Healthy Families Program
Combined Evidence of Coverage and Disclosure Form
ERRATA
Effective November 1, 2009 for the 2009-2010 Benefit Year

The Healthy Families Program (HFP) has made changes to the program. There are new copayment increases as of November 1, 2009 for applicable covered benefit services. These changes have been made to your HFP Combined Evidence of Coverage and Disclosure Form (EOC) for the 2009-2010 benefit year. **THE CHANGES ARE NOTED BY UNDERLINED AND STRIKE-OUT TEXT.** Please read these changes and keep this document with the EOC you have received.

If you have any questions regarding the HFP EOC Booklet please call the Health Plan of San Joaquin Customer Service Department at 1-888-936-PLAN (7526) Monday through Friday, 8:00 a.m. to 5:00 p.m.

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Section: Disclosure

Healthy Families Program Changes

Effective November 1, 2009

Copayments

The HFP has increased copayments for applicable covered services for members who are in Income Categories B & C. This copayment increase does not apply to members in Income Category A. Please refer to the Definitions Section, beginning on page 8 of this EOC booklet to read more about the HFP Income Categories.

On the chart below, locate your family size and net income column to find your income category, A, B or C. If your monthly income is below Category A, your children may be eligible for free coverage through the Medi-Cal Program.

Healthy Families Program
Income Categories A, B, and C
Effective April 1, 2009 through March 31, 2010

Family Size	Category A Monthly Income	Category B Monthly Income	Category C Monthly Income
1	$904 - $1355	$1,355.01 - $1,805	$1,805.01 - $2,257
2	$1,216 - $1,822	$1,822.01 - $2,429	$2,429.01 - $3,036
3	$1,527 - $2,290	$2,290.01 - $3,052	$3,052.01 - $3,815
4	$1,839 - $2,757	$2,757.01 - $3,675	$3,675.01 - $4,594
5	$2,151 - $3,225	$3,225.01 - $4,299	$4,299.01 - $5,373
6	$2,462 - $3,692	$3,692.01 - $4,922	$4,922.01 - $6,153
7	$2,774 - $4,159	$4,159.01 - $5,545	$5,545.01 - $6,932
8	$3,086 - $4,627	$4,627.01 - $6,169	$6,169.01 - $7,711
9	$3,397 -$5,095	$5,095.01 - $6,792	$6,792.01 - $8,490
10	$3,709- $5,562	$5,562.01 - $7,415	$7,415.01 - $9,269
For more than 10 persons, add the following amounts for each additional family member.			
	$313 - $468	$468.01 - $624	$624.01 - 780

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Section: Definitions

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

Income Category, A, B, or C
How much you pay for the monthly premium and copayments is determined by your income category. The income categories are determined based on the current Federal Poverty Income Guidelines as follows:

- Income Category A = 100%-150% of the Federal Poverty Income Guideline
- Income Category B = 151%-200% of the Federal Poverty Income Guideline
- Income Category C = 201%-250% of the Federal Poverty Income Guideline

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Section: Health Plan Covered Benefits Matrix

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 (see the HFP Income Categories A, B, and C Table on page 1 shall pay no more than $5 copayment for applicable covered services as described in this Benefit Descriptions Section of the EOC.

Benefits*	Services	Cost to Member (copayment) ***Income Category A***	Cost to Member (copayment) ***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 • $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 • $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) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
Professional Services	Services and consultations by a physician or other licensed health care provider.	$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 • 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 Care Services	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 members.	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
Prescription Drug Program **	Drugs prescribed by a licensed practitioner.	• $5 per prescription for ~~a~~ up to 30 day supply for brand name or generic drugs. • $5 per prescription for ~~a~~ up to 90 day supply of maintenance drugs	• $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

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
		• 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.	unless there is no generic equivalent or if the use of a brand name drug is medically necessary. • $10 copayment per prescription for up to 90 day supply for maintenance generic drugs purchased either through a participating pharmacy or through the plan's mail order program. • $15 copayment per prescription for up to 90 day supply for maintenance brand drugs purchased either through a participating pharmacy or through the plan's mail order program 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.
Durable Medical Equipment **	Medical equipment appropriate for use in the home which primarily serves a medical purpose, is intended for repeated use, and is	No copayment	No copayment

Benefits*	Services	Cost to Member (copayment) ***Income Category A***	Cost to Member (copayment) ***Income Categories B & C***
	generally not useful to a person in the absence of illness or injury.		
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 a member 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 the member is admitted to the hospital.)	$15 per visit (waived if the member is admitted to the hospital.)
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	• 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	No copayment	No copayment

