



**SAN FRANCISCO  
HEALTH PLAN™**

*Here for you*

# San Francisco Health Plan

Combined Evidence of Coverage and  
Disclosure Form

**December 1, 2009 to June 30, 2010**

**HEALTHY KIDS** ♥

## Healthy Kids Program Changes

Effective December 1, 2009

**The Healthy Kids Program has increased copayments for applicable covered services for members who are in Income Categories B & C.** This copayment increase does not apply to members in Income Category A. Please refer to the Definitions Section, page 29 of this EOC/DF booklet to read more about the Healthy Kids Program Income Categories.

On the chart below, locate your family size and net income (gross income minus program deductions) column to find your income category, A, B or C. If your monthly income is below Category A, your children may be eligible for free coverage through the Medi-Cal Program. **This chart is just a guide, SFHP will help you review your deductions and find the income category for your family.**

### Healthy Kids Program Income Categories A, B, and C\* Effective April 1, 2009 through March 31, 2010

Family Size	Category A Monthly Income	Category B Monthly Income	Category C Monthly Income
<b>1</b>	\$904 - \$1355	\$1,355.01 - \$1,805	\$1,805.01 - \$2,257
<b>2</b>	\$1,216 - \$1,822	\$1,822.01 - \$2,429	\$2,429.01 - \$3,036
<b>3</b>	\$1,527 - \$2,290	\$2,290.01 - \$3,052	\$3,052.01 - \$3,815
<b>4</b>	\$1,839 - \$2,757	\$2,757.01 - \$3,675	\$3,675.01 - \$4,594
<b>5</b>	\$2,151 - \$3,225	\$3,225.01 - \$4,299	\$4,299.01 - \$5,373
<b>6</b>	\$2,462 - \$3,692	\$3,692.01 - \$4,922	\$4,922.01 - \$6,153
<b>7</b>	\$2,774 - \$4,159	\$4,159.01 - \$5,545	\$5,545.01 - \$6,932
<b>8</b>	\$3,086 - \$4,627	\$4,627.01 - \$6,169	\$6,169.01 - \$7,711
<b>9</b>	\$3,397 - \$5,095	\$5,095.01 - \$6,792	\$6,792.01 - \$8,490
<b>10</b>	\$3,709 - \$5,562	\$5,562.01 - \$7,415	\$7,415.01 - \$9,269
For more than 10 persons, add the following amounts for each additional family member.			
	\$313 - \$468	\$468.01 - \$624	\$624.01 - 780

\*The monthly household incomes listed above are pre-tax, gross incomes determined based on the current Federal Poverty Income Guidelines.

