HealthPlan OF SAN MATEO
Healthy is for everyone

Member Handbook

What you need to know about your benefits

Combined Evidence of Coverage (EOC) and Disclosure Form

HealthWorx HMO

Last Updated: 12/01/2023

EN

Our Member Services department 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-Friday:
Phone 8:00am-6:00pm
Office hours 8:00am-5:00pm

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.

Nuestra Unidad de Servicios al Miembro está disponible para ayudarlo

Llámenos al **1-800-750-4776** (número telefónico gratuito) o al **650-616-2133**

Miembros con dificultades auditivas:
TTY 1-800-855-3000 o marque el **7-1-1**

De lunes a Viernes:
Por teléfono 8:00am-6:00pm
Horario de oficina 8:00am-5:00pm

Solicitud de impresión en caracteres grandes
Si desea una copia de este manual en letra grande, llame al Departamento de Servicios al Miembro.

Declaración de privacidad
El Health Plan of San Mateo garantiza la privacidad de su registro médico. Si tiene alguna pregunta o desea obtener más información, llame a Servicios al Miembro.

我們的會員服務部可為您提供協助

請撥打我們的電話 **1-800-750-4776** (免費) 或 **650-616-2133**

有聽力障礙者：
TTY **1-800-735-2929** 或撥 **7-1-1**

星期一到星期五
電話：上午 8:00 至晚上 6:00
辦公室服務時間：上午 8:00 至下午 5:00

大字版需求
若您需要本手冊的大字版，請致電會員服務部

隱私權聲明
聖馬刁健康計劃 (HPSM) 會為您保密病歷資訊。
如有疑問或需要更多資訊，請致電會員服務部

Handa kayong Tulungan ng aming Yunit para sa mga Serbisyo sa mga Miyembro

Tawagan kami sa **1-800-750-4776** (walang bayad) o sa **650-616-2133**

May Kapansanan sa Pandinig:
TTY **1-800-735-2929** o i-dial ang **7-1-1**

Lunes hanggang Biyernes
Telepono: 8:00 a.m. hanggang 6:00 p.m.
Mga oras ng opisina: 8:00 a.m. hanggang 5:00 p.m.

Paghiling para sa Pagkakalimbag na may Malalaking Letra
Kung gusto ninyong makakuha ng librong ito na malalaki ang mga letra sa pagkakalimbag, mangyaring tawagan ang mga Serbisyo para sa mga Miyembro

Pahayag tungkol sa pagiging pribado ng impormasyon
Tinitiyak ng Health Plan of San Mateo ang pagiging pribado ng inyong medikal na rekord. Para sa karagdagang katanungan at impormasyon, mangyaring tawagan ang Mga Serbisyo para sa mga Miyembro.

The Health Plan of San Mateo
HealthWorx HMO Program
Member Handbook and Evidence of Coverage

Table of Contents

Notice of Privacy Practices

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

HPSM is committed to protecting your health information, which is any information about:

- Your past or present physical or mental health.
- Any payments for health services that can be identified with you as an individual.

Examples of health information include your name, date of birth, diagnoses, medical treatments, medical claims, race, ethnicity, language, gender identity and sexual orientation.
This notice summarizes HPSM's privacy practices and your rights as an HPSM member regarding your health information. It explains:

- How HPSM protects your health information in accordance with state and federal law.
- How HPSM can legally use and disclose your health information. ("Use" refers to how we share information within HPSM. "Disclose" refers to sharing information outside of HPSM.)
- How you can access your health information.

This notice *only* covers HPSM's privacy practices. Your provider may have different policies regarding their use and disclosure of your health information created in their office.

If you have questions about this notice, call HPSM Member Services at **1-800-750-4776.** Hours are Monday through Friday, 8:00 a.m. to 6:00 p.m. HPSM CareAdvantage members should call 1-866-880-0606. Hours are Monday through Sunday, 8:00 a.m. to 8:00 p.m. Members with hearing or speech impairments can call the California Relay Service (CRS) at **1-800-735-2929** or **711**.

This notice is effective as of: 10/1/2024

HPSM's legal requirements regarding health information

We are required by law to:

- Maintain security and privacy of electronic and written information, including physical, technical, and administrative procedures to prevent unauthorized access.to your protected health information.
- Make sure that health information that identifies you is kept private.
- Give you this privacy practices notice.
- Follow the terms of the notice that is currently in effect.

How we may use or disclose your health information

State and federal law allow HPSM to use and disclose our members' health information without written authorization. Below is a list of the types of health information and examples of uses and/or disclosures. It does not include every possible allowable use and disclosure. It is not intended to limit uses and disclosures that are permitted by law. However, every way we can use and disclose your health information will fall into one or another of these types.

- **Payment for health services.** We review your health information before approving payment for a treatment your provider has asked for to make sure that it is medically necessary.
- **Improving HPSM operations.** We may use members' health information to review our

providers' performance and compare the quality of our services with that of other health plans.

- **Care management.** Sharing your health information with your providers allows us to review your treatments and medications to make sure they do not conflict with each other.
- **Resource referrals.** We may identify and recommend HPSM benefits, services and/or programs based on your health information.
- **Contractors who assist in our operations.** Contractors agree to keep health information confidential and secure, and to only use it to assist us. For example, we contract with a "Pharmacy Benefit Manager" and provide them with the information they need to pay our members' pharmacy claims.
- **Health insurance program sponsors.** Employers and other organizations contract with HPSM so that we can provide health care services and pay claims. They agree to keep health information confidential and secure, and to only use it to assist us. If you have a plan sponsor, we may notify them when you enroll in or disenroll from our plan. We may also disclose your health information so the sponsor can audit HPSM's performance.
- **Family members or individuals involved in your care or payment for your care.** We may release your health information to family members or others who pay for your health care. We would do this if it is necessary to enable them to pay for your care or make decisions about your care. We only disclose your health information if you are present and agree to it, except when:
    - Your medical condition prevents you from making decisions and we believe that disclosing your information would be in your best interest.
    - After your death (unless you tell us beforehand not to share your information).
- **Schools.** A school may be legally required to have proof of immunization for a student enrolling or enrolled in the school. In those cases, we may provide the school with that student's immunization record.

Special Situations

We disclose health information about you:

- **When required by federal, state or local law.**
- **To avoid a serious threat to your health and safety or the health and safety of others.** We would only disclose the information to someone who can help prevent the threat.
- **If you are a member of the armed forces or a veteran** as required by military authorities or to assist in determining your eligibility for veteran's benefits.
- **If you are in custody of a correctional institution** as part of coordinating your care.
- **To programs that provide workers compensation** and other benefits for work-related injuries or illness.
- **For public health activities**, such as:
    - Preventing or controlling disease, injury or disability.
    - Reporting child abuse or neglect.
    - Reporting births or deaths.

    - Reporting reactions to medications or problems with products.
    - Notifying you of recalls of products you may be using.
    - Notifying you if you may have been exposed to a disease or may be at risk for contracting or spreading a disease.
    - Notifying the appropriate government authority if we believe you are the victim of abuse, neglect or domestic violence. We will only disclose this if you agree or when authorized by law.
- **To health oversight agencies** for activities authorized by law. For example, we may disclose your health information to the public agency responsible for overseeing HPSM's operations. These activities are necessary to enable the government to monitor the health care system and government health benefit programs.
- **For lawsuits and disputes** if ordered by a court, tribunal, subpoena or other lawful process. We only do this after unsuccessful efforts to notify you of the request or obtain an order protecting the information requested.
- **To law enforcement officials** in limited circumstances (i.e., if the official requests it or to report criminal conduct). Generally, this would have to be in connection with a criminal investigation, court order, warrant or legally authorized national security activity.
- **To assist in a military mission** or other governmental activity related to intelligence, national security or protecting the President.
- **To coroners, medical examiners and funeral directors** so they can perform their duties after members are deceased.
- **To organ transplant organizations** working on organ or tissue transplantation for the purposes of facilitating a transplant.
- **50 years after death.** We may disclose the health information of members who are deceased to any agency after the member has been deceased for at least 50 years.
- **To disaster relief organizations.** If you do not want us to disclose your information for disaster relief, you have the right to prevent such sharing.

The previous examples are all subject to the prohibitions and conditions we explain below related to reproductive health care.

Legal limitations

We comply with laws that may limit or prevent the disclosures listed above. For example:

- There are special limits on disclosing health information about HIV/AIDS status, mental health treatment, developmental disabilities, and drug and alcohol abuse treatment.
    - We will not use or disclose the records we receive subject to 42 C.F.R. Part 2, or testimony relaying the content of such records, in civil, criminal, administrative, or legislative proceedings against you unless we have your written consent or a court order, after notice and an opportunity to be heard in court is provided to you. Any court order we receive for a use or disclosure of these records must be accompanied by a subpoena or other legal obligation before we may use or disclose the record.
- Information about race, ethnicity, language, gender identity and sexual orientation cannot be used in underwriting, rate setting, denial of services, coverage and benefit

determinations.

- We cannot sell your information.

Authorization

Other than the situations described above, we do not allow use and disclosure of your health information without your written permission or authorization. For example, we may use and share health information about you for research purposes only if we have your authorization. Your decision to grant us an authorization will not affect your medical treatment, health plan benefits, payment for treatment or enrollment eligibility. You have the right to revoke your authorization even after you have signed an authorization for use or release of your health information. In that case, we would no longer use or disclose your health information for that purpose. However, we cannot reverse any disclosures we made during the time we had your permission to do so.

- **Uses and disclosures related to reproductive health care.** Unless we have received an authorization from you, we are prohibited from disclosing your health information when the request is made by someone other than you or your personal representative for either of the following activities ("Prohibited Purposes"):

    - To conduct a criminal, civil, or administrative investigation into or impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, where such health care is lawful under the circumstances in which it is provided.
    - The identification of any person for the purpose of conducting such investigation or imposing such liability.

  For example, we may receive a subpoena requesting a member's records, and the subpoena was issued in a case seeking to prosecute a provider for prescribing a medication that could terminate a pregnancy or impact fertility, or to prosecute a member for taking such medication. In that situation, if the prescription or ingestion of that medication was lawful under the circumstances, we are prohibited from providing any PHI in response to the request.

  If we receive a request for records from someone other than you or your personal representative, and the requested records contain PHI that potentially relates to reproductive health care, we are required to obtain an attestation from the requestor if the request is for any of the following purposes:

    - Health oversight activities
    - Judicial and administrative proceedings
    - Law enforcement purposes
    - Disclosures to coroners and medical examiners

  The attestation must include specific information about the request, a statement that the request is not for any of the Prohibited Purposes, a statement that an individual signing an attestation known to be false is subject to criminal penalties under federal law, and it must be signed by the requestor. We are prohibited from responding to requests that require an attestation if the attestation does not meet all legal requirements.

  For example, we may receive a subpoena requesting a member's records from state law enforcement officials related to the criminal prosecution of an individual accused of submitting false claims to insurance companies, unrelated to reproductive health care. While the purpose of the investigation is not a Prohibited Purpose, the records requested contain

PHI potentially related to reproductive health care, such as claims paid for pregnancy-related conditions. In that situation, we will require the law enforcement official to provide a valid, signed attestation before we will respond to the request.

Even where we receive a valid attestation, we will still ensure that the request satisfies all requirements under federal law before we disclose any PHI

Note that there is a potential that information disclosed to third parties may no longer be protected by HIPAA, and those third parties could re-disclose your information.

