



**SAN FRANCISCO
HEALTH PLAN™**

Here for you

San Francisco Health Plan

Combined Evidence of Coverage and Disclosure Form

October 1, 2011 to September 30, 2012



The San Francisco Health Plan Evidence of Coverage and Disclosure Form should answer your questions about how to use the plan. For more detailed information, refer to the Evidence of Coverage section of this booklet. This booklet contains:

- A. Quick Guide:** A brief overview about getting started, choosing your Primary Care Physician (PCP), getting care under your new health plan, health plan services and charges, and solving problems, complaints and grievances
- B. Summary of Benefits:** A chart to help you compare coverage benefits.
- C. Evidence of Coverage:** The terms and conditions of your health plan. Also, this gives details about San Francisco Health Plan.

This Combined Evidence of Coverage and Disclosure Form constitute only a summary of the Health Plan policies and coverage under the Healthy Families Program (HFP). The Health Plan contract and the HFP regulations (California Code of Regulations, Title 10, Chapter 5.8) issued by the California Managed Risk Medical Insurance Board (MRMIB), should be consulted to determine the exact terms and conditions of coverage. These regulations may be viewed on the Internet at <http://www.mrmib.ca.gov>.

Additionally, the HFP regulations require the Health Plan to comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code, section 1340, et seq.), and the Act's regulations (California Code of Regulations, Title 28). Any provision required to be a benefit of the program by either the Act or the Act's regulations shall be binding on the Health Plan, even if it is not included in the Evidence of Coverage booklet or the Health Plan contract.

IMPORTANT

Effective October 1, 2010

New Benefit Year

The HFP has a new benefit year starting October 1, 2010 through September 30, 2011

Mental Health Care Services and Alcohol and Drug Abuse Treatment Services

The federal Children's Health Insurance Program Reauthorization Act of 2009 and the Mental Health Parity and Addiction Equity Act of 2008 require the HFP to provide unlimited inpatient days and outpatient visits to all mental health care services and alcohol and drug abuse treatment services.

A. QUICK GUIDE	4	D. Claims Reimbursement for Emergency Services	48
B. SUMMARY OF BENEFITS	10	E. Benefit Program Changes	48
C. EVIDENCE OF COVERAGE & DISCLOSURE FORM	21	8. Exclusions and Limitations (Non- Covered Services).....	49
1. About San Francisco Health Plan (SFHP)	21	General Exclusions and Limitations	49
Member ID Card	21	9. Duplicating Coverage and Third Party Liability	49
2. Disability Access Americans with Disabilities Act Disclosure.....	21	A. Coordination of Benefits	49
A. Physical Access:	21	B. Other Health Insurance	49
B. Access for the Hearing Impaired:	21	C. Third Party Recovery Process and Your Responsibilities	49
C. Access for the Vision Impaired:	21	D. Non-Duplication of Benefits with Workers' Compensation	50
D. The Americans with Disabilities Act of 1990	22	E. Reimbursement Provisions – If You Receive a Bill	50
E. Disability Access Grievance	22	F. Organ and Tissue Donation	50
3. Your Rights and Responsibilities.....	22	10. Benefit Changes, Termination, and Cancellation	50
A. Your Rights	22	A. Benefit Changes	50
B. Your Responsibilities	23	B. Individual's Right of Cancellation	50
4. Definitions.....	23	C. Renewal Provisions	50
5. Choice of Physicians and Facilities...28		D. Termination of Benefits	51
A. Selecting a Primary Care Provider	28	11. Grievance and Appeal Procedures....51	
B. Changing Your Primary Care Provider or Medical Group	28	A. Grievance Process	51
C. A Positive Relationship with Your Primary Care Provider	29	B. Filing a Grievance	51
D. Scheduling Appointments and Initial Health Exam	29	C. Grievance Process	51
6. How to Use SFHP.....	29	D. Expedited Medical Review and Appeals	52
A. Authorization for Services and Utilization Review	29	E. Disability Access Grievances	52
B. Second Opinions	29	F. Member Cooperation with the Grievance Process	52
C. Referrals to Specialists	30	G. Independent Medical Review of Grievances Involving a Disputed Health Care Service	52
D. Services Not Requiring Referrals	30	H. Experimental/Investigational IMRs	53
E. Direct Access to OB/GYNs	30	I. Complaints to the Department of Managed Health Care	53
F. Standing Referrals to Specialists	30	J. Arbitration of Disputes	54
G. Emergency Medical Care	31	12. Other Provisions	54
H. Urgent Care or Care After Regular Hours and on Weekends	31	A. Public Policy Participation	54
I. Post- Stabilization and Follow-up Care After an Emergency	31	B. Non-Assignability	55
J. Co-Payments	32	C. Independent Contractors	55
7. SFHP Benefits and Coverages	33	D. Continuity of Care	55
A. Linkages to Other Benefit Programs and Coordination of Services	33	E. Payment of Providers	55
B. Schedule of Benefits and Coverages	35	F. Confidentiality of Medical Information	56
C. Your Liabilities and Other Charges	47	G. Benefit Program Participation	56
		H. Natural Disasters, Interruptions, and Limitations	56

A. Quick Guide

1. Getting Started
2. Choosing Your Primary Care Provider (PCP)
3. Getting Care Under Your New Health Plan
4. Health Plan Services and Charges

1. Getting Started

Eligibility and Enrollment

Information about eligibility, enrollment, open-enrollment, disenrollment, the starting date of coverage, transfers to another health plan, annual requalification, premium payments, the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), is included in the Healthy Families Program Handbook which was sent to you by the Healthy Families Program. If you have questions on these topics or would like another copy of these materials, please contact the Healthy Families Program at the following address or toll-free telephone number:

Healthy Families Program
P.O. Box 138005
Sacramento, CA 95813-8005

1-800-880-5305

The hearing impaired should call the California Relay Service at 711(TTY).

Additional information about the Healthy Families Program is available at the Managed Risk Medical Insurance Board Website at www.mrmib.ca.gov.

Renewal Provisions

Members who lose eligibility at re-qualification are encouraged to read the sections on continuation of coverage. Member Services can provide details and assistance in transferring to a different coverage program within SFHP.

Help in Other Languages

If English is not your main language, or you would be more comfortable speaking in another language, Member Services can help. Our Member Services representatives speak many languages. If we don't have a Member Services representative who speaks your language, we have outside interpreters available by telephone. Call Member Services at **415-547-7800** (local) or **1-800-288-5555**. Member Services can also help you find a doctor who speaks your language or help you find an interpreter for your medical appointments. You have a right to interpreter services at no cost to you when you receive medical care or use medical services. You also have a right to ask for face-to-face or telephone interpreter services and to not use friends or family members as interpreters unless you request it.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

Nurse Advice Line

Call San Francisco Health Plan's Nurse Advice Line at **1-877-977-3397**:

- If you cannot reach your doctor during the day, after hours or on weekends.
- You can speak with a trained registered nurse who can help answer your health care questions, give you health advice, and instruct you to go to the urgent care center if needed
- This service is free of charge and available to you in your language
- This service is available 24-hours a day, 7 days a week

2. Choosing Your Primary Care Provider

What is a Primary Care Provider (PCP)?

A primary care provider (PCP) is your personal doctor or health professional. Your PCP works with you to keep you healthy. A PCP will provide all your basic healthcare, including:

- Regular check-ups and preventive services such as immunizations (shots), hearing tests, and laboratory tests
- Care when you are sick or injured
- Help with ongoing health problems like asthma, allergies, or diabetes

Also, the PCP will send (refer) you to a specialist and arrange for hospital care if it is needed.

When you think you need medical care, call your PCP first, unless it is an emergency. The PCP will advise you on what to do. Your PCP is available 24 hours a day, 7 days a week. If you need care, your PCP will provide treatment or refer you to a specialist or arrange for hospitalization. Your PCP's phone number is on the member ID card.

What Kind of Doctor Can Be a PCP?

Your PCP can be in:

- **Pediatrics:** health care for children
- **General Practice:** health care for the whole family
- **Family Practice:** health care for the whole family
- **Internal Medicine:** health care for adults
- **Obstetrics/Gynecology (OB/GYN):** health care for women and pregnant women. Nurse practitioners, certified nurse midwives, and physician assistants are also available as primary care providers, as long as they practice with a SFHP physician.

You can contact SFHP, your PCP or medical group to find out what healthcare practitioners are available for you to see.

Where Do PCPs Work?

Your PCP may work in a:

- **Private Office**
- **Health Center**
- **Hospital Clinic**

- **Federally Qualified Health Center**
- **Native American Health Service Facility (Indian Clinic)**

Your PCP's Medical Group

Every PCP and clinic in SFHP is part of a medical group. A medical group is made up of many providers and other health professionals who work together. Each medical group works with a particular hospital.

When you choose a PCP, you are also assigned to the specialists in the PCP's medical group and the hospital or hospitals they work with. Your PCP will refer you to those specialists for most specialty care. If you have to go to the hospital, you will go to the hospital that works with the PCP's medical group. Your PCP will obtain the necessary prior authorizations for specialty care that you need. If you go to a specialist without a prior authorization from your PCP, it may not be covered by the Health Plan. Refer to page 7 of the Evidence of Coverage section for a thorough description of the prior authorization process. If you prefer a particular specialist or hospital, make sure your PCP and their medical group work with those providers. If you see a specialist or PCP who is not with your medical group, without an authorization or in a situation that is not an emergency, you may have to pay for it. Always go to the provider you have been assigned and stay with the providers in that medical group, unless SFHP or the medical group authorizes service elsewhere.

Choosing Your PCP

Every member has a primary care provider (PCP). You may have already chosen a PCP for yourself when you joined SFHP. If you did not choose your own primary care provider (PCP) prior to your enrollment with SFHP, SFHP will assign one to you. You can always call SFHP and ask to change to a different PCP if you do not like the PCP we assigned you. You can also look in the Provider Directory that was sent to you to select a PCP.

Here are some things you may want to think about when choosing a PCP:

- **Is the PCP** close to home, school, or work?
- **Is it easy** to get to the PCP by MUNI, bus, or BART?

- **Does the office staff speak your language?**
- **Does the PCP work with a hospital that you like?**
- **Does the PCP see children of all ages?**

Call us at **415-547-7800** (local) or **1-800-288-5555** and tell us which PCP you would like to choose. If there is more than one child in your family, you may choose a different PCP for each child. We will send you a member ID card that includes the PCP's name and phone number. SFHP wants you to have a PCP who is right for you. If you do not choose a PCP prior to your effective day of coverage, SFHP will choose a PCP for you.

Changing Your Family's PCP

If you are not happy with your *PCP* for any reason, call Member Services at **(415) 547-7800** (local) or **(800) 288-5555** to request a change. It's best to call before the 22nd day of the month so that a new *member* ID card can be sent to you before the beginning of the next month. The new card will have the name and phone number of your new *PCP*.

IMPORTANT NOTE: If you need to see the *PCP* before you get the new card with the name of the new *PCP* on it, call Member Services at **(415) 547-7800** (local) or **(800) 288-5555**. A representative will tell you which *PCP* to see.

3. Getting Care Under Your New Health Plan

Getting Care

As a member of San Francisco Health Plan, you will find getting health care is simple.

Just follow these steps:

1. **Schedule check-ups and routine care**
Do not wait until you are sick to see your PCP. Schedule an appointment for a health assessment (check-up) within 120 days of enrollment. For children under the age of two, please make an appointment with your child's PCP within 60 days of enrollment with SFHP or as soon as possible. Your PCP will advise you about the best time for routine appointments and shots depending on your age.

2. Call and make an appointment

Call the PCP on your member ID card to schedule an appointment. Show the member ID card at PCP's office or clinic. Please give at least 24 hours notice if you need to cancel or change the appointment.

Contact your PCP when you are sick Except in the case of an emergency, always call the PCP first when you get sick or hurt. Your PCP, or a substitute provider, is available 24 hours a day, 7 days a week. Your PCP will make sure you get the health care you need, either by providing treatment or referring to a specialist.

Specialty Care

The PCP will arrange most types of specialty care that you may need. After talking with you, the PCP will send (refer) you to a specialist. The specialist is a member of your medical group. If your PCP determines that a specialist is not available within the medical group, your PCP will send you to another specialist. If you go to another provider without a referral from the PCP, and you are not seeking emergency services or OB/GYN services, these services may not be paid for by SFHP. Unless it is an emergency, always call your PCP first if you are able to. Please see page 30, Section F, **Standing Referrals to Specialists** for more information.

Family Planning

Family planning services are provided for all members, men and women. These services can help you decide when and if you want to have children. Family planning includes birth control and testing for pregnancy and sexually transmitted diseases. You can get family planning services from your PCP or any other participating provider who offers family planning services. Female members can make an appointment for women's health care directly with an OB/GYN or a family practice provider within your medical group, without a referral from your PCP.

For help with family planning services, call your PCP. The phone number is listed on your member ID card.

Second Opinions

If you would like to talk to another provider about a health problem, you may ask the PCP for a second opinion. SFHP will pay for an opinion from another specialist when the PCP refers you. The specialist usually is within your

medical group or another medical group that is contracted with SFHP.

Pharmacy Services

When you need medication, your PCP or referred specialist will prescribe it. To get the medication, take the prescription to a participating pharmacy listed in the Healthy Families Provider Directory, and show your member ID card to the pharmacist. SFHP has a drug formulary. A drug formulary is a list of brand-name and generic prescription medications approved for coverage and available without prior authorization from San Francisco Health Plan. The drug formulary is reviewed at least four times a year by a chosen group of physicians and pharmacists who work in San Francisco County. The group reviews how safe medications are and how well the medications work before they decide which medications should be included in the drug formulary. A copy of the formulary can be downloaded from the SFHP website at <http://www.sfhp.org> or you can request information whether a specific drug is on the formulary by calling Member Services at **(415) 547-7800** (local) or **1-800-288-5555**.

NOTE: The presence of a prescription drug on the formulary does not guarantee that it will be prescribed by your doctor for a particular condition.

SFHP has a generic mandatory policy. If a medication on the drug formulary is available in both a brand-name and generic form, then only the generic form is approved for coverage.

SFHP formulary does not cover experimental or investigational medication. You must be getting the drug for a use approved by the Food and Drug Administration (FDA). Using a drug for a use or in a manner that is not approved by the FDA is also called "off-label use." SFHP does not cover drugs for "off-label use."

If you are on a medication that is discontinued and no longer available on the marketplace, contact your doctor to find out which medications can be used in its place.

