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healthy
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2010–2011

HealthWorx Program

Member Handbook and Evidence of Coverage

Our Member Services Unit is Available to Help You

Call us at **1-800-750-4776** (toll free) or **650-616-2133**
Hearing Impaired: TTY **1-800-735-2929** or dial **7-1-1**

Monday through Thursday
Phone: 8:00 am to 6:00 pm
Office hours: 8:00 am to 5:00 pm

Friday
Phone: 9:30 am to 6:00 pm
Office hours: 9:30 am to 5:00 pm

Large Print Request

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

Privacy Statement

Health Plan of San Mateo ensures the privacy of your medical record.
For questions and more information, please call Member Services

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 **1-800-750-4776** or **650-616-2133**. Members with hearing and or speech impairments can use the California Relay Services (CRS) at **1-800-735-2929** or dial **7-1-1**.

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.
- **Workers’ 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 5 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 5 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 5 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 5 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 63 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 5 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**

Members with hearing and or speech impairments can use the California Relay Services (CRS) at 1-800-735-2929 or dial 7-1-1.

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
1-866-627-7748 or **1-866-788-4989** TTY
(OCR-PRIV)

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 **1-800-750-4776** or **650-616-2133**. Members with hearing and or speech impairments can use the California Relay Services (CRS) at **1-800-735-2929** or dial **7-1-1**.

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THE HEALTH PLAN OF SAN MATEO HEALTHWORX PROGRAM

MEMBER HANDBOOK AND EVIDENCE OF COVERAGE

INTRODUCTION

YOU HAVE THE RIGHT TO REVIEW THIS EVIDENCE OF COVERAGE PRIOR TO ENROLLMENT.

WELCOME

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

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

The Health Plan of San Mateo is located at 701 Gateway Blvd., Suite 400, South San Francisco, CA 94080. If you need assistance or would like more information regarding the HealthWorx Program, call a Health Plan of San Mateo Member Services Representative. Members' toll free number for questions, problems or help in choosing a doctor is **1-800-750-4776** or **650-616-2133**. Members with hearing and or speech impairments can use the California Relay Services (CRS) at **1-800-735-2929** or dial **7-1-1**. The Member Services Call Center hours are Monday through Thursday 8:00 a.m.–6:00 p.m., Friday 9:30 a.m.–6:00 p.m. Our office hours are Monday through Friday 8:00 a.m.–5:00 p.m.

ABOUT THE HEALTH PLAN OF SAN MATEO

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

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

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

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

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

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

HealthWorx is an insurance plan that covers:

- In-Home Supportive Services (IHSS) Workers employed by the San Mateo County Public Authority (SMCPA)
- Extra Help Employees employed by San Mateo County.
- Part-Time Employees of the City of San Mateo

Specific program information may differ depending on the worker's employer. These differences are noted.

PREMIUMS, ELIGIBILITY, ENROLLMENT, TERMINATION, FOR IN-HOME SUPPORTIVE SERVICES (IHSS) WORKERS

Premium Contributions

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

Who is Eligible?

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

You are eligible to enroll as a Member if you are:

1. An In-Home Supportive Services Worker under the San Mateo County Public Authority (SMCPA) who works a specified number of hours as determined by SMCPA and the Service Employees International Union (SEIU), Local 521 and;
2. SMCPA has openings available to add Members to the HealthWorx Program.

Enrollment and Effective Date of Coverage

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

New Employees

Once SMCPA informs you that you are eligible to enroll as a Member, you may enroll yourself by submitting a Health Plan-approved enrollment application to SEIU, Local 521 within 3 days.

Enrollment is not retroactive.

The effective date of coverage for new employees is the first day of the second month following the date that an enrollment or change of enrollment application is signed. For example, if you sign an enrollment application in July your coverage will begin on September 1.

Special Enrollment Due to Loss of Other Coverage

An employee may enroll within 90 days of losing other coverage by submitting to SEIU, Local 521 an enrollment or change of enrollment application in a form agreed upon by SEIU and HPSM. The employee requesting enrollment must have previously waived coverage for self when originally eligible because of the other coverage, continuation of other coverage has expired, or the other employer has ceased making contributions toward the other coverage and the loss of coverage is not due to non-payment or cause. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the second month following the date that an enrollment or change of enrollment application is signed.

Enrollment

You may enroll yourself by submitting a Health Plan-approved enrollment application to SEIU. SEIU will let you know whether you are eligible and your effective date of coverage.

If you have questions about enrollment or would like another copy of these materials, please contact SEIU at:

Service Employees International Union, Local 521
981 Industrial Road, Ste A
San Carlos, CA 94070
English: **650-801-3501**
Spanish: **650-801-3502**
Chinese: **650-801-3503**

If you call SEIU, please identify yourself as a San Mateo County IHSS worker.

Termination of Coverage

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

PREMIUMS, ELIGIBILITY, ENROLLMENT, TERMINATION, FOR COUNTY OF SAN MATEO EXTRA HELP EMPLOYEES

Premium Contribution

Members are entitled to health care coverage only for the period for which the Health Plan of San Mateo has received the appropriate Premium from the County of San Mateo. You are responsible for a monthly premium contribution. The County of San Mateo will tell you the amount you must pay and will arrange for you to pay your contribution through a payroll deduction. If your payroll contribution is insufficient to cover your portion of the monthly premium, the County will send you an invoice. Questions about premium payment should be directed to the County's Employee Benefits Office at **650-363-1919**.

Who is Eligible?

The County of San Mateo is required to inform you of their eligibility requirements. To enroll in HealthWorx you must meet the County's eligibility requirements and live or work in our Service Area which is San Mateo County.

If you have any questions about eligibility, please call the County's Employee Benefits Division at **650-363-1919**.

Enrollment and Effective Date of Coverage

Every July, the County will determine who is eligible for HealthWorx for the coming benefit period (September 1 through August 31). There will be an open enrollment period during July and August. If you are determined eligible based on the number of hours worked during the fiscal year, then your coverage in HealthWorx will begin at 12:01 on September 1.

Termination of Coverage

A Member's coverage will be terminated if the County of San Mateo fails to pay the Member's Premium in accordance with the Contract with the HPSM or the Member no longer lives or works in San Mateo County. The County of San Mateo will provide you written notification prior to the effective date of termination. The notice will be in writing and sent by regular U.S. Mail to the Member's address on file with the County of San Mateo. The notice will clearly indicate the last day of coverage

PREMIUMS, ELIGIBILITY, ENROLLMENT, TERMINATION, FOR CITY OF SAN MATEO PART TIME EMPLOYEES

Premium Contribution

Members are entitled to health care coverage only for the period for which the Health Plan of San Mateo has received the appropriate Premium from the City of San Mateo. You are responsible for a monthly premium contribution. The City of San Mateo will tell you the amount you must pay and will arrange for you to pay your contribution through a payroll deduction. If your payroll contribution is insufficient to cover your portion of the monthly premium, the City will take the amount out of your subsequent paycheck. Questions about premium payment should be directed to the City of San Mateo's Finance Department-Payroll division.

Who is Eligible?

The City of San Mateo is required to inform you of their eligibility requirements. To enroll you must meet the City's eligibility requirements and live or work in our Service Area which is San Mateo County. These include working for the City of San Mateo either as a SEIU Non-Merit Part-Time Worker or SEIU Library Per Diem Worker. You must meet specified number of hours worked. To remain eligible, you must pay your portion of the monthly Premium.

If you have any questions about eligibility, please call the Service Employees International Union at **650-779-9910** or **1-877-734-8521**.

Enrollment

The SEIU will let you know whether you are eligible and your effective date of coverage. SEIU will also notify you when the open enrollment period begins and ends. If eligible, you will only be able to enroll during the open enrollment period. Those Per Diem Workers who become eligible during the benefit year will, however, be able to enroll by submitting an HPSM-approved enrollment application to SEIU.

If you have questions about enrollment, please contact the SEIU at:

Service Employees International Union, Local 521
981 Industrial Road, Ste A
San Carlos, CA 94070
English: **650-801-3501**
Spanish: **650-801-3502**
Chinese: **650-801-3503**

Termination of Coverage

A Member's coverage will be terminated if the City of San Mateo fails to pay for the Member's Premium in accordance with the Contract with HPSM. The City of San Mateo will provide you written notification prior to the effective date of termination. The notice will be in writing and sent by regular U.S. Mail to the Member's address on file with the City of San Mateo. The notice will clearly indicate the last day of coverage.

CONTINUATION OF GROUP COVERAGE UNDER FEDERAL OR STATE LAW—COBRA

Health Benefits Under (COBRA) - The Consolidated Omnibus Budget Reconciliation Act of 1986.

