

NAME OF ORGANIZATION SOLICITING RFP

**REQUEST FOR PROPOSALS
FOR MEDICAL COVERAGE FOR UNINSURED CHILDREN IN
[INSERT COUNTY NAME]**

FOR DISCUSSION ONLY – 1/9/04

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I. Purpose

The *[Insert County Name]* Program (“**Program**”), under the direction of *[Insert name of the CBO or county agency in charge – “Organization”]* seeks a licensed health plan with broad geographic and comprehensive provider access, including traditional and safety net providers, to provide prepaid inpatient and outpatient services to children in *[Insert County Name]*.

[Insert description of the governing body: who it is, how it functions, how it relates to the county.]

The Program seeks to cover all children with family incomes below 300% of the Federal Poverty Level (FPL) who are not eligible for Medi-Cal or Healthy Families. This number is estimated to be *[Insert Number of Children Not Eligible for Public Programs]*. It is generally anticipated that it will take up to three years to fully enroll at least 85% of eligible children, and that a third will be enrolled in the first year, half by end of the second year, and 85% by the end of the third year. It is possible, however, that enrollment targets will be exceeded.

History of Children’s Health Initiative in *[Insert County Name]*

Despite the State’s fiscal picture, over the past three years there has been significant momentum at the local level and across many stakeholders to provide health insurance coverage to uninsured children and youth. Beginning with the Santa Clara Children’s Health Initiative in 2001, followed by San Francisco, San Mateo, and Riverside counties, there has been an increase in locally grown efforts to fill the gaps in the state’s patchwork of health insurance programs for children to provide coverage for all children ages 0-18 under 300% of the poverty level (400% FPL in San Mateo County).

Although there is some variability in program design among these county-based initiatives, all work to reach children by creating a new coverage opportunity that fills the eligibility gaps in existing programs and by integrating outreach, enrollment and renewal processes. The new health insurance product, called **Healthy Kids** in all implementing counties, is for children in low to modest-income families who are not eligible for Medi-Cal and Healthy Families. The target population for Healthy Kids in most of these initiatives is uninsured children, including undocumented children, in families with incomes below 300% of the federal poverty level (\$55,000 for a family of four in 2003).

Counties have used a variety of funding sources – county and city funds, tobacco settlement funds, First 5 tobacco tax revenues, foundation grants, hospital and hospital district contributions, health plan contributions and other provider contributions – to pay for their Children’s Health Initiatives (CHI). In the most innovative models, counties have created integrated, “one open door” outreach and enrollment systems in which families apply for health insurance for their children and then are evaluated for eligibility in Medi-Cal, Healthy Families or Healthy Kids. The “one open door” approach greatly simplifies

both the outreach methods and the message for reaching low to modest-income families.

At present, eight counties are operating expanded coverage programs with the *combined new enrollment of over 30,000 children in the Healthy Kids product, and many more thousands have been enrolled in Medi-Cal and Healthy Families.*¹ This momentum is anticipated to continue with recent multi-year investments in county children's coverage initiatives from many local First 5 Commissions, the State First 5 Commission, local contributors, and several major foundations.

In each county currently operating a CHI, the local initiative plan (LI) or county organized health system (COHS) is the contracted plan for the Healthy Kids insurance product. There are a number of ways that these local plans have supported county CHIs, including: (1) providing a broad, community-based provider network; (2) providing financial contributions towards premiums; (3) providing in-kind administration support; and (4) participating collaboratively in outreach and enrollment efforts to reach uninsured children and families.

As local efforts continue to spread, counties without LI's or COHS's will be seeking qualified health plans (QHPs) to provide inpatient and outpatient services to uninsured children in their geographic areas.

[Insert County Name] Children's Demographics and Progress Toward CHI

[Insert County Name] has [Insert history of county efforts to develop this program and current use of health care services by the population. Also include information about the following:

- *Number of potential enrollees*
- *Linguistic needs*
- *Geographic distribution*
- *Traditional and safety net providers.]*

II. Definitions

The following terms are used throughout this RFP. They are defined below:

- A. ***Children's Health Initiative (CHI)*** - County-based initiative to identify and enroll children in publicly available health insurance by creating a new insurance product that fills the gaps in existing public programs and by integrating outreach, enrollment and retention processes.

¹ The eight counties are Santa Clara, Alameda, San Francisco, San Mateo, Riverside, San Bernardino, Los Angeles and San Joaquin counties. See CFCTAC website at www.cfctac.org.

- B. **Coalition** – The community-based organizations, local residents, advocates, hospitals, health systems, health plans, foundations, First 5 Commissions and government agencies that have come together to form the local CHI.
- C. **Healthy Kids** - A new health insurance product for children in low-income families who are not eligible for Medi-Cal and Healthy Families. The target population for Healthy Kids is generally children who do not qualify for Medi-Cal or Healthy Families, are in families with incomes below 300% of the federal poverty level (\$55,000 for a family of four in 2003) and may be undocumented.
- D. **Organization** – The *[Insert Organization]* is the organization identified by the local organizing group to administer the CHI.
- E. **Traditional and Safety Net Providers** - Current CHDP providers, except for clinical laboratories; community clinics, free clinics, rural health clinics and county owned and operated clinics; university teaching hospitals; children’s hospitals); county owned and operated general acute care hospitals; and any disproportionate share hospital.

III. Program Elements

[Insert Organization] has identified the following program elements and responsibilities as essential to the successful implementation of the CHI in *[Insert County Name]*. These program elements are in compliance with the Knox Keene Act as amended. The health plan should operate those special services for the *[Insert County Name and Organization]*, which comply with Healthy Families requirements set forth in Title 10, California Code of Regulations at Chapter 5.8, Managed Risk Medical Insurance Board Healthy Families Program, Sections 2699.6500–6905. These include:

- A. Cultural and linguistic access and services, including compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and the 45 C.F.R. Part 8) (See Section IX.-B.)
- B. Quality improvement program, including current accreditation status through the National Committee for Quality Assurance/Joint Commission on the Accreditation of Healthcare Organizations (NCQA/JCAHO) and audited clinical quality measures consisting of the NCQA’s Health Plan Employer Data and Information Set (HEDIS) Performance Measures (See Section IX.-E.)
- C. Provider Network, including traditional and safety net providers, as defined by the MRMIB/Healthy Families Program community provider designations (See Section IX.-D.)
- D. Quality customer service (See Section IX.-C.)

