

Healthy Families 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.

Benefits*	Services	Cost to Member (copayment)
Inpatient Hospital Services	Room and board, nursing care, and all medically necessary ancillary services.	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)
Professional Services	Services and consultations by a physician or other licensed health care provider.	\$5 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, routine diagnostic testing and laboratory services, immunizations, and services for the detection of asymptomatic diseases.	No copayment
Diagnostic, X-Ray and Laboratory Services **	Laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, and treat members.	No copayment

Benefits*	Services	Cost to Member (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
Prescription Drug Program **	Drugs prescribed by a licensed practitioner.	\$5 per prescription for a 30-34 day supply for brand name or generic drugs. \$5 per prescription for a 90-100 day supply of maintenance drugs <ul style="list-style-type: none"> • 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.
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
Orthotics and Prosthetics **	Original and replacement devices as prescribed by a licensed practitioner.	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
Maternity Care	Professional and hospital services relating to maternity care.	No copayment
Family Planning Services	Voluntary family planning services	No copayment

Benefits*	Services	Cost to Member (copayment)
Medical Transportation Services **	Emergency ambulance transportation and non-emergency transportation to transfer a member from a hospital to another hospital or facility, or facility to home.	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 the member is admitted to the hospital.)
Inpatient Mental Health Services	<p>Confinement in a participating hospital is covered.</p> <p>Care for members determined to have a serious emotional disturbance (SED) condition will be provided by the county mental health department. The member will remain enrolled in the plan and will continue to receive medical care from plan providers for services not related to the SED condition.</p>	<p>No copayment</p> <p>Benefit is limited to 30 days per benefit year, except for the treatment of severe mental illnesses</p>
Outpatient Mental Health Services	<p>Mental health care is covered when services are ordered and performed by a Plan mental health professional.</p> <p>Care for members determined to have a serious emotional disturbance (SED) condition will be provided by the county mental health department. The member will remain enrolled in the plan and will continue to receive medical care from plan providers for services not related to the SED condition.</p>	<p>\$5 per visit</p> <p>Benefit is limited to 20 visits per benefit year, except for the treatment of severe mental illnesses</p>
Inpatient Alcohol / Drug Abuse Services	Hospitalization to remove toxic substances from the system.	No copayment
Outpatient Alcohol / Drug Abuse Services	Crisis intervention and treatment of alcoholism or drug abuse.	<p>\$5 per visit</p> <p>Benefit is limited to 20 visits per benefit year</p>
Home Health Care Services	Services provided at the home by health care personnel.	<p>No copayment, except</p> <ul style="list-style-type: none"> • \$5 per visit for physical, occupational, and speech therapy

Benefits*	Services	Cost to Member (copayment)
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 copayment for inpatient therapy
Blood and Blood Products **	Includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings.	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
Hospice	For members who are diagnosed with a terminal illness and who elect hospice care instead of traditional health care services.	No copayment
Organ Transplants **	Coverage for organ transplants and bone marrow transplants which are not experimental or investigational.	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
Phenylketonuria (PKU) **	Testing and treatment of PKU.	No copayment
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 copayment per office visit Copayment for prescriptions as described in the "Prescription Drug Program" section

Benefits*	Services	Cost to Member (copayment)
California Children's Services Program (CCS)	<p>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.</p> <p>If the member's condition is determined to be eligible for CCS services, the member remains enrolled in the Healthy Families Program 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.</p>	No copayment
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.