If you are on a medication that is covered by SFHP and the medication is removed from the drug formulary, we will keep giving it to you until your SFHP provider stops prescribing it for the same condition. If your medication is not a part of the SFHP formulary, your provider must submit a prior authorization form to SFHP for it

to review and make a determination if you could use a formulary drug.

PRIOR AUTHORIZATION PROCESS

The SFHP Prior Authorization (PA) form may be filled out by either the prescribing MD, MD's assistant or the Pharmacist.

A PA form can be downloaded from the SFHP website at <http://www.sfhp.org> and may be faxed to InformedRx at **(650) 536-1241** or **(866) 511-2202**. Urgent requests may be faxed to **(630) 536-1242** or **(877) 636-9001**.

The InformedRx Staff Pharmacist, SFHP Pharmacist and/or the SFHP Medical Director review PAs that are either approved, denied, modified, or deferred for more information. The SFHP Medical Director or Pharmacist makes the final decision to modify, defer or deny.

If the information is complete, the standard turnaround time is twenty-four hours or one business day. For urgent requests the standard turnaround time is four business hours. Illegible or incomplete information may delay the request.

If the PA is approved, Informed Rx will fax a message to the requesting provider and the claim can be processed on-line. If the PA is denied, deferred, or significantly modified, SFHP notifies the member and prescribing physician and/or PCP in writing. This notification includes an explanation of the reason for the Plan's decision.

If SFHP denies your request for a medication and you are not happy with the decision, you may appeal the decision. For information about the SFHP's Grievance and Appeals Process please refer to page 51

Facilities

For the name and locations of all SFHP contracted facilities, please call Member Services at **(415) 547-7800** (local) or **1-800-288-5555**.

Hospital Care

Except for emergencies, if you are sick or hurt, call your PCP. Your PCP will see you, refer you to a specialist, or send you to the hospital. If you have to go to the hospital, it will be the hospital where your PCP works. If you have special health care needs, your PCP or specialist may

need to refer you to another hospital that provides the services needed. (If there is a particular hospital that you prefer, be sure and check the hospital listed when choosing your PCP).

Emergency Medical Care

An emergency is when you:

- **Have a condition where it looks like your life is in danger**
- **Are in extreme or intense pain**
- **Have serious difficulty breathing**
- **May have a broken bone**

When you have a medical emergency:

1. **Call 911** or go to the closest emergency room for help
2. **Show your member ID card** to the hospital staff
3. **Ask the hospital staff** to call your PCP

If you are not sure if it is an emergency, call your PCP to find out if you need to go to the emergency room. If you go to the hospital emergency room for care when you reasonably believed that it was an emergency, SFHP will pay for the visit, even if it later turned out not to be an emergency.

Urgent Care after Regular Hours and on Weekends

Some medical problems may require urgent care but are not emergencies. Urgent medical problems are problems that usually can wait 24 to 48 hours for treatment without getting worse. If you think you have an urgent medical problem, call your PCP's office. Your PCP or a substitute provider are always available 24 hours a day, 7 days a week to help if there is an urgent medical problem. They will advise you of what to do.

You should always go to your doctor for care or call with your questions, but sometimes you can't reach your doctor during the day or after hours. When this happens, call San Francisco Health Plan's Nurse Advice Line at **1-877-977-3397**. It is staffed by trained registered nurses who are available 24-hours a day and seven

days a week to help answer your health care questions. The service is free of charge and available to you in your language. The nurse can answer your questions, give you helpful advice, and instruct you to go to the urgent care center if needed, and more.

Health Care Away from Home

If you need emergency care while not in San Francisco County, SFHP will pay for it.

- Call 911 or go to the nearest emergency room
- Show them your member ID card
- Have your PCP call SFHP as soon as possible. The number for SFHP is also listed on your member ID card.

If you need Urgent Care while you are away from home, call your PCP's office, if you are able, and he will tell you what you should do. Call your PCP's office, even if it is during a time when the office is usually closed. Your PCP or another provider is always available to tell you what you should do

Vision and Dental Care

As a Healthy Families Program member, you should already be enrolled in vision and dental plans. SFHP does cover medically necessary eye examinations. SFHP also covers the cost of hospital services if they are required for special dental care. All other dental and vision services, including routine eye exams, are covered under the separate Healthy Families Program Vision and Dental plans. Check the Evidence of Coverage section in this Handbook to see what SFHP covers.

For more information about the dental and vision plans, call the Healthy Families Program at **1-800-880-5305**.

4. Health Plan Services and Charges

Charges (Co-Payments)

You will be required to pay a small amount of money for some services. This is called a copayment. The maximum amount of money you are required to pay in one benefit year is \$250 for all children in your household. All copayments paid for Healthy Families members in your household count toward the \$250 maximum.

Make sure you keep all receipts from your doctor's visits and prescription drugs for all family members enrolled in the Healthy Families Program. As soon as you have paid \$250 in a benefit year, provide SFHP with the receipts and record of all payments that show that the maximum has been paid during the year of membership. When the limit is reached, contact SFHP's Customer Service Department at (415) 547-7800 to get a "no co-pay" member ID card.

No Healthy Families members in your household will have to pay copayments for the rest of the benefit year when San Francisco Health Plan receives your receipts. You will still need to pay copayments until San Francisco Health Plan receives proof that you have paid a total of \$250 in copayments. If you can show that you paid more than \$250 in copayments between October 1, 2011 and September 30, 2012, SFHP will reimburse you for the amount over \$250.

Unless a service is "preventive" or the member seeking medical services is less than 24 months old, you will need to pay a co-payment for office visits or for a prescription at the pharmacy. If you cannot pay at the time of service, you may be billed for the co-payment.

There are no deductibles under the Program and there are no lifetime financial benefit maximums for any of the covered health benefits.

Preventive services do not require co-payments. These include.

- **Regular well-child exams and immunizations**
- **Family planning services**
- **Prenatal care**
- **Vision and hearing testing** for persons through age 16

- **Well-woman exams**
- **Health education services**

To learn more about what services have co-payments, refer to the Summary of Benefits section in this Handbook. The Summary of Benefits lists the benefits provided by SFHP and any applicable co-payments for services.

There are no copayments for members who are determined under Healthy Families Program rules to be American Indians or Alaskan Natives. For information pertaining to copayment waivers for American Indians or Alaskan Natives, please refer to the Healthy Families Program Handbook or contact the Healthy Families Program at **(800) 880-5305**.

Covered Services

SFHP will pay only for services that, unless specified as covered, are medically necessary and provided by the PCP, or specialist to who the PCP referred, as required and authorized according to Plan procedures. Please see the detailed description of how to use your covered services in the Evidence of Coverage section in this Handbook.

Services Not Covered by the Plan

You may be eligible for services that are not covered under the Healthy Families Program. If you receive these services, you will remain a member and all health care services will be coordinated. For more information on what services are available, see Linkages to Other Programs on page 33 of the Evidence of Coverage Section

B. Summary of Benefits

A Chart To Help You Compare Coverage Benefits

Health Plan Covered Benefits Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERED BENEFITS AND IS A SUMMARY ONLY. THE BENEFIT DESCRIPTION SECTION SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERED BENEFITS AND LIMITATIONS

NOTE: Members in the Income Category A (To read about the HFP Income Categories please go to the HFP Website: <http://www.healthyfamilies.ca.gov/Downloads/Applications.aspx>) shall pay no more than \$5 copayment for applicable covered services as described in this Benefit Descriptions Section of the EOC/DF.

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
Inpatient Hospital Services	Room and board, nursing care, and all medically necessary ancillary services.	No copayment	No copayment
Outpatient Hospital Services	Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility.	No copayment except <ul style="list-style-type: none"> • \$5 per visit for physical, occupational and speech therapy performed on an outpatient basis. • \$5 per visit for emergency health care services (waived if the member is hospitalized) 	No copayment except <ul style="list-style-type: none"> • \$10 per visit for physical, occupational and speech therapy performed on an outpatient basis. • \$15 per visit for emergency health care services (waived if the member is hospitalized)

Benefits*	Services	Cost to Member (copayment)	Cost to Member (copayment)
		Income Category A	Income Categories B & C
Professional Services	Services and consultations by a physician or other licensed health care provider.	<ul style="list-style-type: none"> • \$5 per office or home visit except • No copayment for hospital inpatient professional services • No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments • No copayment for members 24 months of age and younger • No copayment for vision or hearing testing, or for hearing aids 	\$10 per office or home visit except <ul style="list-style-type: none"> • No copayment for hospital inpatient professional services • No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments • No copayment for members 24 months of age and younger • No copayment for vision or hearing testing, or for hearing aids
Preventive Health Service	Periodic health examinations, Well Baby Care, routine diagnostic testing and laboratory services, immunizations, and services for the detection of asymptomatic diseases.	No copayment	No copayment
Diagnostic, X-Ray and Laboratory Services **	Laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, and treat you.	No copayment	No copayment
Diabetic Care **	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription	\$5 copayment per office visit Copayment for prescriptions as described in the "Prescription Drug Program" Section	\$10 copayment per office visit Copayment for prescriptions as described in the "Prescription Drug Program" Section

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
Prescription Drug Program **	Drugs prescribed by a licensed practitioner.	<ul style="list-style-type: none"> • \$5 per prescription for up to 30-day supply for brand name or generic drugs • \$5 per prescription for up to 90-day supply of maintenance drugs • No copayment for prescription drugs provided in an inpatient setting. • No copayment for drugs administered in the provider's office or in an outpatient facility. • No copayment for FDA-approved contraceptive drugs and devices. 	<ul style="list-style-type: none"> • \$10 copayment per prescription for up to 30 day supply for generic drugs. • \$15 copayment per prescription for up to 30 day supply for brand name drugs unless there is no generic equivalent or if the use of a brand name drug is medically necessary. • \$10 copayment per prescription for up to 90 day supply for maintenance generic drugs purchased through a participating pharmacy. • \$15 copayment per prescription for up to 90 day supply for maintenance drugs purchased through a participating pharmacy for brand name drugs unless there is no generic equivalent or if the use of a brand name drug is medically necessary, then \$10 copayment applies. • No copayment for prescription drugs provided in an inpatient setting. • No copayment for drugs administered in the doctor's office or in an outpatient facility. • No copayment for FDA-approved contraceptive drugs and devices.

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
Durable Medical Equipment **	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	No copayment
Orthotics and Prosthetics **	Original and replacement devices as prescribed by a licensed practitioner.	No copayment	No copayment
Cataract Spectacles and Lenses **	Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery.	No copayment	No copayment
Maternity Care	Professional and hospital services relating to maternity care.	No copayment	No copayment
Family Planning Services	Voluntary family planning services	No copayment	No copayment
Medical Transportation Services **	Emergency ambulance transportation and non-emergency transportation to transfer you from a hospital to another hospital or facility, or facility to home.	No copayment	No copayment
Emergency Health Care Services **	Emergency services are covered both in and out of the plan's service area and in and out of the plan's participating facilities.	\$5 per visit (waived if you are admitted to the hospital.)	\$15 per visit (waived if the member is admitted to the hospital.)

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
Inpatient Mental Health Care Services:	Mental health care in a participating hospital when ordered and performed by a participating mental health professional for the treatment of a mental health condition		
Mental Health Care	<ul style="list-style-type: none"> • Diagnosis and treatment of a mental health condition. • This includes, but is not limited to inpatient mental health care services for the treatment of Severe Mental Illnesses (SMI) 	No copayment	No copayment
Serious Emotional Disturbance (SED) Services Severe Mental Illness (SMI)	<ul style="list-style-type: none"> • Inpatient mental health care services for the treatment of a member determined by the county to have SED <ul style="list-style-type: none"> ▪ The plan shall provide all necessary covered services until the county mental health department establishes eligibility for a member child with SED and the county mental health department provides the medically necessary services to treat the SED. ▪ The Plan and the county mental health department will 	No copayment	No copayment

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
	coordinate services to ensure that medically necessary services and treatment are provided to a member with a SED condition. <ul style="list-style-type: none"> ▪ The member will remain enrolled in the Healthy Families Program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED from the Plan. 		
Outpatient Mental Health Care Services	Mental health care when ordered and performed by a participating mental health professional.		
Mental Health Care:	<ul style="list-style-type: none"> • 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, or divorce and bereavement. • Family members may be involved in 	\$5 per visit	\$10 per visit

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
	<p>the treatment when medically necessary for the health and recovery of the child.</p> <ul style="list-style-type: none"> This includes, but is not limited to outpatient mental health care services for the treatment of Severe Mental Illnesses (SMI). 		
Serious Emotional Disturbance (SED)	<ul style="list-style-type: none"> Outpatient mental health care visits for the treatment of a member determined by the county to have SED The plan shall provide all medically necessary covered services until the county mental health department establishes eligibility for a member child with SED and the county mental health department provides the medically necessary services to treat the SED. The Plan and the county mental health department will coordinate services to ensure that medically 	No copayment	No copayment

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
	<p>necessary services and treatment are provided to a member with SED</p> <ul style="list-style-type: none"> The member will remain enrolled in the Healthy Families Program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED condition from the Plan. 		
Inpatient Alcohol/Drug Abuse Treatment	Hospitalization to remove toxic substances from the system.	No copayment	No copayment
Outpatient Alcohol/Drug Abuse Treatment	Crisis intervention and treatment of alcoholism or drug abuse.	\$5 per visit	\$10 per visit
Home Health Care Services	Services provided at the home by health care personnel.	No copayment, except \$5 per visit for physical, occupational, and speech therapy	No copayment, except \$10 per visit for physical, occupational, and speech therapy
Skilled Nursing Care	Services provided in a licensed skilled nursing facility. Benefit is limited to a maximum of 100 days per benefit year	No copayment	No copayment
Physical, Occupational, and Speech Therapy **	Therapy may be provided in a medical office or other appropriate outpatient setting.	<p>\$5 per visit when performed in an outpatient setting</p> <p>No copayment for inpatient therapy</p>	<p>\$10 per visit when performed in an outpatient setting</p> <p>No copayment for inpatient therapy</p>

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
Blood and Blood Products **	Includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings.	No copayment	No copayment
Health Education	Includes education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services.	No copayment	No copayment
Hospice	If you are diagnosed with a terminal illness and you elect hospice care instead of traditional health care services.	No copayment	No copayment
Organ Transplants **	Coverage for organ transplants and bone marrow transplants which are not experimental or investigational.	No copayment	No copayment
Reconstructive Surgery **	Performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors, or disease and are performed to improve function or create a normal appearance.	No copayment	No copayment
Phenylketonuria (PKU) **	Testing and treatment of PKU.	No copayment	No copayment

Benefits*	Services	Cost to Member (copayment)	
		Income Category A	Income Categories B & C
Clinical Cancer Trials	Coverage for participation in a cancer clinical trial, phase I through IV, when the member's physician has recommended participation in the trial, and the member meet certain requirements.	\$5 copayment per office visit Copayment for prescriptions as described in the "Prescription Drug Program" Section	\$10 copayment per office visit Copayment for prescriptions as described in the "Prescription Drug Program" Section
California Children's Services Program (CCS)	<ul style="list-style-type: none"> • 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 by the CCS program, you will remain enrolled in the Healthy Families Program and continue to receive medical care from plan providers for services not related to the CCS eligible condition. The member will receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers. 	No copayment	No copayment

Benefits*	Services	Cost to Member (copayment)	Cost to Member (copayment)
		Income Category A	Income Categories B & C
Acupuncture	Does not require referral from the member's provider but services must be obtained from a plan provider. Benefit is limited to 20 visits per benefit year	\$5 per visit	\$10 per visit
Chiropractic	Does not require referral from the member's provider but services must be obtained from a plan provider. Benefit is limited to 20 visits per benefit year	\$5 per visit	\$10 per visit
Deductibles	No deductibles will be charged for covered benefits		
Lifetime Maximums	No lifetime maximum limits on benefits apply under this plan		

*Benefits are provided only for services which are medically necessary.