Your rights regarding your health information

You have the right to:

- **Get a paper copy of this privacy notice.** You can also get this notice on our website at www.hpsm.org/privacy-policy.
- **Assign someone to represent you.** You can give someone medical power of attorney, which allows that person to act on your behalf and make choices about your health information. This right also applies if you have a legal guardian. We will take reasonable steps to confirm that anyone who claims to represent you has this authority before we take any action.
- **Request restrictions or limits on the use or disclosure of your health information.** In your request, you must tell us:
    - What health information you want to limit.
    - Whether you want to limit our use of information, disclosure of information, or both.
    - To whom you want the limits to apply.
- **Control information about sensitive services you receive.** Sensitive services include mental health counseling, reproductive health services, sexually transmitted disease services, sexual assault services and drug treatment. Those who are of the age and capacity to consent to these services are not required to get anyone's authorization to get them or submit a claim on their behalf.
- **Request confidential communications.** You have the right to request that we contact you about medical matters (including sensitive services) privately and with special handling. We will then not give your specified information to anyone without your written permission.
    - You can ask us to send communications about medical matters or sensitive services to another mailing address, email address or telephone number that you choose. If you do not provide another contact method, we will send communications to you at the address or telephone number we have on file.
    - We will honor your requests to get confidential communications in the form and format you asked for. Or we will make sure your communications are easy to put in the form and format you asked for.
    - Your request for confidential communications lasts until you cancel it or submit a new request for confidential communications.
    - We will not ask you for the reason for your request. While we will make every effort to

accommodate reasonable requests, *we are not required to agree to requests.* If we do agree, we will comply unless the information is needed to provide you with emergency treatment.

To request confidential communications or special handling in the way you are contacted, you must mail a written request to HPSM's Privacy Officer.

Mail written requests to HPSM's Privacy Officer at:
Health Plan of San Mateo
Attn: Privacy Officer
801 Gateway Boulevard, Suite 100
South San Francisco, California 94080

- **An accounting of disclosures.** You have the right to request a list of disclosures that we made of your health information. The list does not include some disclosures, such as those made for your treatment, payment for your care, and our operations. It also does not include most other disclosures that we are required or permitted to make without your authorization (such as governmental agencies that review our programs or disclosures you authorize us to make). To request an accounting of disclosures, mail a written request to HPSM's Privacy Officer. Your request must only include dates within the last six years of the date of your request. .
- **Access your health information.**
- Subject to certain exceptions, you have the right to view or get a copy of your PHI that we maintain in records relating to your care or decisions about your care or payment for your care. To request a copy summary, or explanation of this health information, mail a written request to HPSM's Privacy Officer. We may charge a reasonable, cost-based fee.
- In limited situations, we may deny some or all of your request to access these records, but if we do, we will tell you why in writing and explain your right, if any, to have our denial reviewed. by someone other than the person who denied your request. We will comply with the outcome of the review.
- **Receive notice of a breach.** A breach is when protected health information is obtained, used or revealed in a way that violates relevant privacy laws. We are required to send you a notice that explains:
    - What happened.
    - The types of information involved in the breach.
    - Steps you should take to protect your information.
    - What HPSM is doing to investigate the situation, minimize harm to you and prevent future breaches.
- **Amend incorrect or incomplete health and claims records.** You have the right to request an amendment for as long as we maintain the information. A written comment will then be added to your health information at HPSM. To request an amendment, mail a written request to HPSM's Privacy Officer specifying the inaccurate or incorrect health information and reason or evidence that supports your request.
    - If we deny your request to amend your health information, we will tell you why and explain your right to file a written statement of disagreement. You must clearly tell us in writing if you want us to include your statement in future disclosures we make of that part of your record. We may include a summary instead of your statement.

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To learn more about your privacy rights, visit the California Department of Health Services website at www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx.

You will be notified of changes to this notice

We reserve the right to change this notice then make it effective for all health information we already have about you as well as any we receive in the future. We will notify you of changes to this notice by mail within 60 days of the changes. We will also post a copy of the most current notice on our website at www.hpsm.org/privacy-policy.

How to file a grievance regarding your privacy rights

If you believe your privacy rights have been violated, you may file a grievance with HPSM. You will not be penalized for filing a grievance. You may also contact the U.S. Department of Health and Human Services to file a complaint.

Health Plan of San Mateo Attn: Grievance and Appeals Unit 801 Gateway Blvd., Suite 100 South San Francisco, CA 94080 **1-888-576-7557** or **650-616-2850**	**Secretary of the U.S. Department of Health and Human Services** Office of Civil Rights Attn: Regional Manager 90 7th St., Suite 4-100 San Francisco, CA 94103 **1-800-368-1019** or (TTY) **1-800-537-7697**	**California Department of Health Care Services** Attn: Privacy Officer c/o Office of Legal Services 1501 Capitol Avenue P.O. Box 997413, MS0010 Sacramento, CA 95899-7413 **1-916-445-4646** or **1-866-866-0602**

NONDISCRIMINATION NOTICE

Discrimination is against the law HPSM follows State and Federal civil rights laws. HPSM does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

HPSM provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact HPSM Member Services between Monday through Friday, 8:00 a.m. to 6:00 p.m. by calling **1-800-750-4776.** If you cannot hear or speak well, please call TTY 1-**800-735-2929** or **7-1-1**). Upon request, this document can be made available to you in braille, large print, electronic or audio format. To obtain a copy in one of these alternative formats, please call or write to:

Health Plan of San Mateo
Attn.: Member Services
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080
1-800-750-4776 or 650-616-2133
TTY/TDD:1-800-735-2929 7-1-1

HOW TO FILE A GRIEVANCE

If you believe that HPSM has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you can file a grievance with HPSM. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact between Monday through Friday, 8:00 a.m. to 6:00 p.m. by calling **1-800-750-4776.** Or, if you cannot hear or speak well, please call TTY **1-800-735-2929** or dial **7-1-1**.
- In writing: Fill out a complaint form or write a letter and send it to:

Health Plan of San Mateo
Attn.: Civil Rights
Coordinator
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

- In person: Visit your doctor's office or HPSM and say you want to file a grievance.

- Electronically: Visit HPSM's website at grievance.hpsm.org

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **7-1-1** (Telecommunications Relay Service).
- In writing: Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights Department of Health Care Services Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at www.dhcs.ca.gov/Pages/Language_Access.aspx
- Electronically: Send an email to CivilRights@dhcs.ca.gov

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services 200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at www.hhs.gov/ocr/office/file/index.html
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you need help in your language call **1-800-750-4776** (TTY: 1**-800-735-2929**). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-800-750-4776** (TTY:**1-800-735-2929**). These services are free of charge.

الشعار بالعربية (Arabic) يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ **1-800-750-4776** (TTY: **1-800-735-2929**). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل ب(TTY: **1-800-735-2929**) **1-800-750-4776**. هذه الخدمات مجانية.

հայերեն (Armenian): ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1-800-750-4776** (TTY:**1-800-735-2929**): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **1-800-750-4776** (TTY: **1-800-735-2929**): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian): ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-750-4776 (TTY:1-800-735-2929)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-800-750-4776 (TTY: 1-800-735-2929)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

中國人 (Chinese): 请注意：如果您需要以您的母语提供帮助，请致电 **1-800-750-4776** (TTY: **1-800-735-2929**)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 **1-800-750-4776** (TTY:**1-800-735-2929**)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi) توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با **1-800-750-4776** (TTY: **1-800-735-2929**) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با **1-800-750-4776** (TTY:**1-800-735-2929**) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी (Hindi): ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **1-800-750-4776** (TTY: **1-800-735-2929**) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **1-800-750-4776** (TTY:**1-800-735-2929**) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Hmoob (Hmong): CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1-800-750-4776** (TTY:**1-800-735-2929**). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **1-800-750-4776** (TTY: **1-800-735-2929**). Cov kev pab cuam no yog pab dawb xwb.

日本(Japanese): 注意日本語での対応が必要な場合は **1-800-750-4776** (TTY:**1-800-735-2929**)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 **1-800-750-4776** (TTY:**1-800-735-2929**)へお電話ください。これらのサービスは無料で提供しています。

If you have questions, please call Member Services at **1-800-750-4776** or **650-616-2133** (TTY: **1-800-735-2929** or dial **7-1-1**) Monday through Friday 8:00 a.m. – 6:00 p.m. The call is free. For more information visit **www.hpsm.org/healthworx**.

한국인 (Korean)
유의사항: 귀하의 언어로 도움을 받고 싶으시면 **1-800-750-4776** (TTY:**1-800-735-2929**) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **1-800-750-4776** (TTY: **1-800-735-2929**) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ພາສາລາວ (Lao): ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ **1-800-750-4776** (TTY:**1-800-735-2929**). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ **1-800-750-4776** (TTY: **1-800-735-2929**). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien: LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux **1-800-750-4776** (TTY: **1-800-735-2929**). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx **1-800-750-4776** (TTY:1-**800-735-2929**). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

Português (Portuguese): ATENÇÃO: se precisar de ajuda em seu idioma, ligue para **1-800-750-4776** (TTY: **1-800-735-2929**). Auxílios e serviços para pessoas com deficiência, como documentos em braille e letras grandes, também estão disponíveis. Ligue para **1-800-750-4776** (TTY: **1-800-735-2929**). Tais serviços são gratuitos.

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ **1-800-750-4776 (**TTY**:1-800-735-2929)**. ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ**,** ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼**,** ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ **1-800-750-4776 (**TTY**: 1-800-735-2929)**.ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский (Russian): ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1-800-750-4776 (TTY:1-800-735-2929)**. Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1-800-750-4776** (линия **1-800-735-2929)**. Такие услуги предоставляются бесплатно.

Español (Spanish)
ATENCIÓN: si necesita ayuda en su idioma, llame al **1-800-750-4776** (TTY: **1-800-735-2929**). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1-800-750-4776** (TTY:**1-800-735-2929**). Estos servicios son gratuitos.

Tagalog: ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-800-750-4776** (TTY:**1-800-735-2929**). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1-800-750-4776** (TTY:**1-800-735-2929**). Libre ang mga serbisyong ito.

แบบไทย (Thai): โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1-800-750-4776** (TTY:**1-800-735-2929**) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข **1-800-750-4776** (TTY:**1-800-735-2929**) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

українською (Ukrainian): УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **1-800-750-4776** (TTY:**1-800-735-2929**). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер **1-800-750-4776** (TTY:**1-800-735-2929**). Ці послуги безкоштовні.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1-800-750-4776** (TTY:**1-800-735-2929**). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số **1-800-750-4776** (TTY:**1-800-735-2929**). Các dịch vụ này đều miễn phí.

The Health Plan of San Mateo
HealthWorx HMO Program
Member Handbook And Evidence Of Coverage

Introduction

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

Welcome

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

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

The Health Plan of San Mateo is located at 801 Gateway Blvd., Suite 100, South San Francisco, CA 94080. If you need assistance or would like more information regarding the HealthWorx HMO Program, call a Health Plan of San Mateo Member Services Representative. Members' toll-free number for questions, problems or help in choosing a doctor is **1-800-750-4776** or **650-616-2133**. Members with hearing and or speech impairments can use the California Relay Services (CRS) at **1-800-735-2929** or dial **7-1-1**. The Member Services Call Center hours are Monday through Friday8:00 a.m.–6:00 p.m., Our office hours are Monday through Friday 8:00 a.m.–5:00 p.m.

About the Health Plan of San Mateo

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

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

The Health Plan of San Mateo makes personal, cost effective, and convenient health care available for you. HPSM works to meet your health care needs through a network of qualified Medical Groups, Clinics, hospitals, pharmacies, and other Health Care Providers located throughout San Mateo County.

