealthWorx participating providers and pharmacies are responsible for using the Formulary. If a drug is prescribed that is not on the Formulary, the pharmacist will call the provider to request a change to a Formulary drug. If the substitution of a Formulary drug is not approved by the requesting provider, the pharmacist will submit a Treatment Authorization Request (TAR) to HPSM for the non-formulary drug. The pharmacist may phone or fax a TAR request to HPSM .
The average time to process a request for a Non-Formulary TAR is one working day. Additional time may be needed to process the request if the TAR is incomplete, contains erroneous information, HPSM needs additional information from your doctor about a medical condition or we cannot confirm your eligibility. If you have any questions about a request for a Non-Formulary drug, please contact the Member Services Department at **1-800-750-4776**.

Evening, Weekend or Holiday Treatment Authorization Requests (TARs)

HPSM is not able to review TARs after business hours or on the weekend. Eligible members may be given up to a three-day supply of medication to allow the pharmacy to contact HPSM on the next business day for a TAR required prescription.

Changes in Formulary Drugs

If a Member is taking a drug, and HPSM drops the drug from its Formulary, and the provider continues to prescribe the drug for the Member, HPSM will provide continued coverage for the drug with an approved Treatment Authorization Request (TAR).

Deferred, Modified or Denied Treatment Authorization Requests (TARs)

If a request for a drug is deferred, modified or denied, a "Notice of Action" letter will be sent to the Member. The Notice of Action will explain the reason for the action and provide information on the Member's appeal rights.

Mental Health Services

Mental health services are provided by the San Mateo County 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**.

Requests for new mental health services are handled by the Mental Health Plan's Access Team which authorizes services based on the needs of each individual member. Mental Health benefits will be provided on the same basis as any other illness including medically necessary treatment of severe mental illness at any age. Call the Access Team to find out more about receiving mental health services.

The Mental Health Plan provides coverage for psychiatrist prescribed drugs and lab tests. Use the phone numbers below to contact the Mental Health Plan regarding your mental health care needs.

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 911 or go directly to the closest Emergency Room for help.

MENTAL HEALTH SERVICES PATIENT ADVOCATE
Adults 1-800-388-5189

Dental Services

Dental services provided by a dentist or oral surgeon for inpatient, medically indicated dental procedures, are benefits subject to the limitations and exclusions noted in this *Evidence of Coverage*.

Vision Services

Eyeglasses or contacts necessary after cataract surgery are a covered benefit.

Urgent Care or Care After Regular Hours or on Weekends

If you feel sick, have a fever, or some other urgent medical problem, call your Primary Care Physician . If he/she is not available, an on-call doctor will always be available to tell you how to handle the problem at home or if you should go to an urgent care center or a hospital emergency room.

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

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

Emergency Care

A Medical Emergency means a medical condition that causes severe pain or 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:

i) placing the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious danger, or

ii) serious harm to the way your body works, or

iii) 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 provided for care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capability of a facility.

Emergency services and care are provided both in and out of HPSM's service area and in and out of HPSM's participating facilities. When you have a Medical Emergency, call 911 or go to the closest emergency room for help. You do not have to go to the hospital where your Primary Care Physician works if you have a Medical Emergency.

Follow-up Care

After receiving emergency health care services necessary to stabilize your emergency medical condition, be sure to follow-up with your Primary Care Physician.

Non-Qualifying Emergency Services

When a member reports to a hospital emergency room clinic for a non-emergency medical condition, the Emergency Room staff will attempt to contact your Primary Care Physician for instruction. The Plan will pay for services rendered to determine if an emergency condition existed if the Member reasonably believed emergency services were required when presenting to the emergency room.

Out-of-Area Care

If you need Emergency Medical Care outside of the Health Plan's Service Area, the Health Plan of San Mateo will pay for it. The provider who treats you must notify the Health Plan of San Mateo within 24 hours of your arrival or as soon as possible.

If you are out of the area and get sick but it is not a Medical Emergency, call your Primary Care Physician to find out what to do. Always keep your Member ID card with you. Your Primary Care Physician's phone number is listed to help you.