#### 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%-300% of the Federal Poverty Income Guideline

<b>1. GETTING STARTED .....</b>	<b>5</b>	<b>California Children Services (CCS) ...</b>	<b>12</b>
About your SFHP Member Handbook..	5	Mental Health Care .....	12
How Managed Care Works.....	5	<b>5. PROBLEMS, COMPLAINTS, &amp;</b>	<b>12</b>
Eligibility .....	5	<b>GRIEVANCES .....</b>	<b>12</b>
Help in Other Languages and for the		Changing Primary Care Providers and	
Hearing Impaired.....	5	Medical Groups .....	12
Your Member ID Card .....	5	Solving Problems .....	12
<b>2. CHOOSING YOUR PRIMARY</b>		The Complaint Grievance Process....	12
<b>CARE PROVIDER.....</b>	<b>6</b>	Healthy Kids Program Summary of	
What is a Primary Care Provider		Benefits .....	14
(PCP)? .....	6	<b>Combined Evidence of</b>	
What Kind of Doctor Can Be a PCP? ...	6	<b>Coverage/ Disclosure Form</b>	
Where Do PCPs Work?.....	6	<b>and Plan Agreement .....</b>	<b>24</b>
Your PCP’s Medical Group .....	6	I. About San Francisco Health Plan	
Choosing Your PCP .....	7	(SFHP).....	24
Changing Your Family’s PCP .....	7	Member ID Card .....	24
<b>3. GETTING CARE UNDER YOUR</b>		II. Eligibility and Enrollment .....	24
<b>NEW HEALTH PLAN .....</b>	<b>7</b>	A. Availability of Funds for Program .....	24
Getting Care.....	7	B. Requirement for Member Eligibility .....	25
Specialty Care .....	8	C. Application Process.....	26
Second Opinions .....	8	D. Starting Date of Coverage	
Pharmacy Services .....	8	for Members .....	26
Hospital Care.....	8	E. Annual Eligibility Review	
Emergency Medical Care .....	8	for Members .....	26
Urgent Care after Regular Hours and		F. Notification of Eligibility Changes .....	26
on Weekends.....	8	G. Appealing Enrollment Decisions .....	26
Health Care Away from Home.....	9	III. Member Financial Responsibilities .....	26
Vision and Dental Care.....	9	Annual Premium .....	26
<b>4. HEALTH PLAN SERVICES AND</b>		Co-payments and Co-payment Limits ..	26
<b>CHARGES.....</b>	<b>9</b>	IV. Disability Access .....	27
Annual Premiums .....	9	A. Physical Access.....	27
Other Charges (co-payments) .....	9	B. Access for the Vision Impaired.....	27
Claims Reimbursement for Emergency		C. Help in Other Languages and for the	
Services .....	10	Hearing Impaired .....	27
Covered Services .....	11	V. Member Rights and Responsibilities .....	28
Member Liabilities.....	11	Member Rights .....	28
Linkages to Other Benefit Programs		Member Responsibilities .....	28
and Coordination of Services.....	11	VI. Definitions .....	29
		VII. Choice of Physicians and Facilities .....	34
		A. Selecting a PCP .....	34
		B. Changing Your PCP or	
		Medical Group .....	35
		C. Scheduling Appointments .....	35
		D. A Positive Relationship with	
		Your PCP.....	35
		VIII. How to Use SFHP .....	35
		A. Authorization for Services .....	35
		B. Second Opinions .....	36
		C. Referrals to Specialists .....	36
		D. Direct Access to OB/GYNs .....	36
		E. Emergency Medical Care .....	36

F. Urgent Care or Care After Regular Hours and on Weekends.....	37	D. Provisions for Out-of-Network Vision Services.....	58
G. Post Stabilization and Follow-up Care After an Emergency.....	37	E. Vision Claim Appeals .....	58
IX. SFHP Benefits .....	38	F. Vision Benefit Grievances .....	58
A. Linkages to Other Benefit Programs and Coordination of Services .....	38	G. Charges.....	58
B. Preventive Health Services .....	40	H. Vision Benefit Program Changes .....	58
C. Professional Services .....	41	XII. Exclusions and Limitations.....	59
D. Pregnancy and Maternity (Prenatal) Care.....	41	A. General Exclusions and Limitations .....	59
E. Family Planning.....	42	B. Specific Exclusions and Limitations .....	59
F. Abortion Services .....	42	XIII. Coordination of Benefits and Third Party Liability .....	61
G. Infertility Treatment.....	42	A. Coordination of Benefits .....	61
H. Health Facilities.....	42	B. Third Party Liability .....	61
I. Home Health Care Services.....	44	XIV. Benefit Changes, Disenrollment and Cancellation.....	62
J. Hospice Care .....	45	A. Right of San Francisco Health Plan to Change Benefits and Charges .....	62
K. Short-Term Therapy Benefits.....	45	B. Disenrollment.....	62
L. Cancer Clinical Trials.....	45	C. Return of Premium .....	63
M. Prescription Drugs .....	46	D. Individual's Right of Cancellation .....	63
N. Durable Medical Equipment.....	47	E. Review by the Department of Managed Health Care .....	63
O. Orthotics and Prosthetics.....	47	XV. Grievance and Appeal Procedures....	63
P. Health Education .....	48	A. Grievance Process .....	63
Q. Hearing Care.....	48	B. Appeal Hearing.....	64
R. Organ Transplant Benefits .....	48	C. Expedited Medical Review and Appeals.....	64
S. Cosmetic and Reconstructive Surgery .....	49	D. Member Cooperation with the Grievance Process .....	65
T. Alcohol/Substance Abuse Treatment....	49	E. Where to Write.....	65
U. Mental Health Care .....	49	F. Independent Medical Review of Grievances Involving a Disputed Health Care Service .....	65
V. Emergency Services .....	50	G. Experimental/Investigational IMRs.....	66
W. Emergency Hospitalization.....	50	H. Complaints to the Department of Managed Health Care .....	66
X. Medical Transportation Services.....	51	I. Arbitration of Disputes .....	66
X. Dental Benefits .....	51	XVI. Other Provisions .....	67
A. Choice of Physician and Provider .....	51	A. Public Policy Participation .....	67
B. Scheduling Appointments .....	51	B. Non-Assignability.....	67
C. Referrals to Specialists .....	51	C. Independent Contractors.....	67
D. Changing Your Dentist.....	51	D. Continuity of Care by A Terminated Provider .....	68
E. Second Opinions.....	52	E. Continuity of Care for New Members by Non-Contracted Providers .....	68
F. Emergency and Urgent Dental Care Services.....	52	F. Payment of Providers .....	68
G. How to Get Emergency or Urgent Dental Care Services .....	52	G. Notice of Information Practices .....	68
H. Follow-Up Care .....	52	H. Benefit Program Participation .....	69
I. Dental Services That Are Not Covered.....	52	I. Governing Law.....	69
J. Payment Responsibilities.....	52	J. Natural Disasters, Interruptions, Limitations .....	69
K. Your Dental Benefits .....	52		
L. Dental Benefit Exclusions and Limitations .....	53		
M. Dental Benefit Grievances.....	55		
XI. Vision Benefits .....	56		
A. Vision Benefits.....	56		
B. Vision Benefit Exclusions and Limitations .....	57		
C. Payment Responsibilities.....	58		