As an HPSM Member, your health care needs will be managed by the Primary Care Physician you select from among the many physicians who are part of the Health Plan. Your Primary Care Physician will take care of most of your health care needs, including preventive care

such as checkups, immunizations, and PAP smears for women. Your Primary Care Physician will refer you to Specialists when necessary and will make arrangements for hospitalization when required.

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

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

HealthWorx HMO is an insurance plan that covers:

- In-Home Supportive Services (IHSS) Workers employed by the San Mateo County Public Authority (SMCPA)
- Part-Time Employees of the City of San Mateo
- Specific program information may differ depending on the worker's employer. These differences are noted.

Premiums, Eligibility, Enrollment, Termination for In-Home Supportive Services (IHSS) Workers

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

Who Is Eligible?
The San Mateo County Public Authority (SMCPA) is required to inform you about their eligibility requirements. To enroll, you must meet SMCPA requirements that HPSM has approved, and you must live or work in our Service Area, which is San Mateo County. **You also must not be covered by other health insurance.** The Service Area is described in the "Definitions" section of this HealthWorx HMO Member Handbook and Evidence of Coverage. In addition, you must meet the Member eligibility requirements below.

You are eligible to enroll as a Member if:

1. You are an In-Home Supportive Services Worker under the San Mateo County Public Authority (SMCPA) who works a specified number of hours as determined by SMCPA
2. You do not have other health coverage
3. SMCPA has openings available to add Members to the HealthWorx HMO Program.

Enrollment
You may apply for health coverage by submitting a Health Plan-approved enrollment application to The Public Authority. The Public Authority will notify you when the eligibility requirements have been met and of your effective date of Coverage. Membership begins at 12:01 a.m. on the effective date.

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

Public Authority for IHSS
225 37th Ave.
San Mateo, CA 94403
650-573-3773

Termination of Coverage
A Member's Coverage will be terminated if:

1. The San Mateo County Public Authority fails to pay the Member's Premium in accordance with the Group Agreement; or
2. The Member no longer lives or works in San Mateo County; or
3. The Member is found to have other health Coverage.

The San Mateo County Public Authority will provide written notification to the Member no less than thirty (30) days prior to the effective date of termination. The notice will be in writing and sent by regular U.S. Mail to the Member's address on file with the San Mateo County Public Authority. The notice will clearly indicate the last day of Coverage.

Premiums, Eligibility, Enrollment, Termination, For City of San Mateo Part- Time Employees

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

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

If you have any questions about eligibility, please call the Service Employees International Union at **408-678-3300**.

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

HPSM-approved enrollment application to SEIU.
If you have questions about enrollment, please contact the SEIU at:

Service Employees International Union (SEIU), Local 521
2302 Zanker Rd
San Jose, CA 95131
408-678-3300

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

Continuation of Group Coverage Under Federal or State Law
Health Benefits under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). If you reside in San Mateo County or lost your Coverage due to reduction of hours and maintaining continued health coverage is important to you, you may be able to continue your Coverage under HealthWorx HMO. The Coverage can continue at your expense for up to 36 months in accordance with federal and State COBRA laws after you would otherwise lose eligibility due to either termination or a reduction in hours (to fewer than 35 hours/month). If you qualify for COBRA, the San Mateo County Public Authority or the City of San Mateo's third-party administrator (Navia Benefits) will send you an enrollment form for continued Coverage through COBRA with a letter notifying you of the opportunity to continue your HealthWorx HMO Benefits. You must complete the enrollment form and return it to the San Mateo County Public Authority or Navia Benefits for the City of San Mateo, no later than 60 days from the date of the letter. Monthly Premiums for COBRA are payable to the San Mateo County Public Authority or, for the City of San Mateo, Navia Benefits by the 23rd of the month prior to the month Coverage will be effective. Your initial payment for continued Coverage through COBRA will be due no later than forty-five days after you have signed, dated, and submitted your enrollment form. If you have any questions about COBRA, you should contact the San Mateo County Public Authority at **650-573-3900** Ext. 3649 or Navia Benefits for the City of San Mateo at **877-910-8675**.

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

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

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

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

- HPSM staff speak several languages, including Spanish and Tagalog. The Member Services staff is available from 8:00 a.m. to 6:00 p.m. Monday through Friday at **1-800-750-4776** or **650-616-2133** to answer questions, solves problems, or helps you choose a doctor.

- You can see doctors who speak your language. The HealthWorx HMO Provider List has

information about languages spoken in each office, office locations and hours available for appointments, including evening and weekend hours. The Member Services staff can help you choose doctors if you need help or have questions.

- Free interpreter services are available by phone. You do not have to use family or friends as interpreters.
- Sign language interpreters are also available. You do not have to use family or friends as interpreters.
- You can request HealthWorx HMO documents in Spanish, Chinese and Tagalog.

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

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

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

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

How to Use this Member Handbook and Evidence of Coverage
Please read the entire Member Handbook and Evidence of Coverage. Many of the sections go together. If you read just one or two sections you may not have complete information about HealthWorx HMO.

Many words used in the Member Handbook and Evidence of Coverage have special meanings. These words are defined in Section 1, Definitions, and appear in this booklet with capital first letters. Refer to the Definitions to help you understand a Member's Benefits, rights and responsibilities under the Health Plan of San Mateo, HealthWorx HMO Program. From time to time, the Health Plan's contract with the San Mateo County Public Authority or City of

San Mateo may be changed. If that happens, a new Evidence of Coverage or an Amendment of this Evidence of Coverage will be sent to you. Please keep your copy of the most current Evidence of Coverage in a safe place.

If You Have Questions

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

Section 1: Definitions

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

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

Advanced Health Care Directive means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

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

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

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

Appropriately Qualified Health Care Provider means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
    - The National Institutes of Health.
    - The federal Centers for Disease Control and Prevention.
    - The Agency for Healthcare Research and Quality.
    - The federal Centers for Medicare and Medicaid Services.
    - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
    - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of

peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

- The United States Department of Veterans Affairs.
- The United States Department of Defense.
- The United States Department of Energy.

- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.

- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

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

Behavioral Health Treatment means professional services and treatment programs that meet specific criteria, prescribed by a physician or developed by a psychologist, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder.

A treatment plan is required and is reviewed periodically using evidence-based practices to meet treatment goals and objectives. The treatment must be provided under a treatment plan prescribed by a qualified autism service provider, administered by one of the following:

- A qualified autism service provider.
- A qualified autism service professional supervised and employed by the qualified autism service provider.

A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.

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

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

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

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

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

Co-payment means an amount a Member must pay for certain Benefits, at the time of a medical appointment.

Covered Benefits means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this Evidence of Coverage or under California health plan law.

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

DMHC means the Department of Managed Health Care.

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

Emergency Medical Condition means a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

i) Placing the patient's health in serious jeopardy;
ii) Serious impairment to bodily functions; or
iii) Serious dysfunction of any bodily organ or part.

Emergency Services and Care means (1) medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or Active Labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or (2) an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility.

Evidence of Coverage means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

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

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

grievance.

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

Health Care Provider means any professional person, Medical Group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

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

Iatrogenic Infertility means Infertility caused by a medical intervention, including, but not limited to, reactions from prescribed drugs or from medical and surgical procedures.

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

Independent Medical Review (IMR) means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to medical necessity of a proposed service or treatment, Coverage Decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. Your Plan must pay for the services if an IMR decides you need it.

Infertility means a condition or status characterized by any of the following:

- A licensed physician's findings, based on the patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of Infertility before the 12-month or 6-month period to establish Infertility.

- A person's inability to reproduce either as an individual or with their partner without medical intervention.

- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having Infertility.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

(1) Testing is not complete; and

(2) The efficacy and safety of such services in human subjects are not yet established; and

(3) The service is not in wide usage.

Life-Threatening means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

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

Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.

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

Member means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the HealthWorx and for whom coverage is active or live.

Mental Health or Substance Use Disorder means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Outpatient Prescription Drug means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

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

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

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

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

Prescription Drug or "drug'' means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug'' or "Prescription Drug'' includes: (A) disposable devices that are Medically Necessary for the administration of a covered Prescription Drug, such as spacers and inhalers for the administration of aerosol Outpatient Prescription Drugs; (B) syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes; (C) drugs, devices, and FDA-approved products covered under the Prescription Drug Benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (D) at the option of the health plan, any vaccines or other health care Benefits covered under the HealthWorx Prescription Drug Benefit.

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

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

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Reconstructive Surgery is 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.

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

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

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

Seriously Debilitating means diseases or conditions that may cause major irreversible morbidity.

Service Area means the geographic area designated by the plan within which a plan shall provide health care services.

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

Standard Fertility Preservation Services means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

State means the State of California.

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

Trans-Inclusive Health Care means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

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

Section 2: Members' Rights and Responsibilities

As a Member, you have the right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the Plan's member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your Plan's network, including one with a Specialist.
- Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for your disability, including:
    - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
    - Full and equal access, as other members of the public, to medical facilities.
    - Extra time for visits if you need it.
    - Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
    - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
    - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition,

regardless of cost or benefit coverage.

- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and State and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or Medical Group leaves your Plan or you are a new Plan Member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
    - Your Plan or Health Care Provider.
    - Any care you receive, or access to care you seek.
    - Any covered service or benefit decision that your Plan makes.
    - Any improper charges or bills for care.
    - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
    - Not meeting your language needs.

- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.
- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

As a Plan Member, you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
- Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.
- Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.
- Timely pay any Premiums, copayments, and charges for non-covered services.
- Notify your Plan as soon as reasonably possible if you are billed inappropriately.

Section 3: Using the Health Plan

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

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

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

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

How to Choose or Change Your Primary Care Physician

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

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

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

Some doctors and hospitals and other providers do not provide one or more of the following services that may be covered under HealthWorx HMO and that you might need:

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

- Infertility treatments
- Abortion

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

There are three ways you can choose a new PCP:

1) Use the Member Portal on HPSM's website at www.hpsm.org/member-portal-login.

2) Call Member Services at **1-800-750-4776** (toll-free) or **650-616-2133**. They are open Monday through Friday, 8:00 a.m. to 6:00 p.m. TTY users: **1-800-735-2929** or dial **7-1-1**.

Do NOT choose a PCP marked "EPO"

(*established patients only*)

EPO means the PCP is not taking new patients

Use the HPSM Provider Directory. If you do not have a print directory, you can use the online version at www.hpsm.org/findprovider. Then fill out the enclosed PCP Selection/Change form. Mail it to HPSM in the prepaid return envelope. Or fax it to Member Services at **650-616-8581**.

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

If you do not choose a Primary Care Physician when you enroll in the HealthWorx HMO 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 when you are well—not when you are sick.

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

doctor is important.

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

Changing Your Primary Care Provider

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

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

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

A PCP change will be effective the first day of the following month, if we receive the change by the 22nd day of the month.

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

Continuity of Care for New Members

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

- An Acute Condition. Completion of Covered Services shall be provided for the duration of the Acute Condition.
- A Serious Chronic Condition. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by HPSM in consultation with you and the

non-participating provider, and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time you enroll with HPSM.

- A pregnancy, including postpartum care. Completion of Covered Services shall be provided for the duration of the pregnancy. Maternal mental health care during pregnancy shall not exceed twelve (12) months from the diagnosis or from the end of 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 36 months. Completion of Covered Services shall not exceed twelve (12) months from the time you enroll with HPSM.
- Performance of a surgery or other procedure that your previous plan authorized as part of a documented course of treatment and that has been recommended and documented by the non-participating provider to occur within 180 days of the time you enroll with HPSM.

