

Healthy Kids Program Summary of Benefits

A Chart to Help You Compare Coverage Benefits

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The Evidence of Coverage and Plan contract should be consulted for a detailed description of coverage benefits and limitations.

NOTE: Members in the Income Category A (see the Healthy Kids Program Income Categories A, B, and C Table on page 2) shall pay no more than \$5 co-payment for applicable covered services as described in this Benefits Descriptions Section of the EOC/DF.

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B & C</i>
Alaskan Native/Native American Enrolees		\$0	\$0
Deductible	No deductibles will be charged for covered benefits	\$0	\$0
Yearly Co-Payment Maximum		\$250	\$250
Lifetime Maximum	No lifetime maximum limits on benefits apply under this plan	\$0	\$0
Hospitalization Services Inpatient	Medically necessary facility charges, room and board, general nursing care, ancillary services including operating room, intensive care unit, prescribed drugs, laboratory, and radiology during inpatient stay	No co-payment	No co-payment
Hospitalization Services Outpatient	Medically necessary facility charges, general nursing care, ancillary services including operating room, prescribed drugs, laboratory, chemotherapy, and radiology	No co-payment 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 co-payment except <ul style="list-style-type: none"> \$10 per visit for physical, occupational and speech therapy performed on an outpatient basis. \$10 per visit for emergency health care services (waived if the member is hospitalized)

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B & C</i>
Professional Services	Doctor visits, inpatient and outpatient medical and surgical services	\$5 per office or home visit except <ul style="list-style-type: none"> • No co-payment for hospital inpatient professional services • No co-payment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments • No co-payment for members 24 months of age and younger • No co-payment for vision or hearing testing, or for hearing aids 	\$10 per office or home visit except <ul style="list-style-type: none"> • No co-payment for hospital inpatient professional services • No co-payment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments • No co-payment for members 24 months of age and younger • No co-payment for vision or hearing testing, or for hearing aids
Outpatient Services	In a doctor 's office, surgery center, or other designated facility	\$5	\$10
Preventive Health Care Services	Periodic health examinations, Well Baby Care, routine diagnostic testing and laboratory services, immunizations, and services for the detection of asymptomatic diseases.	No co-payment	No co-payment
Diagnostic, X-Ray, and Laboratory Services **	Laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, and treat members.	No co-payment	No co-payment
Diabetic Care **	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription.	\$5 co-payment per office visit Co-payment for prescriptions as described in the "Prescription Program" section	\$10 co-payment per office visit Co-payment for prescriptions as described in the "Prescription Program" section

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B & C</i>
Emergency Health Coverage	24-hour care for sudden, serious and unexpected illness including psychiatric screening, examination and treatment, injury or condition requiring immediate diagnosis in and out of the Plan	\$15 co-payment waived if member is hospitalized	\$15 co-payment waived if member is hospitalized
Ambulance Services	Ambulance transportation when medically necessary	No co-payment	No co-payment
Prescription Drug Coverage **	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 co-payment for prescription drugs provided in an inpatient setting. • No co-payment for drugs administered in the doctor's office or in an outpatient facility. • No co-payment for FDA-approved contraceptive drugs and devices. 	<ul style="list-style-type: none"> • \$10 co-payment per prescription for up to 30 day supply for generic drugs. • \$15 co-payment 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 co-payment per prescription for up to 90 day supply for maintenance generic drugs purchased through a participating pharmacy. • \$15 co-payment per prescription for up to 90 day supply for maintenance brand name drugs purchased through a participating pharmacy unless there is no generic equivalent or if the use of a brand name drug is medically necessary, then the \$10 co-payment

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B & C</i>
			applies. <ul style="list-style-type: none"> • No co-payment for prescription drugs provided in an inpatient setting. • No co-payment for drugs administered in the doctor’s office or in an outpatient facility • No co-payment for FDA-approved contraceptive drugs and devices.
Contraceptives	FDA approved drugs and implanted devices.	No co-payment	
Durable Medical Equipment **	Equipment suitable for use in the home, such as blood glucose monitors, apnea monitors, asthma-related equipment and supplies	No co-payment	No co-payment
Orthotics and Prosthetics **	Original and replacement devices as prescribed by a licensed practitioner.	No co-payment	No co-payment
Maternity Care	Professional and hospital services relating to maternity care	No co-payment	No co-payment
Family Planning Services	Voluntary family planning services	No co-payment	No co-payment

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B & C</i>
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.		
Basic Mental Health Care Services	<ul style="list-style-type: none"> • Diagnosis and treatment of a mental health condition. • 30 days per benefit year. Additional days may be authorized by the Plan. • Plans, with the agreement of the subscriber or applicant or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following: <ul style="list-style-type: none"> ▪ 2 days of residential treatment, ▪ 3 days of day care treatment, or ▪ 4 outpatient visits. 	No co-payment	No-co-payment
Severe Mental Illness (SMI)	<ul style="list-style-type: none"> • Inpatient mental health care services for the treatment of severe mental illnesses. • Unlimited days. 	No co-payment	No co-payment
Serious Emotional Disturbance (SED) Services	<ul style="list-style-type: none"> • Inpatient mental health care services for the treatment for SED condition. • Unlimited days. <ul style="list-style-type: none"> ▪ On or before day 30; the Plan may refer the member to their county mental health department for continued treatment of the SED condition. The Plan and the county mental health department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with a SED condition. ▪ The member will remain enrolled in the Healthy Kids program and will continue to receive 	No co-payment	No co-payment