# 1. Getting Started

---

## About your SFHP Member Handbook

Your SFHP Member Handbook contains important information. It tells you:

- How to choose or change your doctor, called your primary care provider or PCP
- How your *PCP* helps you get primary, *specialty*, and *hospital* care
- What you should do if you have a question or problem

Detailed information about your benefits and services are in the Summary of Benefits and Evidence of Coverage (EOC) sections of this Handbook.

## How Managed Care Works

San Francisco Health Plan is a managed care Plan. In managed care, your *primary care provider (PCP)*, *clinic*, *hospital*, and *specialist* work together to care for you and your family. Your *PCP* provides basic health care needs. Your *PCP* is part of a *medical group*. A *medical group* consists of *specialists* and other providers of health care services. A *hospital* is also connected with the *medical group*. Your *PCP* and *medical group* direct the care for all of your medical needs. This includes authorizations to see *specialists*, or to receive medical services such as lab tests, x-rays, and/or *hospital* care.

## Eligibility

If you have questions about your eligibility, contact Member Services at **(415) 547-7800** (local) or **(800) 288-5555** (toll free), Monday through Friday, 8:30am to 5:30pm.

## Help in Other Languages and for the Hearing Impaired

If you prefer to speak a language other than English, our Member Services team can help. They speak other languages and can help you find a *PCP* who speaks your language. Call Member Services at **(415) 547-7800** (local) or **(800) 288-5555** (toll free), Monday through Friday, 8:30am to 5:30pm.

Member Services also uses the Telecommunications Device for the Deaf (TDD) and the California Relay Services to help callers with a hearing impairment. To access the TDD services, please call **(415) 547-7830** (local), or **(888) 883-7347** (toll free).

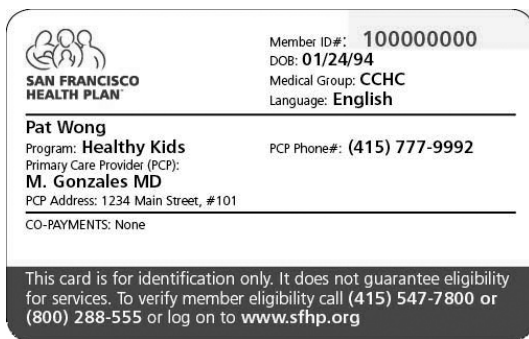
## Your Member ID Card

SFHP mails a *member* ID card to each of its Healthy Kids program members. Check the information on the *member* ID card to make sure it is correct. Call Member Services at **(415) 547-7800** (local) or **(800) 288-5555** if:

- Any information is not correct
- You move, or any information changes
- The card is lost or stolen

Keep the *member* ID card with you so you have it when you or your family members are getting care. The *member* ID card must be shown at the doctor's office, *clinic*, *hospital*, pharmacy or wherever else services are provided.

The picture below shows you what the front of the *member ID card* will look like.



## 2. Choosing Your Primary Care Provider

### What is a Primary Care Provider (PCP)?

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

- Wellness 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 you think it is an emergency. Your *PCP*, or a substitute provider, 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 your *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

### Where Do PCPs Work?

Your family's *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 doctors and other health care providers who work together. Each *medical group* works with a particular *hospital*.