** These services may be covered and paid for by the California Children's Services (CCS) program, if the member is found to be eligible for CCS services.

C. Evidence of Coverage & Disclosure Form

The Terms and Conditions of Your Health Plan

1. About San Francisco Health Plan (SFHP)

San Francisco Health Plan (SFHP) is a licensed health plan, serving residents living within the City and County of San Francisco. It is not a medical provider. All health care services you will receive are provided by independent clinics, hospitals, and other health professionals that have entered into contracts with either SFHP or with medical groups under contract to SFHP. In turn, SFHP contracts with the hospital and medical groups to provide health care services for its members. These individual contracts specify how the Plan works and what it covers.

You are required to select a primary care provider from the many physicians who are part of the Plan. Your primary care provider will manage your care, including preventive care such as check ups and immunizations for children and gynecological examinations for women. The primary care provider will refer you to specialists when necessary and will make arrangements for hospitalization when required.

Each primary care provider is connected to a medical group and will generally refer you only to those specialists, hospitals, and other health professionals used by that medical group. If there are no appropriately qualified health professionals to treat your condition who are associated with your medical group, the primary care provider may refer you to a participating provider belonging to another medical group or who is outside of the Plan's network of providers if necessary.

Member ID Card

Once you select SFHP through the Healthy Families Program, you will be sent a member ID Card. It is important to check the card to make sure all the information is correct. If the information is wrong, if you move, or if the card is lost or stolen, it is important to notify SFHP immediately. Call Member Services at

415-547-7800 (local) or **1-800-288-5555** if you have any questions.

2. Disability Access Americans with Disabilities Act Disclosure

A. Physical Access:

The San Francisco Health Plan has made every effort to ensure that our offices and the offices and facilities of the plan providers are accessible to the disabled. If you are not able to locate an accessible provider, please call our toll free Member Services number at **1-800-288-5555** and a Member Services representative will help you find an alternate provider.

B. Access for the Hearing Impaired:

The hearing impaired may contact our Member Services representative through our TTD number at **1-888-883-7347**, Monday through Friday, from 8:30 a.m. to 5:30 p.m. Between 5:30 p.m. and 8:30 a.m. and on weekends, please call the California Relay Service TTY at 711 to get the help you need.

C. Access for the Vision Impaired:

This Evidence of Coverage (EOC) and other important plan materials will be made available in alternative formats for the vision impaired, such as large print or audiotape. For alternative formats, or for direct help in reading the EOC and other materials, please call our Member Services at **1-800-288-5555**.

D. The Americans with Disabilities Act of 1990

San Francisco Health Plan complies with the Americans with Disabilities Act of 1990 (ADA). This Act prohibits discrimination based on disability. The Act protects members with disabilities from discrimination concerning program services. In addition, section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall be excluded, based on disability, from participation in any program or activity which receives or benefits from federal financial assistance, nor be denied the benefits of, or otherwise be subjected to discrimination under such a program or activity.

E. Disability Access Grievance

If you believe the plan or its providers have failed to respond to your disability access needs, you may file a grievance with the plan. If your disability access complaint remains unresolved with the plan, you may contact the:

ADA Coordinator
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769

(916) 324-4695

The hearing impaired should call the California Relay Service at **1-800-735-2929** (TTY.)

3. Your Rights and Responsibilities

A. Your Rights

As an SFHP Healthy Families Program member, I have the right to:

- **Select a primary care provider** from the SFHP Provider Directory to provide or arrange for all the care I need.
- **Receive good and appropriate medical care** including preventive health services and health education.
- **Get appointments** within a reasonable amount of time.
- **Participate actively** in decisions regarding my medical care needs, including appropriate or medically necessary treatment options for my condition(s), regardless of cost or regardless of whether the treatment is covered by the health plan. To the extent permitted by law, I also have the right to refuse or discontinue treatment.
- **Receive enough information** to help me make a knowledgeable decision before I receive treatment.
- **Know and understand** my medical condition, treatment plan, expected outcome, and the effects these have on my daily living.
- **Receive interpreter services** at no charge (including interpreters for medical appointments).
- **File a complaint or Grievance** if my cultural and linguistic needs are not met.
- **Have the meaning and limits** of confidentiality explained to me. I understand that if I am a minor, my provider or other staff may need to talk with my parents or guardian about certain issues. If this happens, the information will be discussed fully with me as well.
- **Have confidential health records**, except when disclosure is required by law or permitted in writing by me. With adequate notice, I have the right to review my medical records with my primary care provider.
- **Know about any transfer** to another hospital, including information as to why the transfer is necessary and any alternatives available.
- **Obtain a referral** from my primary care provider for a second opinion.

- **Be fully informed** about SFHP's appeals procedure and understand how to use it without fear of interruption of health care and present my appeal in person.
- **Participate in establishing public policy** of SFHP, as outlined in this Evidence of Coverage.
- **Treat all SFHP staff and health professionals respectfully** and courteously.
- As required by Healthy Families Program, pay any premiums, payments, and charges for non-covered services on time.

B. Your Responsibilities

As a Healthy Families Program member, I have the responsibility to:

- **Carefully read all SFHP materials** immediately after I am enrolled so I understand how to use my SFHP benefits.
- **Ask questions** when necessary.
- **Follow the provisions** of my SFHP membership as explained in this Evidence of Coverage.
- **Be responsible** for my health.
- **Follow the treatment plans** my PCP develops for me and consider and accept the potential consequences if I refuse to comply with treatment plans or recommendations.
- **Ask questions** about my medical condition and make certain that I understand the explanations and instructions I am given.
- **Make and keep medical appointments** and inform my PCP ahead of time when I must cancel.
- **Communicate openly** with my PCP so I can develop a strong partnership based on trust and cooperation.
- **Offer suggestions** to improve SFHP.
- **Help SFHP maintain accurate and current medical records** by providing timely information regarding changes in address, family status, and other health plan coverage.
- **Notify SFHP as soon as possible** if I am billed inappropriately or if I have any complaints.

4. Definitions

Active Labor

Labor when there is inadequate time to safely transfer you to another hospital prior to delivery or when transferring you may pose a threat to your health and safety or of the unborn child.

Acute Condition

A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Appeal

A request to reconsider a decision.

Appropriately Qualified Health Care Professional

A primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to a particular illness, disease, condition or conditions.

Authorization

The requirement that your primary care provider or medical group, obtain approval by the medical group to which you belong (and in some instances, also by SFHP) before certain services are provided.

Benefits (Covered Services)

These are services, supplies, and drugs that you are entitled to receive pursuant to the terms of this Agreement. A service is not a benefit, even if described as a covered service or benefit in this booklet, if it is not medically necessary or if it is not provided by a SFHP provider with authorization as required.

Benefit Year

The twelve (12) month period commencing October 1 of each year at 12:01 a.m.

California Children's Services (CCS)

A State and County case management and insurance program for children with certain handicapping medical conditions.

Complaint

A complaint is also called a grievance or an appeal. Examples of a complaint can be when:

- You can't get a service, treatment, or medicine you need.
- Your plan denies a service and says it is not medically necessary.
- You have to wait too long for an appointment.
- You received poor care or were treated rudely.
- Your plan does not pay you back for emergency or urgent care that you had to pay for.
- You get a bill that you believe should not have to pay.

Continuity of Care

Your right to continue seeing your doctor in certain cases, even if your doctor leaves your health plan or medical group.

Copayment

Amount that you are required to pay for certain benefits.

Cosmetic Services

Any surgery, service, drug, or supply designed to alter or reshape normal structures of the body in order to improve appearance.

Coverage Decision

This means a decision made by either the health plan or medical group to deny, approve, defer, or modify a requested health care service substantially based on a finding that the provision of a particular service is included or excluded as a covered service under the terms and conditions of the health plan contract and this Evidence of Coverage.

Covered Services (Benefits)

See Benefits.

Custodial Care

Care furnished primarily to provide room and board or to meet the activities of daily living (which may include nursing care, training in personal hygiene, and other forms of self care) or supervisory care to you if you are mentally or physically disabled.

Dental Care

A service or treatment on or to the teeth or gums whether or not caused by accidental injury, including any appliance or device applied to the teeth, or gums.

Disability

It is an injury or an illness. However, all injuries sustained in any one accident will be considered one disability. All illnesses existing simultaneously, which are due to the same or related causes, will be considered one disability. If any illness is due to causes that are the same as or related to the causes of any prior illness, the succeeding illness will be considered a continuation of the previous disability and not a separate disability.

Disputed Health Care Service

Any requested health care service eligible for coverage and payment under the health plan contract and this Evidence of Coverage that has been denied, modified, or delayed by a decision of the health plan, or by one of its participating providers, in whole or in part due to a finding that the service is not medically necessary.

Domiciliary Care

Care provided in a hospital or other licensed facility because care in the patient's home is not available or is unsuitable.

Durable Medical Equipment (DME)

Medical equipment appropriate for use in the home which: 1) is intended for repeated use; 2) is generally not useful to a person in the absence of illness or injury; and 3) primarily serves a medical purpose. Durable medical equipment also includes oxygen. Durable medical equipment does not include convenience items or disposable supplies, other than ostomy bags and urinary catheter supplies.

Emergency Care

An emergency is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- **Placing** the your health in serious jeopardy, or
- **Causing** serious impairment to the your bodily functions, or
- **Causing** serious dysfunction of any of your bodily organs or parts.

Exclusion

Any medical, surgical, hospital or other treatment for which the program offers no coverage.

Experimental or Investigational Service

Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or

equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional medical standards, or if safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which it is recommended or prescribed.

Evidence of Coverage and Disclosure Form (EOC)

This booklet is the combined Evidence of Coverage and Disclosure Form that describes your coverage and benefits.

Federal Poverty Income Guideline

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

Formulary

A list of brand-name and generic prescription drugs approved for coverage and available without prior authorization from SFHP. The presence of a prescription drug on the formulary does not guarantee that it will be prescribed by your provider for a particular condition.

Grievance

A written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by you or your representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Health Insurance Portability and Accountability Act (HIPAA)

A law that protects your rights to get health insurance and keep your medical records private.

Health Plan

It refers to San Francisco Health Plan.

Healthy Families Program

The state program administered by MRMIB to provide medical, dental and vision coverage to children who meet the eligibility and income requirements and contribute a monthly family contribution.

Hospice Care

Care and services provided to you in a home by

a licensed or certified home health care agency, or in licensed hospice, that are:

- **Designed** to provide palliative and supportive care to individuals who have received a diagnosis of terminal illness for which your life expectancy is twelve months or less.
- **Directed** and coordinated by medical professionals.
- **Pre-authorized** by SFHP.

Hospital

A health care facility licensed by the State of California, and accredited by the Joint Commission on Accreditation of Health Care Organizations, as either: (a) an acute care hospital; (b) a psychiatric hospital; or (c) a hospital operated primarily for the treatment of alcoholism and/or substance abuse. A facility which is primarily a rest home, nursing home or home for the aged, or a distinct part skilled nursing facility portion of a hospital is not included.

Hospital Inpatient Services

These include only those services which are medically necessary and satisfy the hospital requirements, require the acute bed-patient (overnight setting), and which could not have been provided in a PCP's office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient services that are not medically necessary include hospitalization:

- For diagnostic studies that could have been provided on an outpatient basis.
- For medical observation or evaluation.
- To remove the patient from his/her customary work or home environment for personal comfort.
- In a pain management center to treat or cure chronic pain.
- In an eating disorder unit to treat eating disorders.
- For inpatient rehabilitation provided on an outpatient basis.
- SFHP reserves the right to review all services to determine whether they are medically necessary.

Income Category, A, B, or C

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

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

Independent Medical Review (IMR)

A review of your health plan's denial of your request for a certain service or treatment (the review is provided by the Department of managed Health Care and conducted by independent medical experts, and your health plan must pay for the service if an IMR decides you need the service.)

Inpatient

An individual who has been admitted to a hospital as a registered bed patient and receives covered services under the direction of a physician.

Life-threatening

It means either or both of the following: (a) Diseases or conditions where the likelihood of death is high unless the course of the disease or condition is interrupted; (b) Diseases or conditions with potentially fatal outcomes, where the end of point of clinical intervention is survival.

Managed Risk Medical Insurance Board (MRMIB)

The State agency that administers the Healthy Families Program.

Medical Group

It is the integrated medical group, Independent Physician Association (IPA), medical foundation, or similar physician entity with which your primary care provider is associated for the provision of benefits to you and which has entered into a contract with SFHP to provide services to you.

Medically Necessary

Those skilled medical services which have been established as safe and effective, are furnished in accordance with generally accepted professionally recognized standards to treat an illness or injury, and which, as determined by SFHP, are necessary to improve or maintain bodily function; consistent with the symptoms or

diagnosis; not furnished primarily for the convenience of the patient, the attending physician or other provider; and which are furnished at the most appropriate level which can be provided safely and effectively to the patient.

Member

A person who joins SFHP to receive his or her health care. In this booklet, a member is also referred to as "you."

Member Identification Card

The identification card provided to you by SFHP that includes the member number, primary care provider information, and important phone numbers.

Mental Health Care Services

Psychoanalysis, psychotherapy, counseling, medical management or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage and family therapist, for diagnosis or treatment of mental or emotional disorders or the mental or emotional problems associated with an illness, injury, or any other condition.

