**HEALTH PLAN COVERED BENEFITS MATRIX – HEALTHY KIDS**

**Benefit Year** July 1 – June 30

**Important:** This matrix is to help you compare covered benefits and is a summary only. Please read the Benefit Description sections for a detailed description of covered benefits and limitations.

<table>
<thead>
<tr>
<th>CATEGORY DESCRIPTION</th>
<th>MEMBER COPAYMENT &amp; LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><em>Benefits</em> Services</em>*</td>
<td><strong>Cost to Member (Copayment)</strong></td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>Room and board, nursing care and all medically necessary ancillary services.</td>
</tr>
</tbody>
</table>
| 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 admitted directly to the hospital). |
| Professional Services | Services and consultations by a physician or other 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. |
<p>| Preventive Health Service | Periodic health examinations including all routine diagnostic testing, Human Immunodeficiency Virus (HIV) testing, laboratory services appropriate for such examinations, 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. |</p>
<table>
<thead>
<tr>
<th>Benefits Category **</th>
<th>Description</th>
<th>Copayment/Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes Care</strong></td>
<td>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.</td>
<td>$5 copayment per office visit. Copayment for prescriptions as described in the “Prescription Drug Program” Section.</td>
</tr>
</tbody>
</table>
| **Prescription Drug Program** | Drugs prescribed by a licensed practitioner. | $5 per prescription for a 30 day supply for brand name or generic drugs. $5 per prescription for a 90 day supply of maintenance drugs.  
  - 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. |
<p>| <strong>Durable Medical Equipment</strong> | 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. |
| <strong>Orthotics and Prosthetics</strong> | Original and replacement devices as prescribed by a licensed practitioner. | No copayment. |
| <strong>Cataract Spectacles and Lenses</strong> | Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery. | No copayment. |
| <strong>Maternity Care</strong> | Professional and hospital services relating to maternity care. | No copayment. |
| <strong>Family Planning Services</strong> | Voluntary family planning services. | No copayment. |
| <strong>Medical Transportation Services</strong> | 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. |
| <strong>Emergency Health Care Services</strong> | Emergency services are covered both in and out of the Plan’s Service Area and in and out of the Plan’s contracted facilities. | $5 per visit (waived if the member is admitted to the hospital). |</p>
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
<th>Copayment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Mental Health Care Services</strong></td>
<td>Mental health care in a participating hospital when ordered and performed by a Participating Mental Health Provider for the treatment of a mental health condition. Diagnosis and treatment of a mental health condition.</td>
<td>No copayment. Unlimited days.</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health Care Services</strong></td>
<td>Mental health care when ordered and performed by a Participating Mental Health Provider. 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, divorce or bereavement. Family members may be involved in the treatment when medically necessary for the health and recovery of the child.</td>
<td>$5 per visit. Unlimited visits.</td>
</tr>
<tr>
<td><strong>Substance Abuse Treatment Services – Inpatient</strong></td>
<td>Hospitalization to remove toxic substances from the system.</td>
<td>No copayment. Unlimited days.</td>
</tr>
<tr>
<td><strong>Substance Abuse Treatment Services – Outpatient</strong></td>
<td>Crisis intervention and treatment of alcoholism or drug abuse.</td>
<td>$5 per visit. Unlimited visits.</td>
</tr>
<tr>
<td><strong>Home Health Care Services</strong></td>
<td>Services provided at the home by health care personnel.</td>
<td>No copayment, except: $5 per visit for physical, occupational, and speech therapy.</td>
</tr>
<tr>
<td><strong>Skilled Nursing Care</strong></td>
<td>Services provided in a licensed skilled nursing facility.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>**Rehabilitative (Physical, Occupational and Speech) Therapy **</td>
<td>Therapy may be provided in a medical office or other appropriate outpatient setting.</td>
<td>$5 per visit when performed in an outpatient setting. No copayment for inpatient therapy.</td>
</tr>
<tr>
<td>**Blood and Blood Products **</td>
<td>Includes processing, storage and administration of blood and blood products in inpatient and outpatient settings.</td>
<td>No copayment.</td>
</tr>
<tr>
<td><strong>Health Education</strong></td>
<td>Includes education regarding personal health behavior and health care and recommendations regarding the optimal use of health care services.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Copayment Information</td>
</tr>
<tr>
<td>---------------------------------</td>
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</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>For Members who are diagnosed with a terminal illness and who elect hospice care instead of traditional health care services.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>**Organ Transplants **</td>
<td>Coverage for organ transplants and bone marrow transplants which are not experimental or investigational.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>**Reconstructive Surgery **</td>
<td>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.</td>
<td>No copayment.</td>
</tr>
<tr>
<td>**Phenylketonuria (PKU) **</td>
<td>Testing and treatment of PKU.</td>
<td>No copayment.</td>
</tr>
<tr>
<td><strong>Clinical Cancer Trials</strong></td>
<td>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 the Member meets certain requirements.</td>
<td>$5 copayment per office visit. Copayment for prescriptions as described in the “Prescription Drug Program” Section.</td>
</tr>
</tbody>
</table>
| **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 Health Plan 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.                                                                         |
<p>| <strong>Acupuncture</strong>                 | Requires a referral from the Member’s PCP and prior authorization from the Plan. Services must be obtained from an In Service Area Contracted Provider.                                                       | $5 per visit. Benefit is limited to 20 visits per benefit year.                         |
| <strong>Chiropractic</strong>                | Requires a referral from the Member’s PCP and prior authorization from the Plan. Services must be obtained from an In Service Area Contracted Provider.                                                       | $5 per visit. Benefit is limited to 20 visits per benefit year.                         |
| <strong>Biofeedback</strong>                 | Requires a referral from the Member’s PCP and prior authorization from the Alliance. Services must be obtained from an In Service Area Contracted Provider.                                                       | $5 per visit.                                                                         |</p>
<table>
<thead>
<tr>
<th>Deductibles</th>
<th>No deductibles will be charged for covered benefits.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximums</td>
<td>No lifetime maximum limits on benefits apply under this Plan.</td>
</tr>
</tbody>
</table>

* Benefits are provided only for services that are medically necessary.
** These services must be covered and paid for by the California Children’s Services (CCS) program, if the Member is found to be eligible for CCS services.