AGREEMENT

Between

San Mateo Community Health Authority

And the

County of San Mateo County

For the Administration of the Healthy Kids Program

This Agreement is made this day January 1, 2010 by and between the San Mateo Community Health Authority, dba Health Plan of San Mateo (PLAN), and the County of San Mateo (COUNTY).

RECITALS:

WHEREAS, the PLAN is authorized by state law and County Ordinance to arrange the provision of health care services to individuals who are eligible for various publicly funded health care program and to those who lack sufficient annual income to meet the cost of health care,

WHEREAS, the COUNTY receives public funds and has committed some of these funds to provide health care coverage for children through age 18 who do not have other health insurance; And

WHEREAS, both parties hereto desire to enter into this Agreement to provide health care coverage for qualified children;

NOW, THEREFORE, in consideration of the mutual promises and covenants hereinafter contained, the parties agree as follows:

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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 **"Actual Quarterly Premium Due"** shall mean the Premium due from COUNTY to PLAN to provide coverage for Members for a quarter, based on the number of actual member months of coverage per quarter.

1.2 **"Administrative Costs"** shall mean a percentage of all Premiums payable to PLAN under this Agreement not greater than the percentage that administrative expenses represent of the State capitation payments for the annual Medi-Cal budget approved by the San Mateo Community Health Authority at the beginning of each fiscal year.

1.3 **"Authority"** shall mean the San Mateo Community Health Authority.

1.4 **"First 5 San Mateo"** shall mean the organization created in San Mateo County in 1998 as a result of the California Children and Families Act (Proposition 10).

1.5 **"Children's Health Initiative (CHI) Coalition)"** shall mean the advisory body governed by the San Mateo Community Health Authority charge with recommendations regarding CHI related program policies and operational issues.

1.6 **"Copayment"** shall mean the portion of health care costs for covered services for which the member's parent or guardian has financial responsibility under the Healthy Kids Program.

1.7 **"Cost of Health Services"** shall mean the total fiscal year costs of providing Covered Services to Members and shall include Administrative Costs and projections to pay the costs of incurred but not reported Covered Services.

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

1.9 **"Estimated Quarterly Premium Due"** shall mean the amount of premium for the projection of member months to be covered in a quarter.

1.10 **"Evidence of Coverage"** shall mean the document issued by the PLAN to Members that describes Covered Services and Non-Covered Services in Healthy Kids (Attachment A, attached hereto and incorporated herein by reference).

1.11 **"Family Contribution"** shall mean the financial contribution made by the Responsible Party on behalf of a Member of Healthy Kids for either an annual or quarterly period.

1.12 **"Grievance Program"** shall mean a formalized set of activities designed to provide Members and Providers, exercising their rights under applicable state and federal law, to a fair and solution-oriented process to address a perceived problem with the operations of the PLAN, including delivery and access to care, in a reasonable amount of time. This Program includes provisions for evaluation of complaints, assessments of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers.

1.13 **"Health Plan of San Mateo"** shall mean the health plan governed by the San Mateo Community Health Authority.

1.14 **"Healthy Kids"** shall mean the health insurance program for children through age 18 in families with incomes up to 400% of the Federal Poverty Level residing in San Mateo County who are ineligible for Healthy Families and Full-Scope No-Share-of-Cost Medi-Cal.

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

1.16 **"Member"** shall mean a child from birth through age eighteen (18) who has been determined to be eligible by the San Mateo County Human Services Agency to receive Covered Services under Healthy Kids.

1.17 **"Membership Report"** shall mean a report summarizing the Healthy Kids Program membership submitted by the PLAN to COUNTY each quarter to assist in the calculation of the Total Quarterly Premium Amount due from COUNTY to PLAN.

1.18 **"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.

1.19 **"Premium"** shall mean amount paid by COUNTY per Member per Month, to the PLAN for providing coverage to Members under this Agreement.

1.20 **"Protected Health Information"** shall mean individually identifiable health information.

1.21 **"Provider"** shall mean any health professional or institution certified to render Covered Services to Members.

1.22 **"Quality Assessment and Improvement Program"** means the set of formalized activities and structure developed by the PLAN to ensure the continuous review and evaluation of quality of care, performance of medical personnel, utilization of services and facilities, and trends in Grievances filed with the PLAN through quality of care studies and other health related activities in order to make improvements in the care provided to Members.

1.23 **"Quarter for Premium Due"** shall mean any one of the following fixed three-month periods: January 1 through March 31, April 1 through June 30, July 1 through September 30, or October 1 through December 31.

1.24 **"Responsible Party"** shall mean a parent, guardian, other adult, or emancipated minor of San Mateo County who has completed an application for a child for participation in and coverage by the Healthy Kids Program.

1.25 **"Retention Project"** shall mean those activities conducted to increase membership retention, health navigation and utilization and which are set forth in the Retention Scope of Work (Attachment C, attached hereto and incorporated herein by reference).

1.26 **"San Mateo County Human Services Agency (HSA)"** shall mean the agency that is part of the County of San Mateo, which has undertaken a contractual responsibility for determining eligibility for Healthy Kids.

1.27 **"Total Quarterly Premium Amount"** shall mean the payment due each quarter to PLAN from COUNTY. The Quarterly Premium Amount is calculated using the Actual and Estimated Quarterly Premiums.

SECTION II

GENERAL CONTRACTUAL RELATIONSHIP

2.1 Healthy Kids will be funded by several sources which will pay premiums to PLAN on behalf of Members. These include but are not limited to: (1) the County of San Mateo acting on behalf of the First 5 San Mateo Commission, (2) the County of San Mateo acting on behalf of the Silicon Valley Community Foundation, and (3) the County of San Mateo acting on its own behalf.

2.2 Funding sources shall pay the premiums for Members in the following order of priority: (1) First 5 San Mateo for Members up to the age of six (6) until all the Authority's allocated funds are committed; (2) the County of San Mateo acting on behalf of the Silicon Valley Community Foundation for Members meeting the qualifications or restrictions placed on the Foundation's funds, if any, until all the Foundation's allocated funds are committed; and (3) the County of San Mateo acting

2.3 The San Mateo County Human Services Agency will provide eligibility determination for Members.

2.4 In consideration of the Premiums paid and services provided by funding sources, PLAN will administer Healthy Kids and will make payments to Providers for Covered Services for Members according to the guidelines and policies and procedures established by the PLAN.

2.5 In addition to Premiums paid by the funding parties, Responsible Parties will be required to make a Family Contribution. However, as set forth in this agreement, PLAN will not retain any portion of the Family Contribution, pursuant to Section 4.5

SECTION III
ENROLLMENT

3.1 The San Mateo County Human Services Agency has agreed, in a separate contract, to be responsible for (1) determining the eligibility of children for whom Responsible Parties have applied to be covered under Healthy Kids and (2) forwarding completed enrollment information to PLAN for Members for whom the Human Services Agency has determined eligible.

3.2 In consideration of COUNTY's payment of Premiums for those Members determined by Human Services Agency to the be eligible, the PLAN shall be responsible for effecting coverage on the tenth (10^{th}) calendar day following the PLAN's receipt of notification of eligibility from the San Mateo Human Services Agency. The PLAN's responsibilities shall include welcome calls and the mailing of the identification card, provider list, and the combined Member Handbook and Evidence of Coverage booklet to the Member's Responsible Party.

SECTION IV

PREMIUMS/ FAMILY CONTRIBUTION

4.1 Premium Amounts
Premiums for the Covered Services under this Agreement are set forth in Appendix B, attached hereto, and incorporated herein by reference.

4.2 Premium Payment
Total Quarterly Premium Amount is payable to PLAN at PLAN's corporate office by electronic file transfer via ACH, wire transfer, or check via mail addressed to: Director of Finance, Health Plan of San Mateo, 701 Gateway Blvd, Suite 400, South San Francisco, CA 94080. The Quarterly Premium Amount is due by the last work day of January,

April, July, and October. In the event PLAN submits a Membership Report to COUNTY later than the first (1st) working day of a quarter, the Total Quarterly Premium Amount will be due no later than thirty (30) calendar days after receipt of the Membership Report by COUNTY.

4.3 Premium Calculation, Due Date and Grace Period

The PLAN shall submit to the COUNTY a Membership Report by the first (1st) working day of each quarter. This report shall include the Actual Quarterly Premium Due (based on the number of actual member months of coverage for the previous quarter) and an Estimated Quarterly Premium Due (based on a projection of member months to be covered during the previous quarter).

Premiums shall be paid prospectively for the estimated number of member months of coverage for the current quarter. The Estimated Quarterly Premium Due shall be adjusted based on the difference between the Actual Quarterly Premium Due for the last quarter and the Estimated Quarterly Premium Due paid by COUNTY for the last quarter.

For the first month or partial month of a Member's coverage, the COUNTY will pay one hundred percent (100%) of the Premium for Members with effective dates of coverage on the first (1st) through the sixteenth (16th) day of the month. No Premium will be paid for the first partial month of coverage for Members whose coverage begins on the seventeenth (17th) through the last day of the month of partial coverage.

The COUNTY will pay premiums to PLAN as billed by PLAN. However, in the event of a disagreement as to the amount owed, the COUNTY will communicate discrepancies to the PLAN, which will make an effort to resolve any discrepancy noted by the next billing period. Premium adjustments due to discrepancies will be incorporated into the next Total Quarterly Premium Amount due.

4.4 Retroactive Additions and Credits for Member Terminations

4.4.1 Retroactive additions will be honored at the discretion of the PLAN based upon the eligibility guidelines in the Evidence of Coverage. Newborn infants maybe retroactively added back to their date of birth if the mother applies before the date of birth. Retroactive additions are subject to payment of all applicable Premiums and may be subject to all applicable Family Contributions.

4.4.2 Retroactive terminations of Members will be honored at the discretion of the PLAN. The COUNTY may receive credit for Premium related to a retroactive termination, but the PLAN will not honor terminations for a period greater than sixty (60) days prior to the date of notification. The Premium amount credited to the COUNTY will be based on the effective date of termination, subject to the terms of Section 3.2 Information regarding credits due to retroactive terminations will be included in the Membership Report.

4.4.3 The COUNTY shall be responsible to pay the PLAN Premiums for any eligible Members forwarded to PLAN to the extent PLAN enrolled these Members and paid claim(s) based on the Human Services Agency's representation that the Member was eligible, when coverage was not actually valid.

4.4.4 The COUNTY shall be responsible to pay the PLAN Premiums up to a maximum of two months if a Responsible Party fails to pay an eligible Member's Family Contribution.

4.5 Family Contribution

4.5.1 The Children's Health Initiative Oversight Coalition and the Authority sets the Family Contribution amount per Member per quarter. This amount shall be$12, $39, $63 or $90 per quarter, based on the Member's family size and family income as determined through the application process. The Family Contribution will be treated differently than Premiums, and the PLAN will not retain any portion of the Family Contribution. The HPSM will deposit the Family Contribution into a separate account. The disbursement of funds from this account will be at the discretion of the COUNTY with the understanding that funds will be used for expanding access of health care to children in San Mateo County. The PLAN will remit to the COUNTY the entire balance of the Family Contribution account every six (6) months less cost of refunds, returned checks, and checking account fees.

4.5.2 The amount of the Family Contribution is determined at the time of application and the Responsible Party shall choose whether the Family Contribution will be paid on an annual or quarterly basis. As an incentive of Members to make Family Contribution payments on an annual basis rather than a quarterly basis, annual payments will be computed on the basis of three times the quarterly payment amount, i.e., Members who pay for three quarters at once will have the fourth quarter's Family Contribution requirement waived.

4.5.3 The Human Services Agency will determine whether a Responsible Party is eligible for either a total or partial reduction of the Family Contribution. The HSA transmit information concerning changes in the amount of Family Contribution to the PLAN with the eligibility record.

4.5.4 The Responsible Party will be notified at the point of application and in all communications that all payments of the Family Contribution should be made to the PLAN. The PLAN will invoice the Responsible Party for either quarterly or annual payment related as determined at application or redeterminations. If payment is received prior to invoicing, the PLAN will retain and apply payments as appropriate.

4.5.5 To prevent disenrollment due to nonpayment, the PLAN will exercise its best efforts to contact the member by phone or mail. As appropriate, the PLAN will

4.5.6 If all efforts to obtain the Family Contribution payment have proven to be unsuccessful, the PLAN will disenroll the Member effective the last day of the second month of the quarter for which the Family Contribution has not been made. The COUNTY's obligation to pay Premiums on a Member's behalf shall be limited to two month's premium for a Member whose Responsible Party has not made Family Contribution, and PLAN shall not be obligated to provide services for the Member for more than tow months without payment of the Family Contribution. The PLAN will notify the Responsible Party of the Member's termination date due to nonpayment of the Family Contribution at least 15 days prior to the date of disenrollment.

SECTION V

TERM, TERMINATION, AND AMENDMENTS

5.1 Effective Date

This Agreement shall become effective on January 1, 2010.

5.2 Term

The term of the Agreement shall begin with the effective date of the Agreement and last for three years. This Agreement may be renewed or extended by mutual agreement.

5.3 Termination of Notice

This Agreement may be terminated as follows:

5.3.1 Termination- Without Cause

The PLAN or COUNTY may terminate the Agreement without cause upon providing the other party with sixty (60) days prior written notice and shall become effective at the end of the second month following the month in which notice is given. In the event of termination, the PLAN shall furnish the COUNTY copies of documents, reports, and studies prepared for the COUNTY under this Agreement as well as access to data for Members covered under this Agreement.

5.3.2 Termination- For Cause

Either party shall have the right to terminate this Agreement for good cause upon providing thirty (30) days prior written notice to the other party. Good cause may include but not limited to the termination of the funding parties' financial contributions to the Healthy Kids Program.

5.3.2.1 The party claiming the right to terminate hereunder shall set forth in the written notice of intended termination the effective date of such termination and

the facts underlying its claim that there is good cause to terminate this Agreement. Termination will be effective thirty days after delivery of the termination notice.

5.3.2.2 The COUNTY may terminate this Agreement for unavailability of State funds. In this event, the COUNTY shall inform the PLAN of such unavailability as soon as it is known, and to the extent legally possible, the COUNTY shall pay all outstanding amounts due. Termination shall be effective on the last day of the month in which notification is received by the PLAN. The PLAN reserves the right to seek Premium amounts from either entities should COUNTY be unable to make Premium payments.

5.3.2.3 If the COUNTY fails to make any past-due payment within fifteen (15) days after receipt of PLAN's written notice to the COUNTY of past due amount, the PLAN may terminate this Agreement. The COUNTY shall be liable for all unpaid Premiums through the termination date. Termination shall be effective on the last day of the month following in which notice of termination is given by the PLAN.

5.3.3 Termination Based upon Inability to Perform Due to Changed Legal, Contractual, or Regulatory Circumstances.

In the event there are changes effected in (1) the PLAN's Medi-Cal contract with the State of California, or (2) Healthy Kids, or (3) in the Federal Medicaid or SCHIP Programs, (4) in the Federal Medicare Program or (5) under other public or private health care insurance programs or polices, any of which changes will have a material detrimental financial effect on the operations of the COUNTY or PLAN, the COUNTY or PLAN may terminate this Agreement effective on the last day of the month following the month in which notification of intent to terminate is received. In any case where such notice is provided, both parties shall negotiate in good faith in an effort to develop a revised Agreement which, to the extent reasonably practicable under the circumstances, will adequately protect the interests of both parties and members, consistent with the changed legal, contractual or regulatory circumstances which constitute the basis for exercising this termination provision.