Second Opinion Policy

Sometimes you may want a "SECOND OPINION" from another doctor before you make up your mind about your treatment. To ensure that as a Member you receive appropriate and necessary health care services, you can get a second opinion from any appropriately qualified provider in the HPSM provider network. The reasons you or your doctor may ask for another opinion include:

- Questions regarding the necessity of recommended surgical procedures
- Questions regarding a diagnosis or plan of care
- Questions regarding a diagnosis due to unclear or complex clinical conditions or conflicting test results
- Lack of improvement with an ongoing treatment plan after an appropriate amount of time for a specific illness
- Any serious concerns you may have about a diagnosis or plan of care
- Other reasons you may have

If you would like a second opinion, please talk to your PCP. Your PCP or the Participating Plan Specialist to whom you were referred can help you select a qualified health professionals from whom you may receive a second opinion or you can select any appropriately qualified provider from the HealthWorx Provider List. An appropriately qualified health care professional is a Primary Care Physician (PCP), Specialist, or other licensed health care provider who is acting within his or her scope of practice and who has the clinical background, training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion, to understand and treat your particular illness, disease or condition. Please do not go to a doctor for a second opinion without a Referral Authorization Form (RAF) from your PCP.

If you need a second opinion for an urgent medical condition, the Health Plan of San Mateo and your Provider will respond within seventy-two (72) hours.

If you have any questions or concerns about asking for a second opinion, please call a Member Services Representative for help or more information.

Section 5 / COVERED SERVICES, BENEFITS AND COPAYMENTS

Introduction

This Section describes the Covered Services and Benefits provided to HealthWorx Members. The services described in this section are Covered Services if they are medically necessary. Some require Copayments. At the beginning of this Section is a Summary of Benefits, Copayments and Conditions, followed by a more detailed description of Benefits, Copayments, Conditions and Exclusions.

The decision whether services are medically necessary will be made by your Primary Care Physician or the Health Plan of San Mateo. This decision is based on generally accepted medical standards, State laws and regulations, and HPSM policies. Emergency medical services do not require prior authorization. However, a decision regarding the need for emergency services may occur after services have been provided. If you disagree with a decision on medical necessity or on whether a particular situation was a Medical Emergency, you can request a review by the Health Plan of San Mateo through the Grievance procedure described in Section 10.

Copayments

Some visits and services require Members to pay Copayments, as listed in the Summary of Benefits at the end of this Section.

HPSM will also be working with its providers to let you know what to do if you cannot pay all your Copayments. If you have to pay more than $25 in Copayments in one month, many providers will allow you to make the payment within 30 or 60 days rather than at the time of the appointment. If paying the Copayments becomes a problem for you, please talk with your doctor or other provider. If you need assistance, please call our HPSM's Member Services staff at **1-800-750-4776** and we will help you make the arrangements you need.

Other Member Payment Responsibilities

For Covered Services, HealthWorx Members are generally only responsible for Copayments. However, you may be financially responsible for services that need a Referral or Authorization if you get them without a Referral from your Primary Care Physician or Authorization from HPSM. You may also be responsible for: services you receive that are not HealthWorx Covered Services, non-emergency services received in the emergency room, non-emergency services received outside of San Mateo County without prior Authorization from your Primary Care Physician, and, unless authorized, services received that are greater than the limits specified in this *Evidence of Coverage*.

Out-of-Area Services

- If you are outside the HPSM Service Area, the Health Plan of San Mateo provides coverage for Emergency Medical Care. If you are outside of the HPSM's Service Area and you become seriously ill or need Emergency Care, go to the nearest medical facility or call 911. If possible, show the provider your HPSM Identification card.

- If you need Urgent or non-Emergency care, the provider you see must get approval from your Primary Care Physician or HPSM before providing services. You may have to pay for services you receive if the provider does not get prior authorization.

COORDINATION OF SERVICES

California Children's Services (CCS)

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 HealthWorx 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 determined to be eligible for CCS services, 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. As long as the Member remains enrolled in HealthWorx, 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.

The CCS office must verify residential status for each Member in the CCS Program. If you are referred to the CCS Program, you will be asked to complete a short application to verify residential status and ensure coordination of care after the referral has been made.

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

Mental Health Benefits

HealthWorx mental health services are provided by the San Mateo County 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 medically necessary treatment of severe mental illness at any age.

HEALTHWORX EVIDENCE OF COVERAGE

Summary of Benefits, Copayments and Conditions

HPSM provides the Covered Services and Benefits described in this *Evidence of Coverage*. Most Covered Services are available to you when medically necessary and received from, referred by, or authorized by HPSM or your Primary Care Physician. Some are available without a Referral and some require a Copayment.

There are no copayments for preventive services.

There are no annual or lifetime benefit maximums in any of the coverage under the HealthWorx program.