When you choose a *PCP*, you are also choosing the *specialists* in the *PCP's medical group* and the *hospital* 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*. If you prefer a particular *hospital*, make sure your

*PCP* and their *medical group* work with that *hospital*.

## 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 not, follow these instructions or call Member Services for help at **(415) 547-7800** (local) or **(800) 288-5555**.

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?
- Do the office staff members 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 **(800) 288-5555** and tell us which *PCP* you would like to choose. (If you have more than one child, 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 and your family. If you do not choose a *PCP*, 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 that 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 (four months) 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 of 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. (Please give at least 24 hours notice if you need to cancel or change the appointment). Show your *member ID* card at the *PCP's* office or *clinic*.

3. Contact your *PCP* when you are sick

Except in the case of an emergency, always call your *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 your family gets the health care they need, either by providing treatment or referring to a *specialist*.

## Specialty Care

Your *PCP* will arrange most types of specialty care that your family may need. After talking with you, your *PCP* will send (refer) you to a *specialist*. If you go to another doctor without a referral from your *PCP*, these services may not be paid for by SFHP. Always call your *PCP* first.

## Second Opinions

If you would like to talk to another doctor about a health problem, you may ask your *PCP* for a "second opinion". SFHP will pay for an opinion from another doctor when your *PCP* refers you.

## 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 Kids Provider Directory under the Pharmacy section, and show your *member ID card* to the pharmacist.

## Hospital Care

If you are sick or hurt, call your *PCP*. Your *PCP* will either 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* in your *PCP's* medical group. 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 there is not a "true" emergency, the *emergency room* may send you to your *PCP* or *clinic* for treatment. If you think you have an *emergency*, you should go to the nearest *emergency room*. Even if it turns out not to be a real *emergency*, SFHP will still pay for your care.

## 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, you can always call your *PCP's* office for help and to find out what you should do. Your *PCP* or a substitute provider is 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 do not have to contact your *PCP* before you

get care for an *urgent* or *emergency* need. You can go directly to the *emergency* room or an *urgent care* center if you think you need to see a doctor right away.

## Health Care Away from Home

If you are an SFHP *member* and need emergency care while not in San Francisco County, we will pay for it. If you think you have an urgent medical problem, you can always call your *PCP's* office for help and to find out what you should do. Your *PCP* or a substitute provider is 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 do not have to contact your *PCP* before you get care for an *urgent* or *emergency* need. You can go directly to the *emergency* room or an *urgent care* center if you think you need to see a doctor right away.

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

## Vision and Dental Care

As a Healthy Kids program *member*, you are also entitled to vision and dental care benefits. All dental and vision services, including eye exams, are covered by VSP (Vision Service Plan) and Delta Dental plans.

For more information about the vision plan, or to locate a vision provider, call VSP at **(800) 877-7195**.

For more information about the dental plan, call Delta Dental toll-free at **(866) 212-2743** and mention group number "SF60". Or call SFHP at **(415) 547-7800** (local) or

**(800) 288-5555**. Our TDD line for the hearing or speech impaired is **(415) 547-7830**.

The covered dental benefit for each member will be limited to fifteen hundred dollars (\$1,500) per benefit year. This means that the SFHP Healthy Kids Program will pay for covered dental services up to \$1,500 per benefit year\*. Once the limit is reached, you will have to pay for all dental services. The requirements for co-pays stay the same.

\***Benefit Year** means the twelve (12) month period commencing July 1 of each year at 12:01 am.

## 4. Health Plan Services and Charges

---

### Annual Premiums

A premium is the amount of money you pay each year for your health insurance. Depending on your income and family size, you will pay between \$48 to \$189 per year for each member enrolled in the program. Call the Healthy Kids program at **(800) 880-5305** for more information.

It is your responsibility to pay your Healthy Kids program *premium* each year. Call the Healthy Kids program at **(800) 880-5305** if you have questions or problems with your annual premium payments.

### Other Charges (co-payments)

In addition to your annual pre-paid *premium*, some services require a small payment (co-payments) at the time of service.

Note: There are no *co-payments* for preventive visits or for members

under the age of 24 months for well-baby care and office visits. There are no *co-payments* for *members* who are documented Alaska Natives or Native Americans.