In addition, the applicant must:

- E. Administer an equivalent Healthy Families package of medical and mental health services as part of its contracting arrangements for Healthy Kids subscribers. (See Section IX.-F. and Attachment 1)
- F. Provide unbundled rates for medical and mental health services under the benefit plan and co-payment schedule included as Attachment 1 that are comparable to Healthy Families pricing. It is assumed that the applicant will not be required to provide medically necessary services to treat a subscriber under age 18 for California Children's Services (CCS) eligible conditions that are authorized by the CCS program. Rates will be in effect for a one year period with negotiation for the following year. (See Section VIII.-B.)
- G. Submit subscriber enrollment and utilization reports to the *[Insert Organization]* on a monthly basis. The applicant must also coordinate with the County Social Services Agency and other agencies as specified by the *[Insert Organization]* in developing a seamless application, enrollment, referral and transfer process between the Medi-Cal, Healthy Families and Healthy Kids programs. (See Section IX.-G.)
- H. Agree to designate and involve a regional manager or other appropriate staff member in the *[Insert Organization]* Steering Committee meetings.
- I. Cooperate with *[Insert Organization]* in the training and community relations activities (See Section IX.-H.):
 - 1. Agree to attend training developed by the *[Insert Organization]* for screening and enrolling children in Medi-Cal, Healthy Families and Healthy Kids programs.
 - 2. Make presentations on the health plan's role and involvement in the *[Insert Organization]* to the County Board of Supervisors, the First 5 Commission and other key stakeholders as deemed reasonable and appropriate.
- J. Other Provisions
 - 1. Pre-existing Condition Coverage Exclusion Prohibition

The applicant must include the provision that no pre-existing condition exclusion period or post-enrollment waiting period shall be required of subscribers.
 - 2. Contractor Cooperation

The *[Insert Organization]* may have agreements with other carriers/health plans and outreach entities for the purpose of implementing and maintaining the Program. The applicant must agree to cooperate fully and in a timely manner with the *[Insert Organization]* and any of the *[Insert Organization Name]'s* contractors involved in implementing or maintaining the program. This includes

mandatory participation of the appropriate health plan staff in the appropriate Outreach and Enrollment meetings.

3. Evaluation Cooperation

It is expected that an evaluator will be contracted by the *[Insert Organization]* to conduct an evaluation of the processes and outcomes of the Program. In order to support the evaluation, the health plan must:

- a. provide appropriate administrative and utilization data in a timely manner for evaluation of the Program;
- b. provide evidence of the establishment, accessibility and maintenance of grievance procedures, as required by the plan's licensing statute;
- c. provide the *[Insert Organization]* and/or evaluation team with uniform data on customer satisfaction consistent with HEDIS quality performance data; and
- d. within reasonable parameters, actively respond to data requests or survey augmentation from the evaluation team.

IV. Selection Criteria

The qualified health plan shall be selected on a competitive basis. Applicants will be evaluated based on all of the following:

- A. A licensed health plan under California and federal licensing.
- B. Demonstrated capacity to provide a comprehensive provider network available throughout the county, including traditional and safety net providers. Preference is given to those plans already functioning in the county with a comprehensive provider network.
- C. Demonstrated ability to provide culturally and linguistically sensitive services.
- D. Demonstrated ability to provide high quality customer service, with specific attention to pediatric services.
- E. Demonstrated experience with a quality improvement program, with monitoring that uses national standards, such as NCQA's HEDIS system.
- F. Demonstrated experience providing a broad scope of services within a financially stable organization.
- G. Pricing at levels comparable to Healthy Families.

- H. Demonstrated experience with reporting requirements.
- I. Willingness to cooperate with *[Insert Organization]*, including participating in Steering Committee, trainings, presentations and evaluation.
- J. Demonstrated ability to ensure that children and families retain coverage and are informed of available options for health coverage and services when they lose eligibility for a particular program.
- K. Demonstrated ability to provide quality of care and customer satisfaction data for external evaluation.

V. Timeline

The timeline for selection and implementation of Program shall be as follows:

RFP released	Date
Bidder's Conference	Date + 2 weeks
Letter of Intent Due	Date + 3 weeks by 5 pm.
Proposals Due	Date + 6 – 8 weeks by 5 pm.
Notice of Intent to Contract	Date + 3 months
Appeals	Date + 3.5 months
Contract Begins	Date + 6 months

Technical assistance will be available throughout the proposal development process to any interested health plans. For requests for technical assistance or questions, please contact *[Insert Name of Contact, Phone Number and Email Address]*. Furthermore, a list of responses to questions arising at or before the Bidder's Conference and as part of the Request for Proposals will be sent to all those who submit a Letter of Intent or attend the Bidder's Conference.

VI. Letter of Intent to Submit Proposal

A Letter of Intent to Submit a Proposal is required to be submitted by 5 pm on *[Insert Month, Day, Year]*. It may be mailed, hand-delivered, sent electronically or faxed to:

Contact Person
 Organization
 Street
 City, CA Zip
 Fax
 Email.

This Letter of Intent to Submit a Proposal must be on health plan letterhead and signed by a person authorized to commit the applicant health plan. It should be no longer than two (2) pages and give a brief description of the health plan, total plan budget, demographics of subscribers, utilization statistics, and a complete list of Medi-Cal and Healthy Families contracts. This Letter will be used to contact the health plan. Submission of a Letter of Intent does not bind the health plan to submit a full proposal.

VII. Proposal Submission Requirements

A. Technical Requirements

1. Use single-sided 8-1/2 X 11 white paper, with one-inch margins on all sides. Double-space, using at least a 12 point font. Staple the document: do not use clips, binders or presentation folders. The original and six copies must be received by 5:00 pm on *[Insert Month, Day, Year]*. Late proposals will not be accepted.
2. The application may be mailed, hand-delivered or submitted electronically, as long as the application is complete and in one file. Fax submissions will not be accepted.
3. Number pages consecutively throughout the document, including the cover page, table of contents and attachments. Include vendor name in header on each page.
4. Follow the proposal order below:
 - a. Cover Page
 - b. Table of Contents
 - c. Executive Summary
 - d. Technical Response to Program Elements
 - e. Pricing: Unbundled Rates for Medical and Mental Health Services
 - f. Attachments
 - 1) Benefit plan and co-pay schedule
 - 2) Applicant's health plan license
 - 3) List of current Board of Directors
 - 4) Statement that applicant is an equal opportunity employer
 - 5) List of current Medi-Cal and Healthy Families contracts for counties in California

B. Narrative Requirements

Instructions for each section are provided below. Compliance with these requirements is mandatory, and proposals failing to comply may have their overall evaluation score reduced or be disqualified.

