

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 a.m. to 6:00 p.m.
Office hours: 8:00 a.m. to 5:00 p.m.

Friday
Phone: 9:30 a.m. to 6:00 p.m.
Office hours: 9:30 a.m. 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

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Disclosure

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Health Plan's policies and coverage under the Healthy Kids Program (HKP).

Regulations require the Health Plan to comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code, section 1340, et seq.), and the Act's regulations (California Code of Regulations, Title 28). Any provision required to be a benefit of the program by either the Act or the Act's regulations shall be binding on the Health Plan, even if it is not included in the Evidence of Coverage booklet.

THE HEALTH PLAN OF SAN MATEO HEALTHY KIDS PROGRAM

2011 MEMBER HANDBOOK AND EVIDENCE OF COVERAGE

Introduction

Using This Booklet

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

Throughout this booklet, “you,” “your,” and “member” refers to the child or children enrolled in the Healthy Kids Program. “We,” “us,” and “our” refers to the Health Plan of San Mateo. “Provider,” “plan provider,” or “participating provider” refers to a licensed physician, hospital, medical group, pharmacy, or other health care provider who is responsible for providing medical services to you.

Welcome!

About the Health Plan

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

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

Multilingual Services

If you or your representative prefer to speak in any language other than English, call us 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** to speak with a HPSM Member Services Representative. HPSM staff speak several languages including Spanish, and Tagalog. We offer telephone interpreter services for other languages. Our Member Services staff can help you find a health care provider who speaks your language or who has a regular interpreter available. You do not have to use family Members or friends as interpreters. If you cannot locate a health care provider who meets your language needs, you can request to have an interpreter available for discussions of medical information at no charge.

This EOC booklet, as well as other informational material, has been translated into Spanish. To request translated materials, please call HPSM at **1-800-750-4776** or **650-616-2133**. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY **1-800-735-2929** or **dial 7-1-1**. For California Relay Service in Spanish call **1-800-835-3000**.

Member Identification Card

All Members of HPSM are given a member identification (ID) card. This card contains important information regarding your medical benefits. If you have not received a card or if you have lost your Member identification card, please call a Member Services Representative 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.** We will send you a new card. Please show your HPSM Member identification card to your provider when you receive medical care or pick up prescriptions at the pharmacy.

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



Front

informedRx an SXC company
Manual Claims
9343 Tech Center Drive
Suite 200
Sacramento, CA 95826
1-866-441-2422

HealthPlan OF SAN MATEO
Submit medical claims to:
For Provider Use Only
Claims Department
Health Plan of San Mateo
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080
Claims Department: 650-616-2056
Provider Services: 650-616-2106

For information about Mental Health Services call 1-800-686-0101
Providers can also call 1-800-696-4776 for eligibility verification if they have an HPSM
PIN 24 hours a day.
In case of emergency, call 9-1-1 or seek appropriate emergency care.

Back

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

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

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

PCP: This is your Primary Care Physician.

DOB: This is your date of birth.

Copay: These are the amounts that you would need to pay for certain benefits, usually at the time of an appointment. There is no copayment required for well care visits (Well Care) or for authorized inpatient hospital stays (HOSP). There is a charge for all other appointments that you have with a doctor (Dr.), for each necessary visit to the emergency room (ER), and for each prescription (Rx) that you have filled. Your total copayments for your family during the benefit year will not exceed \$250.

SECTION 1 DEFINITIONS

Active Labor

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

Acute Condition

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

Appropriately Qualified Health Care Professional

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

Authorization

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

Benefits (Covered Services)

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

Benefit Year

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

Complaint

A complaint is also called a grievance or an appeal. Examples of a complaint can be when

- You can't get a service, treatment or medicine you need.
- Your plan denies a service and says it is not medically necessary.
- You have to wait too long for an appointment.
- You received poor care or were treated rudely
- Your plan does not pay you back for emergency or urgent care that you had to pay for.
- You get a bill that you believe you should not have to pay.

Copayment

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

Emergency Care

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

- Placing the Member's health 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.