Non-formulary Drug

A drug that is not listed on SFHP's Formulary and requires an authorization from SFHP in order to be covered.

Non-contracted provider

A primary care provider, medical group, hospital or other health professional that is not contracted to provide health care services to *SFHP Members*.

Non-Participating Provider

A provider who has not contracted with SFHP to provide services to members

Occupational Therapy

Treatment under the direction of a physician and provided by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

Orthotic Device

A support or brace designed for the support of a weak or ineffective joint, muscle, or to improve the function of movable body parts.

Outpatient Services

These are services, under the direction of a physician, which do not incur overnight charges at the facility where they are provided.

Out-of Area Services

Emergency care or urgent care provided outside

of SFHP's service area which could not be delayed until you returned to the service area.

Participating Provider or Plan Provider

A physician, hospital, skilled nursing facility or other licensed health professional, licensed facility or licensed home health agency who, or which, at the time care is rendered to you, has a contract in effect with SFHP to provide covered services to its members.

Psychiatric Emergency Medical Condition

A mental disorder where there are acute symptoms of sufficient severity to render either an immediate danger to yourself or others, or you are immediately unable to provide for or use, food, shelter, or clothing due to the mental disorder.

Serious Chronic Condition

A medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Serious Emotional Disturbance (SED)

SED refers to a diagnosed mental condition in a child that is not a "substance abuse disorder" or "developmental disorder." A child with SED also behaves in a way that is not appropriate for the child's age. A county mental health department decides if a child has SED based on California Law (Welfare and Institutions Code Section 5600.3(a)(2)). In making that decision, the county will consider whether a child has certain problems. These could include trouble taking care of him/herself, problems at school, or problems with family relationships. The child might also have other problems such as being at risk of suicide or violence. Or, the child might meet the state's Special Education requirements. The county may also look at whether the child is at risk of being removed from the home and at how long the condition is expected to last.

Seriously Debilitating Illness

It means diseases or conditions that cause major irreversible morbidity.

Service Area

It is the geographical area served by SFHP, which is the City and County of San Francisco.

Severe Mental Illnesses (SMI)

It is defined as a mental health condition that includes: schizophrenia, schizoaffective disorders, bipolar disorder (manic-depressive illness), major depressive disorders, panic

disorders, obsessive-compulsive disorders, pervasive developmental disorder or autism, anorexia nervosa or bulimia nervosa.

SFHP Provider

Provider who has an agreement with SFHP or a medical group to provide SFHP benefits to members.

Skilled Nursing Facility

A facility licensed by the California State Department of Health Care Services as a "Skilled Nursing Facility" to provide a level of inpatient nursing care that is not of the intensity required of a hospital.

Specialist Physician

A plan physician who provides services to you usually upon referral by a primary care provider within the range of his or her designated specialty area of practice and who is specialty board certified or specialty board eligible in such specialty. Some specialty services do not require a referral, e.g., obstetrical services.

Speech Therapy

Medically necessary treatment under the direction of a physician and provided by a licensed speech pathologist or speech therapist.

Standing Referrals

Referrals to a specialist that allow you to visit that specialist on a repeated basis in order to continue treatment of an ongoing problem.

Terminal Illness

An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.

Terminated Provider

Any provider, including an individual practitioner, medical group or hospital whose contract with SFHP has ended. The contract may be ended by the provider or by SFHP.

Total Disability

It refers to:

- **A disability which prevents you from working** (in excess of the sick leave permitted such individual) with reasonable continuity in the your customary employment or in any other employment in which you reasonably might be expected to engage, in view of your station in life and physical and mental capacity.
- **In case you are not employed**, a disability which prevents you from engaging with normal or reasonable continuity in the individual's customary activities or in those in which you otherwise reasonably might

be expected to engage, in view of your station in life and physical and mental capacity.

Urgent Care

Services need to prevent serious deterioration of your health resulting from unforeseen illness or injury for which treatment cannot be delayed. Urgent care services are for medical problems that usually can wait 24 to 48 hours for treatment without getting worse.

5. Choice of Physicians and Facilities

All the health care services to which you may be entitled are provided by PCPs and other health professionals and facilities that are independent of SFHP. SFHP is not a medical provider. These physicians, medical groups, hospitals, and other health professionals are neither employees nor agents of SFHP.

SFHP's service area is the City and County of San Francisco. For more detailed information about your choice of physicians and facilities, see your copy of the Healthy Families Provider Directory. If you do not have a copy, call Member Services at **415-547-7800** (local) or **1-800-288-5555**. Since the participating providers listed in this Directory may change, call Member Services or visit www.sfhp.org to find out whether a particular physician or other health professional is available through SFHP.

A. Selecting a Primary Care Provider

You are required to have a primary care provider and are encouraged to select a primary care provider at the time of enrollment. Each primary care provider is affiliated with a medical group. Each medical group utilizes certain specialists, hospitals, and other health professionals affiliated with that medical group, so your choice of primary care provider will also determine which other providers will be available for health care services. The primary care provider, along with the medical group, is responsible for coordinating and directing all of your medical care needs, arranging referrals to specialists and other providers (including hospitals), and providing the required prior authorization you will need to obtain health care services. The primary care provider

and medical group will also prescribe medically necessary lab tests, x-rays, and other covered services

If you do not select a primary care provider at the time of enrollment, SFHP will designate one for you and you will be notified. This designation will remain in effect until you notify SFHP of your own selection.

In order to obtain benefits, you must have a primary care provider. If you have not selected a primary care provider, call Member Services at **415-547-7800** (local) or **1-800-288-5555**, Monday through Friday, from 8:30 am to 5:30 pm. Remember, for all health care needs (other than emergency services), including services for preventive health, routine health problems, consultation with specialists, and for hospitalization, you must contact your primary care provider to obtain authorization for the services. If you need to cancel a scheduled appointment please be sure to cancel at least 24 hours in advance.

Note: In order to receive medical services covered by SFHP, the primary care provider and medical group must coordinate and authorize your health care.

B. Changing Your Primary Care Provider or Medical Group

You may change primary care providers or medical groups by calling Member Services at **415-547-7800** (local) or **1-800-288-5555**. If you request a change before the 25th day of the month, the change will occur the first day of the next month, following notice of approval by SFHP. Please remember, if you change your primary care provider to one who is affiliated with a different medical group, this selection may also result in a change in the hospitals, specialists, and other health professionals from whom you may receive medical care.

If the primary care provider discontinues participation in SFHP, SFHP will notify you, so you can pick another physician.

C. A Positive Relationship with Your Primary Care Provider

In order to help your primary care provider provide or arrange medically necessary services, it is important that you and your physician maintain a cooperative physician-patient relationship.

If a cooperative and professional relationship cannot be maintained, SFHP will assist you in the selection of another primary care provider.

D. Scheduling Appointments and Initial Health Exam

Do not wait until you are sick to see your PCP. Schedule an appointment for a health assessment (check-up) within 120 days of enrollment. For children under the age of two, please make an appointment with your child's PCP within 60 days of enrollment with SFHP or as soon as possible. Your PCP will advise you about the best time for routine appointments and shots, depending on your age. Call the PCP on your member ID card to schedule an appointment. (Please give at least 24 hours notice if you need to cancel or change the appointment.) Show the member ID card at the PCP's office or clinic.

6. How to Use SFHP

A. Authorization for Services and Utilization Review

In this Evidence of Coverage, we use the words "authorize" or "authorization" to refer to the requirement that you obtain the approval of the medical group and, in some cases, SFHP, for health care services referred by the primary care provider before such services are provided. Usually the primary care provider's office will obtain the authorization.

Except for services provided by the primary care provider, OB/GYN services and medically necessary emergency services (see definition of emergency care on p. 24), all covered services which are provided under SFHP to you must be referred and coordinated by the primary care provider and authorized in accordance with the rules of the primary care provider's medical group and SFHP. Generally, all services (other than those of your primary care provider and emergency service) must be referred by the primary care provider and authorized

by the medical group, which the primary care provider is associated with. In certain cases, however, such as when hospital and skilled nursing facility admissions or home health services are necessary, SFHP may also need to authorize the services. Decisions to authorize, modify, or deny services based on a determination of medical necessity, are based upon criteria or guidelines that are supported by clinical principles and processes. The process the Plan and its participating providers use when authorizing, modifying or denying services, as well as a copy of the criteria and guidelines used to reach a decision based on medical necessity are available to you, participating providers, and the public upon request.

Any needed authorization from the medical group or SFHP will be obtained by the primary care provider on your behalf, but it is always your responsibility to contact your primary care provider to obtain appropriate referrals for covered services not provided by the primary care provider. Please note, however, that a referral by your primary care provider does not guarantee coverage for these services. The eligibility provisions, benefits, exclusions, and limitations described in this Evidence of Coverage will apply, whether or not the services are referred by your primary care provider.

Note: Except for the services for which an exception is made under the rules of this EOC, such as services provided by your primary care provider, OB/GYN services, and for emergency service, all health care services must be authorized prior to the date the services are provided. If the services are not authorized before they are provided, they will not be a covered benefit, even if the services are needed.

B. Second Opinions

To ensure that you receive appropriate and necessary health care services, SFHP allows you to obtain a second opinion. If you are requesting a second opinion about care from your PCP, the second opinion shall be provided by an appropriately qualified health care professional of your choice within the same medical group. If there is no participating provider within the medical group who is appropriately qualified to treat the your condition or offer a second opinion on your behalf, then the Plan shall

authorize a second opinion by an appropriately qualified health professional with another medical group, or if necessary, outside of the Plan's provider network.

If you are requesting a second opinion about care from your specialist, the second opinion shall be provided by any appropriately qualified health care professional of your choice from any medical group within the Plan's network. If there is no appropriately qualified health care professional within the Plan's network to provide an opinion, then the Plan shall authorize a second opinion by an appropriately qualified health care professional outside of the Plan's network.

Requests for second opinions will be authorized in an expeditious manner. In urgent/emergent cases, a second opinion will be authorized as soon as possible, consistent with good professional practice and whenever possible within 72 hours.

C. Referrals to Specialists

Except for emergency services, your primary care provider must refer you to a specialist for all authorized, medically necessary covered services not provided directly by the primary care provider. The member will generally be referred to a specialist who is affiliated with the same medical group as the primary care provider, but the member can be referred to a specialist outside the medical group if the type of specialist care needed is not available within that medical group. In the event that there is no SFHP physician available to perform the needed service, the primary care provider will refer you to a non-SFHP Provider for the services after obtaining authorization. For a list of specialists, call Member Services at **415-547-7800** (local) or **1-800-288-5555**. Or call the TDD/TTY for the hearing impaired at **1-888-883-7347** or **415-547-7830**.

D. Services Not Requiring Referrals

Services that do not require a referral are:

- **PCP Services**
- **Services at an Indian Health Center**
- **OB/GYN visits**
- **Acupuncture/Chiropractic Services**

- **Emergency services**
- **Vision Care**
- **Mental Health Services**

Note: Except for emergency services or OB/GYN care, for all covered services not directly provided by your primary care provider, including specialists, SFHP hospital, and lab and x-ray, you must first contact your primary care provider and the services must be authorized. In consultation with you, the primary care provider will designate the specialist, SFHP hospital, or other provider from whom the services will be received.

E. Direct Access to OB/GYNs

A female member has the right to seek OB/GYNs covered services directly from a specialist who is an OB/GYN, or directly from a physician who is a family practice physician and surgeon, designated by SFHP as providing OB/GYN services, without a referral from a primary care provider. The OB/GYN or specialist must be part of your medical group. Covered services recommended or referred by one of these physicians, other than the initial office visit, must be authorized by the medical group and/or SFHP to the same extent as other covered services. Coverage for an annual cervical cancer screening test shall include the conventional Pap test, human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

F. Standing Referrals to Specialists

You may receive a standing referral to a specialist, or to one or more specialist, pursuant to a treatment plan from your primary care provider, developed in consultation with the specialist. The standing referral must be approved by your medical group or SFHP, and may limit the number of visits to the specialist or limit the period of time that the visits are authorized, or require that the specialist provide the primary care provider with regular reports on the health care provided to you. This standing referral (subject to time and visit limitations) allows you to see the specialist

on a repeated basis. In order to receive SFHP authorization for the standing referral, you must require continuing specialty care over a prolonged period of time that requires coordination of care by a specialist instead of your primary care provider. To obtain a list of specialists with demonstrated expertise in treating a specific medical condition contact your primary care provider or your medical group.

G. Emergency Medical Care

An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain or a psychiatric disturbance such that the absence of immediate medical attention could reasonably be expected to result in one of the following: placing your health or in the case of a pregnant woman, the health of her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

If you believe that a medical condition is an emergency medical condition, call 911 or go to the closest emergency room for help. Show your member ID card to the staff at the hospital and ask them to notify your primary care provider of your medical condition.

For emergency service, it is not necessary to contact your primary care provider before obtaining services. However, you should notify your primary care provider within 24 hours after care is received unless it is determined that it was not reasonably possible to communicate with the physician within 24 hours. In this case, notice should be given as soon as possible. SFHP will cover services rendered in the situation that you reasonably believed to be an emergency, even if it is later determined by SFHP that an emergency did not in fact exist. If you receive non-authorized services in a situation that the health plan determines was not reasonably believed to be an emergency, you will be responsible for the costs of those services.

H. Urgent Care or Care After Regular Hours and on Weekends

If you feel sick, have a fever, or some other urgent medical problem, call your primary care provider's office, even during the hours that your primary care provider's office is normally closed. Your primary care provider or a doctor-on-call will always be available to tell you how to handle the problem at home or if you should go to an urgent care center or a hospital emergency room. Problems that may be urgent but not true emergencies are problems that can usually wait 24 to 48 hours for treatment without getting worse. Call your primary care provider if you have an urgent medical need. Your primary care provider will give you advice on what to do.

Urgent care received while out of the service area is a covered benefit. If you are out of the area and get sick, but it is not an emergency, call your PCP to find out what to do if you are able. Remember to keep your member ID Card with you. Your PCP's phone number is listed on it to help you.

I. Post- Stabilization and Follow-up Care After an Emergency

Once your child's emergency medical condition has been treated at a hospital and an emergency no longer exists because your child's condition is stabilized, the doctor who is treating your child may want your child to stay in the hospital for a while longer before your child can safely leave the hospital. The services your child receives after an emergency condition is stabilized are called "post-stabilization services."