If you reside or work in San Mateo County and maintaining continued health coverage is important to you, you may be able to continue your coverage under HealthWorx. The coverage can continue at your expense for up to 36 months in accordance with federal and state COBRA laws after you would otherwise lose eligibility due to either termination or a reduction in hours (to less than 35 hours/month). If you qualify for COBRA, the San Mateo County Public Authority, County of San Mateo, or the City of San Mateo's third party administrator (TLC) will send you an enrollment form for continued coverage through COBRA with a letter notifying you of the opportunity to continue your HealthWorx

benefits. You must complete the enrollment form and return it to the San Mateo County Public Authority or County of San Mateo Employee Benefits Division or, for the City of San Mateo, TLC no later than 60 days from the date of the letter. Monthly premiums for COBRA are payable to the San Mateo County Public Authority, County of San Mateo or, for the City of San Mateo, TLC by the 23rd of the month prior to the month coverage will be effective. Your initial payment for continued coverage through COBRA will be due no later than forty-five days after you have signed, dated, and submitted your enrollment form. If you have any questions about COBRA, you should contact the San Mateo County Public Authority at **650-573-3900** Ext. 3649 or the County of San Mateo Employee Benefits Division at **650-363-1919**, or, for the City of San Mateo, TLC at **510-795-0103**.

Generally, COBRA coverage is available for up to 18 months. However, if you are disabled at any time during the first 60 days of COBRA coverage, you may be eligible for up to 29 months of COBRA coverage. Please be aware that any break in coverage for more than sixty-three days may cause a loss of coverage portability.

Extension of COBRA Benefits through Cal-COBRA

Under California law, if you have exhausted continuation coverage under COBRA and were entitled to less than 36 months, you may be eligible for up to an additional 18 months of continuation coverage (through "Cal-COBRA"). The San Mateo County Public Authority or County of San Mateo, or, TLC, for the City of San Mateo, will send you a letter of notice and an enrollment form regarding the opportunity for continuation coverage under Cal-COBRA if you are no longer eligible for federal COBRA. You should receive this notice at least 90 calendar days prior to the termination of your coverage under federal COBRA. When you have completed the enrollment form, return it to HPSM. If you have any questions about the enrollment form, or need assistance completing it, please contact the San Mateo County Public Authority, County of San Mateo or TLC for the City of San Mateo. Enrollment forms for Cal-COBRA are due at least 30 calendar days prior to the termination of your federal COBRA benefits. The premium for coverage under Cal-COBRA is, payable to HPSM by the 23rd of the month prior to the month coverage will be effective.

Individual Conversion Plan

If you are entitled to Medicare benefits you are no longer eligible for Cal-COBRA. You may be eligible for HPSM's Individual Conversion Plan after you have exhausted the COBRA and Cal-COBRA continuation coverage available to you. If you have questions about the Individual Conversion Plan option, contact an HPSM Member Services Representative at **1-800-750-4776** or **650-616-2133**.

MEMBER SERVICES

For help in other languages, call **1-800-750-4776**. Members may also reach the Member Services Department at **650-616-2133**.

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

- HPSM staff speak several languages, including Spanish and Tagalog. The Member Services staff is available from 8 a.m. to 6 p.m. Monday through Thursday and 9:30 a.m. to 6:00 p.m. on Friday at **1-800-750-4776** or **650-616-2133** to answer questions, solve problems or help you choose a doctor.
- You can see doctors who speak your language. The HealthWorx Provider List has information about languages spoken in each office, office locations and hours available for appointments, including evening and weekend hours. The Member Services staff can help you choose doctors if you need help or have questions.
- Free interpreter services are available by phone. You do not have to use family or friends as interpreters.
- Sign language interpreters are also available. You do not have to use family or friends as interpreters.
- You can request HealthWorx documents in other languages.

Physical Access

The Health Plan of San Mateo has made every effort to ensure that our offices and the offices and facilities of HPSM providers are accessible to the disabled. If you are not able to locate an accessible provider, please call our toll free Member Services number at **1-800-750-4776** or **650-616-2133** and a Member Services Representative will help you find an alternate provider.

Access for the Hearing Impaired

The hearing impaired may contact our Member Services Representatives through the California Relay Service. TTY users should call **1-800-735-2929** or dial **7-1-1**. Spanish speaking users should call **1-800-835-3000**. HPSM also offers free sign language interpretation. We can arrange for a sign language interpreter to go with you to your appointments if you let us know at least five (5) days in advance. You do not need to use friends or family members to interpret for you.

Access for the Vision Impaired

This Member Handbook and Evidence of Coverage (EOC) and other important HealthWorx materials will be made available in alternate formats for the vision impaired. Large print and enlarged computer disk formats are available. For alternate formats, or for direct help in reading the Member Handbook and EOC and other materials, please call a Member Services Representative at **1-800-750-4776** or **650-616-2133**.

Americans with Disabilities Act of 1990

The Americans with Disabilities Act of 1990 (ADA) prohibits HPSM and its contractors from discrimination on the basis of disability. This Act protects you from discrimination in HPSM's services because of a disability. If you feel you have been discriminated against because of a disability, please call HPSM and ask to speak to a Member Services Representative at **1-800-750-4776** or **650-616-2133**. Members with hearing and or speech impairments can use the California Relay Services (CRS) at **1-800-735-2929** or dial **7-1-1**.

HOW TO USE THIS MEMBER HANDBOOK AND EVIDENCE OF COVERAGE

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

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

If You Have Questions

The information in your HealthWorx Member Handbook and Evidence of Coverage and new member packet should answer most of your questions about your health care benefits. If you have other questions about the Health Plan of San Mateo or about your benefits or your rights with HPSM, always feel free to contact a Member Services Representative at **1-800-750-4776** or **650-616-2133**. Members with hearing and or speech impairments can use the California Relay Services (CRS) at **1-800-735-2929** or dial **7-1-1**.

SECTION 1 DEFINITIONS

Active Labor means 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 means 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.

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

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

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

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

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

Benefit Year for IHSS Workers means a twelve (12) month period starting from the effective date of the employer's HealthWorx coverage. Coverage begins on the 1st of the month.

Benefit Year for County Extra Help Employees means a twelve (12) month period starting September 1 of each year at 12:01 a.m.

Benefit Year for City of San Mateo Employees means a twelve (12) month period starting from the effective date of the employer's HealthWorx coverage. Coverage begins on the 1st of the month.

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

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

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

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

DMHC means the Department of Managed Health Care.

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

Emergency Medical Care means those services required to relieve a medical condition that causes severe pain, or serious illness or injury, including Active Labor, which a prudent lay person (a careful or cautious non-medical person) believes could reasonably expect without speedy medical care to result in:

- i) placing the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious danger,
- ii) causing serious impairment to the Member's bodily functions, or
- iii) causing serious dysfunction of any of the Member's bodily organs or parts.

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

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

Formulary means the list of medications approved by HPSM that may be prescribed without prior authorization.

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

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

HealthWorx Program means the health insurance program under Section 14087.51 of the California Welfare and Institution Code for eligible In-Home Supportive Services (IHSS) workers whose employer of record is the San Mateo County Public Authority; or Extra Help employees whose employer of record is the County of San Mateo; or Part Time Employees whose employer of record is the City of San Mateo.

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

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

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

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

Medical Emergency [See Emergency Medical Care].

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

Medically Necessary Services means those health services which are necessary to meet the basic health needs of an individual. Determination of medical necessity is done on a case by case basis and considers several factors, including but not limited to, the standards of the medical

community. The fact that a Physician has performed, prescribed or recommended a procedure or treatment does not mean that it is medically necessary. In addition, the service must (1) be consistent with the diagnosis of, and prescribed course of treatment for the patient's condition, or be generally accepted by the medical community as a preventive health service, (2) be required for reasons other than the convenience of the patient or his or her Physician, or not be required solely for custodial, comfort, or maintenance reasons, and could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered, (3) be performed in the most cost efficient type of setting appropriate for the condition, and (4) be rendered at a frequency which is accepted by the medical community as medically appropriate. Final determination of what is medically necessary will be made by the HPSM's Medical Director.

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant)

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

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

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

Premium means the monthly contribution made by the San Mateo County Public Authority or County of San Mateo to the Health Plan of San Mateo for a HealthWorx Member.

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.

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

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

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

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

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

City of San Mateo Contract means the Agreement signed by the Health Plan of San Mateo and the City of San Mateo which sets forth the benefits, exclusions, payments, administration and other conditions under which HPSM will provide HealthWorx services to Members of the Health Plan of San Mateo.