1. Cover Page

Please complete the Cover Page (Attachment 2), including health plan name, address, contact person and information, and authorized signature.

2. Table of Contents

Include all sections with page numbers as described in this section of the RFP.

3. Executive Summary – maximum 1 page

The Executive Summary serves to familiarize RFP reviewers with the key elements and unique features of your proposal by briefly describing what you are proposing, and how you intend to accomplish the work. This section shall contain the following:

- a. A summary of your approach to the project, including the main point of each section.
- b. A brief implementation timeline.
- c. A list of exceptions taken to the RFP instructions, if any, and the reason these exceptions were taken.
- d. The pricing for unbundled rates for medical and mental health services, with co-payment schedule.

4. Technical Response to Program Elements – maximum 20 pages

This section shall address how the applicant will ensure the careful design and implementation of the program elements. This is the heart of the proposal. This section should include a description of how your organization will approach the program elements as described in Sections IX. A. – I.

- a. Outreach, Enrollment, Retention and Utilization Activities
- b. Cultural and Linguistic Access and Services
- c. Customer Service
- d. Provider Network, including Traditional and Safety Net Providers
- e. Clinical Quality Measures and Management Practices
- f. Covered Services and Benefits
- g. Administrative Reporting
- h. Willingness to Cooperate with *[Insert Organization]*
- i. Grievance Procedure.

5. Pricing – no page limit

Provide unbundled rates for medical and mental health services under the benefit plan and co-payment schedule as Attachment 1. The plan will not be required to provide medically necessary services to treat a subscriber under age 18 for

California Children's Services (CCS) eligible conditions that are authorized by the CCS program.

6. Attachments – no page limit

See Page 8 for the list of required attachments.

VIII. Proposal Review

All proposals will be reviewed by a panel of internal and external evaluators who will work closely with *[Insert Organization]* to evaluate the proposals. The evaluation will be based on the following criteria:

A. Ability to meet selection criteria (maximum 60 points)

1. A licensed health plan under California and federal licensing.
2. Demonstrated capacity to provide a comprehensive provider network available throughout the county, including traditional and safety net providers.
3. Demonstrated ability to provide culturally and linguistically sensitive services.
4. Demonstrated ability to provide high quality customer service, with specific attention to pediatric services.
5. Demonstrated experience with a quality improvement program, with monitoring that uses national standards, such as NCQA's HEDIS system.
6. Demonstrated experience providing a broad scope of services within a financially stable organization.
7. Demonstrated experience with reporting requirements.
8. Willingness to cooperate with the *[Insert Organization]*, including participation in Steering Committee, trainings, presentations and evaluation.
9. Demonstrated ability to ensure that children and families retain coverage and are informed of available options for health coverage and services when they lose eligibility for a particular program.
10. Demonstrated ability to provide quality of care and customer satisfaction data for external evaluation.

B. Soundness of budget, pricing and fiscal competence (maximum 40 points)

A plan shall demonstrate fiscal soundness as follows:

1. Demonstrate through its history of operations and through projections (which shall be supported by a statement as to the facts and assumptions upon which they are based) that the plan's arrangements for health care services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness.

2. Demonstrate that its working capital is adequate, including provisions for contingencies.
 3. Demonstrate an approach to the risk of insolvency which allows for the continuation of benefits for the duration of the contract period for which payment has been made, the continuation of benefits to subscribers and enrollees who are confined on the date of insolvency in an in-patient facility until their discharge, and payments to unaffiliated providers for services rendered.
 4. Rates are to be in effect for one year, with the option of negotiation for a second year. The Program will also allow for rolling enrollment.
- C. The *[Insert Organization]* may choose not to award a contract based on proposals received. Submitted proposals will be evaluated on the basis of the program features, functionality of the proposed program, vendor ability, and program costs within the framework of the selection criteria.

IX. Technical Requirements for Program Elements

This section describes the expected operational responsibilities of the health plan with the Program and the relationship between the health plan and *[Insert Organization]*. The successful applicant will be able to assure that all health plan requirements will be met, and hence be ready for a contract with *[Insert Organization]*. Again, it is expected that the applicant will be in compliance with both the Knox Keene Act as amended and the Healthy Families Program Regulations. Specifically, *[Insert Organization]* seeks the following:

A. Outreach, Enrollment, Retention And Utilization Activities

Please describe your activities in these areas and information about effectiveness and your experience with the patient population.

1. Enrollment Eligibility

All subscribers who are determined eligible by the *[Insert Organization]* in accordance with the program regulations are eligible to enroll hereunder. The *[Insert Organization]* certifies that its enrollment process shall not be prejudicial to the applicant. The *[Insert Organization]* will enroll eligible subscribers, collect their payments and forward information to the Health Plan.

2. Conditions of Enrollment

The applicant agrees to accept enrollment of all subscribers referred by the *[Insert Organization]* on the date specified by the *[Insert Organization]*.

3. Disenrollment

- a. The applicant agrees to disenroll subscribers when notified to do so by the *[Insert Organization]* on the date specified by the *[Insert Organization]*.
- b. In no event shall any individual subscriber be entitled to the payment of any benefits with respect to health care services rendered, supplies or course of drug treatment received or expense incurred following termination of coverage.

4. Commencement of Coverage

Coverage shall commence for a subscriber at 12:01 a.m. on the day designated by the *[Insert Organization]* as the beginning day of coverage. There may be mid-month enrollments, whose payments will be prorated, according to the day of the month.

5. Identification Cards, Provider Directory and Evidence of Coverage

- a. The applicant shall, no later than the effective date of coverage, issue to subscribers an Identification Card, Provider Directory and Evidence of Coverage booklet setting forth a statement of the services and benefits to which the subscriber is entitled. The applicant agrees that the packet of materials sent to subscribers shall also include information regarding how to access services. The information shall be in addition to the description provided in the Evidence of Coverage booklet. These materials will be available in the required languages and reading levels for the subscribers. (See Section IX.-B.)
- b. The applicant shall, in *[Insert Month]* each year issue to each subscriber enrolled in the health plan an updated Provider Directory, and Evidence of Coverage booklet setting forth a statement of the services and benefits to which the subscriber is entitled or a letter describing any changes to the benefits package which will go into effect at the beginning of the benefit year.
- c. The applicant's Provider Directory shall be updated and distributed by the applicant to subscribers whenever there is a material change in the provider network.
- d. The applicant's Provider Directory shall indicate the language capabilities of the providers and the location of and public transportation access to provider offices.