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B & C</i>
	primary care, specialty care, and all other services for medical conditions not related to the SED condition from the Plan.		
Outpatient Mental Health Care Services:	Mental health care when ordered and performed by a participating mental health professional.		
Basic Mental Health Care Services	<ul style="list-style-type: none"> • This includes 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 the treatment when medically necessary for the health and recovery of the child. • 20 visits per benefit year. Additional days may be authorized by the Plan. 	\$5per visit	\$10 per visit
Severe Mental Illness (SMI)	<ul style="list-style-type: none"> • Outpatient mental health care visits for the treatment of severe mental illnesses. • Unlimited visits. 	\$5per visit	\$10 per visit
Serious Emotional Disturbance (SED) Services	<ul style="list-style-type: none"> • Outpatient mental health care visits for the treatment for SED condition. • Unlimited visits. <ul style="list-style-type: none"> ▪ The Plan may refer the member to the county mental health department for treatment of SED. The Plan and the county mental health department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with a SED condition. 	No co-payment	No co-payment

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B & C</i>
	<ul style="list-style-type: none"> ▪ The member will remain enrolled in the Healthy Kids program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED condition from the Plan. 		
Chemical Dependency Services:			
Inpatient	Inpatient detoxification	No co-payment	No co-payment
Outpatient	Crisis intervention and alcohol or drug abuse treatment as medically necessary. Benefit is limited to 20 visits per benefit year.	\$5per visit	\$10 per visit
Home Health Services	Services provided at the home by health care personnel.	No co-payment except <ul style="list-style-type: none"> • \$5 per visit for physical, occupational, and speech therapy 	No co-payment 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 co-payment	No co-payment
Physical, Occupational, and Speech Therapy **	Therapy may be provided in a medical office or other appropriate outpatient setting.	\$5 per visit when performed in an outpatient setting No co-payment for inpatient therapy	\$10 per visit when performed in an outpatient setting No co-payment for inpatient therapy
Blood and Blood Products **	Includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings	No co-payment	No co-payment
Health Education	Includes education regarding personal health, behavior, and health care, and recommendations regarding the optimal use of health care services	No co-payment	No co-payment

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B & C</i>
Diagnostic X-ray and Laboratory Services	Therapeutic radiological services, ECG, EEG, mammography, other diagnostic laboratory and radiology tests and laboratory tests.	No co-payment	No co-payment
Hospice	Medically necessary skilled care; counseling, drugs and supplies; short-term inpatient care for pain control and system management; bereavement services, physical, speech and occupational therapies; medical social services short-term inpatient and respite care	No co-payment	No co-payment
Organ Transplants	Medically necessary organ and bone marrow transplant; medical and hospital expenses of a donor or prospective donor; testing expenses and charges associated with procurement of donor organ	No co-payment	No co-payment
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 co-payment	No co-payment
Phenylketonuria (PKU) **	Testing and treatment of PKU	No co-payment	No co-payment
Clinical Cancer Trials	Coverage for a member's participation in a cancer clinical trial, phase I through IV, when the member's physician has recommended participation in the trial, and member meets certain requirements	\$5 co-payment per office visit Co-payment for prescriptions as described in the "Prescription Drug Program" section	\$10 co-payment per office visit Co-payment for prescriptions as described in the "Prescription Drug Program" section
California Children's Services Program (CCS)	CCS is a California medical program that treats children who have certain physically handicapping conditions and who need specialized medical care. Services provided through the CCS Program are coordinated by the county CCS office. If the member's condition is determined to be eligible for CCS services, the member remains enrolled in the Healthy Kids Program	No co-payment	No co-payment

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B & C</i>
	and continues to receive medical care from plan providers for services not related to the CCS eligible condition. The member will receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers.		
Biofeedback	Up to 8 visits per Benefit Year with a referral	\$5 per visit	\$10 per visit
Hearing Aids/Services	Audiological evaluations, hearing aids, supplies, visits for fitting, counseling, adjustments, repairs	No co-payment	
Eye Exams/Supplies	Eye examinations, frames and lenses, supplemental care for low-vision benefits	\$5 per visit	\$10 per visit
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 co-payment	No co-payment
Dental			
Oral Surgery	<ul style="list-style-type: none"> Bony impaction- per tooth Root recovery – per tooth 	\$5	\$10
Endodontics	<ul style="list-style-type: none"> Apicoectomy performed in conjunction with root canal Retreatment of previous root canal 	\$5 per canal	\$10 per canal
Periodontics	Osseous or muco-gingival surgery	\$5 per quadrant	\$10 per quadrant
Crowns and Bridges	<ul style="list-style-type: none"> Porcelain crown, porcelain fused to metal crown, full metal crown, and gold onlays or ¾ crowns Pontics 	\$5 per crown or other pontics	\$10 per crown or other pontics

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B & C</i>
Dentures	<ul style="list-style-type: none"> • Complete maxillary denture • Complete mandibular denture • Partial acrylic upper or lower denture with clasps • Partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles • Removable unilateral partial denture • Laboratory reline • Denture duplication 	\$5 each	\$10 each

*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.