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

Serious Chronic Condition means 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.

Seriously Debilitating means diseases or conditions that may cause morbidity.

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

State means the State of California.

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

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

SECTION 2

MEMBER RIGHTS AND RESPONSIBILITIES

As an HPSM Member, you have the right to:

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

MEMBER RIGHTS AND RESPONSIBILITIES

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.
- Notify HPSM if you have other health insurance.

SECTION 3 USING THE HEALTH PLAN

FACILITIES AND PROVIDER LOCATIONS

Please read the following information so you will know from whom or what group of providers health care may be obtained.

CHOOSING A PRIMARY CARE PROVIDER

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

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

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

How to Choose or Change Your Primary Care Physician

- You may choose the doctor you already use if you see his/her name on the list.
OR
- You may choose a new doctor. You will find helpful information about each doctor and the clinics where they work in the Provider List.

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

- Does the doctor work at a clinic I like to use?
- Is the office close to my home or work?
- 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 and other providers do not provide one or more of the following services that may be covered under HealthWorx and that you might need:

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

You should obtain more information before you choose a doctor. Call your prospective doctor, medical group, independent practice association, or clinic or call a Member Services Representative at **1-800-750-4776** or **650-616-2133** to ensure that you can obtain the health care services that you need. Members with hearing and or speech impairments can use the California Relay Services (CRS) at **1-800-735-2929** or dial **7-1-1**.

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

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

Initial Health Exam

All new Members are encouraged to see their primary care provider for an initial health examination when they join the HealthWorx Program. The first meeting with your new doctor is important

It's a time to get to know each other and review your health status. Your doctor will help you understand your medical needs and advise you about staying healthy. Call your doctor's office for an appointment today. You may want to complete a Staying Healthy Assessment Tool to bring to your PCP. You can call a Member Services Representative at **1-800-750-4776** or **650-616-2133** or go to HPSM's website to get the form. The form asks questions about your lifestyle, behavior, environment and cultural and linguistic needs. Filling out the form and taking it to your first appointment will help your PCP to get to know you better. If you do not complete the form, your PCP may ask you to complete it when you come for your appointment.

Changing Your Primary Care Provider

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

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

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

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 ID Card, will be mailed to you, with the name of your new PCP. Your new ID Card will show the date your PCP change is effective. Please continue to see the PCP listed on your current ID Card for all of your health care needs, until the effective date of change. If you do

not receive a new ID Card within ten (10) days or have questions about the effective date of change, please call an HPSM 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.
- 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 imposed upon 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 HealthWorx 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 63.

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 or as soon as the provider informs us.

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.
- 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 63.

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 TTY number for the hearing impaired, **1-877-688-9891**; or online at www.hmohelp.ca.gov.

INDIAN HEALTH SERVICES

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

HEALTHWORX SERVICE AREA

The HealthWorx service area is San Mateo County. It is important that you see doctors who participate with the Health Plan of San Mateo.

SECTION 4 PROCEDURES FOR OBTAINING HEALTH CARE SERVICES

MEMBER IDENTIFICATION CARD

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



Front side of card



Back side of card

This side describes how you use the card

A picture of the Member Identification Card is shown above.

- ID #:** This is the number assigned to you by HPSM.
- Eff Date: (Effective)** This date shows when the information on this card became effective.
- Name:** This person is eligible to receive benefits under the HealthWorx Program.
- PCP:** This is your Primary Care Physician.
- DOB:** This is your date of birth.
- Copayment:** This is the amount that you will need to pay for certain benefits, usually at the time of an appointment.

Refer to Section 6 for a complete list of Copayments.

TIMELY ACCESS TO NON-EMERGENCY HEALTH CARE SERVICES

Sometimes it's difficult to know what kind of care you need. Your doctor or a nurse will be available to assist you by phone 24 hours a day, seven days a week. This is known as "triage." Here are some of the ways that triage can help you.

- They can answer your questions about a health concern, and instruct you on self-care at home if appropriate.
- They can advise you about whether you should get medical care, and how and where to get care (for example, if you are not sure whether your condition is an Emergency Medical Condition, they can help you decide whether you need Emergency Health Care Services or Urgent Care, and how and where to get that care.)
- They can tell you what to do if you need care and your provider's office is closed.

HPSM providers will make sure that you speak with a doctor or nurse over the phone within a time period that is appropriate for your medical condition. The waiting time to receive a return call from a doctor or nurse will not be longer than 30 minutes.

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

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

If you have any questions, please call HPSM Member Services at **1-800-750-4776**, Monday through Thursday, 8:00 a.m. to 6:00 p.m., and Friday 9:30 a.m. to 6:00 p.m.

TTY users may call **1-800-735-2929** (California Relay Service) or dial **7-1-1**.

SCHEDULING APPOINTMENTS

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

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

WOMEN'S SERVICES

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

PRIOR AUTHORIZATION FOR SERVICES

Your Primary Care Physician will coordinate your health care needs and, when necessary, will arrange specialty services for you. In some cases, HPSM must authorize the specialty services before you receive the services. Your Primary Care Physician 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 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.

REFERRALS TO SPECIALTY PHYSICIANS

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

If the request is for an out-of-network specialist, HPSM will ask your PCP to choose an in-network specialist, if possible. In the event that there is no participating provider available to perform the needed service, your primary care provider will refer you to a non-participating provider for the services, after obtaining authorization from HPSM. This will ensure that you receive the highest quality care in a timely manner. The authorization number on the Referral Authorization Form (RAF) lets the specialist know that your PCP has approved your visit and that the specialist will receive payment from HPSM for their services. Additional visits to the specialist, if needed, will be arranged by the specialist. Your PCP will provide directions on how to obtain the specialty care. This may either be in writing or verbal instructions.

STANDING REFERRALS

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 and or speech impairments can use the California Relay Services (CRS) at **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 63.

This is a summary of HPSM's specialist referral policy. To obtain a copy of our policy, please call us at **1-800-750-4776** or **650-616-2133**.

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

OBTAINING A SECOND OPINION

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

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

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

If you ask for a second opinion about care, you will receive a second opinion from an appropriately qualified health care professional of your choice 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 63.

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 **650-616-0050**.

If the request is for an out-of-network Specialist, HPSM will ask the PCP to choose an in-network Specialist, if possible. In the event that there is no participating provider available to perform the needed service, your Primary Care Physician will refer you to a non-participating provider for the services, after obtaining authorization from HPSM.

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 before you receive the service or medication. 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/or 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 about whether or not the service or medication requested for you is medically necessary. Most TARs are approved, but in some cases they may be denied or deferred. When a TAR is denied for a medical reason, that means it has not been approved for the services/treatments that your doctor requested. You and your doctor will then get a letter explaining why the TAR was denied, and why HPSM's medical staff has determined that the service is not medically necessary. The letter will also explain your right to appeal the decision and how to appeal the decision. If your TAR is denied for an administrative (non-medical) reason, we will explain (in a notice to you and your doctor) the reason for the denial. Reasons for administrative TAR denials can include such things as: you do not have HPSM eligibility for the time under review or the service is covered by the state and not by HPSM.

An authorization is deferred if HPSM staff needs more information from your doctor in order to decide if the services/treatment your doctor is requesting can be approved. If that happens, you will receive a notice of action letter to let you know that we have requested more information from your provider in order to approve the authorization

We respond to non-urgent TARs sent to HPSM within five (5) working days. If a TAR is urgent, we will respond to it **as medically necessary but no later than 24 hours**. Requested services are reviewed for medical necessity. Criteria and guidelines used to review TARs are developed with input from practicing health care providers 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 specific TAR decision. Please remember that these relate to the treatment or service requested, the benefits covered under HealthWorx, and individual need. HPSM's overall policies and procedures for making TAR decisions are also 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 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), 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 pages 27 and 52 for more information.

Family Planning services are provided to Members of child bearing age to help you decide when you want to have children. They will also help you if you want to protect yourself from having children until you are ready. These services include all methods of birth control approved by the Federal Food and Drug Administration.

HPSM's Member Services staff can provide referrals to family planning clinics if you want some help, or you can contact the California Office of Family Planning's Information & Referral Service toll-free number at **1-800-942-1054**.

4. Women's Services:

Female Members have unlimited, direct access to OB/GYN services. Members may choose to have these services provided by 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 each per benefit year.

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.

Dental and Vision Services For IHSS Workers Only

Dental and Vision Services are covered through the Services Employees International Union (SEIU), Local 521 for those IHSS workers who meet eligibility requirements. For more information about Dental and Vision Benefits, Members need to call the SEIU, at **650-779-9910**. If you call SEIU, please identify yourself as a San Mateo County IHSS worker.