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

We will request that the non-participating provider agree to the same contractual terms and conditions that are imposed upon Participating Providers providing similar services, including payment terms.

If the non-participating provider does not accept the terms and conditions, HPSM is not required to continue that provider's services. HPSM is not required to provide continuity of care as described in this section to a newly covered Member who was covered under an individual subscriber agreement and undergoing a treatment on the effective date of his or her HealthWorx HMO Coverage. Continuity of care does not provide Coverage for Benefits not otherwise covered under this agreement.

A Member Services Representative will notify you of HPSM's decision. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see HPSM's Grievance and Appeals Process on page 84.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, **1-888-466-2219**; or at the TDD number for the hearing impaired, **1-877-688-9891 or 7-1-1**; or visit the DMHC website for more information: www.dmhc.ca.gov.

Continuity of Care for Termination of Provider

If your Primary Care Physician or other Health Care Provider stops working with HPSM, we will let you know by mail 60 days before the contract termination date or as soon as the provider informs us.

HPSM will provide continuity of care for Covered Services rendered to you by a provider

whose participation has terminated, if you were receiving this care from this provider prior to termination and you have one of the following conditions:

- An Acute Condition. Completion of Covered Services shall be provided for the duration of the Acute Condition.
- A Serious Chronic Condition. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by HPSM in consultation with you and the terminated provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the provider's contract termination date.
- A pregnancy, including postpartum care. Completion of Covered Services shall be provided for the duration of the pregnancy. Maternal mental health care during pregnancy shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy.
- A Terminal Illness. Completion of Covered Services shall be provided for the duration of the Terminal Illness. Completion of Covered Services may exceed twelve (12) months from the time the provider stops contracting with HPSM.
- The care of a newborn child between birth and age 36 months. Completion of Covered Services shall not exceed twelve (12) months from the provider's contract termination date.
- Performance of a surgery or other procedure that HPSM had authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the provider's contract termination date.

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

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

A Member Services Representative will notify you of HPSM's decision. If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see HPSM's Grievance and Appeals Process on page 84.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, **1-888-466-2219**; or at the TDD number for the hearing impaired, **1-877-688-9891 or 7-1-1**; or visit DMHC website for more information: www.dmhc.ca.gov.

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

Sensitive Services
Sensitive services include all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence.

As a HealthWorx Member, you are not required to obtain the approval of the HealthWorx policyholder or primary subscriber, or any other HealthWorx Member to receive sensitive services, or to submit a claim for sensitive services when you have the right to consent to care.

You will receive all communications from HPSM regarding your receipt of sensitive services directly to you at the address, email address, or telephone number you have on file. If you request it, HPSM can send all communications to an alternate address, alternate email address, or alternate telephone number. See "confidential communication" below for instructions.

All communications includes:

1) Bills and attempts to collect payment.
2) Notices of adverse Benefits determination (denial letters).
3) Explanation of Benefits notices.
4) Requests for additional information regarding a claim.
5) Notices of contested claims.
6) The name and address of a provider, description of services provided, and other information related to a visit.
7) Any written, oral, or electronic communication from HPSM that contains your protected health information.

HPSM will not disclose medical information related to sensitive services provided to you to any other HealthWorx policyholder, HealthWorx primary subscriber, or any other HealthWorx Member unless you give HPSM express written authorization to do so.

A STATEMENT DESCRIBING HPSM'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Confidential Communication

You can request confidential communication in your preferred form and format, if HPSM is able to produce the form or format, or at an alternate location such as an alternate mailing address, email address, or telephone number. You must make your request for confidential communication in writing or via electronic transmission (email or fax).

A request for confidential communication will apply to all communications that disclose medical information or providers names and addresses related to your receipt of medical care.

Confidential communication requests will be processed by HPSM with seven (7) calendar days of receipt of an email or fax, or within 14 calendar days of a written request received by mail. HPSM will acknowledge receipt of your request and advise you on the status of the processing of your request.

Written requests must be sent to the following address:

Member Services Department
Health Plan of San Mateo
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

To make a request by telephone, call HPSM Member Services at **1-800-750-4776**, or **650-616-2133** (TTY: **1-800-735-2929** or dial **7-1-1**).

You can email your request to:

customersupport@hpsm.org

Or, you can fax your request to:

Fax: 650-616-8581

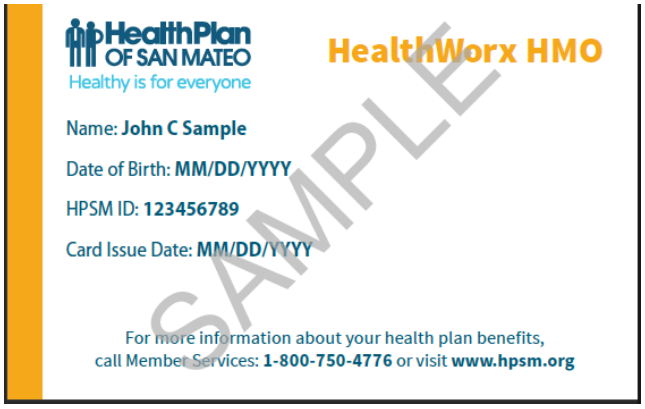
Your request for confidential communication is valid until you submit a revocation of the request, or a new confidential communication request is submitted.

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

Section 4: Procedures for Obtaining Health Care Services

Member Identification Card

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



Front side of card

Back side of card
This side describes how you use the card

A picture of the Member Identification Card is shown above.

ID #:	This is the number assigned to you by HPSM.
Care Issue Date:	This date shows when the information on this card became effective.
Name:	This person is eligible to receive Benefits under the HealthWorx HMO
PCP:	Program. This is your Primary Care Physician.
DOB:	This is your date of birth.
Co-payment:	This is the amount that you will need to pay for certain Benefits, usually at the time of an appointment. Refer to Section 6 for a complete list of Co-payments.

Timely Access to Non-Emergency Health Care Services
Sometimes it is hard to know what kind of care you need. Your doctor or a nurse will be ready to help you by phone 24 hours a day, seven days a week. This is known as "triage." Here are some of the ways that triage can help you.

- They can answer your questions about a health concern and teach you about self-care at home if needed.
- They can guide you about whether you should get health care, and how and where to get care if you are not sure whether your health issue is an Emergency health issue, they can help you decide whether you need Emergency Health Care Services or Urgent Care, and how and where to get that care).
- They can tell you what to do if you need care and your provider's office is closed.

HPSM providers will make sure that you speak with a doctor or nurse over the phone within a time span that is right for your health issue. The waiting time to get a call back from a doctor or nurse will not be longer than 30 minutes.

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

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

If you cannot reach your doctor, a nurse from Nurse Advice Line can triage your health issues and answer some health care questions. You can call the Nurse Advice Line 24 hours per day, 7 days per week. Call Nurse Advice Line at **1-833-846-8773**. TTY users call **1-800-735-2929** or dial **7-1-1**. This call is free.

You have the right to interpreter services to help in getting services. Interpreter services are available by phone free of charge 24 hours per day at service sites, such as your doctor's office. You do not have to use family members, friends, or children as interpreters.

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

Members with hearing and or speech impairments can call TTY: **1-800-735-2929**, or dial **7-1-1** (California Relay Service).

Scheduling Appointments
When you get your ID card, you need to call your main doctor, also called your primary care provider (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. As a new Member you should have a first well exam within four (4) months of being an HPSM Member. During your first well exam, your doctor will record your whole health history and give you a physical exam. This first well exam assesses your health status and health risk.

To make an appointment with your PCP, call the PCP's phone number on your HPSM ID Card. You can ask the office staff how to make appointments, rules about appointments, and directions to the office. We suggest that you go to your doctor's office about 15 minutes

before your appointment. **It is very important to keep your appointments**. This is a key way for you and your PCP to get to know each other and your health care needs. You will need to show your HPSM ID Card. For urgent or routine care, always call your PCP.

When you are sick, call your doctor's office for an appointment. The doctor's office staff will talk to you about seeing the doctor. They will tell you what to do and where to go. By calling your doctor early, you may be able to avoid a trip to the hospital emergency room.

HPSM has to make sure that your doctors give you an appointment that is right for your health care needs. The table below shows the wait time based on the type of appointment you need.

Appointment type	**Waiting time from the day appointment is requested**	**Type of Provider/ Approval**	**Examples**
Urgent Care	Within 2 days (48 hours)	HPSM approval NOT needed	
Urgent Care	Within 4 days (96 Hours)	HPSM approval needed	
Non-Urgent Care	Within 2 weeks (10 business days)	Primary Care Provider	Primary Care Provider
Non-Urgent Care	Within 3 weeks (15 business days)	Specialist Physician	Eye, Ear-Nose-Throat, Orthopedists
Non-Urgent Care	Within 2 weeks (10 business days)	Non-Physician Mental Health Care Provider	Psychologist, Marriage Family Therapist
Non-Urgent Care	Within 3 weeks (15 business days)	Ancillary Services for the diagnosis or treatment of injury, illness, or other health conditions	X-rays, physical therapy

Telehealth Visits

Telehealth visits are available to you. Telehealth means the mode of delivering Covered Services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care from a site where the Member is located at the time healthcare services are provided or the site where the Member's medical information is transmitted from without the presence of the Member to a site where the Provider is located while providing these services, including the real time interactive communication between the Member and the Provider. HPSM will provide Coverage for health care services appropriately delivered through telehealth on the same basis and to the same extent that the Plan is responsible for Coverage for the same service through in-person diagnosis, consultation, or treatment.

Women's Services

Female Members have direct access to OB/GYN services. Members may choose to have these services provided by any Primary Care Physician, including Family Practitioners, Internists

and General Practitioners qualified to provide OB/GYN services and minor surgery. Members may self-refer to any contracted OB/GYN or Primary Care Physician within the HealthWorx HMO network for OB/GYN services.

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

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

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

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

This will ensure that you receive the highest quality care in a timely manner. The authorization number on the Referral Authorization Form (RAF) lets the Specialist know that your PCP has approved your visit and that the Specialist will receive payment from HPSM for their services. Additional visits to the Specialist, if needed, will be arranged by the Specialist. Your PCP will provide directions on how to obtain the specialty care. This may either be in writing or verbal instructions.

Standing Referrals
If you have a condition or disease that requires specialized medical care over a prolonged period of time, you may need a standing Referral to a Specialist in order to receive continuing specialized care. If you receive a standing Referral to a Specialist, you will not need to get Authorization every time you see that Specialist. Additionally, if your condition or disease is Life-Threatening, degenerative, or disabling, you may need to receive a standing Referral to a Specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the Specialist coordinate your health care. To get a standing Referral, call your Primary Care Physician. If you have any difficulty getting a standing Referral, call HPSM at **1-800-750-4776** or **650-616-2133**. Members with hearing and or speech impairments can call TTY: **1-800-735-2929**, or dial **7-1-1** (California Relay

Service). If, after calling the Plan, you feel your needs have not been met, please refer to HPSM's Grievance and Appeals Process on page 84.

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

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

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

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

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

If you ask for a second opinion about care, you will receive a second opinion from an Appropriately Qualified Health Care Provider of your choice in HPSM's network. If there is no Appropriately Qualified Health Care Provider within HPSM's network, HPSM will authorize a second opinion from an appropriately qualified non-participating Health Care Provider. In this case, a written Referral authorized by HPSM is required. You will be responsible for paying all Co-payments for the second opinion.