If the hospital where your child received emergency services is not part of San Francisco Health Plan's contracted network ("non contracted hospital"), the non-contracted hospital will contact San Francisco Health Plan to get approval for your child to stay in the non-contracted hospital.

If San Francisco Health Plan approves your child's continued stay in the non-contracted hospital, you will not have to pay for services except for any copayments normally required by San Francisco Health Plan.

If San Francisco Health Plan has notified the non-contracting hospital that your child can safely be moved to one of the plan's contracted hospitals, San Francisco Health Plan will arrange and pay for your child to be moved from the non-contracted hospital to a contracted hospital.

If San Francisco Health Plan determines that your child can be safely transferred to a contracted hospital, and you or your spouse or legal guardian do not agree to your child being transferred, the non-contracted hospital must give you or your spouse or legal guardian a written notice stating that you will have to pay for all of the cost for post-stabilization services provided to your child at the non-contracted hospital after your child's emergency condition is stabilized.

Also, you may have to pay for services if the non-contracted hospital cannot find out what your name is and cannot get contact information at the plan to ask for approval to provide services once your child(ren) are stable.

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR POST-STABILIZATION SERVICES THAT YOUR CHILD RECEIVED FROM A NON-CONTRACTED HOSPITAL, PLEASE CONTACT SAN FRANCISCO HEALTH PLAN MEMBER SERVICES DEPARTMENT AT (415) 547-7800 or (800) 288-5555, Monday to Friday from 8:30AM to 5:30PM.

J. Co-Payments

You are financially responsible for co-payments as listed in the Summary of Benefits. However, for those who are not able to make all of your co-payments, the Plan will work with you and your Provider to develop a payment plan that meets your needs. Call Member Services at **415-547-7800** (local) or **1-800-288-5555**, if you are having difficulty making co-payments.

Note: There are no co-payments for preventive visits or if you are American Indians and Alaska Native members or under the age of 24 months for well-baby care, health exams, or other office visits. For information pertaining to copayment waivers for American Indians or Alaskan Natives please refer to the Healthy Families Program handbook or contact the Healthy Families Program at **(800) 880-5305**.

You will not have to pay more than \$250 maximum in co-payments for all children in your household during any one benefit year. You should ask for a receipt whenever a co-payment is made and keep the receipt and a record of all payments so that you may demonstrate that the maximum has been paid if this occurs during the year of membership. When the limit is reached, you should contact Member Services at **415-547-7800** (local) or **1-800-288-5555**, to get a non-copay card. You will still need to pay copayments until SFHP receives proof that you have paid a total of \$250 in copayments. If you can show that you paid more than \$250 in copayments between October 1, 2011 and September 30, 2012, the plan will reimburse you for the amount over \$250. Present this card at each visit to the provider's office or pharmacist to provide proof that the maximum co-payment has been reached for the benefit year.

Except for any applicable co-payments, you are not financially responsible for services provided by your primary care provider. For all other services which are SFHP benefits, you are not financially responsible for the costs of such services, other than for any applicable co-payments, if the services are referred by the primary care provider and authorization has been obtained. In the event SFHP or your medical group does not pay a participating provider for services, you will not be liable to the participating provider for any sums owed by SFHP or your medical group.

Services which are SFHP benefits, but which have not been authorized, will not be covered by SFHP and will be your financial responsibility. If you receive non-authorized services in a situation that was not reasonably believed to be an emergency, you will be responsible for the costs of those services. Services that are not SFHP benefits under SFHP benefit program are

your financial responsibility, even if such services are referred by your primary care provider.

There are no annual or lifetime benefit maximums under the Healthy Families Program.

Note: You may also be eligible for California Children's Services or Medi-Cal benefits. Call Member Services at **415-547-7800** (local) or **1-800-28 8-5555**, or talk with your primary care provider.

7. SFHP Benefits and Coverages

SFHP covers the benefits described in this section provided that services are obtained as described in authorization for services. The co-payments for these services are also listed in the Summary of Benefits section of this Handbook.

Important Information: Services are covered as benefits only if they are medically necessary, provided to you and provided either by your primary care provider, or with authorization as required in this booklet. Remember, except for emergency care (please see definition on page 23), all services must first be referred by your primary care provider and authorized by your primary care provider's medical group (and in some instances by SFHP)

A. Linkages to Other Benefit Programs and Coordination of Services

Coordination of Services

1. California Children's Services (CCS)

As part of the services provided through the Healthy Families Program, members needing specialized medical care may be eligible for services through the California Children's Services (CCS) program.

CCS is a California medical program that treats children with certain physically handicapping conditions and who need specialized medical care. This program is available to all children in California whose families meet certain medical, financial and residential eligibility requirements. All children enrolled in the Healthy Families Program are deemed to have met the

financial eligibility requirements of the CCS Program. Services provided through the CCS Program are coordinated by the local county CCS office.

If a member's primary care provider suspects or identifies a possible CCS eligible condition, he or she must refer the member to the local CCS program. SFHP can assist with this referral. SFHP will also make a referral to CCS when a primary care provider refers the member to a specialist or where there is an inpatient admission which appears to involve care for a CCS eligible condition. The CCS program will determine if the member's condition is eligible for CCS services.

If the CCS program determines that the condition is a CCS eligible condition, and CCS is treating the eligible condition; the member will remain enrolled in the Healthy Families Program. He or she will be referred to and should receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers. These CCS providers and specialty centers are highly trained to treat CCS eligible conditions. CCS services must be received from CCS paneled providers. Payment for CCS eligible services obtained from non-CCS paneled providers will be the responsibility of the member's legal guardian.

SFHP will continue to provide primary care, prevention services, and any other services that are not related to the CCS eligible condition, as described in this booklet. SFHP will also work with the CCS program and providers to coordinate care provided by both the CCS program and SFHP. If a condition is determined not to be eligible for CCS program services, the member will continue to receive all medically necessary services from SFHP.

Although all children enrolled in the Healthy Families Program are determined to be financially eligible for the CCS program, the CCS office must verify residential status for each child in the CCS program. If a member is referred to the CCS program, the member's legal guardian will be asked to complete a short application to verify residential status and ensure coordination of the member's care after the referral has been made.

Additional information about the CCS program can be obtained by calling SFHP's Member Services at **415-547-7800** (local) or **1-800-288-5555** or by calling the local county CCS program at **(415) 575-5700**.

2. County Mental Health Benefits for Serious Emotional Disturbance (SED) Children

If the member exhibits the behaviors listed below, the member may be able to access mental health services through SFHP.

- Serious problem eating or sleeping
- Often crying or sad
- Saying things that worry you
- Behaving in ways that cause serious family and school problems
- Ongoing or frequent problems with playmates and friends
- Purposefully hurting him/herself and others

As part of the services provided through the Healthy Families Program, members needing specialized mental health services for a Serious Emotional Disturbance (SED) condition will be referred for a SED assessment to their local county mental health department. The referral may be made by the member's primary care provider or by SFHP. Parents may also refer their child directly to the county mental health department if the parents suspect their child suffers from any of the conditions listed below. The county mental health clinician will have the final determination of whether the child meets SED criteria.

3. What is Serious Emotional Disturbance(SED)?

SED refers to any diagnosable mental disorder (in a child under age 19) that severely disrupts social, academic, and emotional functioning. A child is considered to have SED if his or her inappropriate behavior does not result from drug or alcohol substance abuse or a developmental disorder.

To determine if a child has a SED condition, he or she must meet one or more of the following criteria:

1. Has substantial difficulties in at least two of the following areas: self-care, school functioning, family relationships, or the ability to function in the community, and either of the following occurs:

- (i) the child is at risk of removal from the home or has already been removed; or
- (ii) the mental health condition has been present for more than 6 months or is likely to continue for more than 1 year if not treated.

2. Shows signs of psychotic behavior, risk of suicide or risk of violence which are related to mental disorder.
3. Meets special education eligibility requirements not related to developmental disorders.

If a member is determined to have a SED condition, care for the SED condition will be provided by the county mental health department. The plan may refer the member to the county mental health department for treatment of SED. The plan shall provide all medically necessary covered services until the county mental health department establishes eligibility for a member child with SED and the county mental health department provides the medically necessary services to treat the SED. The Plan and the county mental health department will coordinate services to ensure that medically necessary services and treatment are provided to a member with SED. The member will remain enrolled in the Healthy Families Program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED condition from SFHP.

If a member does **not** meet the SED criteria, the member will continue to receive all medically necessary health and mental health care services subject to applicable limitations from SFHP.

When a member is determined by the county to have a SED condition and the member's legal guardian refuses services from the county mental health department and seeks treatment from other providers (including services from SFHP providers), the legal guardian will be responsible for payment for the services.

Services provided by the county for the SED condition are provided to members at no cost and may include, but not limited to:

- **Outpatient visits** for treatment of SED

- **Inpatient** mental health care
- **Day treatment** programs
- **Individual** or family therapy
- **All medications** prescribed to treat the SED condition
- **Counseling assistance** with medication management related to the SED condition

Additional information about services for children with a SED condition can be obtained by contacting the county's mental health department. The phone number of your county mental health department can be found in the government listing section of the phone book under the heading "County Government".

4. Golden Gate Regional Center (GGRC)

Golden Gate Regional Center (GGRC) was created to meet the needs of people who are developmentally disabled. Disabling conditions include: mental retardation, epilepsy, autism, cerebral palsy, Down's Syndrome, and speech and language delays. GGRC helps their clients and their families to find housing, schools, day programs for adults, transportation, health care, and social activities. Most of their services are free to eligible clients. Your primary care provider will connect him or her with GGRC. If you have a family member who was diagnosed with a disabling condition before age 18, call GGRC at **415-546-9222**. You should see your primary care provider if you think you may have a disabling condition.

5. Early Start

Early Start is a federal program for children from birth to three years old who need early intervention services and:

- **Show a developmental delay** in one of the following areas: cognitive, physical, communicative, social/emotional, adaptive/self-help
- **Have a diagnosed developmental disability** that is expected to continue indefinitely
- **Are at high risk** for a developmental disability

For more information about this program, call **415-546-9222**.

6. Woman, Infants and Children (WIC)

Women, Infants and Children (WIC) is a nutrition/food program that helps young children and women to eat well and stay

healthy. Children under five years of age, pregnant women, women who are breast feeding or who have just had a baby are eligible if they meet the Federal Income Guidelines. Eligible clients receive free food vouchers and nutrition education, and breast feeding support. Ask your primary care provider to help you apply or call to make an appointment at **1-888-WIC-WORKS** or **1-888-942-9675**.

B. Schedule of Benefits and Coverages

The following benefits, subject to referral by your primary care provider, authorization, applicable co-payments, and all other terms, conditions, limitations and exclusions of this Evidence of Coverage, including those listed in "Exclusions and Limitations," when medically necessary, are covered by SFHP under the Healthy Families Program.

NOTE: Members in the Income Category A (To read about the HFP Income Categories please go to the HFP website: <http://www.healthyfamilies.ca.gov/Downloads/Applications.aspx>) shall pay no more than \$5 copayment for applicable covered services as described in this Benefit Descriptions Section of the EOC.

Benefit Descriptions

Inpatient Hospital Services

Cost to You No copayment.

Description General hospital services received in a room of two or more individuals containing customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. Benefit includes all medically necessary ancillary services, including, but not limited to:

- Use of operating room and related facilities
- Intensive care unit and services
- Drugs, medications, and biologicals
- Anesthesia and oxygen
- Diagnostic, laboratory, and x-ray services
- Special duty nursing
- Physical, occupational, and speech therapy

- Respiratory therapy
- Administration of blood and blood products
- Other diagnostic, therapeutic, and rehabilitative services

Coordinated discharge planning, including the planning of such continuing care as may be necessary.

Exclusions Personal or comfort items or a private room in a hospital are excluded unless medically necessary. Services of dentists or oral surgeons are excluded for dental procedures.

Outpatient Hospital Services

Cost to You No copayment, except:

- \$5-\$10 per visit for physical, occupational and speech therapy performed on an outpatient basis.
- \$5-\$15 per visit for emergency health care services, which is waived if you are hospitalized.

Description Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility including:

- Physical, speech, and occupational therapy as appropriate
- Hospital services which can reasonably be provided on an ambulatory basis
- Related services and supplies in connection with outpatient services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during your stay at the facility

Inpatient and Outpatient Hospital Services include coverage for general anesthesia and associated facility charges and outpatient services in connection with dental procedures when the use of a hospital or surgery center is required because of the subscriber's medical condition or clinical status, or because of the severity of the dental procedure. This benefit is only available to you if you are under seven (7) years of age; the developmentally disabled, regardless of age; and if your health is compromised and for whom general anesthesia is medically necessary, regardless of age. SFHP will

coordinate the services with your participating dental plan.

Exclusions Services of dentists or oral surgeons are excluded for dental procedures.

Professional Services

Cost to You

- \$5-\$10 per office or home visit, except:
- No copayment for hospital inpatient professional services
- No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments
- No copayment if you are 24 months of age or younger
- No copayment for vision or hearing testing, or for hearing aids

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. Professional services include:

- Surgery, assistant surgery, and anesthesia (inpatient or outpatient)
- Inpatient hospital and skilled nursing facility visits
- Professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment
- Home visits when medically necessary
- Eye examinations including eye refractions to determine the need for corrective lenses and dilated retinal eye exams
- Hearing tests, hearing aids and related services including audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid
- Hearing aid(s): Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. There is no charge for visits for fitting, counseling, adjustments, repairs, etc., for a one-

year period following receipt of a covered hearing aid.

Exclusions

- Purchase of batteries or other ancillary equipment, except those covered under 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 or repair of hearing aid after the covered one-year warranty period
- Replacement of a hearing aid more than once in any period of thirty-six months
- Surgically implanted hearing devices
- Yearly exams (pelvic exam, Pap smear, and breast exam) and any other gynecological service from your primary care provider or an OB/GYN provider in our plan (primary care provider approval not required).
- Medically accepted cancer screening tests including, but not limited to breast, prostate, and cervical cancer screening
- Health education services, including education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services.

Limitations The frequency of periodic health examinations will not be increased for reasons which are unrelated to the your medical needs, including your desire for additional physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance

Preventive Health Services

Cost to You No Copayment

Description Periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics; and age appropriate immunizations, including immunizations required for travel, consistent with the most current version of the

Recommended Childhood Immunization Schedule/United States, as adopted by the Advisory Committee on Immunization Practices.