B. Cultural And Linguistic Access and Services

Please describe your plan's experience in this area including staffing. Attach protocols and training information where applicable.

1. Linguistic Services

- a. The applicant shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 8) which prohibits recipients of federal financial assistance from discriminating against persons based on race, color or national origin. This is interpreted to mean that a limited English proficient individual is entitled to equal access and participation in federally funded programs through the provision of bilingual services.
- b. The applicant shall provide twenty-four (24) hour access to interpreter services for all limited English proficient subscribers seeking health services within the applicant's network. The applicant shall develop and implement policies and procedures for ensuring access to interpreter services for all limited English proficient subscribers. The procedures must include ensuring compliance of any subcontracted providers to these requirements. The applicant may use qualified bilingual or multilingual staff who can interpret for providers or use a contracted organization for interpreter services. *[Insert Organization]* prefers the use of face-to-face interpreter services.
- c. When the need for an interpreter has been identified by the provider, or requested by a subscriber, the applicant agrees to provide an qualified interpreter for a scheduled appointment. The applicant shall instruct its providers within its provider network to record the language needs of subscribers in the medical record.
- d. The applicant agrees that subscribers shall not be required to or encouraged to utilize family members or friends as interpreters. After being informed of his/her right to use free interpreter services provided by the applicant, subscribers may use an alternative interpreter of his/her choice at his/her cost. The applicant shall encourage the use of qualified interpreters. The applicant agrees that minors shall not be used as interpreters except for only the most extraordinary circumstances, such as medical emergencies. The applicant shall ensure that the request or refusal of language/interpreter services is documented in the medical records.
- e. The applicant shall inform subscribers of the availability of linguistic services as well as the right to file a complaint or grievance if linguistic needs are not met.
- f. The applicant shall ensure that there is appropriate bilingual proficiency at medical and non-medical points of contact for providers who list their bilingual capabilities in provider directories. The applicant agrees that activities to ensure that interpreters are bilingually proficient at medical points of contact, such as advice and urgent care telephone lines and face-to-face encounters with providers, may include but not be limited to: demonstrated conversational

fluency as well as fluency in medical terminology, training to take or assist with gathering information for an accurate medical history with culturally related consent forms, and provision of dictionaries and glossaries for interpreters, if necessary. The applicant agrees that activities to ensure that interpreters are bilingually proficient at non-medical points of contact, such as subscriber/customer service, plan or provider office reception, and appointment services, may include but not be limited to: demonstrated conversational fluency with use of correct grammar and an adequate vocabulary, and demonstrated comprehension of language relating to health care and an ability to assist with forms.

- g. The applicant shall identify and report the on-site linguistic capability of providers and provider office staff through the reporting required for the Network Information Service. (See Section IX.D.2.)

3. Translation of Written Materials

The applicant agrees to translate written informational materials for subscribers that shall include but not be limited to the Evidence of Coverage booklet, form letters, and medical care reminders. Translation of these materials shall be in the following languages: Spanish, and any language representing the preferred mode of communication for the lesser of five percent (5%) of the applicant's enrollment or 3,000 subscribers in the Program. The applicant shall ensure that subscribers who are unable to read the written materials translated into non-English languages have access to the content meaning of the written materials. The applicant shall ensure the quality of the translated material.

4. Operationalizing Cultural and Linguistic Competency

- a. The applicant is encouraged to develop internal systems that meet the cultural and linguistic needs of subscribers in the Program. The applicant is encouraged to provide initial and continuing training on cultural competency to staff and providers. Ongoing evaluation and feedback on cultural competency shall include but not be limited to feedback from subscriber surveys, staff, providers, and encounter/claim data.
- b. The applicant shall report annually on or before *[Insert Date]*, the linguistically and culturally appropriate services provided and proposed to be provided to meet the needs of limited-English proficient applicants and subscribers in the Program. This report shall address types of services including but not limited to: linguistically and culturally appropriate providers and clinics, interpreters, marketing materials, information packets, translated written materials, referrals to culturally and linguistically appropriate community services and programs, and training and education activities for providers. The applicant shall also report its efforts to evaluate cultural and linguistic services and outcomes of cultural and linguistic activities as part of its ongoing quality improvement efforts, through subscriber complaints and grievances,

membership satisfaction, and other supplemental information. The report shall also address activities undertaken by the applicant to develop internal systems to meet the cultural and linguistic needs of subscribers. The format for this report shall be determined by *[Insert Organization]*.

C. Customer Service

Please provide your customer service protocols and training information.

The applicant agrees to provide a toll free telephone number for applicant and subscriber inquiries. This telephone service shall be available on regular business days from the hours of 8:30 a.m. to 5:00 p.m. Pacific Time. The applicant shall provide staff bilingual in English and Spanish during all hours of telephone service. The applicant shall have the capability to provide telephone services via an interpretive service for all limited English proficient persons.

D. Provider Network

Please describe how you include "traditional and safety net providers" and how you achieve geographic access. Provide your provider network information as an attachment.

1. Primary Care Physician Assignment

The *[Insert Organization]* shall provide the applicant with the name of each subscriber's chosen primary care physician, if the name is listed on the program application. The applicant agrees to ensure that all subscribers shall be enrolled with a primary care physician within thirty (30) calendar days of the effective date of coverage in the plan. If the applicant assigns a primary care physician to a subscriber, the applicant shall use a fair and equitable method of assignment from the applicant's physician network and shall promptly notify the subscriber of the selection and the opportunity to change the assigned primary care physician. Such method of assignment shall take into account the geographic accessibility and language capabilities of providers. The applicant also agrees to promptly notify the primary care physician that he/she has been chosen by the subscriber or assigned by the applicant. The applicant also agrees that within 120 days of being assigned a primary care physician, the subscriber will be contacted for an initial health assessment.

