



**SAN FRANCISCO
HEALTH PLAN™**

Here for you

**2012 Benefit Summary Matrix for Conversion Product
San Francisco Health Plan**

This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact San Francisco Health Plan. The comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefit summary is available on San Francisco Health Plan web site.

Plan Name	Plan Contact Phone Number
San Francisco Health Plan	Member Services (415) 547-7800 or 1(800) 288-5555 (toll free)
Coverage Summary	
Eligibility Requirements	An employee or member whose coverage under the IHSS group services agreement has been terminated by the employer is eligible for individual conversion coverage. Such coverage is not required to be offered under the circumstances ¹
The premium cost of each benefit package in the service area in which the individual works or resides.	Premiums charged by Plans vary by age of subscriber. See "Premium Rate" tab for this plan.
When and under what circumstances benefits cease	Benefits cease due to: <ul style="list-style-type: none"> • Fraud; • Loss of eligibility² • Failure to pay premiums or partial payment of premiums • Member may terminate by written notice to plan.

¹ (a) the group contract terminated and is replaced with similar coverage under another contract within 15 days of the date of termination of group coverage or the subscriber's participation;
(b) coverage was terminated because the employee or member failed to pay amounts due the plan;
(c) the employee or member was terminated for cause as set forth in the evidence of coverage;
(d) the employee or member intentionally furnished incorrect information or otherwise improperly obtained benefits of the plan;
(e) the employer's insurance coverage is self-insured;
(f) the employee or member is covered by or eligible for hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured;
(g) the employee or member is covered for similar benefits under an individual contract or policy;
(h) the enrollee or member has not been continuously covered during the three-month period immediately preceding termination of coverage.

² Once enrolled in Conversion plan, an enrollee who subsequently becomes eligible for Medicare does not lose his/her eligibility to remain enrolled in Conversion Plan coverage.



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	<ul style="list-style-type: none"> • Discontinuation of a product. <p>Benefits terminate as follows:</p> <ul style="list-style-type: none"> • Fraud- upon receipt of notice; • Loss of Eligibility – the last day of the month in which the member was no longer eligible; • Failure to pay premium due on the 30th day after the date of the Late Notice • Voluntary termination by the member – the first of the month following adequate notice to the Plan.
The terms under which new coverage may be renewed	New sales are issued throughout the calendar year. All accounts renew annually.
Other coverage that may be available if benefits under the described benefit package cease.	None
The circumstances under which choice in the selection of physicians and providers is permitted	Members are encouraged to choose a primary care physician from a list of available providers in the following specialties: internal medicine, obstetrics/gynecology, family practice, and pediatrics. Members may change their primary care provider at any time.
Lifetime and annual maximums	Lifetime Maximum: None Annual out-of pocket maximum: \$2,500
Deductibles	None



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Benefit Summary ³ & ⁴	Description	Copayment	Limitation
Professional Services	Most primary and specialty care consultations, exams and treatment	\$25 per visit	
	Routine physical maintenance exams	No Charge	
	Well-child preventive care exams (through age 23 months)	No Charge	
	Family planning counseling	No Charge	
	Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No Charge	
	Eye exams for refraction	No Charge	
	Hearing exams	No Charge	
	Urgent care consultations, exams	\$25 per visit	

³ This is a benefit summary. Please consult the individual plan’s Evidence of Coverage for more detailed information on benefits under the plan, including any related exclusions not contained in this benefit summary.

⁴ Percentage co-payments present a percentage of actual cost. When participating providers are compensated on a fee for service basis, the actual cost is the negotiated fee rate. In a PPO, percentage copayments for non-emergency services provided by non-participating providers are a percentage of usual, customary, or reasonable rates or billed charges whichever is less, and enrollees are also responsible for any excess amount.



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	and treatment		
	Physical, occupational and speech therapy	\$25 per visit	
Outpatient Services	Outpatient surgery and certain other outpatient procedures		
		\$100 per procedure	
	Allergy injections (including allergy serum)	\$5 per visit	
	Most immunizations (including vaccines)	No Charge	
	Most X-rays and laboratory tests	\$10 per encounter	
	Preventive X-rays, screenings and laboratory tests as described in the Evidence of Coverage/Disclosure Form	No charge	
	MRI, most CT, and PET scans	\$50 per encounter	
	Health Education		
	Covered individual health education counseling and programs	No Charge	
	Covered group health education programs	No Charge	
Hospitalization Services	Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	\$200 per day	



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Emergency Health Coverage	Emergency room services at San Francisco General Hospital and non-contracted facilities for medically necessary emergency services.	\$100 per visit	The Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered services
Ambulance Services	Ambulance services	\$100 per trip	
Prescription Drug Benefits	Covered outpatient items in accord with our drug formulary guidelines:		
	Most generic items at a Plan Pharmacy	\$10 for up to a 30-day supply, \$20 for a 31 to 60 day supply, or \$30 for a 61 to 100 day supply.	
	Most brand-name items at a Plan Pharmacy	\$35 for up to a 30 day supply, \$70 for a 31 to 60 day supply, or \$105 for a 61 to 100 day supply	
Durable Medical Equipment	The durable medical equipment for home use listed in the Evidence of Coverage (EOC) in accord with our durable medical equipment formulary guidelines (most durable medical equipment is not covered)	20% Coinsurance	



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Mental Health Services	Inpatient psychiatric hospitalization (up to 30 days per calendar year)	\$200 per day	Visit and day limits do not apply to Serious Emotional Disturbances of Children and Severe Mental Illnesses as described in the benefits section of the Evidence of Coverage.
	Outpatient mental health services evaluation and treatment:		
	<ul style="list-style-type: none"> Up to a total of 20 individual and group visits per calendar year that include services for mental health evaluation treatment 	\$25 per individual visit \$12 per group visit	
	Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	\$12 per visit	
Residential Treatment	Transitional Residential Recovery Services	\$100 per admission	Up to 60 days per calendar year, not to exceed 120 days in a five year period.
Chemical Dependency Services	Inpatient detoxification	\$200 per day	
	Individual outpatient chemical dependency evaluation and treatment	\$25 per visit	
	Group outpatient chemical dependency treatment	\$5 per visit	
Home Health Services	Home Health and Hospice Care Services ⁵		Part-time or intermittent home health covered up to: <ul style="list-style-type: none"> Up to 2 hours per visit

⁵ Hospice benefits are available through the plan. Please consult the Plan's Evidence of Coverage.



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	Hospice care Home health care	No Charge No Charge	for visit by a nurse, medical social worker, or physical occupational, or speech therapist and up to 4 hours per visit for visits by a home health aide. <ul style="list-style-type: none"> • Up to 3 visits per day • Up to 100 visits per calendar year
Custodial care and Skilled Nursing Facilities	Skilled Nursing Facility Care	No Charge	Up to 100 days per benefit period
	Custodial Care	Not covered	
Other	The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the Evidence of Coverage (most external prosthetic and orthotic devices are not covered)	No Charge	