Exclusion

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

Experimental or Investigational Service

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

Evidence of Coverage and Disclosure Form (EOC)

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

Federal Poverty Income Guideline

The federal poverty income guideline is set each year by the U.S. Department of Health and Human Services (HHS). The guidelines are used to determine eligibility for certain programs such as HFP or Medi-Cal. The poverty guidelines are sometimes referred to as the “federal poverty level” (FPL).

Formulary

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

Grievance

A written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, 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.

Healthy Kids

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

Hospital

A health care facility licensed by the State of California, and accredited by the Joint Commission on Accreditation of Health Care Organizations, as either:

- (a) an acute care hospital;
- (b) a psychiatric hospital; or
- (c) a hospital operated primarily for the treatment of alcoholism and/or substance abuse.

A facility which is primarily a rest home, nursing home or home for the aged, or a distinct part skilled nursing facility portion of a hospital is not included.

Family Contribution Premium

How much you pay for the monthly premium is determined by your income category. The income categories are determined based on the current Federal Poverty Income Guidelines. You may call HPSM to find out whether you fall into Category A, B, or C.

Inpatient

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

Medically Necessary

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

Member

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

Member Identification Card

The identification card provided to Members by HPSM that includes the Member identification number, primary care provider information, and important phone numbers.

Mental Health Services

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

Non-formulary Drug

A drug that is not listed on HPSM’s Formulary and requires an authorization from HPSM in order to be covered.

Non-Participating Provider

A provider who has not contracted with HPSM to provide services to Members.

Orthotic Device

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

Outpatient

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

Out-of Area Services

Emergency care or urgent care provided outside of HPSM’s service area (San Mateo County) which could not be delayed until Member returned to the service area.

Participating Provider or Plan Provider

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

Pharmacy Benefits Manager (PBM)

A third party administrator of a health plan’s prescription drug program that is mainly responsible for authorizing and paying prescription drug claims. PBMs assist the health plan with development and maintenance of drug formularies, contracts with pharmacies, and negotiate discounts and rebates with drug manufacturers.

Plan or HPSM

Health Plan of San Mateo

Plan Physician

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

Primary Care Provider (PCP)

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

Program

The Healthy Kids Program.

Prosthetic Device

An artificial device used to replace a body part.

Provider

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

Provider List

The directory of all the providers contracted with HPSM to provide services to its Members.

Psychiatric Emergency Medical Condition

A mental disorder with acute symptoms of sufficient severity to render either an immediate danger to yourself or others, or you are immediately unable to provide for or use, food, shelter or clothing due to the mental disorder.

Serious Chronic Condition

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

Serious Emotional Disturbance (SED)

SED refers to a diagnosed mental condition in a child that is not a “substance abuse disorder” or “developmental disorder.” A child with SED also behaves in a way that is not appropriate for the child’s age. The San Mateo Behavioral and Recovery Services decides if a child has SED based on California Law (Welfare and Institutions Code Section 5600.3(a)(2)). In making that decision, Behavioral and Recovery Services will consider whether a child has certain problems. These could include trouble taking care of him/herself, problems at school, or problems with family relationships. The child might also have other problems such as being at risk of suicide or violence. Or, the child might meet the state’s Special Education requirements. Behavioral and Recovery Services may also look at whether the child is at risk of being removed from the home and at how long the condition is expected to last.

Service Area

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

Skilled Nursing Facility

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

Specialist Physician

A plan physician who provides services to a Member usually upon referral by a primary care provider within the range of his or her designated specialty area of practice and who is specialty board certified or specialty board eligible in such specialty. Some specialty services do not require a referral, e.g., obstetrical services.

Terminal Illness

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

Urgent Care

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

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.

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 HPSM 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 by providing timely information regarding changes in address, family status, and other health care coverage. Failure to do so may cause early cancellation of benefits.
- 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.

SECTION 3 ACCESSING CARE

Physical Access

HPSM has made every effort to ensure that our offices and the offices and facilities of HPSM providers are accessible to the disabled. If you are not able to locate an accessible provider, please call us toll free at 1-800-750-4776 or 650-616-2133 and we will help you find an alternate provider.

Access for the Hearing Impaired

The hearing impaired may contact us through the California Relay Service at **1-800-735-2929 (TTY)** or dial **7-1-1** or for the California Relay Service in Spanish call **1-800-835-3000**.