For Covered Services, HealthWorx Members are generally responsible only for Copayments. However, you may also be responsible for:

- services that need a Referral or Authorization if you get them without a Referral from your Primary Care Physician or Authorization from HPSM,
- services you receive that are not HealthWorx Covered Services,
- non-emergency services received in the emergency room, exclusive of those services rendered to determine if an emergency condition existed, if the Member reasonably believes emergency services were required when presenting to the Emergency Room,
- non-emergency services received outside of San Mateo County without prior Authorization from your Primary Care Physician, and
- unless authorized, services received that are greater than the limits specified in this Evidence of Coverage.

Members should read all descriptions of the Covered Services and Benefits in this Evidence of Coverage - and in any riders, inserts, or attachments - to get the full details of their coverage as an HPSM Member.

HEALTHWORX EVIDENCE OF COVERAGE

Summary of Benefits, Copayments and Conditions

BENEFIT	COPAYMENT	CONDITIONS
PHYSICIAN SERVICES		
Well baby care	No copayment	
Age appropriate immunizations and periodic health exams	No copayment	As specified by HPSM and in keeping with current preventive health standards of the U.S. Public Health Services and the American Academy of Pediatrics.
Hearing and vision screening	No copayment	
Primary Care Physician and specialty office visits, including allergy testing and treatment, and second opinions	$5.00 per visit, except where no copayment is indicated	Most specialty visits require a Referral from the PCP. (See page 19 for a listing of specialty services that do not require a referral).
Perinatal care	No copayment	
Outpatient surgery, anesthesia, radiation therapy, chemotherapy, dialysis treatments	No copayment	
Urgent care services	$5.00 per visit	
Home visits	$5.00 per visit	

BENEFIT	COPAYMENT	CONDITIONS
HOSPITAL		
Inpatient services, including doctors' services, nursing services, surgical services, anesthesia, lab, x-ray, drugs, medical supplies, blood and blood products, rehabilitation therapies and services (physical therapy, occupational therapy, speech therapy, respiratory therapy)	No copayment	
Outpatient services, except emergency room visit	No copayment	
EMERGENCY SERVICES		
Emergency room visits	$25.00 per visit	Not covered if used for non-emergency services
Follow-up care services	$5.00 per visit	After receiving emergency health care necessary to stabilize your emergency medical condition, be sure to follow-up with your Primary Care Physician.
Ambulance	No copayment	

BENEFIT	COPAYMENT	CONDITIONS

PRESCRIPTION DRUGS

Received during inpatient stay, doctor's office visit, outpatient setting at the time of an appointment or emergency	No copayment	
FDA - approved contraceptive drugs and devices and emergency contraception	No copayment	
All other prescriptions including prescription to stop smoking	$5.00 per prescription	Up to a 30-34 day supply for brand name drugs or generic drugs Up to a 90-100 day supply for maintenance drugs; e.g., drugs prescribed for 60 days or longer for chronic conditions such as arthritis, heart disease, diabetes, high blood pressure

MENTAL HEALTH

Services arranged and managed by the San Mateo County Mental Health Plan	No copayment	

BENEFIT	COPAYMENT	CONDITIONS
MENTAL HEALTH, Continued		
Inpatient	No copayment	Mental health care when authorized 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 participating hospital. Substitutions allowed for one inpatient day: 2 days of residential treatment, 3 days of day care treatment, 4 outpatient visits. Mental health benefits will be provided on the same basis as any other illness including treatment of severe mental illness. See page 45 for full benefit explanation.
Outpatient	$5.00 per visit	Evaluation, crisis intervention, and treatment for conditions when ordered and performed by a San Mateo County Mental Health Plan provider. See page 44 for full benefit explanation.
ALCOHOL/SUBSTANCE ABUSE		
Inpatient	No copayment	For detoxification only.
Outpatient	$5.00 per visit	20 visit limit per Benefit Year.

BENEFIT	COPAYMENT	CONDITIONS
HOME HEALTH		
Home health care visits and services by nurses and home health aides	No copayment	
Home health care visits and services for physical, occupational, speech and respiratory therapy	$5.00 per visit	
HOSPICE		
Hospice care	No copayment	Available to members with a terminal illness and a life expectancy of one year or less
REHABILITATION THERAPIES		
Physical, occupational, speech and respiratory therapy	No copayment for inpatient therapy $5.00 per visit for outpatient services and services at home	As medically necessary
DURABLE MEDICAL EQUIPMENT (DME), including prosthetics and orthotics	No copayment	
FAMILY PLANNING SERVICES **SEXUALLY TRANSMITTED DISEASES** **CONFIDENTIAL HIV/AIDS TESTING**	No copayment	No Referral needed

