

B. Summary of Benefits

A Chart To Help You Compare Coverage Benefits

Health Plan Covered Benefits Matrix

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

NOTE: Members in the Income Category A (To read about the HFP Income Categories please go to the HFP Website: <http://www.healthyfamilies.ca.gov/Downloads/Applications.aspx>) shall pay no more than \$5 copayment for applicable covered services as described in this Benefit Descriptions Section of the EOC/DF.

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
Inpatient Hospital Services	Room and board, nursing care, and all medically necessary ancillary services.	No copayment	No copayment
Outpatient Hospital Services	Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility.	No copayment except <ul style="list-style-type: none"> • \$5 per visit for physical, occupational and speech therapy performed on an outpatient basis. • \$5 per visit for emergency health care services (waived if the member is hospitalized) 	No copayment except <ul style="list-style-type: none"> • \$10 per visit for physical, occupational and speech therapy performed on an outpatient basis. • \$15 per visit for emergency health care services (waived if the member is hospitalized)

Benefits*	Services	Cost to Member (copayment)	Cost to Member (copayment)
		Income Category A	Income Categories B & C
Professional Services	Services and consultations by a physician or other licensed health care provider.	<ul style="list-style-type: none"> • \$5 per office or home visit except • No copayment for hospital inpatient professional services • No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments • No copayment for members 24 months of age and younger • No copayment for vision or hearing testing, or for hearing aids 	\$10 per office or home visit except <ul style="list-style-type: none"> • No copayment for hospital inpatient professional services • No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments • No copayment for members 24 months of age and younger • No copayment for vision or hearing testing, or for hearing aids
Preventive Health Service	Periodic health examinations, Well Baby Care, routine diagnostic testing and laboratory services, immunizations, and services for the detection of asymptomatic diseases.	No copayment	No copayment
Diagnostic, X-Ray and Laboratory Services **	Laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, and treat you.	No copayment	No copayment
Diabetic Care **	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription	\$5 copayment per office visit Copayment for prescriptions as described in the "Prescription Drug Program" Section	\$10 copayment per office visit Copayment for prescriptions as described in the "Prescription Drug Program" Section

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
Prescription Drug Program **	Drugs prescribed by a licensed practitioner.	<ul style="list-style-type: none"> • \$5 per prescription for up to 30-day supply for brand name or generic drugs • \$5 per prescription for up to 90-day supply of maintenance drugs • No copayment for prescription drugs provided in an inpatient setting. • No copayment for drugs administered in the provider's office or in an outpatient facility. • No copayment for FDA-approved contraceptive drugs and devices. 	<ul style="list-style-type: none"> • \$10 copayment per prescription for up to 30 day supply for generic drugs. • \$15 copayment per prescription for up to 30 day supply for brand name drugs unless there is no generic equivalent or if the use of a brand name drug is medically necessary. • \$10 copayment per prescription for up to 90 day supply for maintenance generic drugs purchased through a participating pharmacy. • \$15 copayment per prescription for up to 90 day supply for maintenance drugs purchased through a participating pharmacy for brand name drugs unless there is no generic equivalent or if the use of a brand name drug is medically necessary, then \$10 copayment applies. • No copayment for prescription drugs provided in an inpatient setting. • No copayment for drugs administered in the doctor's office or in an outpatient facility. • No copayment for FDA-approved contraceptive drugs and devices.

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
Durable Medical Equipment **	Medical equipment appropriate for use in the home which primarily serves a medical purpose, is intended for repeated use and is generally not useful to a person in the absence of illness or injury.	No copayment	No copayment
Orthotics and Prosthetics **	Original and replacement devices as prescribed by a licensed practitioner.	No copayment	No copayment
Cataract Spectacles and Lenses **	Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery.	No copayment	No copayment
Maternity Care	Professional and hospital services relating to maternity care.	No copayment	No copayment
Family Planning Services	Voluntary family planning services	No copayment	No copayment
Medical Transportation Services **	Emergency ambulance transportation and non-emergency transportation to transfer you from a hospital to another hospital or facility, or facility to home.	No copayment	No copayment
Emergency Health Care Services **	Emergency services are covered both in and out of the plan's service area and in and out of the plan's participating facilities.	\$5 per visit (waived if you are admitted to the hospital.)	\$15 per visit (waived if the member is admitted to the hospital.)