Access for the Vision Impaired

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

The Americans with Disabilities Act of 1990

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

Disability Access Grievances

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

USING THE HEALTH PLAN

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

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

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

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

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

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

If you do not choose a Primary Care Physician when you enroll in the Healthy Kids 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 is not when you are sick, but when you are well.

Initial Health Exam

All new Members are encouraged to see their primary care provider for an initial health examination when they join the Healthy Kids 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 **www.hpsm.org** to get the form. The form asks questions about your lifestyle, behavior, environment and cultural and linguistic needs. Filling out the form and taking it to your first appointment will help your PCP to get to know you better. If you do not complete the form, your PCP may ask you to complete it when you come for your appointment.

Changing Your Primary Care 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 fourteen (14) days or have questions about the effective date of change, please call HPSM and speak to a Member Services Representative at **1-800-750-4776 or 650-616-2133**.

Continuity of Care for New Members

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

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

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

We will request that the non-participating provider agree to the same contractual terms and conditions that are accepted by participating providers providing similar services, including payment terms. If the non-participating provider does not accept the terms and conditions, HPSM is not required to continue that provider's services. HPSM is not required to provide continuity of care as described in this section to a newly covered Member who was covered under an individual

Diagnostic X-Ray and Laboratory Services

Cost to Member

No copayment

Description

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

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

Diabetic Care

Cost to Member

- \$10 Copayment per office visit
- Copayments for prescriptions as described in the “Prescription Drug Program” Section below.

Description

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

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

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

Prescription Drug Program

Cost to Member

- No copayment for prescription drugs provided in an inpatient setting
- No copayment for drugs administered in the doctor’s office or in an outpatient facility setting during the Member’s stay at the facility
- No copayment for FDA-approved contraceptive drugs and devices

- \$10 copayment per prescription for up to 30 day supply for generic drugs.
- \$15 copayment per prescription for up to 30 day supply for brand name drugs unless there is no generic equivalent or if the use of a brand name drug is medically necessary.
- \$10 copayment per prescription for up to 90 day supply for maintenance* generic drugs purchased either through a participating pharmacy.
- \$15 copayment per prescription for up to 90 day supply for maintenance* brand drugs purchased through a participating pharmacy unless there is no generic equivalent or if the use of a brand name drug is medically necessary, then \$10 copayment applies.

*Maintenance drugs are drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

Description

Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her 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
- 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 18 of this booklet.

Exclusions

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

If HPSM denies your request for prescription drugs based on a determination that the drug is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to HPSM's Grievance and Appeals Process on page 73.

Durable Medical Equipment

Cost to Member

No copayment

Description

Medical equipment appropriate for use in the home which

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

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

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

Exclusions

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

Orthotics and Prosthetics

Cost to Member

No copayment

Description

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

- Medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her 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 incident to a laryngectomy
- Therapeutic footwear for diabetics
- Prosthetic devices to restore and achieve symmetry incident to mastectomy

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

Exclusion

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

Cataract Spectacles and Lenses

Cost to Member

No copayment

Description

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

Maternity Care

Cost to Member

No copayment

Description

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

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

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

Family Planning Services

Cost to Member

No copayment

Description

Voluntary family planning services are covered, including:

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

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

Medical Transportation Services

Cost to Member

No copayment

Description

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

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

Exclusion

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

Emergency Health Care Services

Cost to Member

\$15 copayment per visit. Copayment will be waived if the Member is admitted to the hospital.

Description

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

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

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

Mental Health Benefits

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

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

Mental Health Access Team

1-800-686-0101

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

Psychiatric Emergency Services

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

Mental Health Services Patient Advocate

Children and Adolescents **650-655-6276**

Inpatient Mental Health Care Services

Cost to Member

No copayment

Description

Mental health care during a certified confinement in a participating hospital when ordered and performed by San Mateo Behavioral and Recovery Services for the treatment of a mental health condition.

Limitations

Unlimited inpatient days.

Inpatient mental health care days for the treatment of serious emotional disturbance (SED) of a child is not limited.