BENEFIT	COPAYMENT	CONDITIONS
SKILLED NURSING FACILITY CARE	No copayment	Up to 100 days per Benefit Year
OTHER SERVICES		
Acupuncture	$5.00 per visit	Up to 20 visits per Benefit Year. No Referral needed.
Chiropractic	$5.00 per visit	Up to 20 visits per Benefit Year. No Referral needed.
Cataract spectacles and lenses	No copayment	Spectacles, contact lenses or intraocular lenses that replace the natural lens of the eye after surgery. One pair of glasses or contact lenses after cataract surgery with insertion of an intraocular lens.
Hearing aids	No copayment	
Annual Cervical Cancer Screening Test	No copayment	
Health education services	No copayment	
X-ray and laboratory services	No copayment	
Blood and blood products	No copayment	

BENEFIT	COPAYMENT	CONDITIONS
OTHER SERVICES, Continued		
Diabetes Treatment	$5 for office visits $5 for 30-40 day supply of brand name or generic drugs $5 for 90-100 day supply of maintenance drugs No copayment for Durable Medical Equipment	
Non-emergency medical transportation	No copayment	
California Children's Services	No copayment	Services arranged and (CCS) managed by the San Mateo County CCS program (see page 28)
Clinical Cancer Trials	No copayment	Must meet specific criteria

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

- 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:
  - 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

- $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

- Medically necessary professional and hospital services relating to maternity care are covered including:
  - Prenatal and postnatal care and complications of pregnancy
  - Diagnostic and genetic testing
  - Counseling for nutrition, health education, and social support needs
  - Labor and delivery care including midwifery services
  - Newborn examinations within the first thirty (30) days of life and nursery care while the mother is hospitalized

- Inpatient hospital care will be provided for up to 48 hours following a normal vaginal delivery and up to 96 hours following delivery by Cesarean Section unless an extended stay is authorized by 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

- Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility including:
  - Physical, occupational, and speech therapy as medically necessary
  - Hospital services which can reasonably be provided on an ambulatory basis
  - Related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the Member's stay at the facility
  - Outpatient services in connection with dental procedures when the use of a hospital or outpatient facility is required because of an underlying medical condition, clinical status, or because of the severity of the dental procedure
  - HPSM will coordinate such services with the Member's dental plan, if any

Cost to Member

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

Exclusions

- Services of a dentist or oral surgeon for dental procedures (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:

- Developement and maintnance 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 symptons associated with a terminal disease, but do not provide for efforts to cure the disease.

Cost to Member ■ No Copayment

CLINICAL CANCER TRIALS

Description

- Coverage for a Member's participation in a cancer clinical trial, Phase I thorough 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
  - Members 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 66.

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 physicans 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

Section 6 / EXCLUSIONS AND LIMITATIONS ON BENEFITS

General Exclusions and Limitations

Benefits and services which are not covered by HealthWorx under State law or the Knox-Keene Health Care Service Act of 1975 as amended are not available through the Health Plan of San Mateo. Services not received from, referred by, or authorized by the Health Plan of San Mateo or the Primary Care Physician you have selected, except for those Covered Services which specifically do not need a referral, are not covered. Members should read all descriptions of the Benefits in this Evidence of Coverage and in any riders, inserts, or attachments to this document to get the full details of their coverage and non-coverage under HPSM Membership. No service is covered unless it is medically necessary.

Specific Exclusions and Limitations

Certain services are limited and are noted in Section 5, Covered Services and Benefits. Unless authorized, any benefits in excess of the limits specified in this *Member Handbook and Evidence of Coverage* that are not required by the Knox-Keene Act are not covered.

The following services and supplies are not covered by HPSM:

1. Services, supplies, items, procedures or equipment, which are not medically necessary, as determined by HPSM, or that are not required by the Knox-Keene Act.

2. Those medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are either :

A. Experimental or investigational, unless the following conditions are met:
   1 you have a life threatening or seriously debilitating condition for which,
   2 standard therapies have not been effective, or are not appropriate, or
   3 there is not standard therapy covered by HealthWorx that is more beneficial than the therapy being proposed.

Members may seek an Independant Medical Review (IMR) if experimental or investigational therapy is delayed, denied, or modified. Please see page 66 for information on how to request an IMR.

3. Emergency facility services for non-emergency conditions, unless the Member believes an emergency existed, even if it is later determined that an emergency did not exist.

4. Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery.

5. Diagnosis and treatment of infertility.

6. Long-term care benefits, including long-term skilled nursing care in a licensed facility and respite care, except as determined by HPSM as medically necessary are not covered.

7. Personal or comfort items such as telephones, TVs, guest trays, personal hygiene items, disposable supplies (except ostomy bags or urinary catheters) and other supplies consistent with HealthWorx Program guidelines.