5.3.4 Termination of Insufficient Provider Participation

If, for any reason, the PLAN is unable to enter into or maintain service contracts with sufficient numbers of Participating Providers to assure adequate Member access to needed Covered Services, the PLAN may terminate this Agreement upon thirty (30) days written notice to the COUNTY.

5.4 Effect of Termination

As of the date of termination pursuant to any provision of this Agreement, this Agreement shall be no further notice or effect whatsoever, except for exception in Section VIII, and each of the parties hereto shall be relieved and discharged from any of

the obligations it has undertaken, except that the COUNTY shall remain liable for due, unpaid Premiums and the PLAN shall remain liable for all Benefits rendered to Members up to the date of termination and for any Covered Services covered by the term of the Premium or required by law, whichever is later, rendered hereunder after such date until such time as appropriate transfer (for other medically acceptable disposition) of Members receiving inpatient services as of the date of termination is achieved.

5.5 Amendment of Agreement

Should either the COUNTY or PLAN desire a change in this Agreement, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within ten (10) calendar days of receipt of the proposal. Any proposal shall be set fourth a detailed explanation of the reason and basis for the proposed change and the text of the desired amendment to this Agreement that would provide for the change. If the proposal is accepted, this Agreement shall be amended to provide for changes mutually agreed to by COUNTY and PLAN in writing.

SECTION VI

MEMBER NOTIFICATION OF TERMINATION

6.1 It is the responsibility of the PLAN to notify Members of the termination of the Agreement in compliance with all applicable laws.

6.2 Termination shall not relieve the COUNTY or PLAN from any obligation incurred prior to the date of termination of this Agreement.

SECTION VII

INDEPENDENT CONTRACTOR RELATIONSHIPS

7.1 Between COUNTY and PLAN

None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purposes of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, the employee, or the representative of the other.

7.2 Between Participating Providers and PLAN

The relationship between the PLAN and Participating Providers is a contractual relationship among independent contractors. Participating Providers are not agents or employees of the PLAN nor is the PLAN or employee of any Participating Provider. Participating Providers maintain their provider-patient relationship with Members and are

solely responsible to their Member patients for any health services rendered to their Member patients.

A Participating Provider's participation may be terminated at any time by either the Participating Provider or PLAN and PLAN makes no express or implied warranties or representations concerning the continue participation of any particular 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 Agreement, nor will PLAN be liable for services or facilities which for any reason beyond its control are unavailable to the Member.

SECTION VIII

RECORDS

8.1 Inspection Rights

8.1.1 PLAN and COUNTY agree to provide to any Federal or State department having monitoring or reviewing authority, or their appropriate audit agencies upon reasonable notice, access to and the right to examine and audit all records and documents necessary to determine compliance with relevant Federal, State, and local statutes, rules and regulations, and this Agreement, and to evaluate the quality, appropriate and timeliness of services performed.

8.1.2 Both parties shall maintain and preserve all records relating to this Agreement for a period of five (5) days from the termination date of this Agreement or until audit findings are resolved, whichever is greater.

8.2 Confidentiality of Member Information

Protected Health Information shall be provided in a manner to protect the confidentiality of member information in accordance with applicable federal and state statutes and regulations

SECTION IX
PROGRAM MONITORING AND EVALUATION

9.1 The PLAN shall collect data pertaining to the goods and services furnished under the terms of this Agreement for each funded year and shall participate in countywide and/or statewide evaluations of the effectiveness of the COUNTY's Healthy Kids efforts, whether they occur during or after the term of this contract. The PLAN shall cooperate with any evaluator hired by the COUNTY for this purpose. The PLAN shall submit additional reports as requested by the COUNTY and agreed to by the PLAN. The PLAN will provide the COUNTY with monthly Member enrollment reports by various parameters, including but not limited to, hospital districts, age, and gender. In

conjunction with the COUNTY evaluator, the PLAN will conduct a Provider survey every other year.
9.2 Within thirty (30) days of the Authority's approval of its annual audit, the PLAN will provide the COUNTY with a copy of the audit and a report listing the following information from the PLAN's previous fiscal year of Healthy Kids: (1) the Cost of Health Services for the Members, (2) the total Premiums accrued to PLAN, (3) the remainder after subtracting the Cost of Health Services for the Members from the total Premiums paid to the PLAN. The Cost of Health Services for Members will be broken down into three sub-categories: the total costs of providing Covered Services to Members, Administrative Costs, and projections to pay the costs of incurred but not reported Covered Services.

9.3 The PLAN will provide services to retain members as particularly described in Exhibit C to this Agreement. In consideration of said services, the COUNTY will pay the PLAN the rates set forth in Exhibit C.

SECTION X

ADMINISTRATION OF THE AGREEMENT

10.1 Entire Agreement

This Agreement, including the Evidence of Coverage, any amendments, endorsements, insets or attachments, constitutes the entire Agreement between the COUNTY and PLAN, and on the effective date as set forth in Section V supersedes all other prior and contemporaneous arrangements, understandings, agreements, negotiations and discussions between the parties, whether written or oral, regarding services provided by this Agreement.

10.2 Terms of this Agreement

The terms of this 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 the 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 the Agreement, the PLAN shall notify the COUNTY in writing of such amendments. The COUNTY agrees to work with the PLAN in good faith effort to accept such an amendment. If the COUNTY does not agree to accept such an amendment, the PLAN may terminate this Agreement pursuant to Section V. 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 by this Agreement.

10.3 Hold Harmless

10.3.1 PLAN and COUNTY agree that nothing in this Agreement shall cause either party to be liable or responsible for any debt, liability, or obligation of the other party or any third party, unless such liability or responsibility is expressly assumed by the party sought to be charged therewith. Each party shall be solely responsible for and shall indemnify and hold the other party harmless against any claim or obligation for the payment of wages, salaries or other compensation (including all state, federal, and local taxes and mandatory employee benefits), insurance and voluntary employment-related or other contractual or fringe benefits as may be due or payable by the party to or on behalf of he other party's employees, agents and representatives.

10.3.2 Insurance
Upon request, each party shall furnish the other party with a certificate of insurance evidencing the required coverage set forth herein.

Bodily Injury Liability and Property Damage Liability Insurances: Each party shall maintain during the life of this Agreement such Bodily Injury Liability and Property Damage Insurance, self insurance, or a combination thereof, as shall protect both properties from any and all claims for damages for bodily injury including accidental death, as well as any and all claims for property damage which may arise from operations under this Agreement. Such insurance shall be combined single limit bodily injury and property damage for each occurrence and shall not be less than the amount specified below.

Such insurance shall include:

a) Comprehensive General Liability $1,000,000.00
b) Motor Vehicle Liability Insurance $1,000,000.00
c) Professional Liability $2,000,000.00

10.3.3 COUNTY shall carry at its sole expense general and professional liability insurance or self-insurance of at least one million dollars ($1,000,000) per person per occurrence, three million dollars ($3,000,000) aggregate. If the COUNTY obtains one or more claims-made insurance policies to fulfill its obligations under this Section, the COUNTY will purchase or provide coverage that assures protection against claims based on acts or omissions that occur during the period of this Agreement but which are asserted after the claims-made insurance policy has expired. This insurance is against professional errors and omissions in providing services under the terms of this Agreement and is solely for the protection and interest of the COUNTY, its employees, Health Plan members and third parties.

10.3.4 Each party shall provide a certificate of insurance so that the other party shall be given immediate notice of lapse, termination, amendment or changes of coverage of any policy or insurance maintained by the other party.

<u>10.3.5 Mutual Hold Harmless</u>

a. It is agreed that PLAN shall defend, save harmless and indemnify COUNTY, its officers and employees from any and all claims which arise out of terms and conditions o this Agreement and which result from the negligent acts or omissions of PLAN, its officers and/or employees.

b. It is agreed that COUNTY shall defend, save harmless, and indemnify PLAN, its officers and employees from any and all claims for injuries or damage to persons and/or property which arise out of the terms and conditions of this Agreement and which result from the negligent acts or omission of COUNTY, its officers and/or employees.

c. In the event of concurrent negligence of COUNTY, its officers and/or employees, and PLAN, its officers and/or employees, then the liability for any and all claims for injuries or damage to persons and/or property which arise out of terms and conditions of this Agreement shall be apportioned according to the California theory of comparative negligence.

10.4 Compliance with Applicable Law

All services to be performed by Contractor pursuant to this Agreement shall be performed in accordance with all applicable Federal, State, County and Municipal laws, ordinances, regulations, including but not limited to appropriate licensure, certification regulations, confidentiality requirements, and applicable quality assurance regulations. Violation of the statutes and regulations, laws, including non-discrimination provisions, shall be considered a breach of this Agreement and shall serve as a basis for termination of this Agreement as well a disqualification for future contracts with the other party.

10.5 Waiver

PLAN's failure to implement, or insist upon compliance with, any provision of this Agreement or the terms of the Evidence of Coverage (Attachment A) 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, the payments of Premiums or Covered Services. This applies whether or not the circumstances are the same.

10.6 Assignability

10.6.1 Without the written consent of the other party, this Agreement is not assignable in whole or in part. Any assignment without the written consent of the other violates this Agreement and shall automatically terminate this Agreement.

10.6.2 All assignees, subcontractors, or consultants used by either party shall be subject to the same terms and conditions applicable to the parties to this agreement, and the party assigning or subcontracting party shall be liable assignees' or the subcontractor's acts and/or omissions.

All agreements between PLAN or COUNTY and subcontractor and/or assignee for services pursuant to this Agreement shall be in writing and shall be available for review.

10.7 Notices

Any notice required or permitted under this Agreement shall be in writing and shall be deemed to have been on the date when delivered in person, or, on the date received if delivered by first class United States mail, UPS, FedEx, or other traceable mail service, proper postage prepaid, and properly addressed to the offices of the COUNTY or the PLAN at the following addresses:

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

Office of the Chief
San Mateo County Health System
225 37th Avenue
San Mateo, CA 94403

10.8 Claim Determinations
PLAN has complete authority to review all claims for Covered Services under this Agreement. In exercising such responsibility, PLAN shall have discretionary authority to determine whether and to what extent eligible Members are entitled to coverage and construe any disputed or doubtful terms under this Agreement. PLAN shall be deemed to have properly exercised such authority unless PLAN abuses its discretion by acting arbitrarily and capriciously.

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

10.10 Inability to Arrange Services
In the event that due to circumstances not within the reasonable control of PLAN, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of PLAN's Participating Providers or entities with whom PLAN has arranged for services under this Agreement, or similar causes, the rendition of medical or Hospital benefits or other services provided under this 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.

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

10.12 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 nor continue coverage which would otherwise be validly terminated nor grant additional benefits to Members if PLAN, in its sole discretion, determines that a clerical error has been made. Upon discovery of such error or delay, an adjustment of Premiums may be made. In no case will adjustments in coverage or Premiums be made for a quantity more than two months coverage and/or 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. Such correction time limitations may not apply for retroactive situations per Section 4.4

10.13 Non-Discrimination

10.13.1 *Section 504* 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 subject to discrimination in the performance of this agreement.

10.13.2 *General Discrimination.* No person shall, on the grounds or 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.

10.13.3 *Equal Employment Opportunity*. 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. Each party's equal employment policies shall be made available to the other party upon request.

10.13.4 *Compliance with Equal Benefits Ordinance*. With respect to the provision of employee benefits, both parties shall comply with the County Ordinance which prohibits contractors from discriminating in the

County of San Mateo Executed by:	Authority Executed by:
_____ Authorized Signature For the County of San Mateo President, County of San Mateo Board of Supervisors	_____ Authorized Signature for the San Mateo Community Health Authority
_____ Print Name	_____ Print Name
_____ Date	_____ Date

ATTACHMENT A

MEMBER HANDBOOK AND EVIDENCE OF COVERAGE

The Healthy Kids Member Handbook and Evidence of Coverage is continually updated to incorporate new requirements and other regulatory changes. The Healthy Kids Member Handbook and Evidence of Coverage dated _____ is attached and incorporated herein.

Both parties agree that subsequent updates to the Healthy Kids Member Handbook and Evidence of Coverage as approved by the Department of Managed Health Care, become the current Healthy Kids Member Handbook and Evidence of Coverage and are incorporated herein.

ATTACHMENT B

PREMIUM SCHEDULE FOR CY 2010, CY 2011 and CY 2012

Premium per Member per month……$74.47

ATTACHMENT C

CHILDREN"S HEALTH COVERAGE PROGRAM'S RETENTION PROJECT

C.1 Children's Health Coverage Programs Retention and Utilization Project

The Health Plan of San Mateo (PLAN) will employ staff to work on retention, navigation, and utilization activities of PLAN members who are between the ages of 0-18 and enrolled in Medi-Cal, Healthy Families and Healthy Kids. The PLAN and COUNTY will identify and prioritized specific MC, HF and HK populations which will be targeted for this project.

The duties of staff assigned to this project will include but not be limited to:

1. Conducting welcome calls for new members to improve member understanding of their benefits, how to access health care, relevant managed care processes, and the need for members to communicate any changes to their demographic information.
2. Following-up with families that have not utilized preventive health care services during the first 120 days
3. Contacting families who are late with their Healthy Kids premium payments to offer financial assistance
4. Contacting families with returned mail and attempt to obtain updated contact information
5. Sending list of dental providers accepting MC, HF and HK and encouraging families to schedule preventive dental care visits

C.2 Payment Schedule

On a quarterly basis, PLAN will invoice COUNTY for Retention Project Payment based on weekly employment of a full-time person for calendar quarter. PLAN will be paid an amount equal to an employee's weekly salary and benefits amount for work performed per this Attachment, up to a maximum of $64,450 for CY 2010, $66,860 for CY 2011 and $69,365 for CY 2012.

HEALTHY KIDS

2007–2008
Evidence of Coverage and Member Handbook

HealthPlan OF SAN MATEO
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080
Tel: 650-616-2133
Toll Free: 1-800-750-4776
TTY: 1-800-735-2929
www.hpsm.org

Our Member Services Unit is Available to Help you

Member Services: 1-800-750-4776 or 650-616-2133
Hearing Impaired: (TTY) 1(800) 735-2929

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

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

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

****

El Health Plan of San Mateo asegura la privacidad de su archivo medico. Para mas información, llame al Departamento de Servicios al Miembro.

NOTICE OF PRIVACY PRACTICES

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

If you have questions about this Notice, please contact a Health Plan of San Mateo (HPSM) Member Services Representative at (800) 750-4776 or (650) 616-2133.

Why am I receiving this Notice?

We understand that health information about you is personal. We are committed to protecting your health information. This notice contains a summary of HPSM's privacy practices and your rights relating to health information. This notice only covers HPSM's privacy practices. Your doctor may have different policies or notices regarding his or her use and disclosure of your health information created in the doctor's office.

We are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices about your health information; and
- Follow the terms of the notice that is currently in effect.

How may HPSM use or share my health information?

The following are ways in which we may use your health information. The types of uses and disclosures of information listed below are allowed by state and federal law. Use refers to how we use information within HPSM. Disclosure means sharing information with someone outside HPSM. Following is a description of each type of use or disclosure and some examples. ***The list below does not include every possible allowable use and disclosure, and it is not intended to limit uses and disclosures that are permitted by law. However, all of the ways we are allowed to use and disclose your health information will fall within one or another of the following purposes:***

- **For Payment.** We use your health information to pay bills for the health services you receive as an HPSM Member.
  For Example: We may need to get information from your doctor about a treatment that the doctor is considering for you. We will review the information to make a decision about whether or not to approve payment for the treatment. Decisions are based on medical need. We may need to let the doctor know if the treatment is a covered benefit for you.