HPSM will provide all medically necessary covered services until Behavioral and Recovery Services establishes eligibility for a member with SED and provides the medically necessary services to treat the SED.

HPSM and Behavioral and Recovery Services will coordinate services to ensure that medically necessary services and treatment are provided to a member with SED.

The member will remain enrolled in the Healthy Kids program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED from HPSM.

Outpatient Mental Health Care Services

Cost to Member

\$10 copayment per visit

Description

Mental health care services are authorized, arranged and provided by San Mateo Behavioral and Recovery Services.

Outpatient mental health care benefits include:

- Treatment for members who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, divorce, or bereavement.
- Involvement of family members in the treatment to the extent the provider determines it is appropriate for the health and recovery of the Member
- Treatment of serious emotional disturbance (SED) of a child

Services are arranged and managed by San Mateo Behavioral and Recovery Services. The Health Plan of San Mateo provides all mental health care services through San Mateo Behavioral and Recovery Services including medically necessary services to treat serious emotional disturbance.

HPSM will provide all medically necessary covered services until Behavioral and Recovery Services establishes eligibility for a member with SED and provides the medically necessary services to treat the SED.

HPSM and Behavioral and Recovery Services will coordinate services to ensure that medically necessary services and treatment are provided to a member with SED.

The member will remain enrolled in the Healthy Kids program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED from HPSM.

Limitations

Unlimited outpatient days

Inpatient Alcohol/Drug Abuse Treatment

Cost to Member

No copayment

Description

Hospitalization for alcoholism or drug abuse as medically necessary to remove toxic substances from the system. Unlimited inpatient days.

Outpatient Alcohol/Drug Abuse Treatment

Cost to Member

\$10 copayment per visit

Description

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

Limitation

Unlimited outpatient visits

Home Health Care Services

Cost to Member

No copayment, except for \$10 copayment per visit for physical, occupational, and speech therapy performed in the home.

Description

Health services provided at home by health care personnel. Benefit includes:

- Visits by RNs, LVNs, and home health aides
- Physical therapy, occupational therapy, and speech therapy
- Respiratory therapy when prescribed by a licensed plan provider acting within the scope of his or her licensure

Limitations

- Home health care services are limited to those services that are prescribed or directed by the Member's primary care provider or another appropriate authority designated by HPSM
- If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the Member's primary care provider or other appropriate authority designated by HPSM to choose the setting for providing the care
- HPSM will exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting

Exclusion

Custodial care

Skilled Nursing Care

Cost to Member

No copayment

Description

Medically necessary services prescribed by a plan provider and provided in a licensed skilled nursing facility. Benefit includes:

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

Limitation

This benefit is limited to a maximum of one hundred (100) days per benefit year

Exclusion

Custodial care

Physical, Occupational, and Speech Therapy

Cost to Member

No copayment for inpatient therapy, including services received in a skilled nursing facility. \$10 copayment per visit when performed in the home or other outpatient setting.

Description

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

Acupuncture

Cost to Member

\$10 copayment per visit

Description

Acupuncture services do not require a referral from the Member's primary care provider or other health care provider. Services must be obtained from a participating provider.

Limitation

Treatment is limited to a maximum of twenty (20) visits per benefit year

Chiropractic Services

Cost to Member

\$10 copayment per visit

Description

Chiropractic services do not require a referral from the Member's primary care provider or other health care provider. Services must be obtained from a participating provider.

Limitation

Treatment is limited to a maximum of twenty (20) visits per benefit year

Blood and Blood Products

Cost to Member

No copayment

Description

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

Health Education

Cost to Member

No copayment

Description

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

Hospice

Cost to Member

No copayment

Description

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

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

The hospice election may be revoked at any time.

Limitation

Members who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect.

Organ Transplants**Cost to Member**

No copayment

Description

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

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

These services may be covered and paid for by the California Children's Services (CCS) program, instead of by HPSM, if the Member is found to be eligible for CCS services. HPSM will coordinate these services with CCS for the Member. For more information about the CCS program, see "Coordination of Services" on pages 51–53.

If HPSM denies your organ transplant request based on a determination that the service is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to HPSM's Grievance and Appeals Process on page 73.