8. Services for the dentist or oral surgeon for inpatient dental procedures (this does not exclude coverage for any surgical procedure for any condition directly affecting the upper or lower jawbone, or associated bone joints).

9. Physical exams, reports or related services required for obtaining or maintaining employment, licenses, insurance, a school sports clearance or a member's desire, unless the exam corresponds to the schedule of routine physical exams listed in this *Member Handbook and Evidence of Coverage.*

10. Drugs or medications for cosmetic use.

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

serve the same function.

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

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

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

15. Services for the following mental health conditions are subject to review by HPSM and the San Mateo County Mental Health Program: chronic psychosis, chronic brain syndrome, intractable personality disorder and mental retardation.

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

17. Skilled nursing custodial care.

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

19. Hospice services include the provision of palliative medical treatment of pain and other symptons associated with a terminal disease, but do not provide for efforts to cure the disease.

20. HPSM provides mental health coverage as listed in this *Member Handbook and Evidence of Coverage*. Services for Members with Severe Mental Illness are provided by the San Mateo County Mental Health Plan.

21. Conditions eligible under the California Children's Services (CCS) Program or the San Mateo County Mental Health Plan.

Section 7 / COORDINATION OF BENEFITS

Coordination of Benefits (COB) Applicability

Most group health plans contain a provision that states when a Member is covered by two or more group health plans, payment will be divided between them so the combined coverages will pay up to 100% of eligible expenses. This is known as Coordination of Benefits (COB). *All of the Benefits provided under the HealthWorx contract are subject to this provision.* The Department of Managed Health Care regulates the administration of such provisions for HMOs in California. Insurers and health plans who are regulated by the Department of Managed Health Care are obligated to comply with these regulations.

Generally one plan is determined by particular rules to be "primary" and that plan will pay without regard to the other. The "secondary plan" will then make only a supplemental payment which will result in a total payment of not more than the allowable expenses for the medical service provided.

Benefit Coordination With Other Coverage

If a HealthWorx Member is covered by more than one group health insurance plan, benefits will be determined by applying COB rules according to Title 28, Division 1, Chapter 1, Article 7, §1300.67.13 of the California Code of Regulations. If you would like additional information regarding coordination of benefits, please contact the HPSM Member Services Department at **1-800-750-4776** or **650-616-0050**.

Recovery From Third Party Liability

If a HealthWorx Member is injured through an act or omission of another person, HPSM will provide benefits in accordance with this *Evidence of Coverage*. However, if the injured member is entitled to recovery, the Member will agree in writing to reimburse HPSM to the extent of the reasonable costs actually paid by HPSM to perfect a lien and one of the following:

- For health care services not provided on a capitated basis, the amount actually paid by HPSM, pursuant to the HealthWorx contract or policy, to any treating medical provider.
- For health care services provided on a capitated basis, the amount equal to 80 percent of the usual and customary charge for the same services by medical providers that provide health care services on a non-capitated basis in the

geographic region in which the service(s) was rendered.

- For health care services provided on both a capitated and non-capitated basis, then the amount of recovery is determined pursuant to the paragraphs above.

Right to Receive and Release Necessary Information

HPSM may obtain or release any information considered to be necessary with respect to any person claiming benefits through the Member's Evidence of Coverage (EOC) without consent of, or notice to, the Member or any other person or organization. However, HealthWorx will not be required to determine the existence of any other group plan or insurer or the benefits payable through such plan or insurer when computing services or benefits covered by the Member's EOC.

Right of Recovery

Whenever the HealthWorx payment for covered services exceeds the maximum amount of payments necessary to satisfy the intent of this provision, HPSM has the right to recover those excessive amounts from any insurer, organization, or persons.

Subrogation

The Member shall cooperate with the HealthWorx Program and the Health Plan of San Mateo in HPSM's legal rights under these subrogation provisions and acknowledges that HPSM's subrogation rights shall be considered as the first priority claim against any third party to be paid before any other claims which may exist are paid, including claims for general damages by the Member to the extent allowed under California Civil Code, §3040.

Section 8 / PAYMENT TO PROVIDERS

For the HealthWorx Program, the Health Plan of San Mateo pays physician and non-physician medical providers on a fee-for-service basis for the care provided to Members. Hospitals, Skilled Nursing Facilities and Hospices are paid on a per diem basis. There are no risk-sharing provisions in these payment arrangements, and no financial penalties designed to limit health care. In fact, there are incentives for many of our providers to provide the appropriate levels and types of health care to our members.