If your request to obtain a second opinion is denied and you would like to appeal our decision, please refer to HPSM's Grievance and Appeals Process on page 84.

This is a summary of HPSM's policy regarding second opinions. To obtain a copy of our policy, please contact us at **1-800-750-4776** or **650-616-0050**.

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

provider for the services, after obtaining Authorization from HPSM.

Utilization Review

Prior Authorization (PA) for Services
Some medical services and some medications that are billed under your medical benefit need prior Authorization from HPSM. Prior Authorization means HPSM and your doctor agree that the services that are needed are Medically Necessary for your treatment before you receive the service or medication. To receive these services, your doctor will need to submit a prior Authorization request by sending a prior Authorization request form to HPSM. This is a request for a service/treatment that needs pre-approval from HPSM. When HPSM receives this form, it is reviewed by our medical staff (doc or, nurse, and/or pharmacy staff for approval. When we review the prior Authorization request, we use current clinical guidelines that meet State and national standards to help make the decision about whether the service or medication requested for you is Medically Necessary. Most prior Authorization requests are approved, but in some cases, they may be denied or deferred. When a prior Authorization request is denied for a medical reason, that means it has not been approved for the services/treatments that your doctor requested. You and your doctor will then get a letter explaining why the prior Authorization request was denied, and why HPSM's medical staff has determined that the service is not Medically Necessary. The letter will also explain your right to appeal the decision and how to appeal the decision. If your prior Authorization request is denied for an administrative (non-medical) reason, we will explain (in a notice to you and your doctor) the reason for the denial. Reasons for administrative prior Authorization request denials can include such things as: you do not have HPSM eligibility for the time under review or the service is covered by the State and not by HPSM.

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

We respond to non-urgent prior Authorization requests sent to HPSM within five (5) working days. If a prior Authorization request is urgent, we will respond to it **as Medically Necessary but no later than 72 hours**. Requested services are reviewed for medical necessity. Criteria and guidelines used to review prior Authorization requests are developed with input from practicing Health Care Providers and are consistent with sound clinical principles and processes.
Criteria and guidelines are evaluated at least annually and updated as necessary. HPSM can provide you with guidelines or criteria used for a specific prior Authorization request decision. Please remember that these relate to the treatment or service requested, the Benefits covered under HealthWorx HMO, and individual need. HPSM's overall policies and procedures for making prior Authorization request decisions are also available upon request.

Services That Do Not Need Prior Authorization
Some services do not require prior Authorization or a Referral from your primary care provider (main doctor). You may go straight to the Health Care Provider for the services listed below. Some of these services are limited. Please see the Benefits section for more info.

1. Emergency and out of area urgent services.
2. Primary and Preventive Care Services.
3. Mental Health or Substance Use Disorder office visits, as well as visits with

Psychiatrists, Psychologists, and Licensed Clinical Social Workers.

4. Family Planning/Sexually Transmitted Disease and Private HIV/AIDS Testing.

   These are services that relate to the prevention, care, or planning of pregnancy. This includes birth control, emergency birth control services, pregnancy tests, prenatal care, abortion, and abortion-related procedures. This also includes the screening, prevention, testing, diagnosis, and care of sexually transmitted infections (STIs), sexually transmitted diseases (STDs), and HIV/ AIDS. This also includes services about the diagnosis and care of sexual assault or rape, as well as the collection of medical proof for the sexual assault or rape. You can get these services from your primary care provider (main doctor), participating family planning office, OB/GYN, or any other trained provider who provides these services. See pages 63 and 70 for more information.

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

   HPSM's Member Services staff can help you find a family planning clinic, or you can call the California Office of Family Planning's Information & Referral Service toll-free number at **1-800-942-1054**.

5. Women's Services:

   Female Members have unlimited, direct access to OB/GYN services. Members may choose to have these services provided by their primary care provider (main doctor) or Members may self-refer to any OB/GYN or primary care provider within HPSM's network for these services.

6. Acupuncture and Chiropractic services are provided as a self-referral benefit up to a maximum of twenty (20) visits each per Benefit Year.

7. Indian Health Services:

8. Behavioral Health Treatment for Autism Spectrum Disorder

If you are an American Indian or Alaskan Native and a Member of HPSM, as provided under federal law, you may choose any available Indian Health Service Provider. The provider does not have to be an HPSM network provider and HPSM will make arrangements to arrange services for you.

Mental Health or Substance Use Disorder Clinical Criteria Education Program

In conducting utilization review of all Covered Services pertaining to the diagnosis, prevention, and treatment of Mental Health or Substance Use Disorder of Members, HPSM applies the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. In order to ensure the proper use of this criteria, HPSM sponsors a formal education program by nonprofit clinical specialty associations to educate HPSM's staff, including any third parties contracted with HPSM to review claims, conduct utilization reviews, or make medical necessity determinations, about the clinical review criteria. All utilization review determination criteria and any education program materials will be made available to Member, Member's authorized representative, and Member's provider(s) upon request at no cost.

Additional Mental Health And Substance Use Disorder Rights

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If HPSM fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Dental and Vision Services for IHSS Workers Only
Dental and Vision Services are covered through the Services Employees International Union (SEIU), Local 521 for those IHSS workers who meet eligibility requirements. For more information about Dental and Vision Benefits, Members need to call the SEIU, at **1-800-842-6635** If you call SEIU, please identify yourself as a San Mateo County IHSS worker.

Dental and vision services are not a Covered Benefit for City of San Mateo Employees.

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

To obtain Urgent Care when you are inside HPSM's Service Area on nights and weekends, call your Primary Care Physician's office even during the hours that your PCP's office is normally closed.

Your PCP or a doctor on call will always be available to tell you how to handle the problem at home or if you should go to an Urgent Care center or a hospital emergency room.

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

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

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

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

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

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

If you have an Emergency Medical Condition, call **9-1-1** or go to the nearest hospital emergency room.

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

Follow-up Care
After receiving emergency health care services necessary to stabilize your Emergency Medical Condition, be sure to follow up with your Primary Care

Physician.

Getting Pharmacy Benefits

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

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

Over-the-Counter/Non-Prescription Drugs
Most over-the-counter medications are excluded from HealthWorx, but HPSM may cover some (such as aspirin 81 mg, smoking cessation products, contraceptives which are mandated by the ACA).

The Health Plan of San Mateo Drug Formulary
HPSM has a list of medications that are covered by your pharmacy benefit. This list is called a Drug Formulary (covered drug list). Medications are added to the Formulary by HPSM's Pharmacy and Therapeutic Committee (P&T). This committee has pharmacists and doctors who decide what medications are included on the Formulary. If you would like to know which medications are on the Formulary visit our website at www.hpsm.org or call a Member Services Representative at **1-800-750-4776** or **650-616-2133** for a copy.

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

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

Brand Name Medications Requested by the Member
Brand name medications which have a generic version available are generally not covered unless there is a medical reason for using it or if the drug has a narrow therapeutic index (a drug where small changes in the dosage level could cause toxic results). In order to get a brand name drug with a generic version available covered, your doctor will need to submit a prior Authorization (PA) to HPSM in order to get it approved. For brand-name drugs with no generic equivalent, HPSM generally covers them if it is listed on the HealthWorx Formulary. If the drug is not listed on the Formulary, your doctor will need to consider changing to a drug that is listed or submit a PA to HPSM to get the unlisted drug approved (see section on "Non-Formulary Drugs").

A narrow therapeutic index means that very small changes in the dosage level of the drug could cause toxic results. To receive a list of medications that are called "Narrow

Therapeutic Index" medications, you can contact HPSM at **1-800-750-4776** or **650-616-2133** and speak to a Member Services Representative. Members with hearing and or speech impairments can call TTY:**1-800-735-2929**, or dial **7-1-1** (California Relay Service).

Non-Formulary Drugs
HPSM's participating doctors and pharmacies are responsible for using the Formulary. If a drug is prescribed that is not on the Formulary, your doctor should consider changing to one that is on the Formulary. If the substitution of a Formulary medication is not appropriate as determined by the doctor, he or she must submit a PA form by fax to HPSM for the non-formulary medication with medical justification in order for the drug to be covered. If the PA is approved based on criteria developed by HPSM staff pharmacists and Medical Director, then the non-formulary medication will be approved.

The average time to process a prior Authorization (PA) request for a non-formulary medication is usually within 24 hours. More time may be needed to process the request if the PA is incomplete or more information is needed. If you have any questions about a request for a non-formulary medication, please talk to your doctor.

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

However, there may be a need for you to use a medication for a condition that is not on the medication label. This is called off-label usage. HPSM allows doctors to prescribe medication for off-label use if there is enough information to support its use for the condition it is being prescribed for. Sometimes, medication prescribed for off-label use requires a PA for reimbursement.

Formulary Drugs with Prior Authorization, Step Therapy, Quantity Limits, or other Restrictions
Some drugs on the Formulary have certain restrictions such as prior Authorization requirements (PA), step therapy (ST), and quantity limits (QI). For drugs that require a prior authorization, your doctor will need to submit a PA to HPSM for approval. For drugs which require a step therapy or quantity limit and you do not meet these requirements, your doctor will also need to submit a PA to HPSM for approval.

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

Submitting Prior Authorization Requests.
As described above, there are several cases when a Prescription Drug Prior Authorization Request Form (PA) is required to get the drug you want. Some examples are:

- Getting a brand name drug which has a generic version available
- Getting a drug that is not on the HPSM Formulary
- Getting a drug for off-label use
- Getting a drug which is on the Formulary and requires a prior Authorization or if you do not meet the requirements as outlined on the Formulary

HPSM pharmacy staff processes all prior Authorization (Pas). Your doctor or your pharmacist can send a PA to HPSM via fax to Pharmacy Services at **650-829-2045** during HPSM's office hours, Monday to Friday from 8:00 a.m. to 5:00 p.m.

The average time to process a pharmacy related PA is usually within 24 hours. More time may be needed if the PA is incomplete or more information is needed. If you have any questions about a PA, please talk to your doctor.

Evening, Weekend or Holiday Prior Authorization Requests (PAs)
HPSM is available to review PAs Mondays through Fridays during regular business hours from 8:00 a.m. to 5:00 p.m. In urgent situations that arise on weekends or holidays, while waiting for a review decision, Members may be given up to a three-day supply of medication to allow time for the pharmacy to receive HPSM's decision on the next business day. The pharmacist can call the pharmacy call center at HPSM's Pharmacy Benefits Manager (PBM), SS&C at **1-888-635-8384**, for an emergency override. A one(1)-time fill may be authorized.

Changes in Formulary Medications
The Formulary can change as often as monthly. These changes include, but are not limited, adding or removing drugs from the Formulary or changing other restrictions such as quantity limits, prior Authorization, or step therapy requirements. HPSM will notify you by mail if any changes affect you. You may also find out about the most recent updates on our website at www.hpsm.org/drug-benefits or call a Member Service Representative at **1-800-750-4776** or **650-616-2133**

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

Section 5: Member Financial Responsibility

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

Other Member Payment Responsibilities
For Covered Services, Members are generally responsible only for Co-payments. However, you may also be responsible for:

- Services that need a Referral or Authorization if you get them without a Referral from your Primary Care Physician or Authorization from HPSM

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

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

In the event HPSM does not pay a Participating Provider for Covered Services, the Member will not be liable to have to pay the Provider for any sums owed by HPSM. However, if HPSM does not pay a non-participating provider for Covered Services, the Member may be liable to have to pay the non-participating provider for the cost of such services. A Member may also be liable for payment of non-covered services, whether received from a Participating or non-participating provider.