The *co-payment* limit per household per year is \$250, no matter how many family members are enrolled in the Healthy Kids program. Ask for a receipt whenever a *co-payment* is made and keep the receipt and a record of all payments so that you can show that the maximum has been paid during the year of membership. When the limit is reached, contact Member Services to get a "no co-pay" *member* ID card.

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

Additionally, no *co-payments* are charged for any office visits for enrolled children under 24 months of age. 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.

## Claims Reimbursement for Emergency Services

If emergency services were received and expenses were incurred by the member for such services, the member should submit a complete

claim with the service record for payment to SFHP 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 the member for such services, the member 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 page 14. SFHP will cover services as medically necessary, or where the member 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 service obtained by the member are covered, SFHP will pay the physicians directly or reimburse the member if the services have been paid for by the member.

If you receive a bill for services provided by your own *physician*, which were *authorized* or which are otherwise *covered services*, please contact *SFHP* right away so that we may assist you. *Participating providers* are prohibited from balance billing any *member* for *covered services* for which *SFHP* is financially responsible.

If you receive non-*authorized* services from a doctor who is not a *participating provider* or who is not with your *medical group*, you will be financially responsible for the services, unless they were *emergency services* or no *authorization* was required.

## Covered Services

SFHP will pay only for services that are *medically necessary* and provided by the *PCP*, or *specialist* to whom 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.

## Member Liabilities

Generally, the only amount a member pays for covered services is the required co-payment.

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 36, section C. Referrals 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 the plan's service area, or specialty services approved by the Plan (see page 24, section I. 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** (local) or **(800) 288-5555**.

## Linkages to Other Benefit Programs and Coordination of Services

You may be eligible for the following services that are not covered under the Healthy Kids program. If you receive these services, you will remain a *member* and all health care services will be coordinated.

## California Children Services (CCS)

The CCS program is the State and County program that provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children and young adults under 21 years of age with CCS-eligible medical conditions. These conditions include genetic diseases, chronic medical conditions, infectious diseases, and traumatic injuries. If your *PCP* suspects that you are eligible, a referral will be made to the local CCS program.

CCS will determine if you have an eligible condition. CCS provides all treatment and services for that condition. You will remain enrolled in the Healthy Kids program for all other care. SFHP will coordinate care with CCS.

If you get services from CCS already, make sure your family's *PCP* is aware of this. Call Member Services at **(415) 547-7800** (local) or **(800) 288-5555** if you have questions about CCS coverage.

## Mental Health Care

As a Healthy Kids *member*, you are also entitled to mental health and behavioral health benefits. All mental health benefits for the Healthy Kids program are provided by San Francisco Community Behavioral Health Services. For a full description of the mental health benefits available, refer to the Evidence of Coverage section of this Handbook. If you would like assistance obtaining mental health benefits, you may call SFHP Member Services at **(415) 547-7800 (local)** or **(800) 288-5555** or you may call San Francisco Community Behavioral Health Services at **(888) 246-3333**.

# 5. Problems, Complaints, & Grievances

---

## Changing Primary Care Providers and Medical Groups

If you are dissatisfied with the services you have received, SFHP would like to know about your concerns. We strongly encourage you to give us a chance to work with you to solve your problem. Please contact Member Services at **(415) 547-7800** (local) or **(800) 288-5555** to talk with us about any problems you may have.

## Solving Problems

SFHP wants your family to have the best care and service possible. We also want to help you resolve any problems you have with SFHP.

If there is a problem, try to talk about it when it first happens. Talking with your doctor or other provider may be the best way to get the issue resolved quickly.

If the problem is not solved for you, call us. Member Services will work with you to fix the problem. If we still cannot solve it in a way that makes you happy, you may file a formal complaint or "grievance."

## The Complaint Grievance Process

Your complaint or grievance will be reviewed under SFHP's Grievance Process. Filing a complaint or grievance is a member right. SFHP will not discriminate against you. Your membership will not be discontinued, nor will you lose eligibility for Healthy Kids program

coverage because you filed a complaint or grievance.

You may file a grievance verbally or in writing. Grievance forms are available at each *PCP's* office or from Member Services and they are also available online at SFHP's website, **[www.sfhp.org](http://www.sfhp.org)**. If you need assistance with filling out the form, require translation services, or want a referral to community advocates, please call Member Services. In most cases, after you file a grievance, the Grievance Coordinator will send you a letter acknowledging receipt of the grievance within 5 days.