Dental and vision services are not a covered benefit for San Mateo County and City of San Mateo employees.

Urgent Care or Care After Regular Hours or on Weekends

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

your Primary Care Physician about what he or she wants you to do when the office is closed and you feel Urgent Care may be needed.

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

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

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

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

Emergency Health Care Services

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

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

Examples include:

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

If you have a medical emergency, call **9-1-1** or go to the nearest hospital emergency room.

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

Follow-up Care

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

GETTING PHARMACY BENEFITS

Prescriptions

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

Refills

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

Over-The-Counter/Non-Prescription Drugs

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

The Health Plan of San Mateo Drug Formulary

HPSM has a list of medications that are covered by your pharmacy benefit. This list is called a Drug Formulary. HPSM uses the State of California Medi-Cal Formulary as a guide. 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 medications by either the generic name or brand name (if one exists). Please note that the presence of a medication on HPSM's Formulary does not guarantee that you will be prescribed the medication by your PCP or a Specialist.

Generic Equivalent Drugs

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

Brand Name Medications Requested by Your Doctor

If your doctor believes a brand name medication must be provided, he or she may write "Dispense as Written" (DAW) or "Do Not Substitute" on the prescription. The pharmacist will then contact HPSM to see if a 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 which would normally be covered. The pharmacist must contact the doctor to determine if there is medical necessity for using the brand name drug. After receiving more information from the doctor, the pharmacist will submit 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 and speech impairments can use the California Relay Service (CRS) at TTY **1-800-735-2929** or dial **7-1-1**.

Non-Formulary Drugs

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

The average time to process a request for a Non-Formulary medication MRF is one (1) working day. More time may be needed to process the request if the MRF is incomplete or more information is needed. 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.

Submitting Prior Authorization Requests

As described above, there are several cases when a Medication Request Form (MRF) is required to get the drug you want. Some examples are:

- Getting a brand name drug
- Getting a drug that is not on the HPSM Formulary
- Getting a drug for off-label use

HPSM staff processes all MRFs. Your doctor or your pharmacist can send a MRF to HPSM via fax to Pharmacy Services at **650-829-2045** during HPSM's office hours, 8 a.m. to 5 p.m.

A decision about a MRF usually takes two (2) working days, but no more than five (5) working days. More time may be needed if the MRF is incomplete or more information is needed. If you have any questions about a MRF, please talk to your doctor.

Evening, Weekend or Holiday Prior Authorization Requests (PAs)

HPSM is available to review MRFs Mondays through Fridays during regular business hours from 8:00 am to 5:00 pm. In urgent situations that arise on weekends or holidays, while waiting for a review decision, members may be given up to a three-day supply of medication to allow time for the pharmacy to receive HPSM's decision on the next business day. The pharmacist can call the pharmacy call center at HPSM's pharmacy benefits manager (PBM), InformedRX at **1-866-441-2422**, for an emergency override. A 1-time fill may be authorized.

Changes in Formulary Medications

If you are taking a medication and HPSM drops the medication from its Formulary, and your doctor chooses to continue to prescribe the medication, 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 it was deferred, modified, or denied and provide information on how you may file an appeal with HPSM about the decision.

SECTION 5

MEMBER FINANCIAL RESPONSIBILITY

COPAYMENTS

Some visits and services require Members to pay Copayments, as listed in the Summary of Benefits in Section 6. Except for the Copayment for certain services, Members are not financially responsible for services that are benefits provided in accordance with HPSM rules as described in this Evidence of Coverage. No deductibles will be charged to Members for health benefits.

HPSM will also be working with its providers to let you know what to do if you cannot pay all your Copayments. If you have to pay more than \$25 in Copayments in one month, many providers will allow you to make the payment within 30 or 60 days rather than at the time of the appointment. If paying the Copayments becomes a problem for you, please talk with your doctor or other provider. If you need assistance, please call our HPSM's Member Services staff at **1-800-750-4776** or **650-616-2133** and we will help you make the arrangements you need.

Other Member Payment Responsibilities

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

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

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

In the event HPSM does not pay a Participating Provider for Covered Services, the Member will not be liable to have to pay the Provider for any sums owed by HPSM. However, if HPSM does not pay a Non-Participating Provider for covered services, the Member may be liable to have to pay the Non-Participating Provider for the cost of such services. A Member 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 adhere to 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 Services and Care section on page 49 of this Evidence of Coverage. Also refer to the Second Opinion Policy section, on page 33 for specifics regarding Second Opinion Referral.

Claims Reimbursement

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 and show your HPSM ID card. If you are asked to pay for services, please ask the doctor to call HPSM so we can explain to them how to bill us. However, if you are billed for a

service by a provider who is in HPSM's network, you may submit the bill to HPSM. You must submit a copy of the bill with your name, ID number (on your Member ID card), your phone number, and date and reason for the bill. If you paid the bill you will need to submit proof of payment acceptable to HPSM (such as a receipt indicating payment and description of services received). 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 for reimbursement should be mailed to HPSM within 90 days (3 months) of the date you received the services, or as soon as reasonably possible, but in no event later than 12 months after receiving the care.

SECTION 6 COVERED SERVICES, BENEFITS AND CO-PAYMENTS

INTRODUCTION

This Section describes the Covered Services and Benefits provided to HealthWorx Members. The services described in this section are Covered Services if they are medically necessary. The decision whether services are medically necessary will be made by your Primary Care Physician or the Health Plan of San Mateo. This decision is based on generally accepted medical standards, State laws and regulations, and HPSM policies. Emergency medical services do not require prior authorization. However, a decision regarding the need for Emergency Services may occur after services have been provided. If you disagree with a decision on medical necessity or on whether a particular situation was a Medical Emergency, you can request a review by the Health Plan of San Mateo through the Grievance procedure described in Section 8. At the beginning of this Section is a Summary of Benefits, Co-payments and Conditions, followed by a more detailed description of Benefits, Co-payments, Conditions and Exclusions.

HPSM provides the Covered Services and Benefits described in this Evidence of Coverage. Most Covered Services are available to you when medically necessary and received from, referred by, or authorized by HPSM or your Primary Care Physician. Some are available without a Referral and some require a Co-payment. There are no co-payments for preventive services. There are no annual or lifetime benefit maximums in any of the coverage under the HealthWorx program.

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

HEALTHWORX EVIDENCE OF COVERAGE SUMMARY OF BENEFITS, CO-PAYMENTS AND CONDITIONS

| BENEFITS | CO-PAYMENTS | CONDITIONS |
|--|---|---|
| PHYSICIAN SERVICES | | |
| Well baby care | No co-payment | 48 hours or 96 hours (after a cesarean section) |
| For adults age appropriate immunizations and periodic health exams | No co-payment | As specified by HPSM and in keeping with current preventive health standards of the U.S. Public Health Services and the American Academy of Pediatrics. |
| Hearing and vision testing | No co-payment | |
| Primary Care Physician and specialty office visits, including allergy testing and treatment, and second opinions | \$5.00 per visit, except where no co-payment is indicated | Most specialty visits require a referral from the PCP. (See page 32) |
| Prenatal Care | No co-payment | |
| Outpatient surgery, anesthesia, radiation therapy, chemotherapy, dialysis treatments | No co-payment | |
| Inpatient visits in a hospital, skilled nursing facility, hospice or mental health facility | No co-payment | |
| Urgent Care services | \$5.00 per visit | |
| Home visits | \$5.00 per visit | |
| HOSPITAL | | |
| Inpatient services, including doctors' services, nursing services, surgical services, anesthesia, lab, x-ray, drugs, medical supplies, blood and blood products, rehabilitation therapies and services (physical therapy, occupational therapy, speech therapy, respiratory therapy) | No co-payment | Includes inpatient hospital services in connection with dental procedures when hospitalization is required because of an underlying medical condition, clinical status, or because of the severity of the dental procedure. |
| Outpatient services, except emergency room visit | No co-payment | |

| BENEFITS | CO-PAYMENTS | CONDITIONS |
|---|--|---|
| EMERGENCY SERVICES | | |
| Emergency room visits | \$25.00 per visit | Co-payment is waived if Member is admitted to the hospital from the Emergency Room |
| Follow-up care | \$5.00 per visit | |
| Ambulance | No co-payment | |
| PRESCRIPTION DRUGS | | |
| Received in inpatient setting, doctor's office, or outpatient setting at the time of an appointment | No co-payment | |
| FDA – approved contraceptive drugs and devices and emergency contraception | No co-payment | |
| All other prescriptions, including prescriptions to stop smoking where no generic is available | <ul style="list-style-type: none"> • \$3.00 per generic prescription • \$3.00 per brand name drugs where no generic is available • \$10.00 for brand name drugs | Up to a 30 day supply for brand name drugs or generic drugs. 90 day supply for maintenance drugs, |
| MENTAL HEALTH | | |
| Services arranged and managed by the San Mateo County Behavioral Health & Recovery Services | | |
| Inpatient | No co-payment | <p>Mental health care when authorized and performed by Behavioral Health & Recovery Services for the treatment of a mental health condition during a certified confinement.</p> <p>Mental health benefits will be provided on the same basis as any other illness including treatment of severe mental illness. See page 54 for full benefit explanation.</p> |

| BENEFITS | CO-PAYMENTS | CONDITIONS |
|-----------------|--------------------|---|
| Outpatient | \$5.00 per visit | Evaluation, crisis intervention, and treatment for conditions when ordered and performed by a San Mateo County Behavioral Health & Recovery Services. See page 54 for full benefit explanation. |