For example, if you need services that are not available from HPSM Providers, you must first talk with your PCP or mental health provider. The PCP or mental health provider will in turn get Authorization to refer you to a non-participating provider. If you do not go to your PCP or mental health provider for the necessary approval, or if you fail to adhere to HPSM's Referral procedures, you may not be covered for such services and you may have to pay the entire cost. If you need emergency care; however, you may receive the services from a non-participating provider without a Referral or Authorization. Please see the Emergency Services and Care section on page 66 of this Evidence of Coverage. Also refer to the Second Opinion Policy section, on page 45 for specifics regarding Second Opinion Referral.

Claims Reimbursement

To make sure your doctor knows how to bill for your care, please tell the doctor's office staff that YOU are an HPSM Member and show your HPSM ID card. If you are asked to pay for services, please ask the doctor to call HPSM so we can explain to them how to bill us. However, if you are billed for a service by a provider who is in HPSM's network, you may submit the bill to HPSM. You must submit a copy of the bill with your name, ID number (on your Member ID card), your phone number, and date and reason for the bill. If you paid the bill you will need to submit proof of payment acceptable to HPSM (such as a receipt indicating payment and description of services received). Send the bill to:

Member Services Department
Health Plan of San Mateo
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080
Email: customersupport@hpsm.org
Fax: 650-616-8581

Your written request for reimbursement should be mailed to HPSM within 90 days (3 months) of the date you received the services, or as soon as reasonably possible, but in no event later than 12 months after receiving the care.

Section 6: Covered Services, Benefits and Co-Payments

Introduction
This Section describes the Covered Services and Benefits provided to HealthWorx HMO Members. The services described in this section are Covered Services if they are Medically Necessary. The decision whether services are Medically Necessary will be made by your Primary Care Physician or the Health Plan of San Mateo. This decision is based on generally accepted medical standards, State laws and regulations, and HPSM policies. Emergency medical services do not require prior Authorization.

However, a decision regarding the need for Emergency Services and Care may occur after services have been provided. If you disagree with a decision on medical necessity or on whether a particular situation was an Emergency Medical Condition, you can request a review by the Health Plan of San Mateo through the Grievance procedure described in Section 8. At the beginning of this Section is a review of summary of Benefits, Co-payments, and conditions.

HPSM provides the Covered Services and Benefits described in this Evidence of Coverage. Most Covered Services are available to you when Medically Necessary and received from, referred by, or authorized by HPSM or your Primary Care Physician. Some are available without a Referral and some require a Co-payment. There are no Co-payments for preventive services and no Co-payments for emergency room medical care and follow-up health care treatment for a Member who is treated following a rape or sexual assault. There are no annual or lifetime benefit maximums in any of the Coverage under the HealthWorx HMO Program.

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

Summary of Benefits, Co-Payments and Conditions

Benefits	Co-Payments	Conditions
Physician Services		
For adults age appropriate immunizations and periodic health exams	No Co-payment	As specified by HPSM and in keeping with current preventive health standards of the U.S. Public Health Services and the American Academy of Pediatrics.
Hearing and vision testing	No Co-payment	

Benefits	Co-Payments	Conditions
Primary Care Physician and specialty office visits, including allergy testing and treatment, and second opinions	$5.00 per visit, except where no Co-payment is indicated	Most specialty visits require a Referral from the PCP (see page 45).
Prenatal Care	No Co-payment	
Outpatient surgery, anesthesia, radiation therapy, chemotherapy, dialysis treatments	No Co-payment	
Inpatient visits in a hospital, skilled nursing facility, hospice or Mental Health or Substance Use Disorder facility	No Co-payment	
Urgent Care services	$5.00 per visit	
Home visits	$5.00 per visit	
Reconstructive Surgery	No Co-payment	As Medically Necessary
Hospital		
Inpatient services, including doctors' services, surgical services, anesthesia, lab, x-ray, drugs, medical supplies, blood and blood products, rehabilitation therapies and services (physical therapy, occupational therapy, speech therapy, respiratory therapy)	No Co-payment	Includes inpatient hospital services, nursing in connection with dental procedures when hospitalization is required because of an underlying medical condition, clinical status, or because of the severity of the dental procedure.
Outpatient services, except emergency room visit	No Co-payment	

Benefits	Co-Payments	Conditions
Emergency Services and Care		
Emergency room visits	$25.00 per visit	$25.00 per visit Co-payment is waived if Member is admitted to the hospital from the Emergency Room.
Follow-up care	$5.00 per visit	
Ambulance	No Co-payment	
Prescription Drugs		
Received in inpatient setting, doctor's office, or outpatient setting at the time of an appointment	No Co-payment	
All FDA-approved contraceptive drugs, devices and products available over the counter, as prescribed by your provider and emergency contraception.	No Co-payment	HPSM will provide Coverage without cost sharing for the original, brand name contraceptive, device and product if there is not a therapeutic equivalent generic substitute available in the market. From January 1, 2024 forward, a prescription shall not be required to trigger Coverage of over-the-counter FDA approved contraceptive drugs, devices, and products. Point-of sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products shall be provided at in-network pharmacies without cost sharing or medical management restrictions.
Certain drugs used for preventative care including prescriptions for drugs used to stop smoking, most vaccines, aspirin 81 mg for adults aged 50-59 years old, prenatal vitamins containing folic acid 0.4 to 0.8 mg for pregnant women, colonoscopy bowel preps for adults aged 50 to 75 years old, statins for adults aged 40 to 75 years old, drugs for HIV pre-exposure prophylaxis, and drugs used for the prevention of breast cancer.	No Co-payment	Up to a 90-day supply unless otherwise indicated on the Formulary

Benefits	Co-Payments	Conditions
All other prescriptions	$3.00 per generic (Tier 1) prescription $10.00 per brand (Tier 2) prescription	Up to a 90-day supply unless otherwise indicated on the Formulary

Mental Health

Inpatient	No Co-payment	Mental health care when authorized by HPSM and performed in-network for the treatment of a mental health condition during a certified confinement. Mental health Benefits will be provided on the same basis as any other illness including treatment of severe mental illness. See page 73 for full benefit explanation.
Outpatient	$5.00 per visit	Evaluation, crisis intervention, services and treatment for conditions when ordered by HPSM and performed in-network. See page 74 for full benefit explanation. Some services may require prior Authorization.
Facility Based Outpatient Services	No Co-payment	Services authorized by HPSM and performed in-network.
Behavioral Health Treatment for Autism Spectrum Disorder	No Co-payment	Prior Authorization is not required for this benefit.

Benefits	Co-Payments	Conditions
Alcohol/Substance Abuse		
Inpatient	No Co-payment	Hospitalization for alcoholism or drug abuse as Medically Necessary.
Outpatient	$5.00 per visit	Evaluation, services and treatment for conditions when performed in-network. Some services may require prior Authorization.
Facility Based Outpatient Services	No Co-payment	Services that are Medically Necessary and authorized by HPSM.
Home Health		
Home health care visits and services by nurses and home health aides	No Co-payment	Home health as Medically Necessary.
Home health care visits and visit services for physical, occupational, speech, and respiratory therapy	$5.00 per visit	
Hospice		
Hospice care	No Co-payment	Available to Members with a Terminal Illness and a life expectancy of 6 months or less as certified by a physician.
Rehabilitation Therapies		
Physical, occupational, speech and respiratory therapy	No Co-payment for inpatient therapy $5.00 per visit of outpatient services and services at home.	As Medically Necessary.
Durable Medical Equipment (DME)	No Co-payment	

Benefits	Co-Payments	Conditions
Prosthetics and Orthotics	No Co-payment	
Family Planning Services, Sexually Transmitted Diseases, Confidential HIV/ AIDS Testing	No Co-payment	No Referral needed. For services on or after January 1, 2024, HPSM shall not impose a deductible, coinsurance, copayment, or any other cost sharing requirement on vasectomy services and procedures
Skilled Nursing Facility Care	No Co-payment	
Other Services		
Acupuncture	$5.00 per visit	Up to 20 visits per Benefit Year. No Referral needed.
Chiropractic	$5.00 per visit	Up to 20 visits per Benefit Year. No Referral needed.
Organ transplants	No Co-payment	
Cataract spectacles and lenses	No Co-payment	Spectacles, contact lenses or intraocular lenses that replace the natural lens of the eye after surgery. One pair of glasses or contact lenses after cataract surgery with insertion of an intraocular lens.
Hearing aids	No Co-payment	
Health education services	No Co-payment	
X-ray and laboratory services	No Co-payment	
Blood and blood products	No Co-payment	
Non-emergency medical transportation	No Co-payment	
Clinical cancer trials	No Co-payment	
Podiatry	$5.00 per visit	Up to 24 visits per Benefit Year. No Referral needed. Other podiatric services, including additional office visit require prior Authorization based on medical necessity.

Preventive Health Services
Description:

- Periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current recommendations of the U.S. Public Health Service.

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

Cost to Member:
No Co-payment for preventive services

Physician and Professional Services
Description

Medically Necessary professional services and consultations by a Physician or other licensed Health Care Provider acting within the scope of his or her license.

- Including:
- Surgeon, assistant surgeon, and anesthesiologist (inpatient or outpatient)
- Inpatient hospital and skilled nursing facility visits
- Professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, dialysis treatment, and sexually transmitted infection care
- Home visits when Medically Necessary
- Hearing tests and eye examinations including eye refractions to determine the need for corrective lenses and dilated retinal eye exams. Please note that eyeglass' or contact lenses are a benefit only after cataract surgery

Cost to Member
$5 Co-payment per office or home visit
No Co-payment for hospital inpatient professional services
No Co-payment for surgery or anesthesia, radiation, chemotherapy, or dialysis treatment

Pregnancy and Maternity Care

Description

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

- Prenatal and postnatal care and complications of pregnancy
- Diagnostic and genetic testing
- Counseling for nutrition, health education, and social support needs
- Labor and delivery care including midwifery services
- Inpatient newborn hospital care will be provided for up to 48 hours following a normal vaginal delivery and up to 96 hours following delivery by Cesarean Section unless an extended stay is authorized by HPSM. Members do not have to leave the hospital before 48 hours after a vaginal delivery or 96 hours after a Cesarean Section unless the Member and doctor decide this together. If Members leave the hospital before 48 or 96 hours, the doctor may prescribe a follow-up visit within 48 hours of discharge.

The follow-up visit shall include parent education, assistance and training in breast or bottle feeding, and any necessary physical assessment of the mother or baby. The mother and doctor together shall decide whether the follow-up visit shall be at home, the hospital, or the doctor's office depending on the family's transportation needs and environmental and social risks

Cost to Member
No Co-payment

Human Milk

Description

Medically Necessary pasteurized donor human milk obtained from a tissue bank is a covered service.

Cost to Member
No Co-payment

Diagnostic X-Ray and Laboratory Services
Description

Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services which will include, but not be limited to, the following:

- General radiology, CT, MRI Testing
- Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes
- Other services necessary to appropriately evaluate, diagnose, treat, and follow up

- Laboratory tests appropriate for the management of diabetes including, at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (Glycohemoglobin)
- All generally medically accepted cancer screening tests subject to physician prescription and utilization review
- All Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate to diagnose, treat or manage osteoporosis

Cost to Member
No Co-payment

Emergency Services and Care (Including "9-1-1 Services")
Description

Twenty-four hour Emergency Services and Care are covered for a condition that causes severe pain, or a serious illness or injury, including Active Labor, which a reasonable person (a careful or cautious non-medical person) believes could reasonably expect without speedy medical care to result in:

- Placing their health or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious danger, or
- Causing serious impairment to the Member's bodily functions, or
- Causing serious dysfunction of any of the Member's bodily organs or parts.
- Emergency Services and Care including psychiatric screening, examination, evaluation, and treatment by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and privileges.
- Coverage is provided both in and out of the HPSM Service Area and in and out of HPSM's participating facilities.