2. Network Information Service

- a. The applicant agrees to provide, to the best of its ability, complete and accurate data on its provider network in an electronic format to be determined by the *[Insert Organization]*. The applicant understands that the *[Insert Organization]* shall establish a minimum data set. The information may be expanded by the *[Insert Organization]* with no less than ninety (90) calendar days notice by the *[Insert Organization]*. The applicant agrees to provide

additional data elements, as requested by the *[Insert Organization]*, to the best of its ability.

- b. The applicant agrees to provide provider network information to the *[Insert Organization]* on a quarterly basis and may update its provider network information on a monthly basis. The applicant is required to provide data for the creation of the database to the *[Insert Organization]* between the 11th and 25th of any submission month.

3. Traditional and Safety Net Providers

The applicant agrees to establish policies and contracts with traditional and safety net providers, as defined by the Healthy Families Program Regulations, Title 10, Chapter 5.8, Section 2699.6805. This includes CHDP providers, except for clinical laboratories, that are on the DHS CHDP Master File as of October 1st of the previous year; community clinics, free clinics, rural health clinics and county owned and operated clinics, which were so identified by the Medi-Cal program as of October 1st of the previous year, a university teaching hospital, a children's hospital (as defined in Section 10727 of the Welfare and Institutions Code), a county owned and operated general acute care hospital, and any disproportionate share hospital. The applicant assures that it has signed contracts with traditional and safety net providers, and shall provide the *[Insert Organization]* with copies of the contracts, if so requested by the *[Insert Organization]*.

E. Clinical Quality Measures and Management Practices

Please describe your quality assurance and improvement program components. Please provide evidence of accreditation through the National Committee for Quality Assurance/Joint Commission on the Accreditation of Healthcare Organizations (NCQA/JCAHO), audited clinical quality measures consisting of: NCQA's HEDIS measures of age relevant measures included in versions of HEDIS numbered higher than 2000.

1. Measuring Clinical Quality

- b. The applicant agrees to provide the *[Insert Organization]* with audited clinical quality measures consisting of the following:
 - 1) The NCQA's HEDIS 2000 Performance Measures. The applicant shall comply with instructions for reporting these measures as outlined in the most current version of HEDIS released by the NCQA.
 - 2) The total number of subscribers, the number of subscribers who were enrolled for 120 consecutive days or four (4) consecutive subscriber months after their effective date of coverage in the applicant's plan, and who received a health assessment visit during that time in the applicant's

health plan or within the twelve (12) months immediately preceding the effective date of coverage.

- 3) Any age relevant HEDIS measures included in versions of HEDIS numbered higher than 2000, as specified by the *[Insert Organization]*.
- b. Data on the measures described in Item a. above shall be provided to the *[Insert Organization]* on an annual basis and shall cover the previous calendar year experience, in a format to be determined by the *[Insert Organization]*. The report shall include data on subscribers enrolled in the health plan through the Program. The report shall be due *[Insert Date]*.
- c. All data reported to the *[Insert Organization]* pursuant to Item a. above shall be measured or audited by an independent third party. Such entities may include the California Cooperative Healthcare Reporting Initiative, the External Quality Review Organization utilized by the State Department of Health Services, or other entities listed in the most recent list of certified HEDIS auditors from the NCQA.

2. Measuring Consumer Satisfaction

- a. The applicant agrees to provide the *[Insert Organization]* with uniform and independently collected and analyzed data on customer satisfaction using the NCQA's Consumer Assessment of Health Plans Survey version 2.0 (H), hereafter referred to as CAHPS, for Program participants.
- b. The applicant agrees to purchase the services of the vendor selected by the County for the uniform and independent collection and analysis of CAHPS data, hereafter referred to as CAHPS Vendor.
- c. The applicant understands that the *[Insert Organization]* intends to release the CAHPS data to parents, subscribers and other interested parties. The applicant understands that the final decision regarding the release of information collected from the CAHPS survey shall be made by the *[Insert Organization]*.
- d. For the *[Insert Contract Year]*, the applicant agrees to pay the survey vendor a monthly survey benefit amount, to be determined by the *[Insert Organization]* based upon plan enrollment and survey milestones which determine the number of families to be surveyed. This shall be paid for a period of ten (10) months, starting in *[Insert Month and Year]* for the benefit of all children enrolled in the Program.

3. Standards Designed to Improve the Quality of Care

- a. The applicant assures the *[Insert Organization]* that its providers shall use, and the applicant shall monitor, the most recent recommendations of the

American Academy of Pediatrics (AAP) with regard to Recommendations For Preventative Pediatric Health Care; the most recent version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices (ACIP) and immunizations for adults as recommended by the ACIP; and the Society for Adolescent Medicine's Guidelines for Adolescent Preventative Services.

- b. The applicant agrees to notify parents or guardians of subscriber children enrolled in applicant's plan, on an annual basis, of the recommended schedule of preventive care visits. The first notice shall be included in the materials provided by the applicant to new subscribers. Such notification shall be provided via a mailed notice or brochure and shall be provided in all required languages.

4. Quality Management Processes

- a. The applicant assures the *[Insert Organization]* that the applicant shall maintain a system of accountability for quality improvement activities which includes the participation of the Governing Body of the applicant's organization, the designation of a Quality Improvement Committee, supervision of the activities of the Medical Director, and the inclusion of contracted physicians and other providers in the process of Quality Improvement development and performance. Evidence of such activities shall be provided to the *[Insert Organization]* upon request.
- b. The applicant assures the *[Insert Organization]* that its Quality Management processes have been reviewed and found to be satisfactory by one of the following review organizations: NCQA or the State of California's Medi-Cal Managed Care Program.

5. Ongoing Efforts To Improve Quality Measures And Accountability

The *[Insert Organization]* intends to convene a Quality Reporting Work Group. The applicant agrees to participate in the Work Group. The purpose of the Work Group is to provide input on quality activities undertaken by the *[Insert Organization]* to measure the quality of care provided to Program subscribers, the utilization of services, and/or changes in subscribers' health status.

F. Covered Services And Benefits

Please provide a chart of scope of services that will be covered under your requested per member per month rate. Please describe any optional services you may provide.

Presented below is a summary of the *[Insert Organization]* Initiative DRAFT Health Benefits. More detailed information on benefits and limitations is presented in the Attachment 1.