Reconstructive Surgery**Cost to Member**

No copayment

Description

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

Mastectomies and Lymph Node Dissection Surgeries**Cost to Member**

No Copayment

Description

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

Phenylketonuria (PKU)

Cost to Member

No-Copayment

Description

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

Clinical Cancer Trials

Cost to Member

- \$10 copayment per office visit
- Copayment for prescriptions as described in the “Prescription Drug Program” Section.

Description

- Coverage for a Member’s participation in a cancer clinical trial, phase I through IV, when the Member’s physician has recommended participation in the trial, and Member meets the following requirements:
- Member must be diagnosed with cancer
- Member must be accepted into a phase I, phase II, Phase III, or phase IV clinical trial for cancer
- Member’s treating physician, who is providing covered services, must recommend participation in the clinical trial after determining that participation will have a meaningful potential to the Member, and
- The trial must meet the following requirements:
 1. Trials must have a therapeutic intent with documentation provided by the treating physician, and
 2. Treatment provided must be approved by one of the following:
 - a) the National Institute of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs, or
 - b) involve a drug that is exempt under the federal regulations from a new drug application.

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

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

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

Exclusions

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

Annual or Lifetime Benefit Maximums

There shall be no lifetime financial benefit maximums in any of the coverages under the program. There is a \$1,500 benefit maximum for Dental Services per benefit year.

Coordination of Services

California Children's Services (CCS)

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

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

If a member's primary care provider suspects or identifies a possible CCS eligible condition, he or she must refer the member to the local CCS program. Health Plan of San Mateo can assist with this referral. Health Plan of San Mateo will also make a referral to CCS when a primary care provider refers the member to a specialist or where there is an inpatient admission which appears to involve care for a CCS eligible condition. The CCS program will determine if the member's condition is eligible for CCS services.

If the CSS program determines that the condition is a CSS eligible condition, the member will remain enrolled in the Healthy Kids Program. He or she will be referred to, and should receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers. These CCS providers and specialty centers are highly trained to treat CCS eligible conditions. CCS services must be received from CCS paneled providers. Payment for CCS eligible services obtained from non-CCS paneled provider will be the responsibility of the member's legal guardian.

Health Plan of San Mateo will continue to provide primary care, prevention services, and any other services that are not related to the CCS eligible condition, as described in this booklet. Health Plan of San Mateo will also work with the CCS program and providers to coordinate care provided by both the

CCS program and Health Plan of San Mateo. If a condition is determined not to be eligible for CCS program services, the member will continue to receive all medically necessary services from Health Plan of San Mateo.

Although all children enrolled in the Healthy Kids Program are determined to be financially eligible for the CCS program, the CCS office must verify residential status for each child in the CCS program. If a member is referred to the CCS program, the member's legal guardian will be asked to complete a short application to verify residential status and ensure coordination of the member's care after the referral has been made.

Additional information about the CCS program can be obtained by calling Health Plan of San Mateo's Member Services at **1-800-750-4776** or **650-616-2133** or by calling the local county CCS program at **650-573-2755**.

Excluded Benefits

The following health benefits are excluded under the Health Plan:

1. Any services or items specifically excluded in the Benefits Description section.
2. Any benefits in excess of limits specified in the Benefits Description section.
3. Services, supplies, items, procedures, or equipment 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.
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). See Section 9 of this document for more information on dental benefits.
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.

SECTION 8 COVERED VISION SERVICES

DETAILED DESCRIPTION OF BENEFITS, COPAYMENTS, CONDITIONS, AND EXCLUSIONS

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

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

Cost to Member

\$10 Copayment per examination

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

Description

Examinations

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

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

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

Lenses

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

Frames

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

Medically Necessary Contact Lenses

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

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

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

Elective Contact Lenses (instead of corrective lenses and a frame):

Limited to once each twelve (12) month period, which begins with the date of the last exam.

Low Vision

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

Exclusions

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

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

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

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

There are no out-of-network benefits.

SECTION 9

COVERED DENTAL SERVICES, BENEFITS AND COPAYMENTS

Dental benefits are provided through the Delta Dental Plan of California. Your eligibility for dental benefits begins the same day as your medical benefits. Each member is allowed \$1500 worth of dental benefits per benefit year.