Cost to Member
$25 Co-payment per visit
No Co-payment if admitted to the hospital

Emergency ("9-1-1") and Non-Emergency Transportation Services
Description

- Emergency ambulance transportation ("9-1-1" service) provided to a Member as a result of a "**9-1-1**" emergency response system request for assistance, is covered to the first hospital or Urgent Care center that accepts the Member for emergency care, where the Member reasonably believes an emergency existed, even if it is later discovered that an emergency did not in fact exist.
- Emergency transportation is covered for a medical condition that causes severe pain, a serious illness or injury, or a psychiatric emergency which a reasonable person (a careful or cautious non-HealthWorx Member) believes is an emergency condition that requires ambulance transport, even if it is later determined that an emergency did not exist.
- Non-emergency transportation for the transfer of a Member from a hospital to another hospital or facility, or facility to home when:
  - Medically Necessary
  - Requested by Participating Provider
  - Authorized in advance by HPSM
- Services provided by a community paramedicine program, triage to alternate destination

program, or mobile integrated health program operating as a Participating or non-participating provider.

Cost to Member
No Co-payment

Diabetes Self-Management
Description

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

Cost to Member
No Co-payment

Prescription Drugs
Description

- Medically Necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes, but is not limited to:
    - Injectable medication, and needles and syringes necessary for the administration of the covered injectable medication
    - Insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin
    - Blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent, and gestational diabetes
    - Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription
    - Medically Necessary drugs administered while a Member is a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when prescribed by a plan physician in connection with a Covered Service and obtained through a plan-designated pharmacy
    - Disposable devices that are necessary for the administration of covered drugs, such as spacers and inhalers for the administration of aerosol Prescription Drugs and syringes for self-injectable Outpatient Prescription Drugs that are not dispensed in pre-filled syringes. The term "disposable" includes devices that may be used more than once before disposal
    - All FDA-approved contraceptive drugs, devices and products, including all FDA approved contractive drugs, devices and products available over the counter, as prescribed by your provider are covered, including internally implanted time-release contraceptives

For information concerning HPSM's Prescription Drug coverage, please refer to "Getting Pharmacy Benefits" on page 50 of this booklet.

Cost to Member

No Co-payment for Prescription Drugs provided in an inpatient setting, for drugs administered in the doctor's office or in an outpatient facility, or for all FDA-approved contraceptive drugs, devices and products including all FDA approved contraceptive drugs, devices and products available over the counter, as prescribed by your provider.

$10 Co-payment per brand name prescription or Tier 2 drugs on the Formulary book.

$3 Co-payment per generic prescription or Tier 1 drugs on the Formulary book.

Outpatient Hospital Services
Description

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

Cost to Member

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

Inpatient Hospital Services
Description

- General hospital services in a room of two or more with customary furnishings and equipment, meals (including special diets as Medically Necessary), and general nursing care. Includes all Medically Necessary ancillary services such as:
  - Use of operating room and related facilities
  - Intensive care unit and services
  - Drugs, medications, and biologicals
  - Anesthesia and oxygen
  - Diagnostic laboratory and x-ray services
  - Special duty nursing as Medically Necessary
  - Physical, occupational, and speech therapy
  - Respiratory therapy
  - Administration of blood and blood products
  - Other diagnostic, therapeutic, and rehabilitative services as Medically Necessary
  - Coordinate discharge planning including the planning of continuing care as Medically Necessary

  Includes inpatient hospital services in connection with dental procedures when

hospitalization is required because of an underlying medical condition, clinical status, or because of the severity of the dental procedure. HPSM will coordinate such services with the Member's dental plan, if any.

Cost to Member

No Co-payment

Family Planning Services
Description

- Voluntary family planning services are covered including the following:
  - Counseling and surgical procedures for sterilization as permitted by State and Federal law.
  - Contraceptive (birth control) drugs, devices and products methods, including all FDA- approved contraceptive drugs, devices and products prescribed by your provider. This includes the insertion or removal of IUD and Norplant, diaphragms, or other FDA approved birth control methods.
    - ▷ You must have a prescription from your provider in order for your birth control to be covered by HPSM. Birth control bought over-the-counter (without a prescription) is not covered. And devices pursuant to the Prescription Drug Benefit including insertion or removal of IUD and Norplant.
    - ▷ You can get a 12-month supply of FDA-approved hormonal birth control at one time from a network pharmacy. This only applies to birth control that you give yourself (self- administered), such as birth control pills, patches, and vaginal rings.
  - Office visits for family planning
  - Lab and x-rays
  - Pregnancy test
  - Treatment for problems resulting from family planning care
  - Pregnancy terminations
  - Emergency contraception when provided by a pharmacist
  - Treatment for Infertility and Fertility Services

Cost to Member

No Co-payment

HPSM will provide Coverage without cost sharing for the original, brand name contraceptive, device and product if there is not a therapeutic equivalent generic substitute available in the market.

From January 1, 2024 forward, a prescription shall not be required to trigger Coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products. Point-of sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products shall be provided at in-network pharmacies without cost sharing or medical management restrictions.

For services on or after January 1, 2024, HPSM shall not impose a deductible, coinsurance, copayment, or any other cost sharing requirement on vasectomy services and procedures.

Starting July 1, 2025, HPSM shall cover the diagnosis and treatment of Infertility and fertility services, including a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society of Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate.

Health Education
Description

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

Cost to Member

No cost

Durable Medical Equipment (DME)
Description

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

Cost to Member

No Co-payment

Orthotics and Prosthetics
Description

- Orthotics and prosthetics are covered as follows:
  - Medically Necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her license
  - Medically Necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her license
  - Initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incidental to a laryngectomy
  - Therapeutic footwear for diabetics
  - Prosthetic device or Reconstructive Surgery incidental to mastectomy
- Covered items must be Physician-prescribed, custom-fitted, standard orthotic or

prosthetic devices, authorized by HPSM, and dispensed by a Participating Provider. Repair is provided unless necessitated by misuse or loss. HPSM, at its option, may replace or repair an item.

Cost to Member
No Co-payment

Outpatient and Facility Based Outpatient Mental Health Services
Description

- Outpatient mental health services are authorized, arranged, and provided by HPSM.
  - Mental health will be provided on the same basis as any other illness including treatment of a Mental Health or Substance Use Disorder Condition. Medically Necessary Benefits include the following:
    1. Outpatient services
    2. Partial hospitalization services
    3. Prescription Drugs
    4. Intensive Outpatient Services
  - Family members may be involved in the treatment to the extent the Health Plan determines it is necessary for the health and recovery of the Member.
  - Behavioral Health Treatment (BHT) services are provided for Autism Spectrum Disorder.
  - There are no visit limitations for any mental health condition.
  - If services for the Medically Necessary treatment of a Mental Health or Substance Use Disorder are not available in HPSM's network within geographic and timely access standards in California law or regulation, HPSM will arrange Coverage to ensure the delivery of Medically Necessary out-of-network services and ay Medically Necessary follow up services that, to the maximum extent possible, meet those geographic and timely access standards.
    - This includes providing services to secure Medically Necessary out-of-network options that are available to you within geographic and timely access standards. You will pay no more than the in-network cost-sharing amount.

Cost to Member

$5 Co-payment per outpatient mental health visit

No copayment for Partial Hospitalization services

No copayment for Behavioral Health Treatment for Autism Spectrum Disorder

Inpatient Mental Health Services
Description

- Inpatient mental health care, including residential treatment, when authorized by HPSM and performed by a participating mental health provider for the treatment of an acute phase of a mental health condition during a certified confinement in a San Mateo County Mental Health Plan Participating Hospital.

Prior Authorization is required for the following:
Mental health services

- Partial hospital services
- Intensive outpatient services

For information about providers and access to care, Members should call the Behavioral Health & Recovery Services ACCESS Call Center at 1-800-686-0101.

Cost to Member
No Co-payment

Outpatient and Facility Based Outpatient Alcohol and Drug Abuse Services
Description

- Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as Medically Necessary
- Intensive Outpatient
- Partial Hospitalization services
    - If services for the Medically Necessary treatment of a Mental Health or Substance Use Disorder are not available in HPSM's network within geographic and timely access standards in California law or regulation, HPSM will arrange Coverage to ensure the delivery of Medically Necessary out-of-network services and any Medically Necessary follow up services that, to the maximum extent possible, meet those geographic and timely access standards.
        - This includes providing services to secure Medically Necessary out-of-network options that are available to you within geographic and timely access standards. You will pay no more than the in-network cost-sharing amount.

Cost to Member
$5 Co-payment per visit
No copayment for partial hospitalization services

Inpatient Alcohol and Drug Abuse Services
Description

- Residential treatment services
- Hospitalization for alcoholism or drug abuse as Medically Necessary to remove toxic substances from the system
    - If services for the Medically Necessary treatment of a Mental Health or Substance Use Disorder are not available in HPSM's network within geographic and timely access standards in California law or regulation, HPSM will arrange Coverage to ensure the delivery of Medically Necessary out-of-network services and any Medically Necessary follow up services that, to the maximum extent possible, meet those geographic and timely access standards.
        - This includes providing services to secure Medically Necessary out-of-network options that are available to you within geographic and timely access standards. You will pay no more than the in-network cost-sharing amount.

Prior Authorization is required for the following:
Alcohol and Substance Abuse services
    - Partial hospital services

- Intensive outpatient services

For information about providers and access to care, Members should call the Behavioral Health & Recovery Services ACCESS Call Center at 1-800-686-0101.

Cost to Member

No Co-payment

Home Health Care Services
Description

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

Cost to Member

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

Skilled Nursing Care
Description

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

Cost to Member

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

Physical, Occupational, and Speech Therapy
Description

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

Cost to Member

No Co-payment for inpatient therapy

$5 Co-payment per visit when provided on an outpatient basis including in the home

Cataract Spectacles and Lenses
Description

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

Cost to Member

No Co-payment

Hearing Aids and Services
Description

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

Cost to Member

No Co-payment

Acupuncture
Description

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

Cost to Member

$5 Co-payment per visit

Chiropractic

Description

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

Cost to Member

$5 Co-payment per visit

Podiatry
Description:

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

Cost to Member
$5 Co-payment per visit.