ALCOHOL/SUBSTANCE ABUSE

| | | |
|------------|------------------|---|
| Inpatient | No co-payment | Hospitalization for alcoholism or drug abuse as medically necessary |
| Outpatient | \$5.00 per visit | |

HOME HEALTH

| | | |
|--|------------------|---|
| Home health care visits and services by nurses and home health aides. | No Co-payment | Home health as medically necessary Custodial care is excluded. |
| Home health care visits and services for physical, occupational, speech, and respiratory therapy | \$5.00 per visit | |

HOSPICE

| | | |
|--------------|---------------|---|
| Hospice care | No co-payment | Available to members with a terminal illness and a life expectancy of one year or less as certified by a physician. |
|--------------|---------------|---|

REHABILITATION THERAPIES

| | | |
|--|--|----------------------------------|
| Physical, occupational, speech and respiratory therapy | No co-payment for inpatient therapy \$5.00 per visit for outpatient services and services at home | As medically necessary. |
| Durable Medical Equipment (DME) | No co-payment | |
| Prosthetics And Orthotics | No co-payment | |
| Family Planning Services, Sexually Transmitted Diseases, Confidential HIV/AIDS Testing | No co-payment | No Referral needed. |
| Skilled Nursing Facility Care | No co-payment | Up to 100 days per Benefit Year. |

| BENEFITS | CO-PAYMENTS | CONDITIONS |
|--------------------------------------|--------------------|--|
| OTHER SERVICES | | |
| Acupuncture | \$5.00 per visit | Up to 20 visits per Benefit Year. No Referral needed. |
| Chiropractic | \$5.00 per visit | Up to 20 visits per Benefit Year. No Referral needed. |
| Organ transplants | No co-payment | |
| Cataract spectacles and lenses | No co-payment | Spectacles, contact lenses or intraocular lenses that replace the natural lens of the eye after surgery. One pair of glasses or contact lenses after cataract surgery with insertion of an intraocular lens. |
| Hearing aids | No co-payment | |
| Health education services | No co-payment | |
| X-ray and laboratory services | No co-payment | |
| Blood and blood products | No co-payment | |
| Non-emergency medical transportation | No co-payment | |
| California Children's Services (CCS) | No co-payment | |
| Clinical cancer trials | No co-payment | |
| Podiatry | \$5.00 per visit | Up to 24 visits per benefit year. No referral needed. Other podiatric services, including additional office visits require prior authorization based on medical necessity. |

HEALTHWORX EVIDENCE OF COVERAGE DETAILED DESCRIPTION OF BENEFITS, CO-PAYMENTS, CONDITIONS AND EXCLUSIONS

PREVENTIVE HEALTH SERVICES

Description:

- Periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current recommendations of the U.S. Public Health Service
- The frequency of such examinations will not be increased for reasons which are unrelated to the medical needs of the Subscriber, including a member's desire for physical examinations or reports or related services for the purpose of obtaining or maintaining employment, licenses or insurance.
- Preventive services, including services for the detection of asymptomatic diseases, including the following:
 1. periodic health examinations (including well baby care during the first 48 or 60 hours of life)
 2. a variety of voluntary family planning services
 3. prenatal care
 4. vision and hearing testing
 5. immunizations
 6. sexually transmitted diseases including confidential HIV/AIDS counseling and testing
 7. annual cervical cancer screening including the conventional Pap smear exam and the option of any cervical cancer screening test approved by the Federal Food and Drug Administration
 8. generally medically accepted cancer screening tests including prostate, breast, and colorectal screening.
 9. effective health education services, including information regarding personal
 10. health behavior and health care, and recommendations regarding the optimal
 11. use of health care services provided by the Plan
- Age appropriate immunizations as recommended by the U.S. Public Health Service

Cost to Member:

- No co-payment for preventive services

PHYSICIAN AND PROFESSIONAL SERVICES

Description

- Medically necessary professional services and consultations by a Physician or other licensed health care provider acting within the scope of his or her license. Including:
 - Surgeon, assistant surgeon, and anesthesiologist (inpatient or outpatient)
 - Inpatient hospital and skilled nursing facility visits
 - Professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, dialysis treatment, and sexually transmitted infection care
 - Home visits when medically necessary
 - Hearing tests and eye examinations including eye refractions to determine the need for corrective lenses and dilated retinal eye exams. **Please note that eyeglass' or contact lenses are a benefit only after cataract surgery.**
 - Well baby care for the first 48 or 96 hours after birth.

Cost to Member

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

PREGNANCY AND MATERNITY CARE

Description

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

Cost to Member

- No co-payment

DIAGNOSTIC X-RAY AND LABORATORY SERVICES

Description

- Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services which will include, but not be limited to, the following:
 - General radiology, CT, MRI Testing
 - Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes
 - Other services necessary to appropriately evaluate, diagnose, treat, and follow-up
 - Laboratory tests appropriate for the management of diabetes including, at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (Glycohemoglobin)
 - All generally medically accepted cancer screening tests subject to physician prescription and utilization review
 - All Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate to diagnose, treat or manage osteoporosis

Cost to Member

No co-payment

EMERGENCY SERVICES AND CARE (INCLUDING "911 SERVICES")

Description

- Twenty-four hour Emergency Services and Care are covered for a medical condition that causes severe pain, or a serious illness or injury, including Active Labor, which a prudent lay person (a careful or cautious non-medical person) believes could reasonably expect without speedy medical care to result in:
 - Placing their health or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious danger, or
 - Causing serious impairment to the Member's bodily functions, or
 - Causing serious dysfunction of any of the Member's bodily organs or parts.

- Emergency Services and care including psychiatric screening, examination, evaluation, and treatment by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and privileges.
- Coverage is coordinated with San Mateo County Behavioral Health & Recovery Services to provide care and treatment necessary to relieve or eliminate the psychiatric emergency within the capability of a facility.
- Coverage is provided both in and out of the HPSM service area and in and out of HPSM's participating facilities.

Cost to Member

- \$25 co-payment per visit
- No co-payment if admitted to the hospital

EMERGENCY (“9-1-1”) AND NON-EMERGENCY TRANSPORTATION SERVICES

Description

- Emergency ambulance transportation (“9-1-1” service) provided to a Member as a result of a “9-1-1” emergency response system request for assistance, is covered to the first hospital or urgent care center that accepts the Member for emergency care, where the Member reasonably believes an emergency existed, even if it is later discovered that an emergency did not in fact exist
- Emergency transportation is covered for a medical condition that causes severe pain, a serious illness or injury, or a psychiatric emergency which a prudent lay person (a careful or cautious non-medical member) believes is an emergency condition that requires ambulance transport, even if it is later determined that an emergency did not exist
- Non-emergency transportation for the transfer of a Member from a hospital to another hospital or facility, or facility to home when:
 1. Medically necessary
 2. Requested by Participating Provider
 3. Authorized in advance by HPSM

Cost to Member

- No co-payment

DIABETES SELF-MANAGEMENT

Description

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

Cost to Member

- No co-payment

PRESCRIPTION DRUGS

Description

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

- Injectable medication, and needles and syringes necessary for the administration of the covered injectable medication
- Insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin

- Blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent, and gestational diabetes
- Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription
- Medically necessary drugs administered while a Member is a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan-designated pharmacy
- Disposable devices that are necessary for the administration of covered drugs, such as spacers and inhalers for the administration of aerosol prescription drugs and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes. The term “disposable” includes devices that may be used more than once before desposal.
- 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. Additional course may be authorized with medication request.
- All FDA-approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered, including internally implanted time-release contraceptives.