Preventive services also include services for the detection of asymptomatic diseases, including, but not limited to:

- Well-baby care during the first two (2) years of life, including newborn hospital visits, health examinations and other office visits.
- A variety of voluntary family planning services
- Contraceptive services
- Prenatal care
- Vision and hearing testing
- Sexually transmitted disease (STD) testing
- Human Immunodeficiency Virus (HIV) testing
- Cytology examinations on a reasonable periodic basis
- Yearly exams (pelvic exam, Pap smear, and breast exam) and any other gynecological service from your primary care provider or an OB/GYN provider in our plan (provider care provider approval not required)
- Medically accepted cancer screening tests including, but not limited to breast, prostate, and cervical cancer screening
- Health education services, including education regarding personal health behavior and health care, including taking your child to a dentist before the first tooth comes through (before age 2) and recommendations on how to get the most out of your health coverage.

Limitations The frequency of periodic health examinations will not be increased for reasons which are unrelated to the member's medical needs, including a member's desire for additional physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

Diagnostic X-Ray and Laboratory Services

Cost to You No copayment

Description Diagnostic laboratory services, diagnostic imaging and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat and follow-up on your care. Benefit includes other diagnostic services, including, but not limited to:

- Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes

Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (Glycohemoglobin)

Diabetic Care

Cost to You

- \$5-\$10 Copayment per office visit
- Copayments for prescriptions as described in the "Prescription Drug Program" Section below

Description 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, including:

1. Blood glucose monitors and blood glucose testing strips
2. Blood glucose monitors designed to assist the visually impaired
3. Insulin pumps and all related necessary supplies
4. Ketone urine testing strips
5. Lancets and lancet puncture devices
6. Pen delivery systems for the administration of insulin
7. Podiatric services to prevent or treat diabetes-related complications
8. Insulin syringes
9. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
10. Insulin

11. Prescriptive medications for the treatment of diabetes

12. Glucagon

Coverage also includes outpatient self-management training, education, and medical nutrition therapy necessary to enable you to properly use the equipment, supplies, and medications and as prescribed by your SFHP provider.

Prescription Drug Program

Cost to You

- drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.
- No copayment for prescription drugs provided in an inpatient setting
- No copayment for drugs administered in the provider's office or in an outpatient facility setting during your stay at the facility
- No copayment for FDA-approved contraceptive drugs and devices
- \$5-\$10 copayment per prescription for up to 30 day supply for generic drugs.
- \$5-\$15 copayment per prescription for up to 30 day supply for brand name drugs unless there is no generic equivalent or if the use of a brand name drug is medically necessary.
- \$5-\$10 copayment per prescription for up to 90 day supply for maintenance drugs* purchased through a participating pharmacy for generic drugs.
- \$15 copayment per prescription for up to 90 day supply for maintenance drugs* purchased through a participating pharmacy for brand name drugs unless there is no generic equivalent or if the use of a brand name drug is medically necessary, then \$5-\$10 copayment applies. Maintenance drugs are drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

Description Medically necessary drugs when prescribed by a licensed practitioner

acting within the scope of his or her licensure. Includes, but is not limited to:

- Injectable medication, and needles and syringes necessary for the administration of the covered injectable medication
- Insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin
- Blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent, and gestational diabetes
- Disposable devices that are necessary for the administration of covered drugs, such as spacers and inhalers for the administration of aerosol prescription drugs and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes. The term “disposable” includes devices that may be used more than once before disposal
- Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription
- Medically necessary drugs administered while you are a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan-designated pharmacy
- Nutritional supplements and formulas for the treatment of Phenylketonuria (PKU) when they are prescribed for you by your primary care provider or specialist
- Nutritional supplements (called “enteral formula”) if you cannot take any regular, blended, or pureed food by mouth

One cycle or course of treatment of tobacco cessation drugs per benefit year. You must attend tobacco cessation classes or programs in conjunction with the use of tobacco cessation drugs

- All FDA-approved oral and injectable contraceptive drugs
- all prescription contraceptive devices are covered, including internally implanted time-release contraceptives
- Tobacco cessation drugs are covered if a prior authorization request form is submitted with proof of your participation in a tobacco cessation program.

Exclusions

- Drugs or medications prescribed solely for cosmetic purposes
- Patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc., even if prescribed by your provider
- Medicines not requiring a written prescription (except insulin and smoking cessation drugs as previously described)
- Dietary supplements (except for formulas or special food products, to treat phenylketonuria or PKU), appetite suppressants, or any other diet drugs or medications, unless medically necessary for the treatment of morbid obesity
- Experimental or investigational drugs
- Any special foods or diet items
- When a generic equivalent is available for a Brand Name drug, only Generic Drugs are covered unless it is medically necessary to receive the non-generic equivalent. The physician must submit a prior authorization request form explaining why the generic equivalent cannot be used.
- Drugs used for the treatment of sexual or erectile dysfunction, unless one of these drugs is used to treat a condition other than sexual or erectile dysfunction and is medically necessary

Experimental or investigational drugs. If SFHP denies your request for prescription drugs based on a determination that the drug is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to SFHP’s

Grievance and Appeals Process on page 51.

Durable Medical Equipment

Cost to You No copayment

Description

- 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

SFHP or your medical group may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Durable medical equipment includes, but is not limited to:

- Oxygen and oxygen equipment
- Blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes
- Insulin pumps and all related necessary supplies
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
- Apnea monitors
- Podiatric devices to prevent or treat diabetes complications
- Pulmonaides and related supplies
- Nebulizer machines, face masks, tubing, related supplies, spacer devices for metered dose inhalers, and peak flow meters
- Ostomy bags and urinary catheters and supplies

Exclusions

- Comfort or convenience items
- Disposable supplies, except ostomy bags, urinary catheters, and supplies consistent with Medicare coverage guidelines
- Exercise and hygiene equipment

- Experimental or research equipment
- Devices not medical in nature, such as sauna baths and elevators, or modifications to the home or automobile
- Deluxe equipment
- More than one piece of equipment that serves the same function

Orthotics and Prosthetics

Cost to You No copayment

Description Orthotics and prosthetics benefits include original and replacement devices, including, but not limited to:

- Medically necessary replacement prosthetic devices as prescribed by a licensed provider acting within the scope of his or her licensure
- Medically necessary replacement orthotic devices when prescribed by a licensed provider acting within the scope of his or her license
- Initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy
- Therapeutic footwear for diabetics
- Prosthetic devices to restore and achieve symmetry incident to mastectomy

Covered items must be prescribed by a physician, authorized by SFHP, and dispensed by a plan provider. Repairs are provided unless necessitated by misuse or loss. SFHP, at its option, may replace or repair an item.

Exclusion

- Corrective shoes, shoe inserts, and arch supports, except for therapeutic footwear and inserts for individuals with diabetes
- Non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts
- Dental appliances
- Electronic voice-producing machines
- More than one device for the same part of the body

- Eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery)

Cataract Spectacles and Lenses

Cost to You No copayment

Description Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Benefits also include one pair of conventional eyeglasses or conventional contact lenses, if necessary, after cataract surgery with insertion of an intraocular lens.

Maternity Care

Cost to You No copayment

Description Medically necessary professional and hospital services relating to maternity care are covered including:

- Prenatal and postpartum care, including complications of pregnancy
- Newborn examinations and nursery care while the mother is hospitalized
- Newborn examinations and nursery care within the first 30 days after birth. Newborns are covered under the mother's membership for the first 30 days of life. After 30 days, the newborn must be separately enrolled to be covered by SFHP.
- Coverage includes participation in the statewide prenatal testing program administered by the California Department of Public Health known as the Expanded Alpha Feto Protein Program
- Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy
- Counseling for nutrition, health education and social support needs
- Labor and delivery care, including midwifery services

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 the SFHP. You do not need specific authorization to stay in the hospital 48 hours after a vaginal delivery or 96 hours

after a C-section and you may remain in the hospital for these time periods unless you and your provider decide otherwise. If, after consulting with you, your provider decides to discharge you before the 48- or 96-hour time period, SFHP will cover a post-discharge follow-up visit within 48 hours of discharge when prescribed by your provider. The visit includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The provider and you will decide whether the post-discharge visit will occur in the home, at the hospital, or at the provider's office depending on the best solution for you.

Family Planning Services

Cost to You No copayment

Description Voluntary family planning services are covered, including:

- Counseling and surgical procedures for sterilization, as permitted by state and federal law
- Diaphragms
- Coverage for other federal Food and Drug Administration approved devices pursuant to the prescription drug benefit
- Voluntary Termination of Pregnancy

Note: Some hospitals and other providers do not provide one or more of the following services: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. Call your prospective provider, medical group, independent practice association, clinic, or SFHP at **415-547-7830 (TDD/TTY)** for the hearing impaired at **1-888-883-7347** to ensure that you can obtain the health care services that you need.

Medical Transportation Services

Cost to You No copayment

Description Emergency ambulance transportation to the first hospital which actually accepts you for emergency care is covered in connection with emergency services. Benefit includes ambulance and ambulance transport services provided through the "911" emergency response system. Also includes, non-emergency transportation for your transfer from a

hospital to another hospital or facility, or facility to home when the transportation is:

- Medically necessary, and
- Requested by a Plan provider, and
- Authorized in advance by SFHP.
- **Exclusion** Coverage for public transportation including transportation by airplane, passenger car, taxi, or other forms of public conveyance.

Emergency Health Care Services

Cost to You

- \$5-\$15 per visit. Copayment will be waived if you are admitted to the hospital.

Description Twenty-four hour care is covered for an emergency medical condition. An emergency medical condition is a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing your health in serious jeopardy, or
- Causing serious impairment to your bodily functions, or Causing serious dysfunction of any of your bodily organs or parts.

Coverage is provided both inside and outside of SFHP's service area, and in participating and non-participating facilities.

Mental Health Care (Provided by Community Behavioral Health Services, SFHP's Mental Health Services provider).

Diagnosis and treatment of a mental health condition. If you think your child may have a mental health condition, San Francisco Health Plan will give you information on how to get services for your child. Call SFHP's Customer Service Department at **(415) 547-7800** to get information on how to get services for your child.

Inpatient Mental Health Care Services

Cost to Member No copayment

Description Mental health care in a participating hospital when ordered and performed by a participating mental health professional.

This includes, but is not limited to inpatient mental health care services for the treatment of Severe Mental Illnesses (SMI). Examples of SMI include, but are not limited to:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa

Serious Emotional Disturbance (SED)

Inpatient mental health care services for the treatment of a member determined by the county to have a SED condition.

The plan will provide all medically necessary covered services until the county mental health department establishes eligibility for a subscriber child while SED and the county mental health department provides the medically necessary services to treat the SED.

The plan and the county mental health department will coordinate services to ensure that medically necessary services and treatment are provided to a member with SED.

The member will remain enrolled in the Healthy Families Program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED from the Plan. For more information about SED diagnosis and treatment benefits, see "Coordination of Services on page 34.

Outpatient Mental Health Care Services

Cost to Member

\$5-\$10 per visit (not applicable to SED)

Description

Mental health care services when ordered and performed on an outpatient basis by a participating Plan mental health provider.

Mental Health Care

- Includes, but is not limited to, treatment for members who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, divorce, or bereavement.
- Involvement of family members in the treatment to the extent the provider determines it is appropriate for the health and recovery of the member.
- This includes, but not limited to outpatient mental health care services for the treatment of Severe Mental Illnesses (SMI). Examples of SMI include, but are not limited to:
 - Schizophrenia
 - Schizoaffective disorder
 - Bipolar disorder (manic-depressive illness)
 - Major depressive disorders
 - Panic disorder
 - Obsessive-compulsive disorder
 - Pervasive developmental disorder or autism
 - Anorexia nervosa
 - Bulimia nervosa

Serious Emotional Disturbance (SED)

Outpatient mental health care visits for the treatment of a member determined by the county to have SED. For members with a Serious Emotional Disturbance (SED), outpatient and related professional services pertaining to the SED may be provided by the county mental health department. The plan may refer the member to the county mental health department for treatment of SED. The plan shall provide all medically necessary covered services until the county mental health department establishes eligibility for a subscriber child with SED and the county mental health department provides the medically necessary services

to treat the SED. The Plan and the county mental health department will coordinate services to ensure that medically necessary services and treatment are provided to a member with SED.

The member will remain enrolled in the Healthy Families Program and will continue to receive primary care, specialty care, and all other covered services for medical conditions not related to SED from the Plan. For more information about SED diagnosis and treatment benefits, see "Coordination of Services" on page 33.

Substance Abuse Treatment (Provided by Community Behavioral Health Services, SFHP's Mental Health Services provider).

Diagnosis and treatment of a substance abuse condition. If you think your child may have a substance abuse condition, SFHP will give you information on how to get services for your child. Call SFHP's Customer Service Department at (415) 547-7800 to get information on how to get services for your child.

Inpatient Alcohol/Drug Abuse Treatment

Exception Outpatient mental health care days for the treatment of severe mental illnesses (SMI) are not limited.

Cost to You No copayment

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

Outpatient Alcohol/Drug Abuse Treatment

Cost to You \$5-\$10 per visit

Description Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically necessary.

Home Health Care Services

Cost to You No copayment, except for \$5-\$10 per visit for physical, occupational, and speech therapy performed in the home.

Description Health services provided at home by health care personnel. Benefit includes:

- Visits by RNs, LVNs, and home health aides

- Physical therapy, occupational therapy, and speech therapy
- Respiratory therapy when prescribed by a licensed plan provider acting within the scope of his or her licensure

Limitations

- Home health care services are limited to those services that are prescribed or directed by your primary care provider or another appropriate authority designated by SFHP

If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of your primary care provider or other appropriate authority

designated by SFHP to choose the setting for providing the care. SFHP will exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting

Exclusion

Custodial care

Skilled Nursing Care

Cost to You No copayment

Description Medically necessary services prescribed by a plan provider and provided in a licensed skilled nursing facility. Benefit includes:

- Skilled nursing on a 24-hour per day basis
- Bed and board
- X-ray and laboratory procedures
- Respiratory therapy
- Physical, speech, and occupational therapy
- Medical social services
- Prescribed drugs and medications
- Medical supplies
- Appliances and equipment ordinarily furnished by the skilled nursing facility

Limitation This benefit is limited to a maximum of one hundred (100) days per benefit year

Exclusion

Custodial care

Physical, Occupational, and Speech Therapy

Cost to You No copayment for inpatient therapy, including services received in a skilled nursing facility \$5-\$10 per visit when performed in the home or other outpatient setting

Description Therapy must be medically necessary. Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home. SFHP may require periodic evaluations as long as therapy is provided.

Acupuncture

Cost to You \$5-10 per visit

Description Acupuncture services do not require a referral from your primary care provider or other health care provider. Services must be obtained from a participating provider.

