

Summary of Benefits

Benefits*	Services	Costs to Member (co-payment)
Physician Services	<ul style="list-style-type: none"> Office, home visits Allergy testing and treatment 	<ul style="list-style-type: none"> \$5 per visit \$5 per visit No charge under 24 months of age
Preventive Care	<ul style="list-style-type: none"> Periodic health examinations (including well-baby care) Variety of voluntary family planning services Prenatal care Vision and hearing testing Immunizations Sexually transmitted disease (STD) testing Confidential HIV/AIDS counseling and testing Annual Pap smear exams Health education services 	<ul style="list-style-type: none"> No charge (including office visits)
Prescription Drugs	<ul style="list-style-type: none"> 30 day supply of brand name or generic drugs, including prescriptions for one cycle of tobacco cessation drugs 90 day supply of maintenance drugs While in hospital FDA approved contraceptive drugs and devices 	<ul style="list-style-type: none"> \$5 per prescription \$5 per prescription No charge No charge
Hospital	<ul style="list-style-type: none"> <i>Inpatient:</i> room and board, nursing care, and all medically necessary services <i>Outpatient:</i> diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility 	<ul style="list-style-type: none"> No charge
Emergency Health Care Services	<ul style="list-style-type: none"> 24-hour emergency for illness, injury, or severe pain requiring immediate diagnosis and treatment to avoid placing the subscriber in danger of loss of life, serious illness, or disability Provided both in and out of the health plan's service area and participating facilities 	<ul style="list-style-type: none"> \$5 per visit unless hospitalized No coverage will be provided if the services received are not an emergency

* Benefits are provided if the insurance plan determines them to be medically necessary.

Summary of Benefits

Benefits*	Services	Costs to Member (co-payment)
Maternity	<ul style="list-style-type: none"> Prenatal and postnatal care, inpatient and newborn nursery care 	<ul style="list-style-type: none"> No charge
Medical Transportation	<ul style="list-style-type: none"> Emergency ambulance transportation to the hospital, and medically necessary non-emergency transportation to transfer a member from a hospital to another hospital or facility, or facility to home. 	<ul style="list-style-type: none"> No charge
Diagnostic X-ray and Laboratory Services**	<ul style="list-style-type: none"> Inpatient and outpatient 	<ul style="list-style-type: none"> No charge
Durable Medical Equipment**	<ul style="list-style-type: none"> Medical equipment appropriate for use in the home, oxygen and oxygen equipment, insulin pumps and all related necessary supplies 	<ul style="list-style-type: none"> No charge
Mental Health**	<ul style="list-style-type: none"> Diagnosis and treatment of mental illness. Outpatient and inpatient services are provided without limit for serious mental illnesses. All non-serious mental illnesses are limited to 20 outpatient and 30 inpatient hospital services 	<ul style="list-style-type: none"> No charge for inpatient services \$5 per visit for outpatient services
Alcohol and Drug Abuse	<ul style="list-style-type: none"> <i>Inpatient:</i> As medically appropriate to remove toxic substances from the system <i>Outpatient:</i> 20 visits per benefit year (Some plans may choose to increase the number of visits in a benefit year if outpatient services are determined medically necessary) 	<ul style="list-style-type: none"> No charge for inpatient services \$5 per visit for outpatient services

* Benefits are provided if the insurance plan determines them to be medically necessary.

** In addition to these benefits some services are also provided by the California Children's Services (CCS) program and by County Mental Health Departments. Families must meet residential requirements and members under the age of 19 must have a medical condition that is covered by CCS to be eligible for CCS services. Members who are under 19 years of age and diagnosed as having a Serious Emotional Disturbance (SED) will receive services from the County Mental Health Department.

Summary of Benefits

Benefits*	Services	Costs to Member (co-payment)
Physical, Occupational, Speech Therapy**	♦ Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home. Plans may require periodic evaluations as long as therapy, which is medically necessary, is provided.	♦ No charge for inpatient services ♦ \$5 per visit for outpatient services
Home Health Care	♦ Must be prescribed or directed by the attending physician or other appropriate authority designated by the plan	♦ No charge
Skilled Nursing Care	♦ Services provided in a licensed skilled nursing facility, 100 days each benefit year	♦ No charge

- * Benefits are provided if the insurance plan determines them to be medically necessary.
 ** In addition to these benefits some services are also provided by the California Children's Services (CCS) program and by County Mental Health Departments. Families must meet residential requirements and members under the age of 19 must have a medical condition that is covered by CCS to be eligible for CCS services. Members who are under 19 years of age and diagnosed as having a Serious Emotional Disturbance (SED) will receive services from the County Mental Health Department.

Optional Health Benefits

Not all health insurance plans provide these benefits. See pages 91-104 of this handbook for information on which insurance plans cover these services.

Optional Benefits	Services	Costs to Member (co-payment)
Acupuncture	♦ 20 visits per benefit year	♦ \$5 per visit
Chiropractic	♦ 20 visits per benefit year	♦ \$5 per visit
Biofeedback	♦ 8 visits per benefit year	♦ \$5 per visit
Elective Abortion	♦ Insurance plans vary (see pages 91-104)	♦ No charge

Summary of Benefits

Vision Benefits

Vision Benefits*	Services	Costs to Member (co-payment)
Eye Examinations	♦ Once every 12 months	♦ \$5 per examination
Prescription Glasses	♦ Once every 12 months	♦ \$5 per glasses, frames, or lenses

Dental Benefits

Dental Benefits*	Services	Costs to Member (co-payment)
Preventive Care (Teeth Cleanings, Topical Fluoride)	♦ Every 6 months	♦ No charge
Fillings	♦ As needed	♦ No charge
Sealants	♦ As needed only for permanent 1 st and 2 nd molars	♦ No charge
Diagnostic Services	♦ X-rays (Bitewing, Full-mouth, and Panoramic) ♦ Consultations	♦ No charge
Major Services	♦ Root canals ♦ Oral surgery ♦ Crowns and bridges ♦ Dentures	♦ \$5 ♦ \$5 ♦ \$5 ♦ \$5
Orthodontia Services	♦ Provided to subscribers under the age of 19 through the California Children's Services Program (CCS) when condition meets the CCS program criteria	♦ No charge

- * Benefits are provided if the insurance plan determines them to be medically necessary.
Note: The Benefits Charts on the preceding pages are only a summary of benefits provided by each plan in the Healthy Families Program. These summaries are for information only. This is not a contract. For exact terms and conditions of the benefits, provisions, exclusions, and limitations for each plan, refer to the Evidence of Coverage booklet or Certificate of Insurance available from each plan. Call the phone number listed on each plan's description page.