For information concerning HPSM’s prescription drug coverage, please refer to “Getting Pharmacy Benefits” on page 37 of this booklet.

Cost to Member

- No co-payment for prescription drugs provided in an inpatient setting, for drugs administered in the doctor’s office or in an outpatient facility, or for FDA-approved contraceptive drugs and devices.
- \$10 per prescription for 30-day supply for brand name or 90 day supply for maintenance drugs.
- \$3 co-payment for generic prescription
- \$3 co-payment for brand name drug prescription when no generic drug is available.

Exclusions

- Over-the-counter medicines including non-prescription contraceptive drugs and devices such as contraceptive jellies, ointments, foams, condoms, etc.
- Medicines not requiring a prescription (except insulin).
- Appetite suppressants, or any other diet drugs or medications (except when medically necessary to treat morbid obesity).
- Over-the-counter devices or medications not requiring a prescription.
- Over-the-counter vitamins unless they are prescribed prenatal vitamins, minerals, and/or food supplements.
- Drugs or medications for cosmetic purposes.
- Experimental or investigational drugs (For information regarding Independent Medical Review for Experimental/Investigational Therapies see page 64.)

OUTPATIENT HOSPITAL SERVICES

Description

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

Cost to Member

- No co-payment, except for the following:
 - \$5 co-payment per visit for physical, occupational, and speech therapy performed on an outpatient basis

Exclusions

- Services of a dentist or oral surgeon for dental procedures (except medically necessary surgical procedures for conditions affecting the upper and lower jawbone or associated bone joints)
- Dental appliances or prosthetics

INPATIENT HOSPITAL SERVICES**Description**

- General hospital services in a room of two or more with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. Includes all medically necessary ancillary services such as:
 - Use of operating room and related facilities
 - Intensive care unit and services
 - Drugs, medications, and biologicals
 - Anesthesia and oxygen
 - Diagnostic laboratory and x-ray services
 - Special duty nursing as medically necessary
 - Physical, occupational, and speech therapy
 - Respiratory therapy
 - Administration of blood and blood products
 - Other diagnostic, therapeutic, and rehabilitative services as medically necessary
 - Coordinate discharge planning including the planning of continuing care as medically necessary
- Includes inpatient hospital services in connection with dental procedures when hospitalization is required because of an underlying medical condition, clinical status, or because of the severity of the dental procedure. HPSM will coordinate such services with the Member's dental plan, if any.

Cost to Member

- No co-payment

Exclusions

- Personal comfort items or a private room in a hospital unless medically necessary
- Services of a dentist or oral surgeon are excluded for dental procedures (except medically necessary surgical procedures for conditions affecting the upper and lower jaw or associate bone joints)

FAMILY PLANNING SERVICES**Description**

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

Cost to Member

- No co-payment

Exclusions

- Infertility treatment

HEALTH EDUCATION**Description**

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

Cost to Member

- No co-payment

DURABLE MEDICAL EQUIPMENT (DME)**Description**

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

Cost to Member

- No co-payment

Exclusions

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

ORTHOTICS AND PROSTHETICS**Description**

- Orthotics and prosthetics are covered as follows:
 - Medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her license
 - Medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her license

- Initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incidental to a laryngectomy
- Therapeutic footwear for diabetics
- Prosthetic device or reconstructive surgery incidental to mastectomy
- Covered items must be Physician-prescribed, custom-fitted, standard orthotic or prosthetic devices, authorized by HPSM, and dispensed by a Participating Provider. Repair is provided unless necessitated by misuse or loss. HPSM, at its option, may replace or repair an item.

Cost to Member

- No co-payment

OUTPATIENT MENTAL HEALTH SERVICES

Description

- Outpatient mental health services are authorized, arranged, and provided by the San Mateo County Behavioral Health & Recovery Services.
 - Mental health will be provided on the same basis as any other illness including treatment of a Severe Mental Illness and Serious Emotional Disturbances (SED). Medically necessary benefits include the following:
 1. Outpatient services
 2. Inpatient services
 3. Partial hospital services
 4. Prescription drugs
 - Family members may be involved in the treatment to the extent the Health Plan determines it is necessary for the health and recovery of the Member.
 - There are no visit limits for treatment of severe mental illnesses and SED. Severe mental illnesses include, but are not limited to the following:
 1. Schizophrenia
 2. Schizoaffective disorder
 3. Bipolar disorder (manic depressive illness)
 4. Major depressive disorder
 5. Panic disorder
 6. Obsessive-compulsive disorder
 7. Pervasive developmental disorder, including, but not limited to, Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, and Asperger’s Disorder
 8. Anorexia Nervosa
 9. Bulimia Nervosa
 - There are no visit limitations for any mental health condition, including conditions that are not Serious Mental Illness (SMI) or Severe Emotional Disturbance (SED).

Cost to Member

- \$5 co-payment per outpatient mental health visit

INPATIENT MENTAL HEALTH SERVICES

Description

- Inpatient mental health care and partial hospitalization when authorized by the San Mateo County Behavioral Health & Recovery Services and performed by a participating mental health provider for the treatment of an acute phase of a mental health condition during a certified confinement in a San Mateo County Mental Health Plan participating hospital.
- No day limitations for severe mental illnesses or SED. Severe mental illnesses include, but are not limited to:
 1. Schizophrenia
 2. Schizoaffective disorder

3. Bipolar disorder (manic depressive illness)
4. Major depressive disorder
5. Panic disorder
6. Obsessive-compulsive disorder
7. Pervasive developmental disorder or Autism
8. Anorexia Nervosa
9. Bulimia Nervosa
 - There are no visit limitations for any mental health condition, including conditions that are not Serious Mental Illness (SMI) or Severe Emotional Disturbance (SED).

Cost to Member

- No co-payment

OUTPATIENT ALCOHOL AND DRUG ABUSE SERVICES

Description

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

Cost to Member

- \$5 co-payment per visit

INPATIENT ALCOHOL AND DRUG ABUSE SERVICES

Description

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

Cost to Member

- No co-payment

HOME HEALTH CARE SERVICES

Description

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

Cost to Member

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

Exclusions

- Custodial care

SKILLED NURSING CARE**Description**

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

Cost to Member

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

Exclusions

- Custodial care

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY**Description**

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

Cost to Member

- No co-payment for inpatient therapy
- \$5 co-payment per visit when provided on an outpatient basis including in the home

CATARACT SPECTACLES AND LENSES**Description**

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

Cost to Member

- No co-payment

Exclusions

- All other eye glasses or lenses.

HEARING AIDS AND SERVICES

Description

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

Cost to Member

- No co-payment

Exclusions

- Purchase of batteries or other ancillary equipment except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss
- Replacement parts for hearing aids and repair of a hearing aid after the covered one-year warranty period
- Replacement of a hearing aid more than once in any 36-month period
- Surgically implanted hearing devices such as cochlear implants

Acupuncture and chiropractic services are limited to two (2) services per Member per calendar month for any combination of these services

ACUPUNCTURE

Description

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

Cost to Member

- \$5 co-payment per visit

CHIROPRACTIC

Description

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

Cost to Member

- \$5 co-payment per visit

PODIATRY

Description:

- 24 outpatient podiatric office visits per Benefit Year are provided as a self referral benefit and do not require referral from a PCP, other doctor, or health professional.
- Other podiatric services, including additional office visits after the 24 self referral visits, require prior authorization based on medical necessity.

Cost to Member

- \$5 co-payment per visit.

HOSPICE SERVICES

Description

- Hospice means care and services provided in a home by a licensed or certified provider that are: (a) designed to provide palliative and supportive care to individuals who have received a diagnosis of a terminal illness, (b) directed and coordinated by medical professionals, and (c) with prior authorization by HPSM. The hospice benefit includes:
 - Development and maintenance of an appropriate plan of care
 - Skilled nursing services
 - Certified home health aide services
 - Homemaker services
 - Bereavement Services
 - Social services/counseling services
 - Dietary counseling
 - Physician services
 - Volunteer services by trained hospice volunteers
 - Short-term inpatient care
 - Physical therapy, occupational therapy, and speech therapy for symptom control or to maintain activities of daily living
 - Pharmaceuticals, medical equipment and supplies to the extent reasonable and necessary for the palliation and management of terminal illness

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

CLINICAL CANCER TRIALS

Description

- Coverage for a Member's participation in a cancer clinical trial, Phase I through IV, when the Member's physician has recommended participation in the trial, and
- Member meets the following requirements:
 - Member must be diagnosed with cancer
 - Member must be accepted into a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer
 - Members' treating physician, who is providing covered services, must recommend participation in the clinical trial after determining that participation will have a meaningful potential to the Member, and
- Trial must meet following requirements:
 - Trials have a therapeutic intent with documentation provided by the treating physician
 - Treatment provided must be approved by one of the following:
 1. 1) the National Institutes of Health, the Federal Food and Drug Administration, the U.S. Veterans Administration, or
 2. 2) involve a drug that is exempt under the federal regulations from a new drug application
- Charges for routine patient care costs of a Member. These are costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be covered if they were not provided in connection with an approved clinical trial program. Routine patient costs for cancer clinical trials include:
 - Health care services required for the provision of the investigational drug, item, device or service
 - Health care services required for the clinically appropriate monitoring of the investigational drug, item, device or service

- Health care service provided for the prevention of complications arising from the provision of the investigational drug, item, device or service
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service including diagnosis or treatment of complications.
- Member may request an Independent Medical Review (IMR) of **HPSM's** coverage decisions. Information on how to request an IMR is on page 63.