The Grievance Coordinator will investigate the issue and send you a proposed resolution within 30 days. You do not have to participate in *SFHP's* grievance process if you have an *urgent grievance*. You may go directly to the Department of Managed Health Care ("DMHC"). Please see page 65 of the Evidence of Coverage section of this handbook for a definition of *urgent grievance* and instructions on how to contact the DMHC.

## Healthy Kids Program Summary of Benefits

### A Chart to Help You Compare Coverage Benefits

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The Evidence of Coverage and Plan contract should be consulted for a detailed description of coverage benefits and limitations.

**NOTE: Members in the Income Category A (see the Healthy Kids Program Income Categories A, B, and C Table on page 2) shall pay no more than \$5 co-payment for applicable covered services as described in this Benefits Descriptions Section of the EOC/DF.**

<b>Benefits*</b>	<b>Covered Services</b>	<b>Member Pays (Co-payment) <i>Income Category A</i></b>	<b>Member Pays (Co-payment) <i>Income Categories B &amp; C</i></b>
<b>Alaskan Native/Native American Enrolees</b>		\$0	\$0
<b>Deductible</b>	No deductibles will be charged for covered benefits	\$0	\$0
<b>Yearly Co-Payment Maximum</b>		\$250	\$250
<b>Lifetime Maximum</b>	No lifetime maximum limits on benefits apply under this plan	\$0	\$0
<b>Hospitalization Services Inpatient</b>	Medically necessary facility charges, room and board, general nursing care, ancillary services including operating room, intensive care unit, prescribed drugs, laboratory, and radiology during inpatient stay	No co-payment	No co-payment
<b>Hospitalization Services Outpatient</b>	Medically necessary facility charges, general nursing care, ancillary services including operating room, prescribed drugs, laboratory, chemotherapy, and radiology	No co-payment except <ul style="list-style-type: none"> <li>\$5 per visit for physical, occupational and speech therapy performed on an outpatient basis.</li> <li>\$5 per visit for emergency health care services (waived if the member is hospitalized)</li> </ul>	No co-payment except <ul style="list-style-type: none"> <li>\$10 per visit for physical, occupational and speech therapy performed on an outpatient basis.</li> <li>\$10 per visit for emergency health care services (waived if the member is hospitalized)</li> </ul>

<b>Benefits*</b>	<b>Covered Services</b>	<b>Member Pays (Co-payment) <i>Income Category A</i></b>	<b>Member Pays (Co-payment) <i>Income Categories B &amp; C</i></b>
<b>Professional Services</b>	Doctor visits, inpatient and outpatient medical and surgical services	\$5 per office or home visit except <ul style="list-style-type: none"> <li>• No co-payment for hospital inpatient professional services</li> <li>• No co-payment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments</li> <li>• No co-payment for members 24 months of age and younger</li> <li>• No co-payment for vision or hearing testing, or for hearing aids</li> </ul>	\$10 per office or home visit except <ul style="list-style-type: none"> <li>• No co-payment for hospital inpatient professional services</li> <li>• No co-payment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments</li> <li>• No co-payment for members 24 months of age and younger</li> <li>• No co-payment for vision or hearing testing, or for hearing aids</li> </ul>
<b>Outpatient Services</b>	In a doctor 's office, surgery center, or other designated facility	\$5	\$10
<b>Preventive Health Care Services</b>	Periodic health examinations, Well Baby Care, routine diagnostic testing and laboratory services, immunizations, and services for the detection of asymptomatic diseases.	No co-payment	No co-payment
<b>Diagnostic, X-Ray, and Laboratory Services **</b>	Laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, and treat members.	No co-payment	No co-payment
<b>Diabetic Care **</b>	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription.	\$5 co-payment per office visit  Co-payment for prescriptions as described in the "Prescription Program" section	\$10 co-payment per office visit  Co-payment for prescriptions as described in the "Prescription Program" section