- **For Health Care Operations.** We may use and disclose health information about you to carry out HPSM's operations. This is done in a confidential manner. These uses and disclosures are necessary to run the health plan and perform many of the services that you receive.
  For Example: We may use health information about you in our review of the doctors who provide your care. We check their performance to make sure you are receiving quality care. We may also use health information about you to compare the quality of our

services to that of other health plans. This will help us check if there are ways we can improve the quality of care you receive.

- **For Treatment.** We may use your health information in managing your care. We may share your health information with a provider for use in treating you.
  For Example: We may review your health information, including medications that you are taking, to make sure that none of the treatments you receive will conflict.

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

- **To Contractors.** We may disclose your health information to our contractors who assist us in our operations. Our contractors agree in writing to keep the health information provided to them confidential and secure, and not to use it except to assist us. For example, we contract with a company known as a "Pharmacy Benefit Manager". This company processes claims for pharmacy services. We provide information that we have that is needed to pay the pharmacy claims for our Members. The Pharmacy Benefit Manager agrees to keep this information confidential.

- **To Health Insurance Program Sponsors.** Employers and other organizations sponsor health insurance programs. These employers or sponsors contract with HPSM to provide services to you and pay claims. We may notify the plan sponsor if you are enrolled in, or disenrolled from the plan. We may also disclose your health information so the plan sponsor can audit HPSM's performance. The sponsor agrees to keep your health information confidential and secure.

- **To Family Members or Individuals Involved in Your Care or Payment for Your Care.** We may release health information about you to a person who is responsible for paying for your health care, as necessary to enable that person to make payment. We may also disclose health information to family members and others who are involved in your health care.

Special Situations

- **As Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.

- **To Avoid a Serious Threat to Health or Safety.** We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of others. We would only give the information to someone who can help prevent the threat.

- **Military and Veterans.** If you are a member of the armed forces or a veteran, we may release health information about you as required by military authorities or to assist in determining your eligibility for veterans' benefits.

- **Correction Institutions.** If you are in custody, release of health information may also be made to correction institutions in the course of coordinating your care.

- **Worker's Compensation.** We may release health information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose health information about you for public health activities. These activities generally include the following:

  - ❖ To prevent or control disease, injury or disability;
  - ❖ To report child abuse or neglect; To report births or deaths;
  - ❖ To report reactions to medications or problems with products;
  - ❖ To notify people of recalls of products they may be using;
  - ❖ To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease.
  - ❖ To notify the appropriate government authority if we believe a Member has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when authorized by law.

- **Health Oversight Activities.** We may disclose health information to a health oversight agency for activities authorized by law. For example, we may disclose your health information to the public agency responsible for overseeing HPSM's operations. These activities are necessary for the government to monitor the health care system and government health benefit programs.

- **Lawsuits and Disputes.** We may disclose health information about you if ordered to do so by a court or tribunal. We may also disclose health information about you in response to a subpoena, or other lawful process, but only if efforts have been made to notify you of the request or to obtain an order protecting the information requested.

- **Law Enforcement.** We may release health information if required to do so by a law enforcement official or, in limited circumstances, if the official requests the information, or in order to report criminal conduct. Generally, this would have to be in connection with a criminal investigation and/or in response to a court order, warrant, or similar process. We also may release your health information to authorized federal officials for national security activities authorized by law.

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

LIMITATIONS

Other laws may limit or prevent the disclosures listed above. For example, there are special limits on the disclosure of health information relating to HIV/AIDS status, mental health treatment, developmental disabilities, and drug and alcohol abuse treatment. We comply with these restrictions in our use of your health information.

AUTHORIZATION

We will not allow uses and disclosures of your health information other than those described on the previous pages without your written permission or authorization. You have the right to change your mind even after you have signed an authorization for use or release of your health information. If you decide to do this, we will not further use or disclose the information. Of course, we cannot take back any disclosures we had already made during the time we had your permission to do so.

For Example: We may use and share health information about you for research purposes with your authorization.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

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

- **Right to Request Restrictions.** You have the right to request a restriction or limits on the use or disclosure of your health information.
  In your request, you must tell us:
  (1) What information you want to limit;
  (2) whether you want to limit our use of information, disclosure of information, or both; and
  (3) to whom you want the limits to apply.

  To request restrictions, you must make your request in writing. See page 6 for instructions

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

- **Right to Request Confidential Communications.** You have the right to request that we contact you about medical matters privately and with special handling. For example, you can ask that we only contact you at work or by mail.

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

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures". This is a list of non-routine disclosures that we made of your health information. This list excludes disclosures that we make for your treatment or our health

plan operations, including payment for your care. However, it includes most other disclosures that we are required or permitted to make without your authorization. For example, these include disclosures to governmental agencies that review our programs. To request this list, or accounting of disclosures, you must submit your request in writing. See page IV for instructions. Your request must be for a period not longer than six (6) years and may not include dates before April 14, 2003.

- **Right to Access Your Health Information.** You have the right to obtain a copy of certain health information that HPSM maintains in its records. In general, this includes health and billing records. You will have to contact your doctor for a copy of your medical record. To get a copy of health information that we maintain, you must submit your request in writing. See page IV for instructions.

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

SEE INSTRUCTIONS ON PAGE VI ABOUT YOUR RIGHT TO MAKE A COMPLAINT OR FILE A GRIEVANCE

- **Right to Amend.** (Add a written comment that will be kept with your health information at HPSM). If you feel that health information we have about you is wrong or incomplete, you may ask us to amend the information. This is usually done if you disagree with the health information that we have on file for you. You have the right to request an amendment for as long as we maintain the information. To request an amendment, your request must be made in writing. See page 6 for instructions.

  We are not required to amend health information that:
  - ❖ was not created by HPSM, unless the person that created the information is no longer available to make the amendment;
  - ❖ is not part of the information we maintain;
  - ❖ is not part of the information which you would be allowed to obtain a copy of; or
  - ❖ is correct and complete.

  If HPSM denies your request to amend your health information, we will notify you in writing. You will also receive a written explanation of why your request was denied.

CHANGES TO THIS NOTICE

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

INSTRUCTIONS:

(1) How to file a Grievance regarding your privacy rights: If you believe your privacy rights have been violated, you may file a grievance with the Health Plan of San Mateo. You may also contact the U.S. Department of Health and Human Services to file a complaint.

Grievance Coordinator
Health Plan of San Mateo
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080
(800) 750-4776 or (650) 616-0050

Secretary of the US Department of Health and Human Services
Office of Civil Rights
Attn: Regional Manager 50 United Nations Plaza, Room 322
San Francisco, CA 94012
For additional information, call U.S. Office for Civil Rights at
(866) OCR-PRIV (866-627-7748) or (866) 788-4989 TTY

You will not be penalized for filing a Grievance.

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

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

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

If you have questions about this Notice, please contact a Health Plan of San Mateo (HPSM) Member Services Representative. They are available to serve you Monday through Thursday, 8:00 am – 6:00 pm and Friday, 9:30 am – 6:00pm at (800) 750-4776 or (650) 616-2133.

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The Health Plan of San Mateo
Healthy Kids

Member Handbook and Evidence of Coverage

Introduction

Using This Booklet

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

Throughout this booklet, "you," "your," and "Member" refers to the child or children enrolled in Healthy Kids. "We," "us," and "our" refer to Health Plan of San Mateo. "Provider," "plan Provider," and "participating Provider" refer to licensed physicians, hospitals, medical groups, pharmacies, or other health care Providers who are responsible for providing medical services to you.

Welcome!

About the Health Plan of San Mateo

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

The Health Plan of San Mateo is located at 701 Gateway Boulevard, Suite 400, South San Francisco, CA 94080. If you need help or want more information, call the Health Plan of San Mateo and ask to speak to a Member Services Representative at **1-800-750-4776** or **650-616-2133**. The Member Services staff is available from 8:00 a.m. to 6:00 p.m. Monday through Thursday and 9:30 a.m. to 6:00 p.m. on Friday.

Multilingual Services

If you or your representative prefers to speak in any language other than English, call us at **1-800-750-4776** or **650-616-2133** to speak with an HPSM Member Services Representative. [For the hearing impaired, please use the California Relay Service at **1-800-735-2929** (TTY) or dial 711 for California Relay in Spanish call **1-800-835-3000**]. HPSM staff speak several languages including Spanish and Tagalog. Interpreter services are also available by phone through use of a language line. Our Member Services staff can help you find a health care Provider who speaks your language or who has a regular interpreter available. You do not have

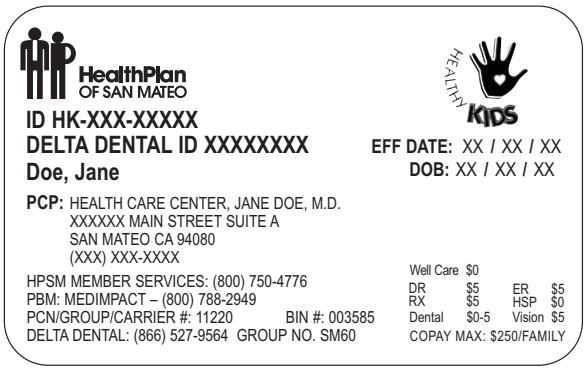
to use family members or friends as interpreters. If you cannot locate a health care Provider who meets your language needs, you can request to have an interpreter available for discussions of medical information at no charge.

This EOC booklet, as well as other informational material, has been translated into Spanish. To request translated materials, please call HPSM at **1-800-750-4776** or **650-616-2133**and ask to speak to a Member Services Representative [For the hearing impaired, please use the California Relay Service at **1-800-735-2929** (TTY) or dial 711 or for California Relay Service in Spanish call **1-800-835-3000**].

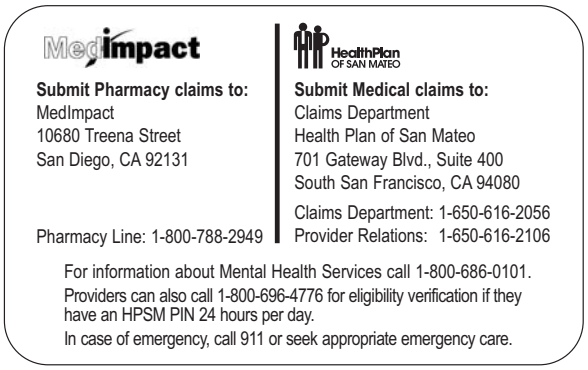
Member Identification Card

All Members of HPSM are given a Member identification card. This card contains important information regarding your medical benefits. If you have not received or if you have lost your Member identification card, please call us at **1-800-750-4776** or **650-616-2133** and ask to speak to a Member Services Representative. [For the hearing impaired, please use the California Relay Service at **1-800-735-2929** (TTY) or dial 711 or for California Relay Service in Spanish call 1-800-835-3000]. We will send you a new card. Please show your HPSM Member identification card to your Provider when you receive medical care or pick up prescriptions at a pharmacy.

Only the Member is authorized to obtain medical services using his or her Member identification card. If a card is used by or for an individual other than the Member, that individual will be billed for the services he or she receives. Additionally, if you let someone else use your Member identification card, HPSM may not be able to keep you in our plan.



Front Side of Card



Back Side of Card

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

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

Name: This person is eligible to receive benefits under Healthy Kids.

PCP: This is your Primary Care Physician.

DOB: This is your date of birth.

Copay: These are the amounts 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 doctor (Dr.), for each necessary visit to the emergency room (ER), and for each prescription (Rx) that you have filled. Your total copayments for your family during the year will not exceed $250.

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

Group #: This is the number assigned to you by Delta Dental for Healthy Kids.

DEFINITIONS

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

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

Anniversary Date ~ The date each year that is the same as the first day of the full month a Member's Healthy Kids coverage began.

Applicant ~ A person applying for Healthy Kids coverage for a child or youth for whom he or she is responsible.

Appropriately Qualified Health Care Professional ~ A primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to a particular illness, disease, condition or conditions.

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

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

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

California Children's Services (CCS) ~ A program for children who have disabling medical conditions. This program provides insurance and case management for certain conditions.

Children's Health Initiative (CHI) Coalition ~ The decision making body established by the San Mateo County Board of Supervisors for the planning and development of Healthy Kids. The coalition consists of representatives from the San Mateo Hospital Consortium, First Five San Mateo, San Mateo Central Labor Council, Peninsula Community Foundation, Health Plan of San Mateo, and San Mateo County Health Services and Human Services Agencies.

Copayment ~ A fee, which the Plan Provider may collect directly from a Member for a particular covered benefit at the time the service is rendered.

DMHC ~ The California State Department of Managed Health Care.

Effective Date of Coverage ~ The date coverage begins for a Member.

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

- Placing the Member's health or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, or
- Causing serious impairment to the Member's bodily functions, or
- Causing serious dysfunction of any of the Member's bodily organs or parts.

Established Patients Only (EPO) ~ Doctors that will only see Members who received services from them in the past.

Family Contribution ~ The annual or quarterly contribution made by Applicants for each Healthy Kids Member.

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

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

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

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

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

Healthy Kids ~ The health insurance program created by the Children's Health Initiative Coalition for children through age 18 in families with incomes up to 400% of the federal poverty level residing in San Mateo County who are ineligible for Healthy Families and full scope Medi-Cal.

Hospital ~ A health care facility licensed by the State of California, and accredited by the Joint Commission on Accreditation of Health Care Organizations, as either: (a) an acute care hospital; (b) a psychiatric hospital; or (c) a hospital operated primarily for the treatment of alcoholism and/or substance abuse. A facility which is primarily a rest home, nursing home or home for the aged, or a distinct part skilled nursing facility portion of a hospital is not included.

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

Life Threatening ~ A disease or condition that is highly likely to cause death unless the disease is promptly treated.

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

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

Member Identification Card ~ The identification card provided to Members by HPSM that includes the Member identification number, Primary Care Physician information, and important phone numbers.

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

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

Non-Participating Provider ~ A Provider who has not contracted with HPSM to provide services to Members.

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

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

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

Participating Provider or Plan Provider ~ A physician, hospital, skilled nursing facility or other licensed health professional, licensed facility or licensed home health agency who, or which, at the time care is rendered to a Member, has a contract in effect with HPSM to provide covered services to its Members.

Pharmacy Benefits Manager (PBM) ~ Is a third party administrator of a health plan's prescription drug program that is mainly responsible for authorizing and paying prescription drug claims. PBMs assist the health plan with development and maintenance of drug formularies, contracts with pharmacies, and negotiate discounts and rebates with drug manufacturers.

Plan or HPSM ~ Health Plan of San Mateo

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

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

Program ~ Healthy Kids

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

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

Provider List ~ The directory of the Providers contracted with HPSM to provide services to Members.

Serious Chronic Condition ~ A medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Service Area ~ The geographic area served by the Health Plan of San Mateo and approved by the State of California Department of Managed Health Care (DMHC), Department of Health Services (DHS) and the Managed Risk Medical Insurance Board (MRMIB). The County of San Mateo is the designated Service Area of the Health Plan of San Mateo.

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

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

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

Treatment Authorization Request (TAR) ~ A request from your doctor for a service/ treatment that needs approval from HPSM. The TAR is reviewed by HPSM medical staff for approval.

Urgent Care ~ Services needed to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed.