Exclusions

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

Cost to Member

- No co-payment

ORGAN TRANSPLANTS

Description

- Coverage for medically necessary organ transplants and bone marrow transplants prescribed by a Participating Provider in accordance with nationally recognized standards of practice
- Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a Member
- Charges for testing of relatives for matching bone marrow transplants
- Charges associated with the search and testing of unrelated bone marrow donors through a recognized donor registry and charges associated with the procurement of donor organs through a recognized donor transplant bank, if the expenses are directly related to the anticipated transplant for a Member
- Member may request an Independent Medical Review (IMR) of HPSM's coverage decisions. Information on how to request an IMR is on page 63.

BLOOD AND BLOOD PRODUCTS

Description

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

Cost to Member

- No co-payment

MASTECTOMIES AND LYMPH NODE DISSECTION SURGERIES

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 lymphedema.

Cost to Member

- No co-payment

Mental Health Services

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

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

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

MENTAL HEALTH ACCESS TEAM

1-800-686-0101

Monday through Friday, 8:00 a.m. to 5:00 p.m.

PSYCHIATRIC EMERGENCY SERVICES

In a psychiatric emergency, please call 911 or go directly to the closest Emergency Room for help.

MENTAL HEALTH SERVICES PATIENT ADVOCATE

Adults **1-800-388-5189**

SECTION 7 EXCLUSIONS AND LIMITATIONS ON BENEFITS

THE FOLLOWING HEALTH BENEFITS ARE EXCLUDED UNDER THE HEALTH PLAN:

1. Any services or items specifically excluded in the Benefits Description section.
2. Any benefits in excess of limits specified in the Benefits Description section.
3. Services, supplies, items, procedures, or equipment which are not medically necessary, unless otherwise specified in the Benefits Description section.
4. Any services which were received prior to the Member's effective date of coverage. This exclusion does not apply to covered services to treat complications arising from services received prior to the Member's effective date.
5. Any services which are received subsequent to the time coverage ends.
6. Experimental or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards or for which the safety and efficacy have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed. Your right to appeal a denial of experimental or investigational services is explained on page 64.
7. Medical services that are received in an emergency care setting for conditions that are not emergencies if you reasonably should have known that an emergency care situation did not exist.
8. Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery which are covered under the "Cataract Spectacles and Lenses" benefit.
9. The diagnosis and treatment of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.
10. Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except when HPSM determines they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to "Skilled Nursing Care" and "Hospice" benefits.
11. Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any worker's compensation benefit plan. HPSM shall provide services at the time of need, and the Member or Member's legal guardian shall cooperate to assure that HPSM is reimbursed for such benefits.
12. Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. HPSM shall provide services at the time of need, and the Member or Member's legal guardian will cooperate to assure that HPSM is reimbursed for such benefits.
13. Cosmetic surgery that is solely performed to alter or reshape normal structure of the body in order to improve appearance.

14. Personal or comfort items such as telephones, TVs, guest trays, personal hygiene items, disposable supplies (except ostomy bags or urinary catheters) and other supplies.
15. Services for the dentist or oral surgeon for inpatient dental procedures (this does not exclude coverage for any surgical procedure directly affecting the upper or lower jawbone or associated bone joints). Consult your chosen Dental Plan for all other coverage.
16. Drugs or medications for cosmetic use.
17. Exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment; or more than one piece of equipment that serves the same function, unless medically necessary.
18. A private room in a hospital unless medically necessary, as determined by HPSM.
19. Corrective shoes and arch supports, (except for therapeutic footwear for diabetics); non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts, dental appliances, electronic voice producing machines; except as medically necessary.
20. Coverage for transportation by airplane, passenger car, taxi or other form of public transportation.
21. Home Health custodial care and physical therapy and rehabilitation which are not medically necessary.
22. Skilled nursing custodial care provided by skilled nurses or skilled nursing facility.
23. Replacement parts for hearing aids, repair of a hearing aid after the covered one year warranty period, replacement of a hearing aid more than once in a thirty six (36) month period, and surgically implanted hearing devices. The purchase of batteries or other ancillary equipment, (except those covered under the terms of the first hearing aid purchase) and any charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss.
24. Pediatric care is excluded except for newborn examinations and nursery care which are provided only up to 48 hours or 96 hours (after a cesarean section) of life while the mother is hospitalized.

SECTION 8 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 Member Services representatives. If you have questions about the services you receive from a plan provider, we recommend that you first discuss the matter with your provider. If you continue to have a concern regarding any service you receive, call HPSM's Member Services at **1-800-750-4776** or **650-616-2133**. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY **1-800-735-2929**.

GRIEVANCE

You may file a grievance with HPSM at any time. You can obtain a copy of HPSM's Grievance Policy and Procedure by calling our Member Services' number in the above paragraph. To begin the grievance process, you can call, write, fax the Plan or go to HPSM's website

**Health Plan of San Mateo
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080
Phone 1-800-750-4776 or 650-616-2133
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 with a written statement on the pending status or disposition of the grievance no later than 72 hours from receipt of your request to expedite review of your grievance.

INDEPENDENT MEDICAL REVIEWS

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

An IMR is available in the following situations:

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

2. The disputed health care service has been denied, modified, or delayed by HPSM or one of its plan providers, based in whole or in part on a decision that the health care service is not medically necessary; and
3. You have filed a grievance with HPSM and the disputed decision was upheld or the grievance remains unresolved after 30 calendar days.

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

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

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

INDEPENDENT MEDICAL REVIEW FOR DENIALS OF EXPERIMENTAL / INVESTIGATIONAL THERAPIES

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

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

REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against HPSM, you should first telephone HPSM at **1-800-750-4776** or **650-616-2133** and use HPSM's grievance process before contacting the department. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY **1-800-735-2929**.

Using this grievance procedure does not prohibit any legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by HPSM, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial view of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment

disputes for emergency and urgent medical services. The Department of Managed Health Care has a toll-free telephone number, **1-888-HMO-2219**, to receive complaints regarding health plans. The hearing and speech impaired may use the department's TDD line (**1-877-688-9891**) number, to contact the department. The Department's Internet website (<http://www.hmohelp.ca.gov>) has complaint forms, IMR application forms and instructions online.

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

MEDIATION

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

SECTION 9 GENERAL INFORMATION

ENTIRE CONTRACT

The San Mateo County Public Authority Contract for IHSS workers, the County of San Mateo's contract for Extra Help Employees, the City of San Mateo's contract for part time employees, this Member Handbook and Evidence of Coverage, and any amendments or attachments shall constitute the entire Contract of coverage.

AMENDMENTS AND ALTERATIONS

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

No alteration of the contract and no waiver of any of its provisions shall be valid unless evidenced by an Amendment for the San Mateo Health Commission's part, executed by an authorized officer of the San Mateo Health Commission. No agent has authority to change the contract or to waive any of its provisions. HPSM reserves the right to amend this Agreement unilaterally to address any law or regulatory requirements. Members will be given at least thirty (30) days notice of any increases in amounts paid (Premium or Copayments) or change in benefits.

NOTICE OF CHANGES

At the expiration or termination of the San Mateo County Public Authority (SMCPA) or County of San Mateo or City of San Mateo Contract, the Health Plan shall cooperate fully with San Mateo County Public Authority (SMCPA) or County of San Mateo or City of San Mateo in effecting an orderly transition of the Members covered under the contract to other contractors. The Health Plan shall send a notice approved by San Mateo County Public Authority (SMCPA) or County of San Mateo or City of San Mateo to all known members at least 15 days prior to the expiration or termination of the San Mateo County Public Authority (SMCPA) or County of San Mateo or City of San Mateo's Contract.