Section 9 / STATE CONTRACT PAYMENTS AND OTHER CHARGES

The San Mateo County Public Authority (SMCPA) pays a monthly fee to the Health Plan of San Mateo for the health care benefits provided to you. If SMCPA fails to pay the Health Plan of San Mateo on your behalf, your benefits under the HealthWorx Program will end on the last day of the month for which SMCPA has paid for you.

Limits on Member Financial Liability

By law, each contract between the Health Plan of San Mateo and Participating Providers states that in the event HPSM fails to pay the provider for Covered Services, the Member is not responsible to the provider for any money owed by the Health Plan of San Mateo. In the event the Health Plan of San Mateo fails to pay providers who do not have contracts with HPSM, the Member may be responsible to the non-contracting provider for the cost of service if HPSM has not authorized the care.

The HealthWorx Program requires HealthWorx Subscribers to pay $5.00 Copayments for some Benefits. Your provider will tell you if you need to pay a copayment. HPSM cannot make these Copayments for you. However, HPSM can help you work with your providers if you cannot pay all your Copayments. Please see Section 5 of this *Member Handbook and Evidence of Coverage.*

Section 10 / MEMBER GRIEVANCES

PLEASE NOTE: The Grievance process described here is for responding to member Grievances that involve (1) the delay, denial, or modification of a health care service in non-urgent situations; or (2) medical care situations in which care has already been received or delivered. This process does not cover urgent Grievances.

Urgent medical concerns are referred to the HPSM Health Services Department and Medical Director. Urgent concerns involve serious and imminent threat to your health or a bodily function and require decisions by HPSM within twenty-four (24) hours of receipt of the information. You may request an expedited review of HPSM's decision in cases involving serious medical concerns. Expedited reviews will be conducted in no more than three (3) days.

INTRODUCTION

The Health Plan of San Mateo (HPSM) and our Participating Providers encourage your questions, suggestions, and Grievances regarding any and all aspects of the care you receive through HPSM. It is through your suggestions that we are able to improve the quality of service provided to our members.

If you have a problem with a doctor or doctor's staff, we urge you to talk to them to see if you can solve the problem together. You may be able to solve the problem informally. Often your Primary Care Physician, his office staff or HPSM staff will be able to assist you with your questions, whether they have to do with your care, procedures or medical instructions you need to follow.

The Health Plan of San Mateo maintains a staff of Member Services Representatives who are ready to help you if you have questions or need assistance in any way. You may contact a HPSM Member Services Representative with any problems or questions, including those concerning coverage, procedures, physicians, hospitals, other health care providers, Copayments or to file a Grievance.

If you wish to file a Grievance, the Member Services Representative will arrange for you to talk with HPSM's Grievance Coordinator. HPSM will notify Members of the receipt of grievances within three (3) days. Grievances must be resolved within 30 days. This includes all levels of HPSM review as described on page 64. Member Services Representatives are available Monday through Friday, 8 a.m. to 6 p.m., by calling **1-800-750-4776**, or by writing to the Health Plan of San Mateo at:

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

Grievances regarding HealthWorx eligibility are not subject to consideration by the Health Plan of San Mateo. A Grievance of this type is referred to the San Mateo County Public Authority.

ACCESS TO THE GRIEVANCE PROCESS

Your access to the Health Plan of San Mateo Grievance process shall be ensured by:

- Having a Member Services Representative available by telephone during normal business hours to receive calls and assist you in the Grievance process.
- Having a Tele-Communication Device for the Deaf (TDD) and appropriate translation services available, encouraging an awareness of gender and language sensitivity and making appropriate physical accommodations, etc.
- Mailing Grievance forms when requested and in response to HPSM deferral and denial actions.
- Assisting members who request help in submitting a Grievance.
- Mailing correspondence concerning a Grievance via certified mail, return receipt requested.
- Enclosing with the written notice of the decision or proposed resolution information about the Member Grievance process, including rights to a review by the Grievance Committee, the San Mateo Health Commission, and the Department of Managed Health Care.

FILING A GRIEVANCE IS YOUR RIGHT

You have the right to file a Grievance if you are not satisfied with the care, service or treatment you have received as an HPSM member. We want to help resolve your Grievance to your satisfaction as quickly as possible. The Health Plan of San Mateo will not discriminate against you or limit your benefits just because you express your concerns or file a Grievance. If you are not satisfied with your care you can:

1. Try to talk directly with your provider to resolve the problem.
2. If this is not possible or you would like help, call an HPSM Member Service Representative at **1-800-750-4776**.

He/she will try to solve your problem, answer your questions, and tell you how to get more help if you need it.