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

Choosing A Primary Care Dental Provider

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

Scheduling Appointments

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

Changing Your Provider

You can choose any participating dentist at any time. If you wish to change dentists, simply review the Provider List for dentists and call to schedule an appointment. Delta's Customer Service department is available to assist you in choosing a new dentist. You may also review the list of dentists by going to www.deltadentalca.org/gov.

Continuity Of Care For New Members

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

Department toll-free at **1-866-527-9564**. The hearing impaired may contact Delta Dental through Delta's TDD/TTY number at **1-800-735-2922**. If Delta approves the continued treatment from a Non-Participating Provider, Delta Dental will give you a written authorization. If we determine that you do not meet the criteria for continuity of care and you disagree with Delta's determination, you may file a grievance with Delta Dental (see page 60) or with HPSM (see page 73).

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

Follow-Up Care

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

Copayments

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

No deductibles are charged for dental benefits.

Member Liabilities

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

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

Missed Or Broken Appointments

Your dentist may charge you a \$10.00 fee if you fail to cancel an appointment at least 24 hours prior to the appointment. This fee will be waived if it was not reasonably possible for you to cancel your appointment.

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

Grievances Concerning Dental Services

If you have questions about the services you receive from a network dentist, first discuss the matter with your dentist. If you continue to have concerns or complaints, call Delta Dental's Customer Service Department at **1-866-527-9564**, Monday through Friday from 8:00 a.m. through 5:00 p.m.

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

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

Endodontic	Direct pulp capping, Pulpotomy and vital pulpotomy, Apexification filling with calcium hydroxide, Root amputation, Root canal therapy, including culture canal, Retreatment of previous root canal therapy, Apicoectomy, Vitality tests.	The following copayments may apply: <input type="checkbox"/> \$10 copayment per canal for root canal therapy or retreatment of previous root canal therapy <input type="checkbox"/> \$10 copayment per root for an apicoectomy
Periodontics	Emergency treatment, including treatment for periodontal abscess and acute periodontitis, Periodontal scaling and root planing, and subgingival curettage, Gingivectomy, Osseous or muco-gingival surgery.	The following copayments may apply: <input type="checkbox"/> \$10 copayment per quadrant for osseous or muco-gingival surgery
Crown and Fixed Bridge	Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel, Related dowel pins and pin build-up, Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, Recementation of crowns, bridges, inlays and onlays, Cast post and core, including cast retention under crowns, Repair or replacement of crowns, abutments or pontics.	The following copayments may apply: <input type="checkbox"/> \$10 copayment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns. <input type="checkbox"/> \$10 copayment per pontic. <input type="checkbox"/> The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.
Removable Prosthetics	Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, Office or laboratory relines or rebases, Denture repair, Denture adjustment, Tissue conditioning, Denture duplication, Stayplates.	The following copayments may apply: <input type="checkbox"/> \$10 copayment for a complete maxillary or mandibular denture <input type="checkbox"/> \$10 copayment for partial acrylic upper or lower denture with clasps <input type="checkbox"/> \$10 copayment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles <input type="checkbox"/> \$10 copayment for removable unilateral partial denture <input type="checkbox"/> \$10 copayment for reline of upper, lower or partial denture when performed by a Laboratory <input type="checkbox"/> \$10 copayment for denture duplication

Other Benefits	Local anesthetics, Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of licensure, Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of licensure, Emergency treatment, palliative treatment, Coordination of benefits with member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.	No Charge
Orthodontia Services	Not a Healthy Kids Program covered benefit. Services are provided to members under the age of 19 through the California Children's Services Program (CCS) when condition meets the CCS program criteria.	Not applicable
Deductibles	No deductibles will be charged for covered benefits.	
Annual Maximums	\$1,500 is the maximum amount that the dental plan will pay for covered benefits for each member each benefit year.	
Lifetime Maximums	No lifetime maximum limits on benefits apply under this plan.	