Healthy Kids Health Benefits

Benefit	Covered Services	Copayment
Health Facilities	All Inpatient Acute and Skilled Nursing (100 days)	No Copayment
	All Outpatient Services	\$5 Copayment
Professional Services	Inpatient based	No Copayment
	Office or home visit	\$5 Copayment
	Visits for chemotherapy, dialysis, surgery, anesthesiology, radiation	\$5 Copayment
Preventive Care	Visits during which the following are provided: immunizations, periodic health exams, well-child visits, STD tests, cytology exams, family planning, vision and hearing tests, prenatal care, health education	No Copayment
Therapeutic & Diagnostic X-ray and Laboratory Services	Therapeutic radiology services, ECG, EEG, mammography, other outpatient diagnostic laboratory and radiology tests	No Copayment
Prescription Drugs	Generic or brand name drugs dispensed	\$5 Copayment
	Inpatient drugs and drugs administered in a doctor's office as well as FDA approved contraceptive drugs and devices	No Copayment
Mental Health	Inpatient limited to 30 days per year	No Copayment
	Outpatient visits up to 20 per year	\$5 Copayment
Alcohol and Drug Abuse	Inpatient detoxification	No Copayment
	Crisis intervention and abuse treatment	\$5 Copayment
Other Services	Orthoses, Prostheses, Medical Transportation	No Copayment
	Outpatient Physical, Occupational, Speech Therapy	\$5 Copayment

G. Administrative Reporting

Please describe your ability to provide enrollment and disenrollment data by a variety of variables, as well as the timeframe for producing this information.

1. Enrollment Data

- a. The *[Insert Organization]* and the applicant agree to the following regarding the transmission, receipt and maintenance of enrollment data. The *[Insert Organization]* shall transmit subscriber enrollment and disenrollment information, subscriber data updates as well as transfer and reinstatement information to the applicant using Electronic Data Interchange (EDI) each business day. The applicant shall establish and maintain a HIPAA-compliant process to receive the transmitted information data and file sent through the EDI.
- b. The *[Insert Organization]* shall develop an electronic bulletin board system, available 24 hours a day, excluding maintenance periods usually on Sundays, to provide the applicant with enrollment reports.
- c. The *[Insert Organization]* shall establish and manage a plan liaison function for the purpose of enhancing the program operations through the sharing and coordination of information with the applicant. Common or persistent problems or issues with the applicant shall be communicated to the *[Insert Organization]*. The *[Insert Organization]* shall provide a separate contact for communication between the *[Insert Organization]* and the applicant.
- d. The *[Insert Organization]* shall transmit to the applicant on a weekly basis a separate confirmation file at the applicant's request. This shall consist of a record count of the different record types in the weekly enrollment file.
- e. The *[Insert Organization]* shall complete weekly transmissions by 4:00 a.m. Pacific Standard Time each Monday or by 4:00 a.m. Pacific Standard Time Tuesday, when Monday is an official State holiday.
- f. On a quarterly basis the *[Insert Organization]* shall provide audit files of all eligibility activity for the applicant, including but not limited to currently active subscribers and disenrolled subscribers.
- g. The *[Insert Organization]* shall transmit the files described in Items a., d., e. and f. above to the applicant at no charge.
- h. The *[Insert Organization]* shall provide, at the applicant's request, retransmission files of the data files set forth in Items d., e. and f. above within six months of the original transmissions. The applicant agrees to pay for assembly and transmissions costs of the files in Items d., e. and f. above at the rate of \$85 per hour or \$250 per report or file, whichever cost is greater.

- The *[Insert Organization]* shall waive the assembly and retransmission fee if it is determined by the *[Insert Organization]* that the original transmission file was corrupted or unusable.
- i. With respect to Items d., e. and f. above, the applicant shall utilize the *[Insert Organization]*'s liaison personnel as much as possible. There shall be no charge for the services of the *[Insert Organization]*'s liaison personnel.
 - j. The applicant agrees to use either the Program's unique Family Member Number (FMN) in their database for subscriber tracking purposes or maintain a cross-reference mechanism between the applicant's unique identifier and the Program's unique identifier.

H. Willingness To Cooperate with *[Insert Organization]*

Please describe your experience working with coalitions, your partnerships with nonprofit organizations and relationships with County Boards of Supervisors and First 5 Commissions.

I. Grievance Procedure

Please provide information about grievance policies, procedures, processes and experience.

1. The applicant shall establish a grievance procedure to resolve issues arising between itself and subscribers. The applicant's process shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by applicant's licensing statute, the Knox-Keene Health Care Service Plan Act of 1975, as amended. These procedures shall be described in the applicant's Evidence of Coverage booklet.
2. The applicant shall report to the *[Insert Organization]* by *[Insert Date]* in a format determined by the *[Insert Organization]*, the number and types of benefit grievances filed by subscribers and by applicants on behalf of subscribers in the previous calendar year in the Program. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and grievances pertaining to the administration and delivery of medical benefits in the Program. The report shall also provide information on subscriber's benefit grievances by geographic region, ethnicity, gender and primary language of the subscriber. The format for the report shall be determined by the *[Insert Organization]*.

HEALTHY KIDS INITIATIVE BENEFIT PACKAGE

Benefit Descriptions

Please note that benefits may change if Healthy Families benefits change due to federal or state funding or benefit restrictions.

Physician and Professional Services

Description

- Medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license.

Cost to Subscriber

- \$5 per office or home visit.
- No Copayment for hospital inpatient professional services.
- No Copayment for surgery or anesthesia, radiation, chemotherapy, or dialysis treatments.
- No Copayment for subscribers under 24 months of age for well-baby care, health exams, or other office visits.

Preventive Health Services

Description

- Periodic health examinations, including all routine diagnostic testing and laboratory
- Immunizations consistent with the most current recommendations for preventive pediatric health care, as adopted by the American Academy of Pediatrics, and the most current version of Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians, and the Society for Adolescent Medicine's most recent version of Guidelines for Adolescent Preventative Services. Immunizations required for travel as recommended by the U.S. Public Health Service. Other age appropriate immunizations as recommended by the U.S. Public Health Service.

Cost to Subscriber

- No Copayment for preventive services

Pregnancy and Maternity Care

Description

- Medically necessary professional and hospital services relating to maternity care are covered, including:
 - a. Pre-natal and post-natal care and complications of pregnancy.
 - b. Diagnostic and genetic testing.
 - c. Counseling for nutrition, health education, and social support needs.
 - d. Labor and delivery care, including midwifery services.