MEMBER RIGHTS AND RESPONSIBILITIES

AS AN HPSM MEMBER, YOU HAVE THE RIGHT TO:

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

YOUR RESPONSIBILITIES ARE TO:

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

ACCESSING CARE

PHYSICAL ACCESS

HPSM has made every effort to ensure that our offices and the offices and facilities of HPSM Providers are accessible to the disabled. If you are not able to locate an accessible Provider, please call us toll free at **1-800-750-4776** or **650-616-2133** and ask to speak to a Member Services Representative. We will help you find an alternate Provider.

ACCESS FOR THE HEARING IMPAIRED

You may call the California Relay Service at **1-800-735-2929** (TTY) or dial 711, or for California Relay in Spanish call **1-800-835-3000**.

ACCESS FOR THE VISION IMPAIRED

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

THE AMERICANS WITH DISABILITIES ACT OF 1990

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

DISABILITY ACCESS GRIEVANCES

If you believe the Plan or its Providers have failed to respond to your disability access needs, you may file a Grievance with HPSM by calling **1-800-750-4776** or **650-616-2133**.

USING THE HEALTH PLAN

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Choosing a Primary Care Physician

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

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

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

How To Choose or Change Your Primary Care Physician

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

OR

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

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

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

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

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

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

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

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

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

Scheduling Appointments

Call your Primary Care Physician (PCP) and make an appointment. The best time to get to know your PCP is not when you are sick, but when you are fine.

Initial Health Exam

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

Changing Your Primary Care Physician

If you and your doctor are not able to establish a good relationship, either of you have the right to ask for a change. For example, if you miss many appointments, do not follow your PCP's medical advice, or are disruptive or abusive, your PCP may request that you select a new PCP.

If you are not satisfied with the treatment or service of your PCP, you may select a new doctor. The Member Services Representative may ask the reason for your change. This information helps HPSM be sure our Providers meet the needs of our Members.

If you decide to choose a different PCP, we will do our best to meet your request. A PCP selection or choice may not be granted in the following situations: (1) the PCP is accepting Established Patients Only (EPO) and the Member has not seen the PCP before; (2) the Provider's practice is full; (3) you have been removed from the PCP's practice in the past; or (4) you selected a PCP who does not see Members in your age group. A PCP change will be effective the first day of the following month if we receive the change by the 22nd day of the month.

Please note: A new Member Identification Card, will be mailed to you, with the name of your new PCP. Your new Identification Card will show the date your PCP change is effective. Please continue to see the PCP listed on your current Identification Card for all of your health care needs, until the effective date of change. If you do not receive a new Identification Card within ten (10) days or have questions about the effective date of change, please call HPSM and ask to speak to a Member Services Representative at **1-800-750-4776** or **650-616-2133**.

Continuity of Care for New Members

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

- An Acute Condition. Completion of covered services shall be provided for the duration of the Acute Condition.
- A Serious Chronic Condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by HPSM in consultation with you and the Non-Participating Provider, and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with HPSM.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A Terminal Illness. Completion of covered services shall be provided for the duration of the Terminal Illness. Completion of covered services may exceed twelve (12) months from the time you enroll with HPSM.
- The care of a newborn child between birth and age thirty-six (36) months.
- Completion of covered services shall not exceed twelve (12) months from the time you enroll with HPSM.
- Performance of a surgery or other procedure that your previous plan authorized as part of a documented course of treatment and that has been recommended and documented by the Non-Participating Provider to occur within 180 days of the time you enroll with HPSM.

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

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

A Member Services Representative will notify you of HPSM's decision. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see HPSM's Grievance and Appeals Process on page 87.

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

Continuity of Care for Termination of Provider

If your Primary Care Physician or other health care Provider stops working with HPSM, we will let you know by mail 60 days before the contract termination date.

HPSM will provide continuity of care for covered services rendered to you by a Provider whose participation has terminated, if you were receiving this care from this Provider prior to termination and you have one of the following conditions:

- An Acute Condition. Completion of covered services shall be provided for the duration of the Acute Condition.
- A Serious Chronic Condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by HPSM in consultation with you and the terminated Provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the Provider's contract termination date.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A Terminal Illness. Completion of covered services shall be provided for the duration of the Terminal Illness. Completion of covered services may exceed twelve (12) months from the time the Provider stops contracting with HPSM.
- The care of a newborn child between birth and age thirty-six (36) months.

- Completion of covered services shall not exceed twelve (12) months from the Provider's contract termination date.
- Performance of a surgery or other procedure that HPSM had authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the Provider's contract termination date.

Continuity of care will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity. The terminated Provider must agree in writing to provide services to you in accordance with the terms and conditions, including reimbursement rates, of his or her agreement with HPSM prior to termination. If the Provider does not agree with these contractual terms and conditions and reimbursement rates, we are not required to continue the Provider's services beyond the contract termination date.

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

A Member Services Representative will notify you of HPSM's decision. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see HPSM's Grievance and Appeals Process on page 87.

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

Prior Authorization for Services

Your Primary Care Physician (PCP) will coordinate your health care needs and, when necessary, will arrange specialty services for you. In some cases, HPSM must authorize the specialty services before you receive the services. Your PCP will obtain the necessary referrals and authorizations for you. Some specialty services, such as OB/GYN services, do not require prior authorization before you receive the services.

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

Referrals to Specialty Physicians

Your PCP may decide to refer you to a physician who is a specialist to receive care for a specific medical condition. A written referral authorized by HPSM is not required if the service

is provided by an HPSM contracted provider. In consultation with you, your PCP will choose a participating Specialist Physician, participating hospital, or other Participating Provider from whom you may receive services. For a list of specialists, call Member Services at **1-800-750-4776** or **650-616-2133**. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY: **1-800-735-2929** or **dial 711**. In the event that there is no Participating Provider available to perform the needed service, your PCP will refer you to a Non-Participating Provider for the services, after obtaining authorization from HPSM.

Standing Referrals To Non-HPSM Providers

If you have a condition or disease that requires specialized medical care over a prolonged period of time, you may need a standing referral to a specialist in order to receive continuing specialized care. If you receive a standing referral to a specialist, you will not need to get authorization every time you see that specialist. Additionally, if your condition or disease is life threatening, degenerative, or disabling, you may need to receive a standing referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate your health care. To get a standing referral, call your Primary Care Physician. If you have any difficulty getting a standing referral, call HPSM at **1-800-750-4776** or **650-616-2133**. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY: **1-800-735-2929** or **dial 711**. If, after calling the plan, you feel your needs have not been met, please refer to HPSM's Grievance and Appeals Process on page 87.

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

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

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

Obtaining a Second Opinion

Sometimes you may have questions about your illness or your Primary Care Physician's (PCP's) recommended treatment plan. You may want to get a second opinion. You may request a second opinion for any reason, including the following:

- You question the reasonableness or necessity of a recommended surgical procedure.

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

You should speak to your PCP if you want a second opinion. If your request to obtain a second opinion about care, you will receive a second opinion from an Appropriately Qualified Health Care Professional of your choice from any appropriate doctor in HPSM's network. If there is no Appropriately Qualified Health Care Professional within HPSM's network, HPSM will authorize a second opinion from an appropriately qualified non-participating health care professional. In this case, a written referral authorized by HPSM is required. You will be responsible for paying all copayments for the second opinion.

If your request to obtain a second opinion is denied and you would like to appeal our decision, please refer to HPSM's Grievance and Appeals Process on page 87. This is a summary of HPSM's policy regarding second opinions. To obtain a copy of our policy, please contact us at **1-800-750-4776** or **650-616-2133**.

UTILIZATION REVIEW

TREATMENT AUTHORIZATION REQUEST (TAR)

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

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

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

We respond to all TARs sent to HPSM within five (5) working days. If a TAR is urgent we will respond to it within 24 hours. Requested services are reviewed for medical necessity, level of care, appropriateness of site and length of time (e.g., for a hospitalization). Criteria and guidelines used to review TARs are developed with input from practicing health care Providers and national guidelines and are consistent with sound clinical principles and processes. Criteria and guidelines are evaluated at least annually and updated as necessary. HPSM can provide you with guidelines or criteria used for a TAR decision. Please remember that these are specific to the treatment or service requested, the benefits covered under Healthy Kids and individual need. HPSM's policies and procedures for making TAR decisions are available upon request.

SERVICES EXCLUDED FROM PRIOR AUTHORIZATION

Some services do not require prior authorization or a referral from your PCP. You may go directly to the medical Provider for the services listed below. Some of these services are limited. Please see the benefits section for details.

1. Emergency and Out-Of-Area Urgent Care 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 (STDs), and confidential testing and counseling for STDs and HIV/AIDS. These services are available from your PCP, participating family planning agency, OB/GYN, or any other qualified doctor who provides these services. See page 34 and 43 for more information.
   - Family Planning services are provided to Members of childbearing 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's toll-free number at 1-800-942-1054.

4. Women's Services – Female Members have unlimited, direct access to OB/GYN services. Members may choose to have these services provided by their PCP, or Members may self-refer to any OB/GYN or PCP within HPSM's network for these services.
5. Acupuncture and Chiropractic Services are provided as a self-referral benefit up to a maximum of twenty (20) visits per benefit year. Chiropractic services are restricted to youth 16 and older.
6. Indian Health Services – If you are an American Indian or Alaskan Native and a Member of HPSM, as provided under federal law you may choose any available Indian Health Service Provider. The Provider does not have to be an HPSM network Provider, and HPSM will make arrangements to coordinate services for you.

Getting Pharmacy Benefits

Prescriptions

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

Refills

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

Over-the-Counter/Non-Prescription Drugs

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

The Drug Formulary

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

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

Generic Equivalent Drugs

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

Brand Name Medications Requested by Your Doctor

If your doctor believes a brand name medication must be provided, he or she may write "Dispense as Written" (DAW) or "Do Not Substitute" on the prescription. The pharmacist will then contact HPSM to see if a Medication Request Form (MRF) is required. If a MRF is required, the pharmacist will submit a request by phone or by fax to MedImpact, HPSM's Pharmacy Benefit Manager (PBM).

Brand Name Medications Requested by the Member

If you prefer a brand name medication there must be a medical reason for using it rather than the generic medication that is normally covered. The pharmacist must contact the doctor to determine if there is medical necessity for using the brand name drug. After receiving more information from the doctor, the pharmacist will submit a MRF to MedImpact asking for approval of the brand name medication. A brand name drug will also be prescribed if there is no generic medication available or if a medication has a narrow therapeutic index. In the latter case, although a generic medication may be available, you will be provided the brand name medication as written by the Provider. A narrow therapeutic index means that very small changes in the dosage level of the drug could cause toxic results. To receive a list of medications that are called "Narrow Therapeutic Index" medications, you can contact HPSM at **1-800-750-4776** or **650-616-2133** and speak to a Member Services Representative. Members with hearing or speech impairment can use the California Relay Service (CRS) at TTY **1-800-735-2929** or **dial 711**.

Non-Formulary Drugs

HPSM's participating doctors and pharmacies are responsible for using the Formulary. If a drug is prescribed that is not on the Formulary, the pharmacist will call the doctor to request a change to a Formulary medication. If the substitution of a Formulary medication is not approved by the requesting doctor, the pharmacist or doctor must submit a MRF form to MedImpact for the non-Formulary medication with medical justification. The pharmacist or doctor may phone or fax a MRF to MedImpact. If the MRF is approved based on criteria developed by HPSM staff pharmacists and Medical Director, then the non-formulary medication will be dispensed as written. If there is not enough information on the MRF form to determine whether the medication requested meets the criteria, then the MRF will be sent to an HPSM staff pharmacist for follow-up.

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

Availability of Drugs for Off-Label Usage

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

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

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

Evening, Weekend or Holiday Prior Authorization Submissions

MedImpact is available on the weekends to review MRF forms (Saturday, 6:00 AM to 2:00 PM; Sunday, 7:00 AM to 2:00 PM). If MRF's submitted on the weekend are approvable based on criteria, the non-Formulary medication will be dispensed as written. If the MRF does not have enough information to be approved, then it will be forwarded to the HPSM staff pharmacists for follow-up. HPSM is not able to review MRF's after business hours or on the weekend. In these situations, Members may be given up to a three-day supply of medication to allow time for the pharmacy to contact HPSM on the next business day for a MRF required prescription.

Changes in Formulary Medications

If you are taking a medication and HPSM drops the medication from its Formulary, and your

doctor chooses to continue to prescribe the medication, HPSM will provide coverage for the medication for up to 90 days. An approved MRF will be required for continued use of non-Formulary drugs beyond 90 days.

Deferred, Modified or Denied MRF's

If your request for a medication is deferred, modified, or denied, a "Notice of Action" letter will be sent to you. The Notice of Action letter will explain the reason your request was deferred, modified, or denied and provide information on how you may file an appeal with HPSM about the decision.

ENROLLMENT, EFFECTIVE DATE OF COVERAGE, AND MEMBER FINANCIAL RESPONSIBILITY

AVAILABILITY OF FUNDS FOR HEALTHY KIDS

The acceptance of any application for enrollment in Healthy Kids is contingent upon the availability of public and private funds from funding entities to pay the premium. Upon initial enrollment, a Member will be guaranteed one year of participation in Healthy Kids. At or before each Member's Anniversary Date, it will be determined whether funds are available to cover the premiums for the Member's next year of enrollment.

REQUIREMENTS FOR MEMBER ELIGIBILITY

To be eligible a child must be:

- Less than 19 years of age.
- A resident of San Mateo County.
- In a family with an annual or monthly household income equal to or less than 400% of the federal poverty level. Family income will be adjusted if the responsible parent(s) or guardian(s) works, pays for child support and/or alimony, or pays for childcare.
- Ineligible for Healthy Families or full scope Medi-Cal.
- Not covered by employer-sponsored health insurance for the previous six (6) months, except in the case of newborns who may be covered for their first 30 days.

A child may, however, be eligible if:

- The responsible parent or guardian providing health care coverage has lost his/her job which covered the child, or
- The family has moved into an area where employer sponsored coverage is not available, or
- The parent or guardian's employer has discontinued health benefits for all employees, or
- The child's health care coverage was provided under a federal Consolidated Omnibus Budget Reconciliation Act (COBRA) policy, and the COBRA coverage ended. If the parent or guardian chooses to terminate COBRA coverage, then he or she can immediately apply for Healthy Kids.

Pregnant minors are eligible for pregnancy-related services, and their newborn babies will automatically be covered for the first thirty (30) days of life. If you have a baby, call HPSM at **1-800-750-4776** or **650-616-2133** and ask to speak with a Member Services Representative to learn what health coverage options, including Healthy Kids, may be available for your baby. You may want to call **650-573-3595** to see if you may be eligible for Medi-Cal.

Application Process

To apply for Healthy Kids, an Applicant submits all information, documentation, and declarations required to determine eligibility to the San Mateo County Human Services Agency. Healthy Kids Elegibility Unit Information, documentation, and declarations include the Applicant's name and address, name and address of the child for whom enrollment is being requested, statement of the potential Member's household income, proof of age, and a statement indicating which person(s) is currently enrolled in an employer-sponsored health insurance plan. An applicant cannot apply for HK on their own and an applicant must seek assistance from a HK certified application assistant (HK CAA). Pregnant women may begin the application process prior to their babies' birth. However, all application requirements must be completed after the baby is born.

Starting Date of Coverage for Members

Coverage begins for Members ten (10) calendar days from the date the Member is determined to be eligible. Coverage continues for a full twelve (12) months unless the Program is terminated. HPSM will notify Members in writing of the effective date of coverage. For application, enrollment information, or to enroll additional children, call (650) 573-3595.