Benefits Description

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

Diagnostic And Preventive Benefits

Cost to Member

No Copayment

Description

Benefit includes:

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

Limitations

Roentgenology (x-rays) is limited as follows:

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

Restorative Dentistry

Cost to Member

No Copayment

Description

Restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries
- Micro filled resin restorations which are noncosmetic.
- Replacement of a restoration
- Use of pins and pin build-up in conjunction with a restoration
- Sedative base and sedative fillings

Limitations

Restorations are limited to the following:

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

- Composite resin or acrylic restorations in posterior teeth are optional.

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

Oral Surgery

Cost to Member

No Copayment, except:

- \$10.00 Copayment for the removal of impacted teeth for a bony impaction (no Copayment for the removal of a soft tissue impaction)
- \$10.00 Copayment per root recovery

Description

Oral surgery includes:

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

Limitations

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

Endodontic

Cost to Member

No Copayment, except

- \$10.00 Copayment per root canal therapy
- \$10.00 Copayment for an apicoectomy when performed as a separate procedure

Description

Endodontics benefits include:

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

Limitations

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

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

Periodontics

Cost to Member

No Copayment, except

- \$10.00 Copayment per quadrant for osseous or muco-gingival surgery

Description

Periodontics benefits include:

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

Limitations

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

Crown And Fixed Bridge

Cost to Member

No Copayment, except

- \$10.00 Copayment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns.
- \$10.00 Copayment per pontic.
- The Copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.

Description

Crown and fixed bridge benefits include:

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

Limitations

The crown benefit is limited as follows:

- Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the dental plan.
- Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a

filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

The fixed bridge benefit is limited as follows:

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. For children under the age of 16, it is considered optional dental treatment. If performed on a Member under the age of 16, the Applicant must pay the difference in cost between the fixed bridge and a space maintainer.
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair. The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.

Removable Prosthetics

Cost to Member

No Copayment, except:

- \$10.00 Copayment for a complete maxillary denture
- \$10.00 Copayment for a complete mandibular denture
- \$10.00 Copayment for partial acrylic upper or lower denture with clasps
- \$10.00 Copayment for partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles
- \$10.00 Copayment for removable unilateral partial denture
- \$10.00 Copayment for relines of upper, lower or partial denture when performed by a laboratory
- \$10.00 Copayment for denture duplication

Description

The removable prosthetics benefit includes:

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

Limitations

The removable prosthetics benefit is limited as follows:

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

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

Other Benefits

Cost to Member

No Copayment

Description

Other dental benefits include:

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

Orthodontic Benefits

Orthodontic treatment is not a benefit of this dental plan. However, orthodontic treatment may be provided by the California Children's Services (CCS) program if the Member meets the eligibility requirements for medically necessary orthodontia coverage under the CCS program. For more information about the CCS program, see page 51.

Excluded Benefits

The following dental benefits are excluded under the Plan:

1. Services which, in the opinion of the attending dentist, are not necessary to the Member's dental health.
2. Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
3. Cosmetic dental care.
4. General anesthesia or intravenous/conscious sedation.
5. Experimental procedures.
6. Services that are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. Delta shall provide services at the time of need, and the Member or Member's legal guardian will cooperate to assure that Delta is reimbursed for such benefits.
7. Services that are provided without cost to the Member by State government or an agency thereof, or any municipality, county or other subdivisions.
8. Hospital charges of any kind.
9. Major surgery for fractures and dislocations.
10. Loss or theft of dentures or bridgework.
11. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
12. Any service that is not specifically listed as a covered benefit.
13. Malignancies.
14. Dispensing of drugs not normally supplied in a dental office.
15. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Member.
16. The cost of precious metals used in any form of dental benefits.
17. The removal of implants.
18. Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by his or her panel Provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her panel Provider is a pedodontist/pediatric dentist. Note: There is a \$10.00 Copayment for children under six years of age who are unable to be treated by their panel Provider and who have been referred to a pedodontist/pediatric dentist.
19. Services which are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, or dental plan. The participating dental plan shall provide the services at the time of need, and the Member shall cooperate to assure that the participating dental plan is reimbursed for such benefits.

SECTION 10

BENEFITS CHANGES, DISENROLLMENT, TERMINATION, AND CANCELLATION

Changes In Benefits And Charges

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

Disenrollment

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

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

The responsible individual will receive an invoice for the Member's family contribution. If payment is not received by HPSM, a final notice is sent notifying the responsible individual that the Member's health coverage will end if payment is not received. The notice states the effective date that coverage will end and is sent at least fifteen (15) days prior to that date.