3. You can file a Grievance with HPSM. A Member Services Representative or the HPSM Grievance Coordinator can explain the Grievance process to you and help you complete the necessary forms. For further information on your rights and the appeal process, contact a Member Services Representative or the Grievance Coordinator at **1-800-750-4776** or **650-616-0050**.

4. Once a decision regarding your Grievance is made, you will be sent a letter explaining the resolution. For Grievances involving the delay, denial, or modification of a health care service, the letter will describe the criteria used and the clinical reason(s) for the decision, including criteria and clinical reasons related to medical necessity.

5. Urgent concerns involving serious and imminent threat to your health or a major bodily function require decisions made by HPSM within 24 hours of receipt of information. In these situations, if you disagree with HPSM's decision you may file a Grievance to request an expedited review of HPSM's decision. HPSM must send you a letter describing the resolution or pending status of your Grievance no later than three (3) days after HPSM receives your Grievance.

6. The California Department of Managed Health Care is responsible for regulating health care service plans. The Department's Health Plan Division has a toll-free telephone number **1-888-HMO-2219** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **1-800-735-2929** (TTY) or **1-888-877-5378** (TTY) to contact the Department. The department's Internet website (http://www.hmohelp.ca.gov) has complaint forms and instructions online. If you have a Grievance against HPSM, you should first telephone HPSM at **1-800-750-4776** or **650-616-0050** and use the Health Plan's Grievance process before contacting the Department. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by HPSM, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. HPSM's Grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

7. You or your authorized representative can request voluntary mediation with HPSM prior to submitting a Grievance to the Department of Managed Health Care. You can still submit a Grievance with the Department of Managed Health Care after completing mediation. You and HPSM will share the cost of mediation.

As a member of the Health Plan of San Mateo, the following points are important for you to remember in the Grievance process:

- You may be represented by an advocate;
- You may propose a resolution to your Grievance;
- You may request translation services;
- If you are dissatisfied with the results of the Grievance proceedings, you may request a review by the Grievance Review Committee;
- If you are dissatisfied with the results of the Grievance Review Committee review, you may request a review by the San Mateo Health Commission.
- All Grievances must be resolved within thirty (30) days. This includes completion of all levels of HPSM review;
- You may directly file a Grievance for urgent review by the Department of Managed Health Care for cases involving, severe pain or imminent and serious threats to your health.

* **If your problem or Grievance involves mental health services, please call the Mental Health Consumer Relations Department at 1-800-388-5189.**

INDEPENDENT MEDICAL REVIEW OF GRIEVANCE INVOLVING A DISPUTED HEALTH CARE SERVICE

You may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you believe that health care services have been improperly denied, modified, or delayed by HealthWorx or one of its contracting providers. A "disputed health care service" is any health and service eligible for coverage and payment that has been denied, modified, delayed by HPSM or one of its contracting provider, in whole or in part because the service is not medically necessary, or is experimental or investigational.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. HPSM must provide you with an IMR application form with any Grievance "Notice of Action" letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against HPSM regarding the disputed health care service.

Eligibility: Your application for IMR will be reviewed by the DMHC to confirm that all of the following criteria are met:

(1) (A) Your provider has recommended a health care service as medically necessary, or (B) you have received urgent care or emergency services that a provider determined were medically necessary, or (C) you have been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which you seek independent review;

(2) The disputed health care service has been denied, modified, or delayed by HPSM or one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary; and

(3) You have filed a Grievance with HPSM or a contracting HPSM provider and the disputed decision is upheld or the Grievance remains unresolved after 30 days. If your Grievance requires expedited review, you may bring it immediately to the Department's attention. The DMHC may waive the requirement that you follow HPSM's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, the Health Plan will approve the requested health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within 30 days of receipt of your application and supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within 3 business days.

For more information regarding the IMR process or to request an application form, please call the Member Services Department at **1-800-750-4776**.

Section 11 / GENERAL PROVISIONS

Entire Contract

The San Mateo County Public Authority Contract for IHSS workers, this *Member Handbook and Evidence of Coverage*, and any amendments or attachments shall constitute the entire contract of coverage.

Amendments and Alterations

Amendments to the Contract including any change in benefits, shall be effective as stated in the written amendment signed by San Mateo County Public Authority and by an authorized officer of the San Mateo Health Commission.

No alteration of the contract and no waiver of any of its provisions shall be valid unless evidenced by an Amendment for the San Mateo Health Commission's part, executed by an authorized officer of the San Mateo Health Commission. No agent has authority to change the contract or to waive any of its provisions.