Annual Eligibility Renewal

Approximately 75 days before the end of the Member's Benefit Year, an Applicant will receive written notification of the annual eligibility review. The letter will advise an Applicant to see a Healthy Kids Certified Application Assistant (HK CAAs) to complete the renewal process. This process will be completed in One-e-App, a web-based application processing system. A final renewal notice will be sent 30 days before the Member's termination date. The One-e-App renewal application must be completed by the date stated in the notification letter or the Member will be terminated from Healthy Kids. If a Member is under 19, continues to reside in San Mateo County, meets income guidelines and does not have any other health insurance, the Member will be eligible for an additional 12 months of health insurance through Healthy Kids, unless the Member turns 19 during the year.

Continued eligibility of each Member also depends upon the availability of public and private funds to pay for the costs of Healthy Kids.

Notification of Eligibility Changes

It is the Member's or, where the Member is a minor, the Applicant's responsibility, to notify HPSM within 31 days of all changes in eligibility affecting the Member's enrollment in the program.

Appealing Enrollment Decisions

If you believe that the San Mateo County Human Services Agency Healthy Kids Elegibility Unit made a mistake in deciding whether your child is eligible, you can file an appeal with the San Mateo County Human Services Agency Healthy Kids Elegibility Unit by calling **650-802-6460**.

MEMBER FINANCIAL RESPONSIBILITY

Quarterly Family Contributions

The quarterly Family Contribution is set by the Children's Health Initiative (CHI) Coalition and determined by family size and income. Copayment responsibilities are set for Healthy Kids by the CHI Coalition. Under Healthy Kids, you pay a quarterly Family Contribution of $12, $18, $36, or $60 per child depending on family income. If an applicant chooses to pay nine (9) months of Family Contribution at the time of enrollment or redetermination, this will result in a free 10th, 11th, and 12th month.

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

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

Use one of the following methods to pay:

- Cashier's check
- Money order
- Personal check

The CHI Coalition will not increase the amount of the Family Contribution unless the Applicant is given thirty (30) days' written notice sent by postage prepaid, regular U.S. mail to the Applicant's most current address of record with HPSM. If you experience hardship paying your family contribution, contact the San Mateo County Human Services Agency Healthy Kids Elegibility Unit at **650-802-6460**.

Copayments

You will be required to pay a small amount of money for some services. This is called a Copayment. The maximum amount of money you are required to pay out in one Benefit Year per household is $250. All copayments paid for Healthy Kids Members in your household apply to the $250 maximum.

Make sure that you keep all receipts from your doctors' visits and prescriptions for all family members enrolled in Healthy Kids. HPSM will send you a letter to inform you when your family has paid $250.

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

HPSM is also working with our Providers to help you if you cannot pay all your 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 HPSM's Member Services staff at **1-800-750-4776** or **650-616-2133** and we will help you make the arrangements you need.

Other Member Payment Responsibilities

Generally, the only amount a Member pays for covered services is the required Copayment. However, you may be financially responsible for specialty services you receive without obtaining a referral or authorization. You may also be responsible for services you receive that are not covered services; non-emergency services received in the emergency room; non-emergency or non-urgent services received outside of HPSM's service area without prior authorization; and, unless authorized, services received that are greater than the limits specified in this Evidence of Coverage booklet.

In the event HPSM does not pay a Participating Provider for covered services, you will not be liable to the Provider for any money owed by HPSM. However, if HPSM does not pay a Non-Participating Provider for covered services, you may be liable to the Non-Participating Provider for the cost of the services. You may also be liable for payment of non-covered services, whether received from a Participating or Non-Participating Provider.

For example, if you need services that are not available from HPSM Providers, you must first talk with your PCP. The PCP will in turn get authorization to refer you to a Non-Participating Provider. If you do not go to your PCP for the necessary approval, or if you fail to follow HPSM's referral procedures, you may not be covered for such services and you may have to pay the entire cost. If you need Emergency Care, however, you may receive the services from a Non-Participating Provider without a referral or authorization. Please see the Emergency Care section on page 25 of this Evidence of Coverage. Also refer to the second opinion section on page 14 for specifics regarding Second Opinion Referral.

Reimbursement Provisions – If You Receive a Bill

To make sure your doctor knows how to bill for your care, please tell the doctor's office staff that you are an HPSM Member. Always show your Identification card when you get services. You should not be billed for services except in certain cases:

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

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

If you receive a bill for a service that is a benefit, please do not pay the bill. Call the Provider's office immediately and ask them to bill HPSM. The Provider can call HPSM, and we can explain to them how to bill us. The number for a Provider to call is on your Identification card. If you are unsure what to do, you can call a Member Services Representative.

Please do not ignore bills from Providers. If you end up being sent to collections for a bill, we

may not be able to help you as easily. You may end up being responsible for part or all of the bill.

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

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

Your written request should be mailed to HPSM within 3 months from the date you received services, or as soon as reasonably possible, but in no event later than 12 months after receiving the care.

GETTING URGENT CARE

GETTING URGENT CARE

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

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

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

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

To obtain Urgent Care when you are outside HPSM's services area, try to contact your PCP. If you cannot reach your PCP, go to the nearest medical facility. Always show your HPSM Identification card when seeking medical care.

EMERGENCY HEALTH CARE SERVICES

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

- Placing the Member's health or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, or
- Causing serious impairment to the Member's bodily functions, or
- Causing serious dysfunction of any of the Member's bodily organs or parts.

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

If you have a medical emergency, call 911 or go to the nearest emergency room.

Emergency Services are covered inside and outside of HPSM's service area and in and out of HPSM's participating facilities. When you have a Medical Emergency, call 911 or go to the closest emergency room for help. You do not have to go to the hospital where your PCP works if you have a Medical Emergency.

What to Do If You Are Not Sure If You Have an Emergency

If you are not sure whether you have an Emergency or require Urgent Care, contact your PCP for advice.

Follow-up Care

After receiving any Emergency or Urgent Care services, you will need to call your PCP for follow-up care.

Non-Covered Services

HPSM does not cover medical services that are received in an Emergency or Urgent Care setting for conditions that are not Emergencies or urgent if you reasonably should have known that an Emergency or Urgent Care situation did not exist. You will be responsible for all charges related to these services.

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 HPSM's Member Services staff at **1-800-750-4776** or **650-616-2133** and we will help you make the arrangements you need.

HEALTH PLAN COVERED BENEFITS MATRIX

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERED BENEFITS AND IS A SUMMARY ONLY. THE BENEFIT DESCRIPTION SECTION SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERED BENEFITS AND LIMITATIONS.

BENEFITS	SERVICES	COST TO MEMBER (COPAYMENT)
Inpatient Hospital Services	Room and board, nursing care, and all medically necessary ancillary services	No Copayment
Outpatient Hospital Services	Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility.	No Copayment except • $5 per visit for physical, occupational and speech therapy performed on an outpatient basis. • $5 per visit for emergency health care services (waived if the Member is hospitalized)
Professional Services	Services and consultations by a physician or other licensed health care Provider.	$5 per office or home visit except • No Copayment for hospital inpatient professional services • No Copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments • No Copayment for Members 24 months of age and younger • No Copayment for vision or hearing testing, or for hearing aids
Preventive Health Service	Periodic health examinations, routine diagnostic testing and laboratory services, immunizations, and services for the detection of asymptomatic diseases.	No Copayment
Diagnostic, X-Ray and Laboratory Services **	Laboratory services, diagnostic imaging and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, and treat Members.	No Copayment

BENEFITS	SERVICES	COST TO MEMBER (COPAYMENT)
Diabetic Care **	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription.	$5 Copayment per office visit. Copayment for prescriptions as described in the "Prescription Drug Program" Section.
Prescription Drug Program **	Drugs prescribed by a licensed practitioner.	$5 per prescription for a 30 day supply for brand name or generic drugs. $5 per prescription for a 90 day supply of maintenance drugs • No Copayment for prescription drugs provided in an inpatient setting. • No Copayment for drugs administered in the doctor's office or in an outpatient facility. • No Copayment for FDA-approved contraceptive drugs and devices.
Durable Medical Equipment **	Medical equipment appropriate for use in the home which primarily serves a medical purpose, is intended for repeated use, and is generally not useful to a person in the absence of illness or injury.	No Copayment
Orthotics and Prosthetics **	Original and replacement devices as prescribed by a licensed practitioner.	No Copayment
Cataract Spectacles and Lenses **	Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery.	No Copayment
Maternity Care	Professional and hospital services relating to maternity care.	No Copayment
Medical Transportation Services **	Emergency ambulance transportation and non-emergency transportation to transfer a Member from a hospital to another hospital or facility, or facility to home.	$5 per visit (waived if the Member is admitted to the hospital.)

BENEFITS	SERVICES	COST TO MEMBER (COPAYMENT)
Emergency Health Care Services **	Emergency services are covered both in and out of the plan's service area and in and out of the plan's participating facilities. Confinement in a participating hospital.	No Copayment
Inpatient Mental Health Services	Services are arranged and managed by the San Mateo County Health Plan.	No Copayment Benefit is limited to 30 days per benefit year, except for the treatment of severe mental illnesses or serious emotional disturbance of a child.
Outpatient Mental Health Services	Services are arranged and managed by the San Mateo County Health Plan.	$5 per visit Benefit is limited to 20 visits per benefit year, except for the treatment of severe mental illnesses and SED.
Inpatient Alcohol / Drug Abuse Services	Hospitalization to remove toxic substances from the system.	No Copayment
Outpatient Alcohol / Drug Abuse Services	Crisis intervention and treatment of alcoholism or drug abuse.	$5 per visit Benefit is limited to 20 visits per benefit year
Home Health Care Services	Services provided at the home by health care personnel.	No Copayment, except • $5 per visit for physical, occupational, and speech therapy
Skilled Nursing Care	Services provided in a licensed skilled nursing facility.	No Copayment
Physical, Occupational, and Speech Therapy **	Therapy may be provided in a medical office or other appropriate outpatient settings.	$5 per visit when performed in an outpatient setting No Copayment for inpatient therapy

BENEFITS	SERVICES	COST TO MEMBER (COPAYMENT)
Blood and Blood Products **	Includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings.	No Copayment
Health Education	Education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services.	No Copayment
Hospice	For Members who are diagnosed with a terminal illness and who elect hospice care instead of traditional health care services.	No Copayment
Organ Transplants **	Coverage for organ transplants and bone marrow transplants which are not experimental or investigational.	No Copayment
Reconstructive Surgery **	Performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors, or disease and are performed to improve function or create a normal appearance.	No Copayment
Phenylketonuria (PKU) **	Testing and treatment of PKU.	No Copayment
Clinical Cancer Trials	Coverage for a Member's participation in a cancer clinical trial, phase I through IV, when the Member's physician has recommended participation in the trial, and Member meets certain requirements.	$ 5 Copayment per office visit. Copayment for prescriptions as described in the "Prescription Drug Program" Section.

BENEFITS	SERVICES	COST TO MEMBER (COPAYMENT)
California Children's Services Program (CCS)	CCS is a California medical program that treats children who have certain physically handicapping conditions and who need specialized medical care. Services provided through the CCS Program are coordinated by the county CCS office. If the Member's condition is determined to be eligible for CCS services, the Member remains enrolled in the Healthy Kids and continues to receive medical care from plan Providers for services not related to the CCS eligible condition. The Member will receive treatment for the CCS eligible condition through the specialized network of CCS Providers and/or CCS approved specialty centers.	No Copayment
Acupuncture	Does not require referral from the Member's Provider but services must be obtained from a Plan Provider.	$5 per visit Benefit is limited to 20 visits per benefit year
Chiropractic	Does not require referral from the Member's Provider but services must be obtained from a Plan Provider and are restricted to Members 16 and older.	$5 per visit Benefit is limited to 20 visits per benefit year

DEDUCTIBLES

No deductibles will be charged for covered benefits

LIFETIME MAXIMUMS

No lifetime maximum limits on benefits apply under this plan.
* Benefits are provided only for services that are medically necessary.
** These services may be covered and paid for by the California Children's Services (CCS) program, if the Member is found to be eligible for CCS services.

DETAILED BENEFIT DESCRIPTIONS

INPATIENT HOSPITAL SERVICES

Cost to Member: No Copayment.

Description: General hospital services received in a room of two (2) or more individuals containing customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. Benefit includes all medically necessary ancillary services, including, but not limited to:

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

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

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

OUTPATIENT HOSPITAL SERVICES

Cost to Member: No Copayment, except:

- $5 per visit for physical, occupational and speech therapy performed on an outpatient basis.
- $5 per visit for emergency health care services, which is waived if the Member is hospitalized.

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

- Physical, speech, and occupational therapy as appropriate
- Hospital services that can reasonably be provided on an ambulatory basis
- Related services and supplies in connection with outpatient services including operating room, treatment room, ancillary services, and medications that are supplied by the hospital or facility for use during the Member's stay at the facility

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

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

PROFESSIONAL SERVICES

Cost to Member: $5 per office or home visit, except:

- No Copayment for hospital inpatient professional services
- No Copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments
- No Copayment for Members 24 months of age or younger
- No Copayment for vision or hearing testing, or for hearing aids

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. Professional services include:

- Surgery, assistant surgery, and anesthesia (inpatient or outpatient)
- Inpatient hospital and skilled nursing facility visits
- Professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment
- Home visits when medically necessary
- Eye examinations including eye refractions to determine the need for corrective lenses and dilated retinal eye exams
- Hearing tests, hearing aids and related services including audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid
- Hearing aid(s): Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. There is no charge for visits for fitting, counseling, adjustments, repairs, etc., for a one-year period following receipt of a covered hearing aid.

Exclusions:

- ◆ Purchase of batteries or other ancillary equipment, except those covered under the initial hearing aid purchase, and charges for a hearing aid that exceeds specifications prescribed for correction of a hearing loss
- ◆ Replacement parts for hearing aids or repair of hearing aid after the covered one-year warranty period
- ◆ Replacement of a hearing aid more than once in any period of thirty-six months & Surgically implanted hearing devices

PREVENTIVE HEALTH SERVICES

Cost to Member: No Copayment

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

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

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

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

IMMUNIZATIONS ARE AVAILABLE TO PROTECT YOUR CHILD FROM THE DANGEROUS DISEASES LISTED BELOW:

- **Chickenpox** (also called Varicella) is a common childhood disease. It is usually mild, but it can be serious, especially in young infants and adults. Getting a chickenpox vaccine is much safer than getting the chickenpox disease.The chickenpox virus can be spread from person to person through the air, or by contact with fluid from chickenpox blisters. It causes a rash, itching, fever, and tiredness. It can lead to severe skin infections, scars, pneumonia, brain damage, or death. A person who has had chickenpox can get a painful rash called shingles (also called herpes zoster) years later.

- **Diptheria** is a disease caused by bacteria. The disease causes a thick covering in the back of the throat. It can lead to breathing problems, paralysis, heart failure, and even death. The bacteria can spread from person to person through close contact.

- **Haemophilus influenzae type b (HIB)** disease is a serious disease caused by bacteria. The disease is a leading cause of serious illness in children under 5 years old. It can lead to meningitis, pneumonia, and a severe throat infection that can cause choking. It can spread from person to person through close contact.

- **Hepatitis A** is a virus that causes jaundice, tiredness, stomach pain, loss of appetite, vomiting, diarrhea and fever. Hepatitis A is spread from person to person by putting something in the mouth that has been contaminated with the stool of a person infected with Hepatitis A.