Limitation Treatment is limited to a maximum of twenty (20) visits per benefit year

Chiropractic Services

Cost to You \$5-\$10 per visit

Description Chiropractic services do not require a referral from your primary care provider or other health care provider. Services must be obtained from a participating provider.

Limitation Treatment is limited to a maximum of twenty (20) visits per benefit year

Blood and Blood Products

Cost to You No copayment

Description Benefit includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Also includes the collection and storage of autologous blood when medically indicated.

Health Education

Cost to You No copayment

Description Benefit includes health education services, including education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services

provided by the plan or health care organizations affiliated with the plan.

Hospice

Cost to You No copayment

Description The hospice benefit is provided to you if you are diagnosed with a terminal illness with a life expectancy of twelve months or less and if you elect hospice care for such illness instead of the traditional services covered by the plan. The hospice benefit includes:

- Nursing care
- Medical social services
- Home health aide services
- Physician services, drugs, medical supplies and appliances
- Counseling and bereavement services
- Physical, occupational, and speech therapy
- Short-term inpatient care
- Pain control and symptom management

Homemaker services, services of volunteers, and short-term inpatient respite care

The hospice election may be revoked at any time

Limitation If you elect hospice care you are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect.

Organ Transplants

Cost to You No copayment

Description Benefits include coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational. The benefit includes payment for:

- Medically necessary 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 you
- Testing your relatives for matching bone marrow transplants
- Searching for and testing unrelated bone marrow donors through a recognized Donor Registry

- Charges associated with procuring donor organs through a recognized Donor Transplant Bank are covered if the expenses are directly related to your anticipated transplant

These services may be covered and paid for by the California Children's Services (CCS) program, instead of by SFHP, if you are found to be eligible for CCS services. SFHP will coordinate these services with CCS for you. For more information about the CCS program, see "Linkages to other benefit programs" on page 33.

If SFHP denies your organ transplant request based on a determination that the service is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to SFHP's Grievance and Appeals Process on page 51.

Reconstructive Surgery

Cost to You No copayment

Description Medically necessary reconstructive surgical services 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 to the extent possible. This benefit includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

This includes medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures or services. Cleft Palate treatment may be provided by the California Children's Services (CCS) program upon referral by the Plan and coordination with the local CCS program. However, the plan is ultimately responsible for providing services if the child is not eligible for CCS or if CCS services are not authorized or provided by the CCS program. Please read page 33 of this booklet for more information on the CCS program.

Phenylketonuria (PKU)

Cost to You No-Copayment

Description Testing and treatment of PKU, including those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with

a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the plan, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

Clinical Cancer Trials

Cost to You \$5-\$10 copayment per office visit

Copayments for prescriptions as described in the "Prescription Drug Program" Section

Description Coverage for your participation in a cancer clinical trial, phase I through IV, when your physician has recommended participation in the trial, and you meet the following requirements:

- You must be diagnosed with cancer
- You must be accepted into a phase I, phase II, Phase III, or phase IV clinical trial for cancer
- Your treating physician, who is providing covered services, must recommend participation in the clinical trial after determining that participation will have a meaningful potential to you, and
- The trial must meet the following requirements:
 1. Trials must have a therapeutic intent with documentation provided by the treating physician, and
 2. Treatment provided must be approved by one of the following: 1) the National Institute of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs, or 2) involve a drug that is exempt under the federal regulations from a new drug application.

Benefits include the payment of costs associated with the provision of routine patient care, including drugs, items, devices and services that would otherwise be covered if they were not provided in connection with an approved clinical trial program. Routine patient costs for cancer clinical trials include:

- Health care services required for the provision of the investigational drug, item, device or service
- Health care services required for the clinically appropriate monitoring of the investigational drug, item, device, or service
- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis or treatment of complications

Exclusions

- Provision of non-FDA-approved drugs or devices that are the subject of the trial
- Services other than health care services, such as travel, housing, and other non-clinical expenses that you may incur due to participation in the trial
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient
- Health care services that are otherwise not a benefit (other than those excluded on the basis that they are investigational or experimental)
- Health care services that are customarily provided by the research sponsors free of charge for any enrollee in the trial

Coverage for clinical trials may be restricted to participating hospitals and physicians in California, unless the protocol for the trial is not provided in California

Annual or Lifetime Benefit Maximums

There shall be no annual or lifetime financial benefit maximums in any of the coverage under the program.

Excluded Benefits

The following health benefits are excluded under the Health Plan:

1. Any services or items specifically excluded in the Benefits Description section.

2. Any benefits in excess of limits specified in the Benefits Description section.
3. Services, supplies, items, procedures, or equipment which are not medically necessary, unless otherwise specified in the Benefits Description section.
4. And services which were received prior to your effective date of coverage. This exclusion does not apply to covered services to treat complications arising from services received prior to your effective date.
5. Any services which are received subsequent to the time coverage ends.
6. Experimental or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards or for which the safety and efficacy have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed.
7. Medical services that are received in an emergency care setting for conditions that are not emergencies if you reasonably should have known that an emergency care situation did not exist.
8. Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery which are covered under the "Cataract Spectacles and Lenses" benefit.
9. The diagnosis and treatment of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.
10. Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except when SFHP determines they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to "Skilled Nursing Care" and "Hospice" benefits.
11. Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any worker's compensation benefit plan. SFHP shall provide services at the time of need, and you or your legal guardian shall cooperate to assure that SFHP is reimbursed for such benefits.
12. Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. SFHP shall provide services at the time of need, and you or your legal guardian will cooperate to assure that SFHP is reimbursed for such benefits.
13. Cosmetic surgery that is solely performed to alter or reshape normal structure of the body in order to improve appearance.
14. Biofeedback

C. Your Liabilities and Other Charges

For non-preventive services, you are responsible for paying a minimum charge (co-payment) to the physician or provider of services at the time services are received. The specific co-payments are listed in the Summary of Benefits section of this Handbook. The maximum aggregate co-payment per benefit year is \$250 per family or household, no matter how many children are enrolled in the Healthy Families Program. You should ask for a receipt whenever a co-payment is made and keep the receipt and a record of all payments so that they can demonstrate that the maximum has been paid if this occurs during the year of membership. When the limit is reached, you should contact Member Services at **415-547-7800** (local) or **1-800-288-5555** to get a "no co-pay" card. Present this card at each visit to your provider's office or pharmacist to provide proof that the maximum co-payment has been met.

There are no deductibles under the program and there are no lifetime financial benefit maximums for any of the covered health benefits.

D. Claims Reimbursement for Emergency Services

If emergency service were received and expenses were incurred by you for such services, you should submit a complete claim with the service record for payment to the medical group identified on the member's ID card within 90 days after the date of the services for which payment is requested, or as soon as possible. If emergency mental health services were received and expenses incurred by you for such services, you should submit a complete claim with the service record for payment to SFHP within 90 days after the date of services for which payment is requested. If the services are not previously authorized, SFHP will review the claim retrospectively for coverage as set forth on p. 33. SFHP will cover services as medically necessary, or where you reasonably believed that an emergency medical condition existed, even if it is determined later that an emergency did not in fact exist. In the event that SFHP determines that emergency services obtained by you are covered, SFHP will pay the physicians directly or reimburse you if the services have been paid for by you.

Member Liabilities

Generally, the only amount a member pays for covered services is the required copayment.

You may have to pay for services you receive that are NOT covered services, such as:

Non-emergency services received in the emergency room;

Non-emergency or non-urgent services received outside of San Francisco Health Plan's service area if you did not get authorization from San Francisco Health Plan before receiving such services;

Specialty services you receive if you did not get a required referral or authorization from San Francisco Health Plan before receiving such services. (see page 30, section C. Referral to Specialists)

Services from a non-participating provider, unless the services are for situations

allowed in this Evidence of Coverage booklet, for example, emergency services, urgent services outside of San Francisco Health Plan's service area, or specialty services approved by San Francisco Health Plan (see page 21, section 1. About San Francisco Health Plan (SFHP))

Services you received that are greater than the limits described in this Evidence of Coverage booklet unless the services were authorized by San Francisco Health Plan.

San Francisco Health Plan is responsible to pay for all covered services including emergency services. You are not responsible to pay a provider for any amount owed by the health plan for any covered service.

If San Francisco Health Plan does not pay a non-participating provider for covered services, you do not have to pay the non-participating provider for the cost of the covered services. Covered services are those services that are provided according to this Evidence of Coverage booklet. The non-participating provider must bill San Francisco Health Plan, not you, for any covered service. But remember, services from a non-participating provider are not "covered services" unless they fall within the situations allowed by this Evidence of Coverage booklet.

If you receive a bill for a covered service from any provider, whether participating or non-participating, contact the San Francisco Health Plan Member Services department at (415) 547-7800 or (800) 255-8888.

E. Benefit Program Changes

Benefits, exclusions, and limitations are subject to change, cancellation, or discontinuance at any time either by the Healthy Families Program or by SFHP, following at least thirty-one (31) days' written notice by SFHP to you. Benefits for services or supplies furnished after the effective date of any such change or cancellation will be provided based on the change. There is no vested right to any benefits, even if the provision of the benefits commenced prior to the effective date of the change. Benefits for services or supplies furnished after the effective date of any benefit modification, limitation, exclusion, or

cancellation shall be provided based on that modification, exclusion, or cancellation.

8. Exclusions and Limitations (Non-Covered Services)

General Exclusions and Limitations

Services are covered benefits only if obtained in accordance with the procedures described in this document, including all authorization requirements and referral and coordination by your primary care provider.

Note: No service is covered unless it is medically necessary or specified as covered in the Healthy Families Program regulations. The fact that a physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically necessary, even though it is not specifically listed as an exclusion or limitation. SFHP excludes from coverage all services that are not medically necessary.

9. Duplicating Coverage and Third Party Liability

A. Coordination of Benefits

If you are also entitled to benefits under any of the conditions listed below, SFHP's liability for benefits shall be reduced by the amount of benefits paid, or the reasonable value of the services provided without any cost to you, because he or she is entitled to these other benefits. The Plan shall provide the benefits at the time of need, and you shall cooperate with the Plan to ensure that the Plan is reimbursed for such benefits provided. This coordination of benefits provision is applicable to benefits received from any of the following sources:

- Benefits to which you are entitled from any other insurer, health care service plan, or union health care trust fund, including coverage under workers' compensation.
- Benefits provided by any other federal or state government agency, including CCS, or by any county or other political subdivisions, including services provided at a Veterans' Administration facility for a condition related to military service or at a Department of Defense

facility, provided the person is not on active duty.

- Benefits provided free of charge or without expectation of payment.

Benefits provided under a Workers' Compensation claim, including any injury arising out of, or in the course of any employment for salary, wage or profit, or any disease covered, with respect to such employment, by any workers' compensation law, occupational disease law or similar legislation. SFHP will pay for such services at the time of need, and you or applicant shall cooperate to ensure that the Plan is reimbursed for such benefits provided. Also, SFHP may recover the cash value of its benefits (up to and not to exceed the amount actually paid by the Plan) from you to the extent that such benefits have been covered or paid for as Workers' Compensation benefits.

B. Other Health Insurance

It is to your advantage to let your network provider know if you have medical coverage in addition to this program. Most carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both programs.

Coverage provided under this program is secondary to all other coverage, except Medi-Cal. Benefits paid under this program are determined after benefits have been paid as a result of your enrollment in any other health care program.

Be sure to advise your provider of all programs under which you have coverage so that you will receive all benefits to which you are entitled. For further information, contact SFHP's Member Service department.

C. Third Party Recovery Process and Your Responsibilities

You agree that, if benefits of this Agreement are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, provided that you are made whole for all other damages resulting from the wrongful act or omission before SFHP is entitled to reimbursement, you shall:

- Reimburse SFHP for the reasonable cost of services paid by SFHP to the extent permitted by California Civil Code section 3040 immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
- Fully cooperate with SFHP's effectuation of its lien rights for the reasonable value of services provided by the SFHP to the extent permitted under California Civil Code section 3040. SFHP's lien may be filed with the person whose act caused the injuries, his or her agent or the court.

SFHP shall be entitled to payment, reimbursement, and subrogation in third party recoveries and you shall cooperate to fully and completely effectuate and protect the rights of SFHP including prompt notification of a case involving possible recovery from a third party.

D. Non-Duplication of Benefits with Workers' Compensation

If, pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of medical services provided by SFHP, we will provide the benefits of this Agreement at the time of need. You will agree to provide SFHP with a lien on such Workers' Compensation medical benefits to the extent of the reasonable value of the services provided by the SFHP. The lien may be filed with the responsible third party, his or her agent, or the court.

For purposes of this subsection, reasonable value will be determined to be the usual, customary, or reasonable charge for services in the geographic area where the services are rendered

By accepting coverage under this Agreement, you agree to cooperate in protecting the interest of SFHP under this provision and to execute and to deliver to SFHP or its nominee any and all assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of SFHP or its nominee.

E. Reimbursement Provisions – If You Receive a Bill

Notify SFHP as soon as possible if you are billed inappropriately or if you have any questions or complaints.

F. Organ and Tissue Donation

Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities. The Department of Health and Human Services' Internet website (<http://www.organdonor.gov>) has additional information on donating your organs and tissues. You can also call **1-800-355-SHARE** (7427) to get a donor card and to obtain more information about organ donation.

10. Benefit Changes, Termination, and Cancellation

A. Benefit Changes

Notification of changes in the benefits offered under this Program will be provided to you as required by the Healthy Families Program.

B. Individual's Right of Cancellation

Healthy Families Program members can cancel at any time, with 31 days' written notice.

C. Renewal Provisions

Please refer to the Healthy Families Program Handbook, which is provided to you by the State of California Healthy Families Program.

D. Termination of Benefits

Please refer to the Healthy Families Program Handbook, which is provided to you by the State of California Healthy Families Program.

11. Grievance and Appeal Procedures

A. Grievance Process

Filing a Grievance or appeal is your right and is a confidential process. SFHP cannot discriminate against you or dis-enroll you from the Plan, if you choose to file a grievance or appeal. In addition, your provider cannot withhold or terminate medical care because you have filed a grievance.

You are encouraged to bring grievances to the attention of your provider's office staff first in order to resolve the issue directly. If this approach fails to resolve the problem, or if you wish to immediately file a grievance, please notify SFHP as soon as possible. SFHP may be able to resolve your problem or answer your questions informally at that time or shortly thereafter. You can also ask for a copy of the complete Grievance Procedure. Please contact Member Services and a copy will be sent to you

You can ask someone who is not an employee of the Plan to act as your advocate. An advocate can help you file your grievance or appeal and can, if you wish, speak for you during the grievance process. Please call Member Services for more information at **415-547-7800** (local) or **1-800-288-5555**.