Benefits*	Services	Cost to Member (copayment) ***Income Category A***	**Cost to Member (copayment)** ***Income Categories B & C***
	hospitalization any of the following: ▪ 2 days of residential treatment, ▪ 3 days of day care treatment, or ▪ 4 outpatient visits.		
Severe Mental Illness (SMI)	• Inpatient mental health care services for the treatment of severe mental illnesses. • Unlimited days.	No copayment	No copayment
Serious Emotional Disturbance (SED) Services	• Inpatient mental health care services for the treatment of SED conditions. • Unlimited days. ▪ On or before day 30; the Plan may refer the member to the 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 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.	No copayment	No copayment
Outpatient Mental Health Care Services:	Mental health care when ordered and performed by a participating mental health professional.		
Basic Mental Health Care Services	• 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,	$5 per visit	$10 per visit

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
	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 visits may be authorized by the Plan.		
Severe Mental Illness (SMI)	• Outpatient mental health care visits for the treatment of severe mental illnesses. • Unlimited visits.	$5 per visit	$10 per visit
Serious Emotional Disturbance (SED) Services	• Outpatient mental health care visits for the treatment for SED condition. • Unlimited visits. ▪ 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. ▪ 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.	No copayment	No copayment
Inpatient Alcohol / Drug Abuse Services	Hospitalization to remove toxic substances from the system.	No copayment	No copayment
Outpatient Alcohol / Drug Abuse Services	Crisis intervention and treatment of alcoholism or drug abuse. Benefit is limited to 20 visits per benefit year	$5 per visit ~~Benefit is limited to 20 visits per benefit year~~	$10 per visit

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
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 ~~Benefit is limited to a maximum of 100 days per benefit year~~	No 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	$10 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	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	For members who are diagnosed with a terminal illness and who 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

Benefits*	**Services**	**Cost to Member (copayment)** ***Income Category A***	**Cost to Member (copayment)** ***Income Categories B & C***
Phenylketonuria (PKU) **	Testing and treatment of PKU.	No copayment	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	$10 copayment per office visit Copayment 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 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.	No copayment	No copayment
Acupuncture (optional)	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 ~~Benefit is limited to 20 visits per benefit year~~	$10 per visit
Chiropractic (optional)	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 ~~Benefit is limited to 20 visits per benefit year~~	$10 per visit

Benefits*	Services	Cost to Member (copayment) *Income Category A*	Cost to Member (copayment) *Income Categories B & C*
Biofeedback (optional)	Does not require referral from the member's provider but services must be obtained from a plan provider.	$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.

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Section: Benefit Descriptions

NOTE: Members in the Income Category A (see the HFP Income Categories A, B, and C Table on page1) shall pay no more than $5 copayment for applicable covered services as described in this Benefit Descriptions Section of the EOC.

Outpatient Hospital Services
Cost to Member
No copayment, except:
- $~~5~~$10 per visit for physical, occupational and speech therapy performed on an outpatient basis.
- $~~5~~$15 per visit for emergency health care services, which is waived if the member is hospitalized.

Professional Services
Cost to Member
$~~5~~$10 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 or younger.
- No copayment for vision or hearing testing, or for hearing aids.

Diabetic Care
Cost to Member
- $~~5~~$10 copayment per office visit.
- Copayments for prescriptions are described in the "Prescription Drug Program" Section.

Prescription Drug Program

Cost to Member

- No copayment for prescription drugs provided in an inpatient setting.
- No copayment for drugs administered in the doctor's office or in an outpatient facility setting during the member's stay at the facility.
- No copayment for FDA-approved contraceptive drugs and devices.
- $~~5~~$10 copayment per prescription for up to 30 day supply for generic drugs.
- $~~5~~$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.
- $~~5~~$10 copayment per prescription for up to 90 day supply for maintenance* generic drugs purchased either through a participating pharmacy or through the plan's mail order program.
- $~~5~~$15 copayment per prescription for up to 90 day supply for maintenance* brand drugs purchased either through a participating pharmacy or through the plan's mail order program unless there is no generic equivalent or if the use of a brand name drug is medically necessary, then $10 copayment applies.

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

Emergency Health Care Services

Cost to Member

$~~5~~15 copayment per visit. Copayment will be waived if the member is admitted to the hospital.

Outpatient Mental Health Care Services

Cost to Member

$~~5~~10 copayment per visit.

Outpatient Alcohol/Drug Abuse Services

Cost to Member

$~~5~~10 copayment per visit.

Home Health Care Services

Cost to Member

No copayment, except for $~~5~~10 copayment per visit for physical, occupational, and speech therapy performed in the home.

Physical, Occupational, and Speech Therapy

Cost to Member

No copayment for inpatient therapy, including services received in a skilled nursing facility.
$~~5~~10 copayment per visit when performed in the home or other outpatient setting.

Acupuncture (Optional)

Cost to Member

$~~5~~10 copayment per visit.

Chiropractic Services (Optional)

Cost to Member

$~~5~~10 copayment per visit.

Biofeedback (Optional)

Cost to Member

$~~5~~10 copayment per visit.

Clinical Cancer Trials

Cost to Member

$~~5~~10 copayment per office visit.
Copayments for prescriptions are described in the "Prescription Drug Program" Section.