- **Hepatitis B** is a serious disease caused by a virus that attacks the liver. The virus which is called hepatitis B virus (HBV), can cause lifelong infection, scarring of the liver, liver cancer, liver failure and death. The disease can cause jaundice (yellow skin or eyes), vomiting, loss of appetite, joint pain, tiredness and stomach pain. The virus can be spread through blood or body fluids from someone who has the disease. Everyone under 18 years of age should get the vaccine to prevent the disease.

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

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

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

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

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

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

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

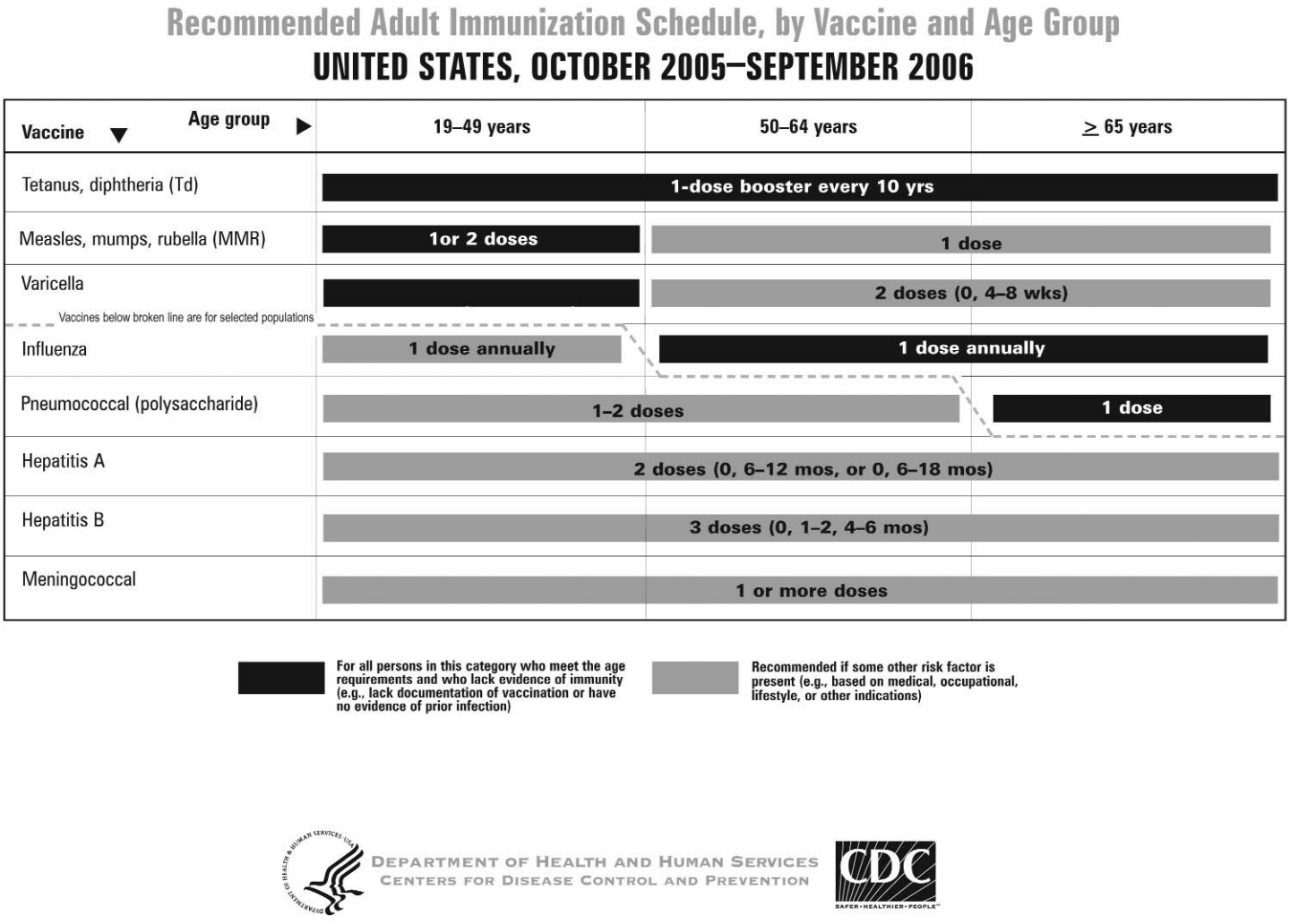
- **Polio** is a disease caused by a virus. It enters the body through the mouth. It can cause paralysis (can't move arm or leg). It can kill people who get it by paralyzing the muscles that help them breathe.

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

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

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

RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE



Recommended Immunization Schedule for Children and Adolescents Who Start Late or Who Are More Than 1 Month Behind

UNITED STATES • 2006

The tables below give catch-up schedules and minimum intervals between doses for children who have delayed immunizations. There is no need to restart a vaccine series regardless of the time that has elapsed between doses. Use the chart appropriate for the child's age.

CATCH-UP SCHEDULE FOR CHILDREN AGED 4 MONTHS THROUGH 6 YEARS

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Diphtheria, Tetanus, Pertussis	6 wks	4 weeks	4 weeks	6 months	6 months[1]
Inactivated Poliovirus	6 wks	4 weeks	4 weeks	4 weeks[2]	
Hepatitis B[3]	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Measles, Mumps, Rubella	12 mo	4 weeks[4]			
Varicella	12 mo				
Haemophilus influenzae type b[5]	6 wks	4 weeks if first dose given at age <12 months 8 weeks (as final dose) if first dose given at age 12-14 months No further doses needed if first dose given at age ≥15 months	4 weeks[6] if current age <12 months 8 weeks (as final dose)[6] if current age ≥12 months and second dose given at age <15 months No further doses needed if previous dose given at age ≥15 mo	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal[7]	6 wks	4 weeks if first dose given at age <12 months and current age <24 months 8 weeks (as final dose) if first dose given at age ≥12 months or current age 24–59 months No further doses needed for healthy children if first dose given at age ≥24 months	4 weeks if current age <12 months 8 weeks (as final dose) if current age ≥12 months No further doses needed for healthy children if previous dose given at age ≥24 months	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	

CATCH-UP SCHEDULE FOR CHILDREN AGED 7 YEARS THROUGH 18 YEARS

Vaccine	Minimum Interval Between Doses		
	Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Booster Dose
Tetanus, Diphtheria[8]	4 weeks	6 months	6 months if first dose given at age <12 months and current age <11 years; otherwise 5 years
Inactivated Poliovirus[9]	4 weeks	4 weeks	IPV[2,9]
Hepatitis B	4 weeks	8 weeks (and 16 weeks after first dose)	
Measles, Mumps, Rubella	4 weeks		
Varicella[10]	4 weeks		

Diagnostic X-Ray and Laboratory Services

Cost to Member: No Copayment

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

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

Diabetic Care

Cost to Member:

- ◆ $5 Copayment per office visit
- ◆ Copayments for prescriptions as described in the "Prescription Drug Program" Section below

Description: Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription, including:

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

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

PRESCRIPTION DRUG PROGRAM

Cost to Member:

- ◆ No Copayment for prescription drugs provided in an inpatient setting
- ◆ No Copayment for drugs administered in the doctor's office or in an outpatient facility setting during the Member's stay at the facility
- ◆ No Copayment for FDA-approved contraceptive drugs and devices.
- ◆ $5 per prescription for up to a 30 day supply for brand name or generic drugs, including tobacco use cessation drugs
- ◆ $5 per 90 day supply of maintenance drugs supplied through the Plan's participating pharmacies. Maintenance drugs are drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

Description:

Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her license. Includes, but is not limited to:

- Injectable medication, needles and syringes necessary for the administration of the covered injectable medication
- Insulin, glucagon, syringes, needles and pen delivery systems for the administration of insulin
- Blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent, and gestational diabetes
- Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins that require a prescription
- Medically necessary drugs administered while a Member is a patient or resident in a rest home, nursing home, con valescent hospital, or similar facility when prescribed by a Plan physician in connection with a covered service and obtained through a Plan-designated pharmacy
- Disposable devices that are necessary for the administration of covered drugs such as spacers and inhalers for the administration of aerosol prescription drugs and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes. The term 'disposable' includes devices that may be used more than once before disposal.
- One cycle or course of treatment of tobacco cessation drugs per benefit year. The Member must attend tobacco cessation classes or programs in conjunction with the use of tobacco cessation drugs.
- All FDA-approved oral and injectable contraceptive drugs and prescription contraceptive devices, including internally implanted time-release contraceptives.

For information concerning HPSM's prescription drug coverage, please refer to "Getting Pharmacy Benefits" on page 20 of this booklet.

Exclusions:

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

If HPSM denies your request for prescription drugs based on a determination that the drug is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to HPSM's Grievance and Appeals Process on page 82.

DURABLE MEDICAL EQUIPMENT

Cost to Member: No Copayment

Description: Medical equipment appropriate for use in the home that:

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

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

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

Exclusions:

- Comfort or convenience items

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

Orthotics and Prosthetics

Cost to Member: No Copayment

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

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

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

Exclusion:

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

Cataract Spectacles and Lenses

Cost to Member: No Copayment

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

Maternity Care

Cost to Member: No Copayment

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

- Prenatal and postpartum care, including complications of pregnancy
- Newborn examinations and nursery care while the mother is hospitalized
- Participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program
- Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy
- Counseling for nutrition, health education and social support needs
- Labor and delivery care, including midwifery services

Inpatient hospital care will be provided for 48 hours following a normal vaginal delivery and 96 hours following delivery by Cesarean section (C-section), unless an extended stay is authorized by HPSM. You do not need specific authorization to stay in the hospital 48 hours after a vaginal delivery or 96 hours after a C-section, and you may remain in the hospital for these time periods unless you and your doctor decide otherwise. If, after consulting with you, your doctor decides to discharge you before the 48- or 96-hour time period, HPSM will cover a post-discharge follow-up visit within 48 hours of discharge when prescribed by your doctor. The visit includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The doctor and you will decide whether the post-discharge visit will occur in the home, at the hospital, or at the doctor's office depending on the best solution for you.

FAMILY PLANNING SERVICES

Cost to Member: No Copayment

Description: Voluntary family planning services are covered, including:

- Counseling and surgical procedures for sterilization, as permitted by state and federal law
- Diaphragms
- Coverage for other federal Food and Drug Administration approved devices pursuant to the prescription drug benefit
- Voluntary Termination of Pregnancy

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

MEDICAL TRANSPORTATION SERVICES

Cost to Member: No Copayment

Description: Emergency ambulance transportation to the first hospital that actually accepts the Member for emergency care is covered in connection with emergency services. Benefits include ambulance and ambulance transport services provided through the "911" emergency response system. They also include, non-emergency transportation for the transfer of a Member from a hospital to another hospital or facility, or facility to home when the transportation is:

- Medically necessary, and
- Requested by a Plan Provider, and
- Authorized in advance by HPSM.

Exclusion: Coverage for public transportation including by airplane, passenger car, taxi, or other forms of public conveyance.

EMERGENCY HEALTH CARE SERVICES

Cost to Member: $5 per visit. Copayment will be waived if the Member is admitted to the hospital.

Description: Twenty-four (24) hour care is covered for an Emergency Medical Condition. An Emergency Medical Condition is a medical or psychiatric condition, including Active Labor or severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

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

MENTAL HEALTH BENEFITS

Mental health services are provided by the San Mateo County Managed Mental Health Plan. Members utilizing mental health services must comply with the Mental Health Plan's Authorization requirements. For information about mental health Providers and access to care, Members should call the Mental Health Plan at **1-800-686-0101**.

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

MENTAL HEALTH ACCESS TEAM
1-800-686-0101, Monday through Friday, 8:00 a.m. to 5:00 p.m.

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

MENTAL HEALTH SERVICES PATIENT ADVOCATE
Children and Adolescents **650-655-6276**.

INPATIENT MENTAL HEALTH SERVICES

Cost to Member: No Copayment

Description: Mental health care during a certified confinement in a participating hospital when ordered and performed by San Mateo County Mental Health Plan provider for the treatment of a mental health condition.

Limitation: Inpatient mental health care is limited to thirty (30) days per Benefit Year. With the agreement of the Member, the Member's legal guardian, or other responsible adult if appropriate, any of the following may be substituted for each day of inpatient care:

- Two (2) days of residential treatment,
- Three (3) days of day care treatment, or
- Four (4) outpatient visits.

Exception: Inpatient mental health care days for the treatment of serious emotional disturbance (SED) of a child and severe mental illnesses (SMI), are not limited. Examples of SMI include, but are not limited to:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, and Asperger's Disorder
- Anorexia Nervosa
- Bulimia Nervosa

OUTPATIENT MENTAL HEALTH SERVICES

Cost to Member: $5 per visit

Description: Mental health care services are authorized, arranged and provided by the San Mateo Mental Health Plan. Outpatient mental health benefits include:

1. Treatment for Members who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, divorce, or bereavement
2. Involvement of family members in the treatment to the extent the Provider determines it is appropriate for the health and recovery of the Member

3. Treatment of serious emotional disturbance (SED) of a child and severe mental illnesses (SMI), which include, but are not limited to:
    - Schizophrenia
    - Schizoaffective disorder
    - Bipolar disorder (manic-depressive illness)
    - Major depressive disorders
    - Panic disorder
    - Obsessive-compulsive disorder
    - Pervasive developmental disorder, including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, and Asperger's Disorder
    - Anorexia Nervosa
    - Bulimia Nervosa

Limitations: Outpatient mental health care is limited to twenty (20) visits per Benefit Year, except that the number of treatment days may be increased when outpatient treatment days are substituted for inpatient hospitalization days as described in "Inpatient Mental Health Services" on page 46.

Exception: Outpatient mental health care days for the treatment of severe mental illnesses (SMI) are not limited.

Inpatient Alcohol/Drug Abuse Services

Cost to Member: No Copayment

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

Outpatient Alcohol/Drug Abuse Services

Cost to Member: $5 per visit

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

Limitation: Twenty (20) visits per Benefit Year. Additional visits may be covered if approved and authorized by HPSM.

HOME HEALTH CARE SERVICES

Cost to Member: No Copayment, except for $5 per visit for physical, occupational, and speech therapy performed in the home.

Description: Health services provided at home by health care personnel. The benefit includes:

1. Visits by RNs, LVNs, and home health aides
2. Physical therapy, occupational therapy, and speech therapy
3. Respiratory therapy when prescribed by a licensed plan Provider acting within the scope of his or her licensure
4. Limitations:
    - Home health care services are limited to those services that are prescribed or directed by the Member's PCP or another appropriate authority designated by HPSM.
    - If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the Member's Primary Care Physician or other appropriate authority designated by HPSM to choose the setting for providing the care.
    - HPSM will exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting.

Exclusion: Custodial care

SKILLED NURSING CARE

Cost to Member: No Copayment

Description: Medically necessary services prescribed by a Plan Provider and provided in a licensed skilled nursing facility. Benefit includes:

- Skilled nursing on a 24-hour per day basis
- Bed and board
- X-ray and laboratory procedures
- Respiratory therapy
- Physical, speech, and occupational therapy
- Medical social services
- Prescribed drugs and medications
- Medical supplies
- Appliances and equipment ordinarily furnished by the skilled nursing facility

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

Exclusion: Custodial care

Physical, Occupational, and Speech Therapy

Cost to Member: No Copayment for inpatient therapy, including services received in a skilled nursing facility. $5 per visit when performed in the home or other outpatient setting

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

Acupuncture

Cost to Member: $5 per visit

Description: Acupuncture services do not require a referral from the Member's PCP or other health care Provider. Services must be obtained from a Participating Provider.