CLERICAL ERROR

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

OTHER HEALTH INSURANCE

It is to your advantage to let your network provider know if you have medical coverage in addition to this program. Most carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both programs. If you have other insurance there are rules which decide which insurance company pays first. The insurance that pays first is the "primary payer" and pays up to the limits of its coverage. The insurance that pays second, called the "secondary payer" only pays if there are costs left uncovered by the primary coverage. As long as you are working, HealthWorx is primary to your other insurance.

MEMBERS WITH MEDICARE

This plan is not intended for most Medicare beneficiaries. If you are or become eligible for Medicare, you should contact HPSM at **1-800-750-4776** or **650-616-2133**. Members with hearing and or speech impairments can use the California Relay Services (CRS) at **1-800-735-2929** or dial **7-1-1**.

WHO PAYS FIRST WHEN YOU HAVE MEDICARE

When you have other insurance (like employer group health coverage), there are rules that decide whether Medicare or your other insurance pays first. The insurance that pays first is called the “primary payer” and pays up to the limits of its coverage. The one that pays second, called the “secondary payer,” only pays if there are costs left uncovered by the primary coverage.

If your other coverage is HealthWorx, the following rules apply:

- As long as you are working, HealthWorx is primary to Medicare.
- If you are retired, Medicare pays first.
- If you are over age 65 and still working, HealthWorx pays first.

If you have Medicare, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call HPSM.

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 the HPSM. The lien may be filed with the responsible third party, his or her agent, or the court. For purposes of this subsection, reasonable value will be determined to be the usual, customary, or reasonable charge for services in the geographic area where the services are rendered. By accepting coverage under this Agreement, Members agree to cooperate in protecting the interest of HPSM under this provision and to execute and to deliver to HPSM or its nominee any and all assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of HPSM or its nominee.

COORDINATION OF BENEFITS

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

COORDINATION OF SERVICES

California Children's Services (CCS)

CCS is a California medical program that treats those under 21 with certain physically handicapping conditions and who need specialized medical care. This program is available to those in California, whose families meet certain medical, financial and residential eligibility requirements. Services provided through the CCS Program are coordinated by the local county CCS office. If a HealthWorx member's Primary Care Physician (PCP) suspects or identifies a possible CCS eligible condition, he/she must refer the Member to the local county CCS Program. The CCS Program (local or the CCS Regional Office) will determine if the Member's condition is eligible for CCS services. If determined to be eligible for CCS services, he or she will be referred and must receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers. These CCS providers and specialty centers are highly trained to treat CCS eligible Evidence of Coverage 63 Section 6 conditions. As long as the Member remains enrolled in HealthWorx, the Health Plan of San Mateo will continue to provide primary care and prevention services that are not related to the CCS eligible condition, as described in this document, and will also work with the CCS Program to coordinate care provided by both the CCS Program and HPSM. The CCS office must verify residential status for each Member in the CCS Program. If you are referred to the CCS Program, you will be asked to complete a short application to verify residential status and ensure coordination of care after the referral has been made. If a Member does not meet CCS financial eligibility criteria, HPSM will provide coverage for care related to a CCS eligible condition. Additional information about the CCS Program can be obtained by calling CCS at **650-573-2755**.

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 a daily rate. There are no risk-sharing provisions in these payment arrangements, and no financial penalties designed to limit health care. In fact, there are incentives for many of our providers to provide the appropriate levels and types of health care to our Members.

Reimbursement Provisions—If You Receive a Bill

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

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

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

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

If you receive a bill for a service that is a benefit, please do not pay the bill. Call the provider's office immediately and ask them to bill HPSM. The provider can call HPSM and we can explain to them how to bill us. The number for a provider to call is on your ID card. If you are unsure what to do, you can call 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 ID card), your phone number, a receipt of payment, and date and reason for the bill.

You must also submit proof of payment. Send the bill to:

**Member Services Department
Health Plan of San Mateo
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.

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 the Health Plan can best serve Members. It also reviews policy issues which the Commission will decide so that the Members can participate before final decisions are made. The consumer member of HPSM's governing body represents consumers on HPSM's 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 to 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.

A copy of HPSM's Notice of Privacy Practice is included in this Member Handbook. Contact HPSM's Member Services Department at **1-800-750-4776** or **650-616-2133** for an additional copy. 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

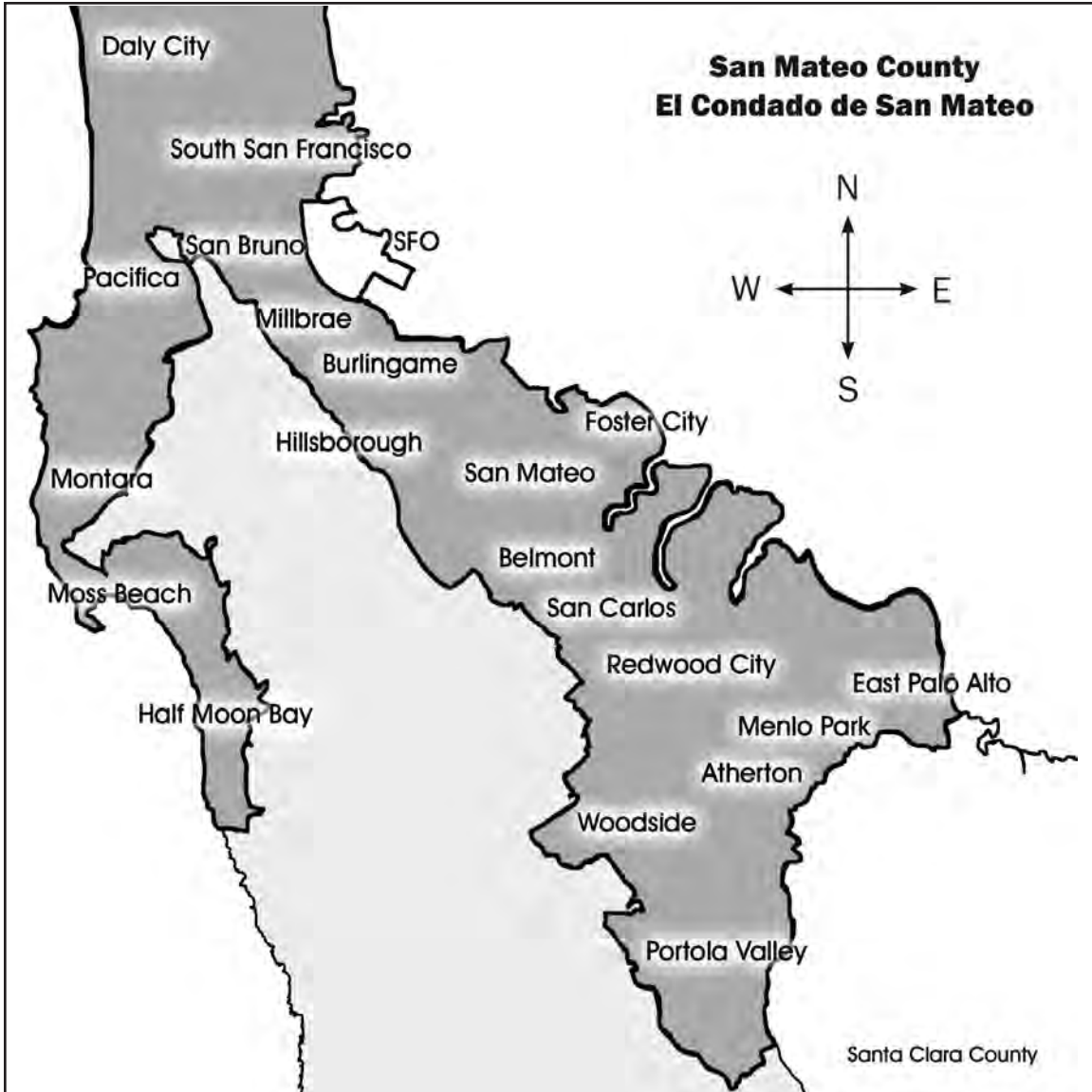
Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your 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 U.S. Department of Health and Human Services' Internet website (www.organdonor.gov) has additional information on donating your organs and tissues.

ADVANCE DIRECTIVES

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including:

- A Power of Attorney for Health Care which lets you appoint someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments.
- Individual health care instructions let you express your wishes concerning life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that made a part of your medical chart.

For additional information about advance health care directives, including how to obtain forms and instructions, contact our Member Services Department at **1-800-750-4776** or **650-616-2133**.



the healthy fight.

healthy is for everyone.

Health Plan of San Mateo
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