Relationship Between Parties

The relationships between the San Mateo Health Commission and Participating Providers, and between the San Mateo Health Commission and San Mateo County Public Authority are contractual relationships between independent contractors. Participating Providers and SMCPA are not agents or employees of the Health Plan of San Mateo nor is the Health Plan of San Mateo or any employee of the Health Plan an agent or employee of any Participating Provider or SMCPA.

The relationship between a Participating Provider and any Member is that of provider and patient. SMCPA is solely responsible for determining eligibility. SMCPA is also responsible for the timely payment of the monthly fee to the Health Plan of San Mateo.

Authorization for Release of Information

HPSM will not release individually identifiable medical or personal information without obtaining authorization from the patient or the patient's designee, except as allowed in statute. HPSM may release information that is not individually identifiable.

In order to release medical information (including any release of individually specific genetic testing information) HPSM will seek authorization from the Member or the Member's designee. The authorization will:

- Be handwritten or typed in type face no smaller than 8 point type
- Be clearly separate from any other language present on the same page and executed by its own signature
- Be signed and dated by the Member, legal representative of the Member if the Member is a minor or incompetent, the spouse or person financially responsible for the Member, the beneficiary or representative of a deceased Member
- State the specific use and limitations of the types of information that can be disclosed
- State the name or functions of the provider of health care that may disclose the information
- State the specific uses and limitations of the information
- State a specific date after which the provider of health care or health service plan is no longer authorized to disclose the information

Except for purposes authorized by the Member (or his/her designee) and the activities listed above. HPSM will not share, sell, or use medical information for any purpose other than to provide health care services.

Examination of Members

In the event of a question or dispute concerning the provision of health services or payment for such services under the contract, the Health Plan of San Mateo may also reasonably require that a Member be examined, at the Health Plan's expense, by a Participating Physician acceptable to the Health Plan.

Clerical Error

A clerical error shall not deprive any Member of Coverage under the Contract. Failure to report the termination of Coverage shall not continue such Coverage beyond the date it is scheduled to according to the terms of the contract. Upon discovery of a clerical error, an appropriate adjustment in Health Services fees shall be made.

Notice of Changes

At the expiration or termination of the SMCPA Contract, the Health Plan shall cooperate fully with SMCPA in effecting an orderly transition of the members covered under the contract to other contractors. The Health Plan shall send a notice

approved by SMCPA to all known members at least 15 days prior to the expiration or termination of the SMCPA Contract.

Covered Benefits

In no event shall any Member be responsible to pay for Benefits received in accordance with the SMCPA Contract except as otherwise provided therein.

Workers' Compensation Not Affected

If a HealthWorx Member requires services for which benefits are in whole or in part either payable or required to be provided in accordance with any Workers' Compensation or Occupational Disease law, HPSM will provide covered services to which the Member is entitled and will pursue recovery.

Conformity with Statutes

Any provision of the SMCPA Contract which, on its effective date, is in conflict with the statutes of the jurisdiction in which the Health Plan of San Mateo operates is hereby amended to conform to the requirements of such statutes.

The Health Plan of San Mateo is subject to the requirements of Chapter 2.2 of Division 2 of the Health and Safety Code and of Division 1, Chapter 1 of Title 28 of the California Code of Regulations. The Health Plan shall conform to the requirements of Section 1300.69(I)(1) of Title 28 of the California Code of Regulations regarding public policy and consumer representation. Communication of such will be through the Health Plan newsletter.

Non-discrimination

A Primary Care Physician shall not discriminate on the basis of sex; race, creed, color, ancestry, religious creed, national origin, marital status, sexual orientation, physical disability including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, age, medical condition or mental status. In addition, all Primary Care Providers shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment.

Confidentiality of Member Records

The Health Plan of San Mateo will protect the names of Members from unauthorized disclosure and will not use any information about Members for any purpose other than carrying out the express terms of the SMCPA Contract, in conformance with Federal

and State law and regulations.

Section 12 / PARTICIPATION IN PUBLIC POLICY MAKING

The Consumer Advisory Committee, which is made up of HPSM Members and professional advocates who work on behalf of HPSM's membership, is a standing advisory group of the San Mateo Health Commission, which is responsible for the Health Plan of San Mateo. The committee advises the commission on how the Health Plan can best serve Members. It also reviews policy issues which the commission will decide so that the Members can participate before final decisions are made. A member of the Consumer Advisory Committee represents Health Plan Members on the Health Plan's Quality Assessment and Improvement Committee.

If you would like to apply for membership on the Consumer Advisory Committee, please contact a Member Services Representative of the Health Plan of San Mateo.