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
Inpatient Mental Health Care Services:	Mental health care in a participating hospital when ordered and performed by a participating mental health professional for the treatment of a mental health condition		
Mental Health Care	<ul style="list-style-type: none"> • Diagnosis and treatment of a mental health condition. • This includes, but is not limited to inpatient mental health care services for the treatment of Severe Mental Illnesses (SMI) 	No copayment	No copayment
Serious Emotional Disturbance (SED) Services Severe Mental Illness (SMI)	<ul style="list-style-type: none"> • Inpatient mental health care services for the treatment of a member determined by the county to have SED <ul style="list-style-type: none"> ▪ The plan shall provide all necessary covered services until the county mental health department establishes eligibility for a member child with SED and the county mental health department provides the medically necessary services to treat the SED. ▪ The Plan and the county mental health department will 	No copayment	No copayment

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
	coordinate services to ensure that medically necessary services and treatment are provided to a member with a SED condition. <ul style="list-style-type: none"> ▪ The member will remain enrolled in the Healthy Families Program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED from the Plan. 		
Outpatient Mental Health Care Services	Mental health care when ordered and performed by a participating mental health professional.		
Mental Health Care:	<ul style="list-style-type: none"> • This includes, but is not limited to the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement. • Family members may be involved in 	\$5 per visit	\$10 per visit

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
	<p>the treatment when medically necessary for the health and recovery of the child.</p> <ul style="list-style-type: none"> This includes, but is not limited to outpatient mental health care services for the treatment of Severe Mental Illnesses (SMI). 		
Serious Emotional Disturbance (SED)	<ul style="list-style-type: none"> Outpatient mental health care visits for the treatment of a member determined by the county to have SED The plan shall provide all medically necessary covered services until the county mental health department establishes eligibility for a member child with SED and the county mental health department provides the medically necessary services to treat the SED. The Plan and the county mental health department will coordinate services to ensure that medically 	No copayment	No copayment

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
	<p>necessary services and treatment are provided to a member with SED</p> <ul style="list-style-type: none"> The member will remain enrolled in the Healthy Families Program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED condition from the Plan. 		
Inpatient Alcohol/Drug Abuse Treatment	Hospitalization to remove toxic substances from the system.	No copayment	No copayment
Outpatient Alcohol/Drug Abuse Treatment	Crisis intervention and treatment of alcoholism or drug abuse.	\$5 per visit	\$10 per visit
Home Health Care Services	Services provided at the home by health care personnel.	No copayment, except \$5 per visit for physical, occupational, and speech therapy	No copayment, except \$10 per visit for physical, occupational, and speech therapy
Skilled Nursing Care	Services provided in a licensed skilled nursing facility. Benefit is limited to a maximum of 100 days per benefit year	No copayment	No copayment
Physical, Occupational, and Speech Therapy **	Therapy may be provided in a medical office or other appropriate outpatient setting.	<p>\$5 per visit when performed in an outpatient setting</p> <p>No copayment for inpatient therapy</p>	<p>\$10 per visit when performed in an outpatient setting</p> <p>No copayment for inpatient therapy</p>

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
Blood and Blood Products **	Includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings.	No copayment	No copayment
Health Education	Includes education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services.	No copayment	No copayment
Hospice	If you are diagnosed with a terminal illness and you elect hospice care instead of traditional health care services.	No copayment	No copayment
Organ Transplants **	Coverage for organ transplants and bone marrow transplants which are not experimental or investigational.	No copayment	No copayment
Reconstructive Surgery **	Performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors, or disease and are performed to improve function or create a normal appearance.	No copayment	No copayment
Phenylketonuria (PKU) **	Testing and treatment of PKU.	No copayment	No copayment

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
Clinical Cancer Trials	Coverage for participation in a cancer clinical trial, phase I through IV, when the member's physician has recommended participation in the trial, and the member meet certain requirements.	\$5 copayment per office visit Copayment for prescriptions as described in the "Prescription Drug Program" Section	\$10 copayment per office visit Copayment for prescriptions as described in the "Prescription Drug Program" Section
California Children's Services Program (CCS)	<ul style="list-style-type: none"> • CCS is a California medical program that treats children who have certain physically handicapping conditions and who need specialized medical care. Services provided through the CCS Program are coordinated by the county CCS office. • If the member's condition is determined by the CCS program, you will remain enrolled in the Healthy Families Program and continue to receive medical care from plan providers for services not related to the CCS eligible condition. The member will receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers. 	No copayment	No copayment

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
Acupuncture	Does not require referral from the member's provider but services must be obtained from a plan provider. Benefit is limited to 20 visits per benefit year	\$5 per visit	\$10 per visit
Chiropractic	Does not require referral from the member's provider but services must be obtained from a plan provider. Benefit is limited to 20 visits per benefit year	\$5 per visit	\$10 per visit
Deductibles	No deductibles will be charged for covered benefits		
Lifetime Maximums	No lifetime maximum limits on benefits apply under this plan		

*Benefits are provided only for services which are medically necessary.

** These services may be covered and paid for by the California Children's Services (CCS) program, if the member is found to be eligible for CCS services.