Please note: All health plan enrollees have the right to file a complaint with the Department of Managed Health Care at any time before, during or after the grievance or appeal process. If you want more information about the Department of Managed Health Care, please go to the section called "Independent Medical Review of Grievances Involving a Disputed Health Care Service" on page 52.

B. Filing a Grievance

You can file a grievance about the provision of health services or benefits by:

- Phone: Call Member Services at **415-547-7800** (local) or **1-800-288-5555**, or

- In person at San Francisco Health Plan:

201 Third Street, 7th floor

San Francisco, CA 94103

- US mail: You may make a written complaint to SFHP, 201, Third Street, 7th Floor, San Francisco, CA 94103.
- Internet: You can also submit a grievance through the SFHP's website at **www.SFHP.org**.

Grievance forms and grievance procedures can be obtained from SFHP, your provider's office, your provider's medical group, or from SFHP's website at www.SFHP.org.

C. Grievance Process

When you or your representative files a grievance this is what happens:

Step 1: You file your grievance over the telephone, in writing, via the website or in person. Grievance forms and grievance procedures can be obtained from SFHP, your provider's office, your provider's medical group, or from SFHP's website at www.SFHP.org. Member Services will be available to help you with your grievance if you wish.

Step 2: SFHP will send you a letter within five calendar days to confirm receipt of your grievance. The letter will also give you information about the grievance procedure and about your rights as an SFHP member.

Step 3: SFHP will send a letter to you with our proposed resolution within 30 days of the complaint or grievance. If you haven't received a letter from us within 30 days or if you do not accept the resolution we propose, you can immediately contact the Department of Managed Health Care at **1-888-HMO-2219**, and a TDD line **1-877-688-9891**. If the grievance involves SFHP's decision to deny or modify a request for a health care service based on medical necessity, the SFHP Medical Director will review the case and forward to an external medical consultant for a second opinion.

If, for some reason, your mail is returned as undeliverable and SFHP cannot reach you by telephone, SFHP will continue to work on your grievance until you contact SFHP. If we do not hear from you, the grievance will be closed after 6 months from the date the grievance was filed.

Any suggestion you might have to resolve your problem is welcome at any time during the grievance or appeal process.

SFHP must complete the entire grievance process for you within 30 days. If we have not resolved your grievance after 30 days (no matter what level of the process you are at), you may immediately contact the Department of Managed Health Care at **1-888-HMO-2219**, or a TDD line **1-877-688-9891**.

D. Expedited Medical Review and Appeals

You can ask that the Plan review your grievance or appeal within 72 hours when you have an Urgent Grievance. An Urgent Grievance is when a delay in getting medical care would pose an imminent and serious threat to your health including, but not limited to loss of life or limb, major bodily function or severe pain.

To initiate an Urgent Grievance, call SFHP at **1-800-288-5555** or **(415) 547-7800** and tell them that you wish to file an Urgent Grievance. SFHP will immediately notify you of your right to contact the DMHC and that you do not have to participate in SFHP's grievance process before you contact the DMHC for help.

When you file an Urgent Grievance with SFHP, we will issue a decision within 72 hours.

E. Disability Access Grievances

If you believe the Plan or its physicians have failed to respond to your disability access needs, you may file a grievance with the Plan. If your disability access complaint remains unresolved, you may contact the ADA Coordinator at the California Managed Risk Medical Insurance Board in Sacramento. See the Americans with Disabilities Act Compliance Statement on p.21 for how to contact the Board.

F. Member Cooperation with the Grievance Process

In order for SFHP to consider your grievance as quickly as possible, you may be asked to provide information or to permit the release of medical records. SFHP asks that you respond to these requests as quickly as possible.

G. Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review (IMR) of disputed health care services from the Department of Managed Health Care (DMHC), if you believe that health care services have been improperly denied, modified, or delayed by SFHP or your medical group. You may apply for IMR within six months of any of the qualifying events described below. Your decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the Plan regarding the health care services at issue.

The IMR process is in addition to any other procedures or remedies that are available, such as filing a grievance or an appeal. The IMR process is free. You have the right to provide any information you have to support your request for an IMR. SFHP or your medical group must provide you with an IMR application form along with any grievance disposition letter that denies, modifies, or delays health care services.

If you submit an IMR application to the DMHC it will be reviewed to confirm that:

(1) Your physician has recommended a health care service as medically necessary, or you have received urgent care or emergency service that a provider determined was medically necessary, or you have been seen by a physician for the diagnosis or treatment of the medical condition for which you seek an IMR;

(2) The disputed health care service has been denied, modified, or delayed by SFHP or your medical group, based in whole or in part on a decision that the health care service is not medically necessary; and you have filed a grievance with SFHP or your medical group and the disputed decision is upheld or the grievance remains unresolved

after 30 days. If your grievance requires expedited review you are not required to file a grievance with SFHP prior to requesting an IMR. The DMHC may waive the requirement that you follow SFHP's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, SFHP or your medical group will provide the health care services.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within 30 days of receipt of your application and supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within 3 business days.

For more information regarding the IMR process, or to request an application for, please call Member Services at **415-547-7800** (local) or **1-800-288-5555**.

H. Experimental/Investigational IMRs

If your provider has recommended a drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, or if you or your provider request a therapy that they believe, based upon appropriate documentation, is likely to be more beneficial to you than any available standard therapy, then you can apply for an Experimental/Investigational IMR.

If your provider determines that the proposed Experimental/ Investigational therapy would be significantly less effective if not promptly initiated, then a determination of your review will be rendered within seven (7) days of the request for the expedited IMR.

We will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an experimental/investigational therapy within five (5) business days of the decision to deny coverage.

You do not have to participate in SFHP's grievance process before contacting the DMHC for an Experimental/Investigational IMR. You may contact the DMHC immediately to apply for the IMR and SFHP will assist you with this process.

I. Complaints to the Department of Managed Health Care

The California Department of Managed Health Care requires that we advise you of the following:

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against San Francisco Health Plan, you should first telephone Member Services at 1-415-547-7800 (local) or 1-800-288-5555 or the TDD number at 1-888-883-7347 and use SFHP's grievance process before contacting the DMHC. Using this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by SFHP, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by SFHP related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The DMHC also has a toll-free telephone number 1-888-466-2219, and a TDD line 1-877-688-9891 for the hearing and speech impaired. The DMHC Internet Web site (<http://www.hmohelp.ca.gov>) has

complaint forms, IMR application forms and instructions online.

J. Arbitration of Disputes

If there is any dispute or disagreement between you and SFHP (other than a claim of medical malpractice) that exceeds the jurisdiction of Small Claims Court, you and the Plan shall settle the dispute by final and binding arbitration. The arbitration shall take place in San Francisco, California. You shall request arbitration by written notice to the Plan within the same time limits provided by California law if you were to file a civil lawsuit regarding the same matter.

If the total amount of damages claimed by you is \$200,000 or less, the dispute shall be resolved by a single arbitrator selected by the parties within thirty days of the date the Plan receives yours request for arbitration, or if the parties can not agree on a single arbitrator, then selected by the method provided in Section 1281.6 of the California Code of Civil Procedure. Such arbitrator shall have no jurisdiction to award more than \$200,000.

If the amount of damages claimed by you exceeds \$200,000, the within thirty (30) calendar days of the date the Plan receives your request for arbitration, you and the Plan shall attempt to agree upon a single arbitrator. If the parties can not agree upon a single arbitrator within this fifteen day period, then one arbitrator will be named by SFHP and one arbitrator shall be named by you, and a third neutral arbitrator will be named by the arbitrators within thirty (30) calendar days of your request for arbitration. If the two arbitrators cannot agree on a neutral arbitrator, or if for any other reason a neutral arbitrator is not selected within thirty days of your request for arbitration, the method set forth in Section 1281.6 of the California Code of Civil Procedure may be used by either party to select the neutral arbitrator.

Except as otherwise described in this section, "Arbitration of Disputes," the arbitration provisions set forth in Title 11 of Part 3 of the California Code of Civil Procedure, including Section 1283.05 thereof permitting expanded discovery proceedings, shall be applicable to all disputes or controversies which are arbitrated between you and SFHP.

The decision and award of the arbitrator shall be rendered as soon as possible after the hearing and submission of the matter by the parties, but not longer than thirty (30) calendar days thereafter. The decision shall be in writing, shall indicate the prevailing party, the amount of any award, other relevant terms of any award, and the reasons for any award rendered. Judgment upon the award rendered by the arbitrators may be entered by either party in any court having jurisdiction thereof. The arbitrators shall have no authority to award punitive or exemplary damages. Each party shall be solely responsible for his/her/its own attorneys' fees and costs.

The costs of the neutral arbitrator shall be shared equally by you and SFHP, provided that in the case of extreme hardship, the Plan shall be responsible for all costs of the neutral arbitrator. An application for you to request that the Plan be responsible for all costs for of the neutral arbitrator may be obtained from Member Services. If SFHP does not agree to be responsible for all costs of the neutral arbitrator when an application for such relief is made by you, such determination shall be made by the neutral arbitrator.

It is understood that the parties are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. This requirement does not waive your right to a jury trial for claims of medical malpractice.

12. Other Provisions

A. Public Policy Participation

SFHP is a publicly sponsored health plan. Meetings of its Governing Board are open to the public. The Plan has established a Member Advisory Committee (MAC) to advise its Governing Board on policy decisions. Two members of this committee also are members of the Governing Board and one is a member of the SFHP Quality Improvement Committee. In conformance with Health and Safety Code, Section 1369, SFHP encourages you to participate in the establishment of its policies related to acts performed by SFHP (and its employees and staff) to assure the comfort, dignity and convenience of patients who rely on the Plan's facilities to provide health care

services to them, their families and the public. The names of the members of the Member Advisory Committee and of the Governing Board may be obtained by calling Member Services at **415-547-7800** (local) or **1-800-288-5555**. If you are interested in participation in the future, please contact Member Services.

B. Non-Assignability

Benefits of SFHP are not assignable without the written consent of SFHP.

C. Independent Contractors

SFHP physicians are neither agents nor employees of SFHP but are independent contractors. Physicians may be independent contractors to the medical group with which SFHP contracts. In no instance shall SFHP be liable for negligence or wrongful acts or omissions of any person who provides services to you, including any physician, hospital or other provider or their employees.

D. Continuity of Care Continuity Of Care By A Terminated Provider

If you are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), terminal illness, or who are children from birth to 36 months of age or who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment can request continuation of covered services in certain situations with a provider who is terminated. Contact Member Services to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Continuity Of Care For New Members By Non-Contracting Providers

If you are a newly covered member who is being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), terminal illness, or who is children from birth to 36 months of age or who has received authorization from a provider for surgery or

another procedure as part of a documented course of treatment can request continuation of covered services in certain situations with a non-contracting provider who was providing services to you at the time your coverage became effective under this Plan. Contact Member Services to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a non-contracting provider.

Call Member Services at 415-547-7800 (local) or 1-800-288-5555, for more information.

E. Payment of Providers

SFHP pays some of its contracted medical groups and some of its contracted hospitals by a method called capitation. Under this method, each medical group and each hospital is paid a fixed monthly fee for the members assigned to that medical group and to that hospital. In return, each medical group and hospital assumes risk for the cost of the health care services that are covered by its contract with SFHP for the assigned members.

SFHP pays some of its other providers by a method called fee for service. This means that the providers get paid for the services that they provide to you. Under some agreements, the Plan requires that the providers who are paid fee for service only receive a sum of money that is equal to what they would be paid under capitation. If the providers exceed this amount, they must pay the Plan back. If the providers do not get paid at least what they would receive under capitation, then the Plan will pay the providers an extra amount to equal the capitation amount.

Hospitals may enter into incentive arrangements with affiliated medical groups. Under such incentive arrangements, the hospital and medical group may share in the cost of hospital services and the medical group may receive a bonus if the cost of such services is below a fixed amount. Call SFHP at **415-547-7800** (local) or **1-800-288-5555**, your primary care provider, or your medical group, for more information on payment of providers.

F. Confidentiality of Medical Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

San Francisco Health Plan (SFHP) is required by law to safeguard privacy of your health information. We are also required to let you know of our privacy practices regarding your protected health information (PHI).

SFHP may use your health information to pay for your health care, to allow your doctor to provide treatment to you or for other SFHP operations. You have the right to request a complete description of our policies describing how we use your information. You also have the right to see your medical record or to request a restriction on how we use or disclose your health information, except for purposes of treatment, payment or SFHP operations. Contact the SFHP Privacy Officer to file a complaint about the Plan's use of your health information, or to request a copy of our privacy policies.

San Francisco Health Plan and its physicians are prohibited from intentionally sharing, selling, using or disclosing any medical information unrelated to a patient's health care without the patient's authorization, unless the disclosure is legally compelled. Every SFHP physician handling medical records must preserve patient confidentiality.

For a complete description of your rights to confidential medical records, including your rights of access to your own medical records or for a copy of our Privacy Practices, you can contact San Francisco Health Plan at **(415) 547-7800** or **1-800-288-5555** and we will send you a copy of our Notice of Privacy Practices.

G. Benefit Program Participation

SFHP shall have the power and discretionary authority to construe and interpret the provisions of the health plan contract and the Evidence of Coverage and to determine the benefits of SFHP. SFHP shall exercise this authority for the benefit of all persons entitled to receive benefits under the contract and Evidence of Coverage.

Governing Law

SFHP's Healthy Families Program coverage is subject to the requirements of the California Knox-Keene Act, Chapter 2.2 of Division 2 of the California Health and Safety Code, and the regulations set forth at Subchapters 5.5 and 5.8 of Chapter 3 of Title 10 of the California Administrative Code. Any provision required to be in this benefit program by either the Knox-Keene Act or the regulations shall be binding on SFHP, even if it is not included in this Evidence of Coverage or the health plan contract.

H. Natural Disasters, Interruptions, and Limitations

In the event of a natural disaster or other unforeseeable circumstance which are beyond SFHP's reasonable control, it may be impossible for SFHP to provide services to you. Examples of reasons beyond SFHP's control include natural disaster, war, riot, labor and or dispute involving a SFHP or other health professional, civil insurrection, or epidemic. In the event of a natural disaster, you should proceed to the nearest emergency room if you believe you have an emergency medical condition. SFHP will reimburse you for the services received.