Limitation: Treatment is limited to a maximum of twenty (20) visits per Benefit Year.

Chiropractic Services

Cost to Member: $5 per visit

Description: Chiropractic services do not require a referral from the Member's PCP or other health care provider. Services must be obtained from a Participating Provider.

Limitation: Treatment is limited to a maximum of twenty (20) visits per benefit year. Services are restricted to Members 16 and older.

Blood and Blood Products

Cost to Member: No Copayment

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

HEALTH EDUCATION

Cost to Member: No Copayment

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

HOSPICE

Cost to Member: No Copayment

Description: The hospice benefit is provided to Members who are diagnosed with a Terminal Illness with a life expectancy of twelve (12) months or less and who elect hospice care for such illness instead of the traditional services covered by the plan. The hospice benefit includes:

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

The hospice election may be revoked at any time.

Limitation: Members who elect hospice care are not entitled to any other benefits under the plan for the Terminal Illness while the hospice election is ineffect.

ORGAN TRANSPLANTS

Cost to Member: No Copayment

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

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

These services may be covered and paid for by the California Children's Services (CCS) program, instead of by HPSM, if the Member is found to be eligible for CCS services. HPSM will coordinate these services with CCS for the Member. For more information about the CCS program, see "Coordination of Services" on page 58.

If HPSM denies your organ transplant request based on a determination that the service is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to HPSM's Grievance and Appeals Process on page 86.

RECONSTRUCTIVE SURGERY

Cost to Member: No Copayment

Description: Medically necessary reconstructive surgical services performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors or disease and are performed to improve function or create a normal appearance to the extent possible. This benefit includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

Mastectomies and Lymph Node Dissection Surgeries

Cost to Member: No Copayment

Description:

- The length of a hospital stay associated with mastectomies and lymph node dissections are determined by the attending physician and surgeon in consultation with the Member.
- Coverage includes all complications from a mastectomy including lympedema.

Phenylketonuria (PKU)

Cost to Member: No Copayment

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

Clinical Cancer Trials

Cost to Member:

- $5 copayment per office visit
- Copayment for prescriptions as described in the "Prescription Drug Program" Section.

Description: Coverage for a Member's participation in a cancer clinical trial, phase I through IV, when the Member's physician has recommended participation in the trial, and Member meets the following requirements:

- Member must be diagnosed with cancer.
- Member must be accepted into a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer.
- Member's treating physician, who is providing covered services, must recommend participation in the clinical trial after determining that participation will have a meaningful potential to the Member, and
- The trial must meet the following requirements:

    1. Trials must have a therapeutic intent with documentation provided by the treating physician, and

2. Treatment provided must be 1) approved by one of the following: the National Institute of Health, the federal Food and Drug Administration, the U.S.Department of Defense, or the U.S. Department of Veterans Affairs, or 2) involve a drug that is exempt under the federal regulations from a new drug application.

Benefits include the payment of costs associated with the provision of routine patient care, including drugs, items, devices and services that would otherwise be covered if they were not provided in connection with an approved clinical trial program. Routine patient costs for cancer clinical trials include:

- Health care services required for the provision of the investigational drug, item, device or service
- Health care services required for the clinically appropriate monitoring of the investigational drug, item, device, or service
- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service

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

Exclusions:

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

Annual or Lifetime Benefit Maximums

There shall be no annual or lifetime financial benefit maximums for any of the coverage provided by the Program.

COORDINATION OF SERVICES

California Children's Services (CCS)

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

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

If a Member's Primary Care Physician suspects or identifies a possible CCS eligible condition, he or she must refer the Member to the local CCS program. HPSM can assist with this referral. HPSM will also make a referral to CCS when a Primary Care Physician refers the Member to a specialist or where there is an inpatient admission that appears to involve care for a CCS eligible condition. The CCS program will determine if the Member's condition is eligible for CCS services.

If the condition is determined to be eligible for CCS services, the Member will remain enrolled in Healthy Kids. He or she will be referred and should receive treatment for the CCS eligible condition through the specialized network of CCS Providers and/or CCS approved specialty centers. These CCS Providers and specialty centers are highly trained to treat CCS eligible conditions. CCS services must be received from CCS paneled Providers and payment for CCS eligible services obtained from non-CCS paneled Provider will be the financial responsibility of the Member's legal guardian.

HPSM will continue to provide primary care, prevention services, and any other services that are not related to the CCS eligible condition, as described in this booklet. HPSM will also work with the CCS program and Providers to coordinate care provided by both the CCS program and HPSM. If a condition is determined not to be eligible for CCS program services, the Member will continue to receive all medically necessary services from HPSM.

The CCS office must verify residential status for each child in the CCS program. If a Member is referred to the CCS program, the Member's legal guardian will be asked to complete a short application to verify residential status and ensure coordination of the Member's care after the referral has been made.

Additional information about the CCS program can be obtained by calling HPSM's Member Services at **1-800-750-4776** or **650-616-2133**. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY 1-800-735-2929 or dial 711 or by calling San Mateo County CCS program at (650) 573-2755.

EXCLUDED BENEFITS

The following health benefits are excluded under the Health Plan:

1. Any services or items specifically excluded in the Benefits Description section.

2. Any benefits in excess of limits specified in the Benefits Description section.

3. Services, supplies, items, procedures, or equipment that are not medically necessary, unless otherwise specified in the Benefits Description section.

4. Any services that were received prior to the Member's effective date of coverage. This exclusion does not apply to covered services to treat complications arising from services received prior to the Member's effective date.

5. Any services that are received after the Member's coverage ends.

6. Experimental or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards or for which the safety and efficacy have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed.

7. Medical services that are received in an Emergency Care setting for conditions that are not emergencies if you reasonably should have known that an Emergency Care situation did not exist.

8. The diagnosis and treatment of infertility unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.

9. Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care, except when HPSM determines they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to "Skilled Nursing Care" and "Hospice" benefits.

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

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

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

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

14. Drugs or medications for cosmetic use.

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

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

17. Corrective shoes and arch supports, (except for therapeutic footwear for diabetics); non-rigid devicessuch as elastic knee supports, corsets, elastic stockings, and garter belts, dental appliances, electronicvoice producing machines; except as medically necessary.

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

19. Home Health custodial care and physical therapy and rehabilitation that are not medically necessary.

20. Skilled nursing custodial care provided by skilled nurses or skilled nursing facilities.

21. 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.

COVERED VISION SERVICES

DETAILED DESCRIPTION OF BENEFITS, COPAYMENTS, CONDITIONS, AND EXCLUSIONS

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

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

Cost to Member: $5 Copayment per examination

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

Description: Examinations

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

- Case History: Review of Member's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.
- Evaluation of the health status of the visual system including:
    1) external and internal examination, including that of direct and/or indirect ophthalmoscopy
    2) assessment of neurological integrity, including that of papillary reflexes and extraocular muscles
    3) biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes
    4) screening of gross visual fields
    5) pressure testing through tonometry
- Evaluation of refractive status including:

1) evaluation of visual acuity
2) evaluation of subjective, refractive, and accommodative function
3) objective testing of a Member's prescription through retinoscopy

- binocular function test
- diagnosis and treatment plan, if needed
- examinations are limited to once each twelve (12) month period, which begins with the date of the last exam.

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

Frames
Frames are limited to once every twelve (12) month period, which begins with the date of the last exam.

Medically Necessary Contact Lenses
Medically necessary contact lenses may be prescribed for certain conditions with prior authorization from HPSM, such as:

1) following cataract surgery,
2) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
3) certain conditions of Anisometropia; and
4) keratoconus.

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

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

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

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

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

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

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

There are no out-of-network benefits.

COVERED DENTAL SERVICES, BENEFITS AND COPAYMENTS

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

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

CHOOSING A PRIMARY CARE DENTAL PROVIDER

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

SCHEDULING APPOINTMENTS

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

CHANGING YOUR PROVIDER

You can choose any participating dentist at any time. If you wish to change dentists, simply review the Provider List for dentists and call to schedule an appointment. Delta's Customer Service department is available to assist you in choosing a new dentist.

CONTINUITY OF CARE FOR NEW MEMBERS

Under some circumstances, Delta will provide continuity of care for new Members who are receiving dental services from a Non-Participating dental Provider when Delta determines that continuing treatment with a Non-Participating Provider is medically appropriate. If you are a new Member, you may request permission to continue receiving dental services from a Non-Participating Provider if you were receiving this care before enrolling in Healthy Kids.

You may request authorization for continuity of care by contacting Delta's Customer Service

Department toll-free at **1-866-527-9564**. The hearing impaired may contact Delta Dental through Delta's TDD/TTY number at **1-800-735-2922**. If Delta approves the continued treatment from a Non-Participating Provider, we will give you a written authorization. If we determine that you do not meet the criteria for continuity of care and you disagree with Delta's determination, you may file a grievance with Delta Dental (see page 64) or with HPSM (see page 82).

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

Continuity of Care for Termination of Provider

If your dental care Provider stops working with Delta Dental, Delta will let you know by mail.

Prior Authorization for Services

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

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

Referrals to Specialists

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

Obtaining a Second Opinion

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

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

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

A second opinion may also be requested by Delta prior to authorizing treatment when it is necessary to make a benefit determination. Both you and the treating dentist will be notified when a second opinion is necessary and appropriate. When a second opinion is requested by Delta, the Program will pay all charges.

Utilization Review

The goal of Delta's Utilization Management (UM) Program is to ensure that dental services provided to you are necessary and appropriate, the services are provided in an appropriate setting, the services are delivered in a timely manner and the services are provided in accordance with the scope of benefits of Healthy Kids. The Delta Dental Utilization Review (UR) system includes an automated information processing system, employees who use that system, and policies and procedures that govern that usage.

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

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

Getting Urgent Care

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

Getting Emergency Services

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

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

What to Do If You Are Not Sure If You Have an Emergency

If you are not sure whether you have an emergency or require Urgent Care you may contact your Participating dental Provider or call Delta's Customer Service Department toll-free at **1-866-527-9564**.

Non-Covered Services

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

Follow-Up Care

After receiving any emergency or Urgent Care services, you will need to call your Participating Provider for any necessary follow-up care. If you don't have a regular Participating Provider, you may select one from the Delta Provider Directory. If you need help selecting a Provider, contact Delta's Customer Service Department toll-free at **1-866-527-9564**.

COPAYMENTS

You will be required to pay a Copayment. You are responsible to pay the Copayment to the dental Provider at the time services are provided. There are no Copayments for the preventive and diagnostic services listed in the Benefits section of this EOC. Additionally, there are no Copayments for Members who are American Indians or Alaska Natives.

No deductibles are charged for dental benefits.

MEMBER LIABILITIES

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

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

MISSED OR BROKEN APPOINTMENTS

Your dentist may charge you a $5.00 fee if you fail to cancel an appointment at least 24 hours prior to the appointment. This fee will be waived if it was not reasonably possible for you to cancel your appointment.

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

GRIEVANCES CONCERNING DENTAL SERVICES

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

If appropriate, an arrangement can be made for you to be examined by another dentist in your

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

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

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

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

- Visit your network dentist's office, and request a Grievance form in person. The dental office staff my assist you in filling out the form, but we strongly encourage you to contact a Delta Dental Customer Service Representative to ensure that the form is accurately completed and submitted to Delta Dental.

If you file a Grievance in writing, include the group name (San Mateo Healthy Kids) and number (SM60), the Member's name, Member identification number, and a telephone number on all correspondence. You should also include a copy of the treatment form (available from your dentist) and any other relevant information. Delta Dental's address and telephone number are as follows:

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

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

If your Grievance involves a serious and imminent threat to your health, please call Delta Dental's Customer Service Department, and state you want to file an urgent Grievance.

Your urgent Grievance will be assigned highest priority and will be resolved within three (3) business days from receipt of the Grievance.

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

APPEALS

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

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

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

If you have a Grievance involving dental services, you should first contact Delta Dental toll free at **1-866-527-9564** and use Delta Dental's Grievance process. However, if within 30 days after filing your Grievance you need help, a Grievance has not been satisfactorily resolved by Delta Dental, or you are not satisfied with the result of Delta Dental's Grievance process, you have the Option to contact the Department of Managed Health Care as described in Section 14 of this Combined Member Handbook and Evidence of Coverage, or you may use the Grievance process administered by HPSM (see page 86).

DENTAL PLAN BENEFITS AND COVERAGE MATRIX

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERED BENEFITS AND IS A SUMMARY ONLY. THE BENEFIT DESCRIPTION SECTION SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERED BENEFITS AND LIMITATIONS.

BENEFITS*	SERVICES	COST TO MEMBER (COPAYMENT)
Diagnostic and Preventive Care	Initial and periodic oral examinations, Consultations, including specialist consultations, Topical fluoride treatment, Preventive dental education and oral hygiene instruction, Roentgenology (x-rays), Prophylaxis services (cleanings), Dental sealant treatments.	No charge
Restorative Dentistry (Fillings)	Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries, Micro filled resin restorations which are noncosmetic, Replacement of a restoration, Use of pins and pin build-up in conjunction with a restoration, Sedative base and sedative fillings.	No charge
Oral Surgery	Extractions, including surgical extractions, Removal of impacted teeth, Biopsy of oral tissues, Alveolectomies, Excision of cysts and neoplasms, Treatment of palatal torus, Treatment of mandibular torus, Frenectomy, Incision and drainage of abscesses, Post-operative services, including exams, suture removal and treatment of complications, Root recovery (separate procedure).	No charge, except • $5.00 Copayment for the removal of impacted teeth for a bony impaction • $5.00 Copayment per root recovery

BENEFITS*	SERVICES	COST TO MEMBER (COPAYMENT)
Endodontic	Direct pulp capping, Pulpotomy and vital pulpotomy, pexification filling with calcium hydroxide, Root amputation, Root canal therapy, including culture canal, Retreatment of previous root canal therapy, Apicoectomy, Vitality tests.	No charge, except • $5.00 Copayment per canal for root canal therapy • $5.00 Copayment per root for an apicoectomy
Periodontics	Emergency treatment, including treatment for periodontal abscess and acute periodontitis, Periodontal scaling and root planing, and subgingival curettage, Gingivectomy, Osseous or muco-gingival surgery.	No charge, except • $5.00 copayment per quadrant for osseous or muco-gingival surgery
Crown and Fixed Bridge	Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel, Related dowel pins and pin build-up, Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, Recementation of crowns, bridges, inlays and onlays, Cast post and core, including cast retention under crowns, Repair or replacement of crowns, abutments or pontics.	No copayment, except • $5.00 Copayment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns. • $5.00 Copayment per pontic. • The Copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.

BENEFITS*	SERVICES	COST TO MEMBER (COPAYMENT)
Removable Prosthetics	Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, Office or laboratory relines or rebases, Denture repair, Denture adjustment, Tissue conditioning, Denture duplication, Space Maintainers Stayplates.	No copayment, except: • $5.00 Copayment for a complete maxillary or mandibular denture • $5.00 Copayment for partial acrylic upper or lower denture with clasps • $5.00 Copayment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles • $5.00 Copayment for removable unilateral partial denture • $5.00 Copayment for reline of upper, lower or partial denture when performed by a laboratory • $5.00 Copayment for denture duplication
Other Benefits	Local anesthetics, Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of licensure, Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of licensure, Emergency treatment, palliative treatment, Coordination of benefits with Member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.	No Charge

BENEFITS*	SERVICES	COST TO MEMBER (COPAYMENT)
Orthodontia Services	**Not a Healthy Kids covered benefit** Services are provided to Members under the age of 19 through the California Children's Services Program (CCS) when condition meets the CCS program criteria.	Not applicable
Deductibles	No deductibles will be charged for covered benefits.	
Lifetime Maximums	No lifetime maximum limits on benefits apply under this plan.	