- e. Newborn examinations within the first thirty (30) days after birth and nursery care while the mother is hospitalized.
- Inpatient hospital care will be provided for 48 hours following a normal vaginal delivery and 96 hours following delivery by Cesarean section, unless an extended stay is authorized by applicant.

Cost to Subscriber

- No Copayment

Therapeutic and Diagnostic X-Ray and Laboratory Services

Description

- Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services, which will include, but not be limited to, the following:
 - a. Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes.
 - b. Other services necessary to appropriately evaluate, diagnose, treat, and follow-up on the care of children and adolescents.
 - c. Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (Glycohemoglobin).

Cost to Subscriber

- No Copayment

Emergency Services and Care (Including "911 Services")

Description

- Twenty-four hour emergency services and care are covered for emergency medical conditions both in and out of the service area.

Cost to Subscriber

- \$5 per visit

Emergency ("911") and Non-Emergency Transportation Services

Description

- Emergency ambulance transportation, "911" Service
- Non-emergency transportation for the transfer of a subscriber from a hospital to another hospital or facility, or facility to home when:

Cost to Subscriber

- No Copayment

Diabetes Self-Management

Description

- Medically necessary equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin using diabetes, and gestational diabetes, even if items are available without a prescription.

- Diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable subscriber to properly use covered equipment supplies and medications and additional diabetes outpatient self-management training, education, and medical nutrition therapy upon direction or prescription of those services by subscriber's participating physician.

Cost to Subscriber

- No Copayment

Prescription Drugs

Description

- Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes:
 - a. Injectable medication (including insulin), needles and syringes necessary for the administration of the covered injectable medication.
 - b. Insulin, medications for the treatment of diabetes, and glucagon, in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent, and gestational diabetes.
 - c. Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription.
 - d. Drugs administered while a subscriber is a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when provided through a participating pharmacy.
 - e. One cycle or course of treatment of prescription tobacco cessation drugs per Benefit Year. The Plan should require the subscriber to attend tobacco cessation classes or programs in conjunction with the use of prescription tobacco cessation drugs.
 - f. Prescription Contraceptive Drugs and Devices: all FDA-approved oral and injectable contraceptive drugs and devices, including internally implanted time-release contraceptives such as Norplant. If your participating provider determines that none of the methods designated by the Plan as covered or preferred (on the Plan's Formulary) are medically appropriate, then your doctor must contact the Plan in advance for prior authorization to prescribe a non-Formulary contraceptive drug or device.
- Health Plan will dispense available generic equivalent prescription drugs, provided that the prescribed drug is medically appropriate and safe for the subscriber.

Cost to Subscriber

- No Copayment for prescription drugs provided in an inpatient setting, or for drugs administered in the doctor's office or in an outpatient facility, or for FDA-approved contraceptive drugs and devices.
- \$5 per prescription for up to a 32-day supply for brand name or generic drugs, including prescription tobacco use cessation drugs.

- Maintenance Drugs: \$5 for up to a 100-day supply. Maintenance drugs are drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions such as heart disease, diabetes, or hypertension.

Exclusion

- Patent or over-the-counter medicines, including non-prescription contraceptive drugs and devices, such as contraceptive jellies, ointments, foams, condoms, etc.
- Medicines not requiring a written prescription order (except insulin).
- Dietary supplements, appetite suppressants, or any other diet drugs or medications.
- Over-the-counter devices or medications not requiring a prescription, minerals and food supplements.
- Over-the-counter vitamins, unless they are prescribed prenatal vitamins.

Phenylketonuria (PKU)

Description

- Screening and treatment for PKU.
- Formula, and certain “special food products”, as defined below, which may be prescribed for the treatment of PKU. Formula and special food products are covered to the extent that the subscriber’s costs for such items exceed the cost of a normal diet.
- “Special food product” means a food product that is (1) prescribed by a physician or nurse practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to and experience in the treatment and care of PKU. It does not include food that is naturally low in protein, but may include food that is specially formulated to have less than one gram of protein per serving, and (2) used in place of normal food products, such as foods found in retail food establishments, and used by the general population.

Cost to Subscriber

- No Copayment

Outpatient Hospital Services

Description

- Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility, including:
 - a. Physical, speech, and occupational therapy as appropriate.
 - b. Hospital services which can reasonably be provided on an ambulatory basis.
 - c. Related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the subscriber’s stay at the facility.

Cost to Subscriber

- No Copayment, except for the following:

- a. \$5 per visit for physical, occupational, and speech therapy performed on an outpatient basis.
- b. \$5 per visit for emergency services and care

Inpatient Hospital Services

Description

- General hospital services, in a room of two or more, with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. Includes all medically necessary ancillary services.
- Includes inpatient hospital services in connection with dental procedures when hospitalization is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. The Plan will coordinate such services with the subscriber's participating dental plan. Services of dentist or oral surgeon are excluded for dental procedures.

Cost to Subscriber

- No Copayment, except \$5 per visit for emergency services and care.

Family Planning Services

Description

Voluntary family planning services are covered, including the following:

- Counseling and surgical procedures for sterilization, as permitted by State and Federal law.
- Contraceptive drugs and devices pursuant to the prescription drug benefit, including insertion or removal of IUD and Norplant.
- Office visits for family planning.
 - a. Lab and x-rays.
 - b. Pregnancy tests.
- Treatment for problems resulting from family planning care.

Cost to subscriber

- No Copayment

Health Education

Description

- Effective health education services, including tobacco cessation classes, information regarding personal health behavior and care, and recommendations regarding the optimal use of health services provided by the Plan and care organizations affiliated with the Plan.

Cost to Subscriber

- No Copayment

Durable Medical Equipment

Description

- Medical equipment appropriate for use in the home which:

- e. Primarily serves a medical purpose.
- f. Is intended for repeated use.
- g. Is generally not useful to a person in the absence of illness or injury.
- Plan may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss.
- Durable Medical Equipment that is covered includes:
 - a. Oxygen and oxygen equipment.
 - b. Blood glucose monitors and apnea monitors
 - c. Pulmoaides and related supplies
 - d. Nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers
 - e. Insulin pumps and related necessary supplies.
 - f. Ostomy bags and urinary catheters and supplies

Cost to Subscriber

- No Copayment

Orthotics and Prosthetics

Description

- Orthotics and prosthetics are covered as follows:
 - g. Medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her licensure.
 - h. Medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her license.
 - i. Initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy.
 - j. Therapeutic footwear for diabetics.
- Covered items must be physician-prescribed, custom-fitted, standard orthotic or prosthetic devices, authorized by the Plan and dispensed by a participating provider. Repair is provided unless necessitated by misuse or loss. The Plan, at its option, may replace or repair an item.