4. The Member or his/her legal representative requests so in writing. Disenrollment for this reason will be effective at the end of the month for which the request was made. HPSM may also accept a Member's request that is made over the phone.
5. The applicant or Member has intentionally made false statements in order to establish Program eligibility for any person or has obtained or attempted to obtain services or benefits by means of false, materially misleading, or fraudulent information, acts or omissions. [The Member will be provided at least fifteen (15) days notice prior to termination of coverage.]
6. The Member, or applicant on behalf of the Member, fails to provide the necessary information to be requalified. Disenrollment for this reason shall be effective after one year of coverage.
7. Death of a Member. Disenrollment for this reason shall be effective the day following the date of death.
8. HPSM terminates the program. Disenrollment for this reason shall be effective no sooner than ninety (90) days after the day of mailing the notice to Members of termination of the Program.
9. The Member or applicant has allowed a Non-Member to use a Member Identification Card to obtain services and benefits or otherwise permits another person to fraudulently or deceptively use HPSM services or facilities. The Member will be provided at least fifteen (15) days notice prior to termination of coverage.
10. The Member moves out of San Mateo County. Residence in San Mateo County is a criteria for Healthy Kids eligibility. It is a Member's responsibility to report a change of address.

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

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

Return Of Family Contribution

In the event of disenrollment for the reasons identified in subsections (4), (7), (10), and (11) , above, HPSM will return to the Applicant the prorated portion of the Family Contribution paid to HPSM which corresponds to any unexpired period for which payment had been received by HPSM.

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

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

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

Individual's Right Of Cancellation

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

Review By The Department Of Managed Health Care

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

SECTION 11

GRIEVANCE AND APPEALS PROCESS

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by plan providers to the courtesy extended you by our telephone representatives. If you have questions about the services you receive from a plan provider, we recommend that you first discuss the matter with your provider. If you continue to have a concern regarding any service you received, call HPSM's Member Services at **1-800-750-4776 or 650-616-2133**. Members with hearing or speech impairments can use the California Relay Service (CRS) at TTY **1-800-735-2929 or dial 7-1-1**.

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 Service's number in the above paragraph. To begin the grievance process, you can call, write, or fax HPSM at:

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 650-616-8235
www.hpsm.org

You may also submit your grievance through the internet by going to HPSM's website and completing the online complaint form on the Healthy Kids Member Grievances page.

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

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

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

Independent Medical Reviews

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

An IMR is available in the following situations:

1. (a) Your provider has recommended a health care service as medically necessary, or
(b) You have received urgent care or emergency services that a provider determined was medically necessary, or
(c) You have been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which you seek independent review; and
2. The disputed health care service has been denied, modified, or delayed by HPSM or one of its plan providers, based in whole or in part on a decision that the health care service is not medically necessary; and
3. You have filed a grievance with HPSM and the disputed decision was upheld or the grievance remains unresolved after 30 calendar days.

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

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

The IMR process is in addition to any other procedures or remedies that may be available to you. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the plan regarding the care that was requested. You pay no application or processing fees for an IMR. You have the right to provide information in support of your request for IMR. For more information regarding the IMR process or to request an application form, please call HPSM's Member Services 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**.

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 or dial 7-1-1**. 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 12

GENERAL INFORMATION

Other Health Insurance

Healthy Kids members usually do not have 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.

Coverage provided under this program is secondary to all other coverage, except Medi-Cal. Benefits paid under this program are determined after benefits have been paid as a result of a Member's enrollment in any other health care program.

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 Service 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.

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

Limitations of Other Coverage

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

Provider Payment

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

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 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 copayment at the time of your visit.

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

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

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, 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. A Member of the Consumer Advisory Committee represents Health Plan Members on the Health Plan's Quality Assessment and Improvement Committee.

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

Notifying You of Changes in the Plan

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

Privacy Practices

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

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

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

Authorization for Release of Information

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

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

Organ and Tissue Donation

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





healthy is for everyone.

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