Hospice Services
Description

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

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

Clinical Cancer Trials
Description

- Coverage for a Member's participation in a cancer clinical trial, Phase I thorough IV, when the Member's physician has recommended participation in the trial, and
- Member meets the following requirements:
  - Member must be diagnosed with cancer
  - Member must be accepted into a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer
  - Members' treating physician, who is providing Covered Services, must recommend participation in the clinical trial after determining that participation will have a meaningful potential to the Member, and
- Trial must meet following requirements:
  - Trials have a therapeutic intent with documentation provided by the treating physician
  - Treatment provided must be approved by one of the following:
    1. the National Institutes of Health, the Federal Food and Drug Administration, the U.S. Veterans Administration, or
    2. involve a drug that is exempt under the federal regulations from a new drug application
- Charges for routine patient care costs of a Member. These are costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be covered if they were not provided in connection with an Approved Clinical Trial program. Routine patient costs for cancer clinical trials include:
  - Health care services required for the provision of the investigational drug, item, device or service
  - Health care services required for the clinically appropriate monitoring of the investigational drug, item, device or service
  - Health care service provided for the prevention of complications arising from the provision of the investigational drug, item, device or service
  - Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service including diagnosis or treatment of complications
- Member may request an Independent Medical Review (IMR) of HPSM's Coverage Decisions.
  Information on how to request an IMR is on page 87

Cost to Member

No Co-payment

Organ Transplants
Description

- Coverage for Medically Necessary organ transplants and bone marrow transplants prescribed by a Participating Provider in accordance with nationally recognized standards of practice
  Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a Member
- Charges for testing of relatives for matching bone marrow transplants

- Charges associated with the search and testing of unrelated bone marrow donors through a recognized donor registry and charges associated with the procurement of donor organs through a recognized donor transplant bank, if the expenses are directly related to the anticipated transplant for a Member
- Member may request an Independent Medical Review (IMR) of HPSM's Coverage Decisions.
    - Information on how to request an IMR is on page 87

Blood and Blood Products
Description

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

Cost to Member

No Co-payment

Mastectomies and Lymph Node Dissection Surgeries
Description

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

Cost to Member

No Co-payment

Care and Treatment Following Rape and Sexual Assault
Description

- Coverage for emergency room medical care and follow-up health care treatment following a rape or sexual assault, as defined in Sections 261, 261.6, 263, 263.1, 286, 287, and 288.7 of the Penal Code.
- Follow-up health care treatment includes medical or surgical services for the diagnosis, prevention or treatment of medical conditions arising from an instance of rape or sexual assault.
- HPSM does not require any of the following as a condition of Coverage: (1) a Member to file a police report on the rape or sexual assault; (2) charges to be brought against an assailant; or (3) an assailant to be convicted of rape or sexual assault
- If services for the Medically Necessary follow-up health care treatment following a rape or sexual assault are not available in HPSM's network, HPSM will arrange for the provision of follow-up health care treatment from out-of-network providers to ensure timely access to these Covered Services.
- HPSM does not impose a deductible, coinsurance, Co-payment, or any other cost sharing requirement on emergency room medical care and follow-up health care treatment following a rape or sexual assault.

Cost to Member

No Co-payment

Section 7: Exclusions and Limitations of Benefits

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this EOC.

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary Treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the HealthWorx HMO or required by law.

1. Clinical Trials

   - This Plan does not cover clinical trials, except Approved Clinical Trials as described in this EOC in SECTION 6 or as required by law. Coverage of Approved Clinical Trials does not include the following:
     - The investigational drug, item, or service itself.
     - Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.
     - Drugs, items, devices, and services specifically excluded from coverage in this EOC, except for drugs, items, devices, and services required to be covered pursuant to State and federal law.
     - Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.
   - This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in this EOC in SECTION 6, or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this EOC in SECTION 8.

2. Experimental Services or Investigational Services

   - This Plan does not cover Experimental Services or Investigational Services, except as described in this EOC in SECTION 6 or required by law.
   - Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.
   - Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in

progress but:

- (1) Testing is not complete; and
- (2) The efficacy and safety of such services in human subjects are not yet established; and
- (3) The service is not in wide usage.

- The determination that a service is an Experimental Service or Investigational Service is based on:
  - (1) Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
  - (2) Consultation with provider organizations, academic and professional Specialists pertinent to the specific service;
  - (3) Reference to current medical literature.
- However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an external, independent review.
- Qualifications
  - 1. You must have a Life-Threatening or Seriously Debilitating condition.
  - 2. Your Health Care Provider must certify to the Plan that you have a Life-Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.
  - 3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
  - 4. You have been denied coverage by the Plan for the recommended or requested service.
  - 5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.
- External, Independent Review Process
  - If the Plan denies coverage of the recommended or requested therapy and you meet

all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other Benefits to which you are entitled.

- DMHC's Independent Medical Review (IMR)
    - This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this EOC in SECTION 8. In certain circumstances, you do not have to participate in the Plan's Grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See SECTION 8.

3. Dental Services
    - This Plan does not cover dental services or supplies, except as required by law.
4. Vision Care
    - This Plan does not cover vision services, except as described in this EOC in SECTION 6 or as required by law.
5. Reversal of Voluntary Sterilization
    - This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as required by law.
6. Cosmetic Services, Supplies, or Surgeries
    - This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in this EOC in SECTION 6, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this EOC in SECTION 6, or as required by law.
    - This exclusion does not apply to the following:
        - Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
        - Reconstructive Surgery as described in this EOC in SECTION 6.
        - For gender dysphoria, Reconstructive Surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the

standard of care as practiced by physicians specializing in Reconstructive Surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in SECTION 6.

7. Disposable Supplies for Home Use

   - This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this EOC in SECTION 6 or as required by law.

8. Personal or Comfort Items

   - This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

9. Prescription Drugs / Outpatient Prescription Drugs

   - The Plan does not cover the following Prescription Drugs, except as required by law:

     - When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.

     - When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.

     - When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of severe obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.

     - When prescribed solely for the purpose of shortening the duration of the common cold.

     - Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to:

       - Insulin,

       - Over-the-counter drugs as covered under preventive services, e.g., over-the-counter FDA-approved contraceptive drugs),

       - Over-the-counter drugs for reversal of an opioid overdose, or

       - An entire class of Prescription Drugs when one drug within that class becomes available over the counter.

- Replacement of lost or stolen drugs.

- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

10. Dietary or Nutritional Supplements

    - This Plan does not cover dietary or nutritional supplements, except as described in this EOC in SECTION 6 or as required by law.

11. Custodial or Domiciliary Care

    - This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as described in this EOC in SECTION 6 or as required by law.

    - This exclusion does not apply to the following:

        - Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.

        - Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.

        - Custodial care provided in a healthcare facility.

12. Non-licensed or Non-certified Providers

    - This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as required by law.

    - This exclusion does not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable State law.

13. Private Duty Nursing

    - This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as required by law.

14. Surrogate Pregnancy

    - This Plan does not cover testing, services, or supplies for a person who is not covered under this HealthWorx HMO for a surrogate pregnancy, except as required by law.

15. Therapies

    - This Plan does not cover the following physical and occupational therapies, except as described in this EOC in SECTION 6 or as required by law:

- Massage therapy, unless it is a component of a treatment plan;
- Training or therapy for the treatment of learning disabilities or behavioral problems;
- Social skills training or therapy; and
- Vocational, educational, recreational, art, dance, music, or reading therapy.

16. Routine Physical Examination

- The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as required by law.

17. Travel and Lodging

- This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this EOC in SECTION 6, or as required by law.

18. Weight Control Programs and Exercise Programs

- This Plan does not cover weight control programs and exercise programs, except as required by law.

Section 8: Grievance and Appeals Process

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

Appeal

If you think that HPSM has denied your request for a service or other benefit incorrectly, you can request an appeal of HPSM's decision. You can file an appeal with HPSM within **180 calendar days** from the date of HPSM's original decision. Appeals can be filed with either a Member Services Representative by calling **1-800-750-4776** or **650-616-2133** or by speaking with a Grievance and Appeals Coordinator at **1-888-576-7227** or **650-616-2850**. You can obtain a copy of HPSM's Grievance and Appeals Policy and Procedure by calling our Member Services Department.

Grievance

If you have any other type of complaint against HPSM or a provider, you can file a Grievance. You can file a Grievance with HPSM within **180 calendar days** from the date of the incident. Grievances can be filed with either a Member Services Representative by calling **1-800-750-4776** or **650-616-2133** or by speaking with a Grievance and Appeals Coordinator at **1-888-576-7227** or 6**50-616-2850**. You can obtain a copy of HPSM's Grievance and Appeals Policy and Procedure by calling our Member Services Department.

How to Submit a Grievance or Appeal

To begin the Grievance or Appeal process, you can call, write, or fax the plan at:

Grievance and Appeals Unit
Health Plan of San Mateo
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

Phone: **1-800-750-4776** or **650-616-2850**
Fax: **650-829-2002**
Website: www.hpsm.org

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

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

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

Independent Medical Reviews

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

An IMR is available in the following situations:

1. (a) Your provider has recommended a health care service as Medically Necessary, or
   (b) You have received Urgent Care or Emergency Services and Care 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 call TTY: **1-800-735-2929** or dial **7-1-1** (California Relay Service).

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 your health plan, you should first telephone your health plan at Member Services at **1-800-750-4776** (TTY **1-800-735-2929** or **7-1-1**) and use your health plan's Grievance process before contacting the department. Utilizing this Grievance procedure does not prohibit any potential 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 your health plan, 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 IMR, the IMR process will provide an impartial review 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 or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **https://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

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.

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Section 9: General Information

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

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

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

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

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

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

The San Mateo County Public Authority does not allow San Mateo County In-Home Supportive Services (IHSS) Workers to enroll in HealthWorx if the IHSS worker has other health coverage at the time of enrollment. IHSS Workers may be disenrolled from the HealthWorx program if they have other health coverage.

Members with Medicare

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

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

If you have HealthWorx HMO and Medicare, the following rules generally apply:
- If you are working, HealthWorx HMO pays first.
- If you are retired, Medicare pays first.
- If you are over age 65 and still working, HealthWorx HMO pays first.

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

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

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

- Reimburse HPSM for the reasonable cost of services paid by HPSM to the extent permitted by California Civil Code section 3040 immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
- Fully cooperate with HPSM's effectuation of its lien rights for the reasonable value of services provided by 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 that may be necessary or proper to fully and completely effectuate and protect the rights of HPSM or its nominee.

Coordination of Benefits
By enrolling in HPSM each Member agrees to complete and submit to HPSM such consents, releases, assignments and any other document reasonably requested by HPSM to ensure 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.

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

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

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

If you receive a bill for these services you are responsible to pay.
If you receive a bill for a service that is a benefit or from an out-of-network provider at an in-hospital or in-network facility that was authorized by HPSM, **please do not pay the bill.** Call the provider's office immediately and ask them to bill HPSM. The provider can call HPSM and we can explain to them how to bill us. The number for a provider to call is on your ID card. If you are unsure what to do, you can call a Member Services Representative.

Please do not ignore bills from providers. If you end up being sent to Collections for a bill, we may not be able to help you as easily. You may end up being responsible for part or all of the bill.

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

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

Member Services Department
Health Plan of San Mateo
801 Gateway Blvd., Suite 100

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 that the Commission will decide so that the Members can participate before final decisions are made. The consumer member of HPSM's governing body represents consumers on HPSM's Quality Assessment and Improvement Committee.

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

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

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

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

A copy of HPSM's Notice of Privacy Practice is included in this Member Handbook. Contact HPSM's Member Services Department at **1-800-750-4776** or **650-616-2133** for an additional copy. Our Notice of Privacy Practices is also on our website at www.hpsm.org.

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

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

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

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

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

For additional information about Advanced Health Care Directives, including how to obtain forms and instructions, visit our website at https://www.hpsm.org/member/forms or contact our Member Services Department at **1-800-750-4776** or **650-616-2133**.

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

Healthy is for everyone

HealthPlan OF SAN MATEO

Healthy is for everyone

ACCREDITED NCQA HEALTH PLAN

801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

tel 800.750.4776 toll-free
tel 650.616.0050 local
fax 650.616.0060
tty 800.735.2929 or dial 7-1-1

www.hpsm.org