Cost to Subscriber

- No Copayment

Outpatient Mental Health Services

Description

- Mental health care when ordered and performed by a participating mental health provider.
- Mental health services are limited to the evaluation, crisis intervention, and treatment of conditions which are subject to significant improvement through relatively short term therapy.
- 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, divorce or bereavement.

- Family members may be involved in the treatment to the extent the Plan determines it is appropriate for the health and recovery of the child.
- There is a maximum of twenty (20) visits per Benefit Year, except as substituted for inpatient days, as described below, or for the treatment of a serious emotional disturbance and severe mental illness which are not limited. These conditions include but are not limited to:
 - a. Schizophrenia;
 - b. Schizoaffective disorder;
 - c. Bipolar disorder (manic depressive illness);
 - d. Major depressive disorder;
 - e. Panic disorder;
 - f. Obsessive-compulsive disorder;
 - g. Pervasive developmental disorder or autism;
 - h. Anorexia nervosa; and
 - i. Bulimia nervosa.

Cost to Subscriber

- \$5 per outpatient mental health visit

Inpatient Mental Health Services

Description

- Inpatient mental health care and partial hospitalization when ordered and performed by a participating mental health provider for the treatment of an Acute phase of a mental health condition during a certified confinement (or stay) in a participating hospital.
- Limit of thirty (30) days per Benefit Year, except for the treatment of a serious emotional disturbance and severe mental illness which are not limited. There conditions include, but are not limited to:
 - a. Schizophrenia;
 - b. Schizoaffective disorder;
 - c. Bipolar disorder (manic depressive illness)
 - d. Major depressive disorder
 - e. Panic disorder
 - f. Obsessive-compulsive disorder;
 - g. Pervasive developmental disorder or autism;
 - h. Anorexia nervosa; and
 - i. Bulimia nervosa.
- With the agreement of the subscriber or applicant or other responsible adult, if appropriate, each day of inpatient hospitalization may be substituted for any of the following outpatient mental health services:
 - g. Two (2) days of residential treatment.
 - h. Three (3) days of day care treatment (care in which patients participate during the day, returning to their home or other community placement during the evening and night).
 - i. Four (4) outpatient visits.

Cost to Subscriber

- No Copayment

Outpatient Alcohol and Drug Abuse Services**Description**

- Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate.
- Standard benefits of twenty (20) visits per Benefit Year.

Cost to Subscriber

- \$5 per visit

Inpatient Alcohol and Drug Abuse Services**Description**

- Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system.

Cost to Subscriber

- No Copayment

Home Health Care Services**Description**

- Services provided at the home by health care personnel.
- Includes visits by RNs (registered nurses), LVNs (licensed vocational nurses), and home health aides.
- Short-term physical therapy, occupational therapy, speech therapy, and respiratory therapy when prescribed by a licensed participating provider acting within the scope of his or her licensure (subject to visit limitations under the physical/occupational/speech therapy benefit, if any).
- Home health services are only those services that are prescribed or directed by an attending participating physician or other appropriate authority designated by the Plan.
- If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending participating physician or other appropriate authority designated by the Plan to choose the setting for providing the care.

Cost to Subscriber

- No Copayment except for \$5 per visit for physical, occupational, and speech therapy performed in the home.

Skilled Nursing Care**Description**

- Services prescribed by a participating physician or nurse practitioner and provided in a licensed skilled nursing facility when medically necessary. Includes:

- a. Skilled nursing on a 24-hour per day basis.
- b. Bed and board.
- c. X-ray and laboratory procedures.
- d. Respiratory therapy.
- e. Physical, speech, and occupational therapy (subject to visit limitations under the physical/ occupational/speech therapy benefit, if any).
- f. Medical social services.
- g. Prescribed drugs and medications.
- h. Medical supplies.
- i. Appliances and equipment ordinarily furnished by the skilled nursing facility.
- Maximum of one hundred (100) days per Benefit Year.

Cost to Subscriber

- No Copayment, including physical, occupational, or speech therapy performed on an inpatient basis.

Physical, Occupational, and Speech Therapy

Description

- Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home.

Cost to Subscriber

- No Copayment for inpatient therapy.
- \$5 per visit when provided on an outpatient or home visit basis.

Cataract Spectacles and Lenses

Description

- Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery.
- One pair of conventional eyeglasses or conventional contact lenses, if necessary after cataract surgery with insertion of an intraocular lens.

Cost to Subscriber

- No Copayment

Hearing Aids and Services

Description

- Audiological evaluation to measure the extent of hearing loss.
- Hearing aid evaluation to determine the most appropriate make and model of hearing aid.
- Monaural or binaural hearing aids including ear mold(s), hearing aid instrument, initial battery, cords, and other ancillary equipment.
- Visits for fitting, counseling, adjustments, repairs, etc., at no charge for a one-year period following the provision of a covered hearing aid.

Exclusions

- Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss.
- Replacement parts for hearing aids, repair of a hearing aid after the covered one-year warranty period.
- Replacement of a hearing aid more than once in any 36-month period.
- Surgically implanted hearing devices.

Cost to Subscriber

- No Copayment

Acupuncture (Optional)Chiropractic (Optional)Biofeedback (Optional)Hospice Services**Description**

- Hospice means care and services provided in a home by a licensed or certified participating provider that is:
 - a. Designed to provide palliative and supportive care to individuals who have received a diagnosis of terminal illness.
 - b. Directed and coordinated by medical professionals.
 - c. Prior authorized by the Plan.

Cost to Subscriber

- No Copayment

Organ Transplants**Description**

- Coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational in nature.
- Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a subscriber.
- Charges for testing of relatives for matching bone marrow transplants.
- Charges associated with the search and testing of unrelated bone marrow donors through a recognized donor registry and charges associated with the procurement of donor organs through a recognized donor transplant bank, if the expenses are directly related to the anticipated transplant of a subscriber.

Cost to Subscriber

- No Copayment

Blood and Blood Products

Description

- Processing, storage, and administration of blood and blood product and outpatient settings.
- Includes the collection of autologous blood when medically indicated.

Cost to Subscriber

- No Copayment

SAMPLE