BENEFITS

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

DIAGNOSTIC AND PREVENTIVE BENEFITS

Cost to Member: No Copayment

Description: Benefit includes:

- Initial and periodic oral examinations
- Consultations, including specialist consultations
- Topical fluoride treatment
- Preventive dental education and oral hygiene instruction
- Roentgenology (x-rays)
- Prophylaxis services (cleanings)
- Dental sealant treatments

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

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

RESTORATIVE DENTISTRY

Cost to Member: No Copayment

Description: Restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries
- Micro filled resin restorations which are noncosmetic.

- Replacement of a restoration
- Use of pins and pin build-up in conjunction with a restoration
- Sedative base and sedative fillings

Limitations: Restorations are limited to the following:

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

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

Oral Surgery

Cost to Member: No Copayment, except:

- $5.00 Copayment for the removal of impacted teeth for a bony impaction (no Copayment for the removal of a soft tissue impaction)
- $5.00 Copayment per root recovery

Description: Oral surgery includes:

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

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

ENDODONTIC

Cost to Member: No Copayment, except

- $5.00 Copayment per root canal therapy
- $5.00 Copayment for an apicoectomy when performed as a separate procedure

Description: Endodonitcs benefits include:

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

Limitations: Root canal therapy, including culture canal, is limited as follows:

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

PERIODONTICS

Cost to Member: No Copayment, except

- $5.00 Copayment per quadrant for osseous or muco-gingival surgery

Description: Periodontics benefits include:

- Emergency treatment, including treatment for periodontal abscess and acute periodontitis
- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy
- Osseous or muco-gingival surgery

Limitations: Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any 12 consecutive months.

CROWN AND FIXED BRIDGE

Cost to Member: No Copayment, except

- $5.00 Copayment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns.
- $5.00 Copayment per pontic.
- The Copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.

Description: Crown and fixed bridge benefits include:

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

Limitations: The crown benefit is limited as follows:

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

The fixed bridge benefit is limited as follows:

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

optional dental treatment. If performed on a Member under the age of 16, the Applicant must pay the difference in cost between the fixed bridge and a space maintainer.
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair. The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.

Removable Prosthetics

Cost to Member: No Copayment, except:

- $5.00 Copayment for a complete maxillary denture
- $5.00 Copayment for a complete mandibular denture
- $5.00 Copayment for partial acrylic upper or lower denture with clasps
- $5.00 Copayment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles
- $5.00 Copayment for removable unilateral partial denture
- $5.00 Copayment for reline of upper, lower or partial denture when performed by a laboratory
- $5.00 Copayment for denture duplication

Description: The removable prosthetics benefit includes:

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

Limitations: The removable prosthetics benefit is limited as follows:

- Partial dentures will not be replaced within 36 consecutive months, unless:

- ❖ It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
- ❖ The denture is unsatisfactory and cannot be made satisfactory.

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

OTHER BENEFITS

Cost to Member: No Copayment

Description: Other dental benefits include:

- ◆ Local anesthetics
- ◆ Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure
- ◆ Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of his/her license
- ◆ Emergency and palliative treatment
- ◆ Coordination of benefits with Member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services

ORTHODONTIC BENEFITS

Orthodontic treatment is not a benefit of this dental plan. However, orthodontic treatment may be provided by the California Children's Services (CCS) program if the Member meets the eligibility requirements for medically necessary orthodontia coverage under the CCS program. For more information about the CCS program, see page 58.

Excluded Benefits

The following dental benefits are excluded under the Plan:

1. Services which, in the opinion of the attending dentist, are not necessary to the Member's dental health.

2. Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.

3. Cosmetic dental care.

4. General anesthesia or intravenous/conscious sedation.

5. Experimental procedures.

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

7. Services that are provided without cost to the Member by State government or an agency thereof, or any municipality, county or other subdivisions.

8. Hospital charges of any kind.

9. Major surgery for fractures and dislocations.

10. Loss or theft of dentures or bridgework.

11. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.

12. Any service that is not specifically listed as a covered benefit.

13. Malignancies.

14. Dispensing of drugs not normally supplied in a dental office.

15. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Member.

16. The cost of precious metals used in any form of dental benefits.

17. The removal of implants.

18. Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by his or her panel Provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her panel Provider is a pedodontist/pediatric dentist. Note: There is a $5.00 Copayment for children under six years of age who are unable to be treated by their panel Provider and who have been referred to a pedodontist/pediatric dentist.

19. Services which are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, or dental plan. The participating dental plan shall provide the services at the time of need, and the Member shall cooperate to assure that the participating dental plan is reimbursed for such benefits.

BENEFITS CHANGES, DISENROLLMENT, TERMINATION, AND CANCELLATION

CHANGES IN BENEFITS AND CHARGES

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

DISENROLLMENT

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

- The Member does not meet eligibility requirements during the annual eligibility review.
- The Member turns 19 years of age. Disenrollment will be on the last day of the month the Member turns 19.
- The required quarterly family contribution is not paid for the Member for two (2) consecutive calendar months. Disenrollment for this reason will be effective the last day of the second month for which the family contribution was not paid. The Member or responsible individual may be financially responsible for any service provided after the effective date that coverage was terminated.

  The responsible individual will receive an invoice for the Member's family contribution. If payment is not received by HPSM, a final notice is sent notifying the responsible individual that the Member's health coverage will end if payment is not received. The notice states the effective date that coverage will end and is sent at least fifteen (15) days prior to that date.
- The Member or his/her legal representative requests so in writing. Disenrollment for this reason will be effective at the end of the month for which the request was made.
- The applicant or Member has intentionally made false statements in order to establish Program eligibility for any person or has obtained or attempted to obtain services or benefits by means of false, materially misleading, or fraudulent information, acts or omissions. The Member will be provided at least fifteen (15) days notice prior to termination of coverage.
- The Member, or applicant on behalf of the Member, fails to provide the necessary information to be requalified. Disenrollment for this reason shall be effective after one year of coverage.
- Death of a Member. Disenrollment for this reason shall be effective the day following the date of death.

- HPSM terminates the program. Disenrollment for this reason shall be effective no sooner than ninety (90) days after the day of mailing the notice to Members of termination of the Program.

- The Member or applicant has allowed a Non-Member to use a Member Identification Card to obtain services and benefits or otherwise permits another person to fraudulently or deceptively use HPSM services or facilities. The Member will be provided at least fifteen (15) days notice prior to termination of coverage.

- The Member moves out of San Mateo County. Residence in San Mateo County is a criteria for Healthy Kids eligibility. It is a Member's responsibility to report a change of address. Disenrollment for this reason will be effective at the end of the month in which the address change will be effective. In cases where the Member does not report a change of address directly to HPSM, the Member will be provided at least fifteen (15) days notice prior to termination of coverage. Returned mail will be evidence of failure to notify HPSM of a change of address (as indicated in Rights and Declarations you signed upon enrollment). You may be able to get low cost health insurance through a similar program in your new county of residence.

- Member is covered by other health insurance. To qualify for Healthy Kids, a Member must have no other health insurance. It is a Member's responsibility to report changes in health insurance status. Disenrollment for this reason will be effective at the end of the month in which the other health insurance becomes effective. In cases where the Member does not report a change in insurance status directly to HPSM, the Member will be provided at least fifteen (15) days notice prior to termination of coverage.

Return of Family Contribution

In the event of disenrollment for the reasons identified in subsections (4), (5), (7) and (9), above, HPSM will return to the Applicant the prorated portion of the Family Contribution paid to HPSM which corresponds to any unexpired period for which payment had been received by HPSM.

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

A Member who is disenrolled for failure to pay family contribution cannot participate in the Program unless family contribution owed is paid in full unless:

- the Applicant, Member, or other Family member lost employment; or
- the Applicant or other Family member has suffered a catastrophic illness that resulted in the Applicant being unable to work for more than two (2) weeks.

Individual's Right of Cancellation

Healthy Kids Applicants can cancel at any time with thirty-one (31) days' written notice.

REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE

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

GRIEVANCE AND APPEALS PROCESS

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Plan Providers to the courtesy extended you by our telephone representatives. If you have questions about the services you receive from a Plan Provider, we recommend that you first discuss the matter with your Provider. If you continue to have a concern regarding any service you received, call HPSM's Member Services at **1-800-750-4776** or **650-616-2133**. Members with hearing or speech impairments can use the California Relay Servie (CRS) at TTY **1-800-735-2929 or dial 711**.

GRIEVANCE

You may file a Grievance with HPSM at any time. You can obtain a copy of HPSM's Grievance and Appeals Procedures by contacting our Member Services Department. To begin the Grievance process, you can call, write, or fax the plan at:

Health Plan of San Mateo
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080
(800) 750-4776 or (650) 616-0050
Fax (650) 829-2002
www.hpsm.org

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

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

1. You have the right to notify the Department of Managed Health Care about your Grievance involving an imminent and serious threat to health, and
2. We will respond to you and the Department of Managed Health Care with a written statement on the pending status or disposition of the Grievance no later than 72 hours from receipt of your request to expedite review of your Grievance.

INDEPENDENT MEDICAL REVIEWS

If medical care that is requested for you is denied, delayed or modified by HPSM or a Plan

Provider, you may be eligible for an Independent Medical Review (IMR). If your case is eligible and you submit a request for an IMR to the Department of Managed Health Care (DMHC), information about your case will be submitted to a medical specialist who will review the information provided and make an independent determination on your case. You will receive a copy of the determination. If the IMR specialist so determines, HPSM will provide coverage for the health care services.

An IMR is available in the following situations:

1. (a) Your Provider has recommended a health care service as medically necessary, or (b) you have received Urgent Care or Emergency Services that a Provider determined was medically necessary, or (c) you have been seen by an in-plan Provider for the diagnosis or treatment of the medical condition for which you seek independent review; and

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

3. You have filed a Grievance with HPSM and the disputed decision was upheld or the grievance remains unresolved after 30 calendar days.

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

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

The IMR process is in addition to any other procedures or remedies that may be available to you. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the Plan regarding the care that was requested. You pay no application or processing fees for an IMR. You have the right to provide information in support of your request for IMR. For more information regarding the IMR process or to request an application form, please call HPSM's Member Services Department at **1-800-750-4776** or **650-616-2133**. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY **1-800-735-2929 or dial 711.**

Independent Medical Review for Denials of Experimental/ Investigational Therapies

You may also be entitled to an Independent Medical Review through the Department of

Managed Health Care, when we deny coverage for treatment we have determined to be experimental or investigational.

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

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a Grievance against HPSM, you should first telephone HPSM at **1-800-750-4776** or **650-616-2133**. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY **1-800-735-2929 or dial 711** and use HPSM's Grievance process before contacting the department. Using this Grievance procedure does not prohibit any legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by HPSM, or a Grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial view of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency and urgent medical services. The Department of Managed Health Care has a toll-free telephone number, **1 (888) HMO-2219**, to receive complaints regarding health plans. The hearing and speech impaired may use the department's TDD line **(1-877-688-9891)** number, to contact the department. The Department's Web site (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.

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

Arbitration

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

General Information

Other Health Insurance

Healthy Kids is a program for children who do not have health insurance. If you do have other insurance, it is to your advantage to let your network Provider know. Most carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both programs.

Be sure to advise your Provider of all programs under which you have coverage so that you will receive all benefits to which you are entitled. For further information, contact HPSM's Member Services Department.

Third Party Recovery Process and Member Responsibilities

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

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

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

Non-Duplication of Benefits with Workers' Compensation

If, pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of medical services provided by HPSM, we will provide the benefits of this Agreement at the time of need. The Member will agree to provide HPSM with a lien on such Workers' Compensation medical benefits to the extent of the reasonable value of the services provided by HPSM. The lien may be filed with the responsible third party, his or her agent, or the court. For purposes of this subsection, reasonable value will be determined to be the usual, customary, or reasonable charge for services in the geographic area where the services are rendered.

By accepting coverage under this Agreement, Members agree to cooperate in protecting the

interest of HPSM under this provision and to execute and to deliver to HPSM or its nominee any and all assignments or other documents that may be necessary or proper to fully and completely effectuate and protect the rights of HPSM or its nominee.

Coordination of Benefits

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

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

Limitations of Other Coverage

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

Provider Payment

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

Public Participation

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 HPSM can best serve Members. It also reviews policy issues that the Commission will decide so that the Members can participate before final decisions are made. A Member of the Consumer Advisory Committee represents HPSM on its Quality Assessment and Improvement Committee.

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

Notifying You of Changes in the Plan

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

Privacy Practices

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

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

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

Authorization for Release of Information

The Health Plan of San Mateo will not release individually identifiable medical or personal information without obtaining authorization from the Member or the Member's designee, except as allowed in statute. HPSM may release information that is not individually identifiable.

In order to release medical information for purposes not related to treatment, payment, or health care operations, or as required by law (including any release of individually specific genetic testing information), HPSM will seek authorization from the Member or the Member's designee.

Organ and Tissue Donation

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


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

County of San Mateo
Contractor's Declaration Form

I. CONTRACTOR INFORMATION

Contractor Name:	San Mateo Community Health Authority	Phone:	650-616-2145
Contact Person:	Maya Altman	Fax:	650-616-8038
Address:	701 Gateway Blvd. Suite 400 South San Francisco, CA 94080		

II. EQUAL BENEFITS (check one or more boxes)

Contractors with contracts in excess of $5,000 must treat spouses and domestic partners equally as to employee benefits.

- ☐ Contractor complies with the County's Equal Benefits Ordinance by:
  - ☐ offering equal benefits to employees with spouses and employees with domestic partners.
  - ☐ offering a cash equivalent payment to eligible employees in lieu of equal benefits.
- ☐ Contractor does not comply with the County's Equal Benefits Ordinance.
- ☐ Contractor is exempt from this requirement because:
  - ☐ Contractor has no employees, does not provide benefits to employees' spouses, or the contract is for $5,000 or less.
  - ☐ Contractor is a party to a collective bargaining agreement that began on _____ (date) and expires on _____ (date), and intends to offer equal benefits when said agreement expires.

III. NON-DISCRIMINATION (check appropriate box)

- ☐ Finding(s) of discrimination have been issued against Contractor within the past year by the Equal Employment Opportunity Commission, Fair Employment and Housing Commission, or other investigative entity. Please see attached sheet of paper explaining the outcome(s) or remedy for the discrimination.
- ☐ No finding of discrimination has been issued in the past year against the Contractor by the Equal Employment Opportunity Commission, Fair Employment and Housing Commission, or any other entity.

IV. EMPLOYEE JURY SERVICE (check one or more boxes)

Contractors with original or amended contracts in excess of $100,000 must have and adhere to a written policy that provides its employees living in San Mateo County up to five days regular pay for actual jury service in the County.

- ☐ Contractor complies with the County's Employee Jury Service Ordinance.
- ☐ Contractor does not comply with the County's Employee Jury Service Ordinance.
- ☐ Contractor is exempt from this requirement because:
  - ☐ the contract is for $100,000 or less.
  - ☐ Contractor is a party to a collective bargaining agreement that began on _____ (date) and expires on _____ (date), and intends to comply when the collective bargaining agreement expires.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that I am authorized to bind this entity contractually.

_____ _____
Signature Name

_____ _____
Date Title