<b>Benefits*</b>	<b>Covered Services</b>	<b>Member Pays (Co-payment) <i>Income Category A</i></b>	<b>Member Pays (Co-payment) <i>Income Categories B &amp; C</i></b>
<b>Emergency Health Coverage</b>	24-hour care for sudden, serious and unexpected illness including psychiatric screening, examination and treatment, injury or condition requiring immediate diagnosis in and out of the Plan	\$15 co-payment waived if member is hospitalized	\$15 co-payment waived if member is hospitalized
<b>Ambulance Services</b>	Ambulance transportation when medically necessary	No co-payment	No co-payment
<b>Prescription Drug Coverage **</b>	Drugs prescribed by a licensed practitioner	<ul style="list-style-type: none"> <li>• \$5 per prescription for up to 30 day supply for brand name or generic drugs.</li> <li>• \$5 per prescription for up to 90 day supply of maintenance drugs.</li> <li>• No co-payment for prescription drugs provided in an inpatient setting.</li> <li>• No co-payment for drugs administered in the doctor's office or in an outpatient facility.</li> <li>• No co-payment for FDA-approved contraceptive drugs and devices.</li> </ul>	<ul style="list-style-type: none"> <li>• \$10 co-payment per prescription for up to 30 day supply for generic drugs.</li> <li>• \$15 co-payment 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.</li> <li>• \$10 co-payment per prescription for up to 90 day supply for maintenance generic drugs purchased through a participating pharmacy.</li> <li>• \$15 co-payment per prescription for up to 90 day supply for maintenance brand name drugs purchased through a participating pharmacy unless there is no generic equivalent or if the use of a brand name drug is medically necessary, then the \$10 co-payment</li> </ul>

<b>Benefits*</b>	<b>Covered Services</b>	<b>Member Pays (Co-payment) <i>Income Category A</i></b>	<b>Member Pays (Co-payment) <i>Income Categories B &amp; C</i></b>
			applies. <ul style="list-style-type: none"> <li>• No co-payment for prescription drugs provided in an inpatient setting.</li> <li>• No co-payment for drugs administered in the doctor’s office or in an outpatient facility</li> <li>• No co-payment for FDA-approved contraceptive drugs and devices.</li> </ul>
<b>Contraceptives</b>	FDA approved drugs and implanted devices.	No co-payment	
<b>Durable Medical Equipment **</b>	Equipment suitable for use in the home, such as blood glucose monitors, apnea monitors, asthma-related equipment and supplies	No co-payment	No co-payment
<b>Orthotics and Prosthetics **</b>	Original and replacement devices as prescribed by a licensed practitioner.	No co-payment	No co-payment
<b>Maternity Care</b>	Professional and hospital services relating to maternity care	No co-payment	No co-payment
<b>Family Planning Services</b>	Voluntary family planning services	No co-payment	No co-payment

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B &amp; C</i>
<b>Inpatient Mental Health Care Services:</b>	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.		
<b>Basic Mental Health Care Services</b>	<ul style="list-style-type: none"> <li>• Diagnosis and treatment of a mental health condition.</li> <li>• 30 days per benefit year. Additional days may be authorized by the Plan.</li> <li>• Plans, with the agreement of the subscriber or applicant or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following: <ul style="list-style-type: none"> <li>▪ 2 days of residential treatment,</li> <li>▪ 3 days of day care treatment, or</li> <li>▪ 4 outpatient visits.</li> </ul> </li> </ul>	No co-payment	No-co-payment
<b>Severe Mental Illness (SMI)</b>	<ul style="list-style-type: none"> <li>• Inpatient mental health care services for the treatment of severe mental illnesses.</li> <li>• Unlimited days.</li> </ul>	No co-payment	No co-payment
<b>Serious Emotional Disturbance (SED) Services</b>	<ul style="list-style-type: none"> <li>• Inpatient mental health care services for the treatment for SED condition.</li> <li>• Unlimited days. <ul style="list-style-type: none"> <li>▪ On or before day 30; the Plan may refer the member to their county mental health department for continued treatment of the SED condition. The Plan and the county mental health department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with a SED condition.</li> <li>▪ The member will remain enrolled in the Healthy Kids program and will continue to receive</li> </ul> </li> </ul>	No co-payment	No co-payment

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B &amp; C</i>
	primary care, specialty care, and all other services for medical conditions not related to the SED condition from the Plan.		
<b>Outpatient Mental Health Care Services:</b>	Mental health care when ordered and performed by a participating mental health professional.		
<b>Basic Mental Health Care Services</b>	<ul style="list-style-type: none"> <li>• This includes the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement.</li> <li>• Family members may be involved in the treatment when medically necessary for the health and recovery of the child.</li> <li>• 20 visits per benefit year. Additional days may be authorized by the Plan.</li> </ul>	\$5per visit	\$10 per visit
<b>Severe Mental Illness (SMI)</b>	<ul style="list-style-type: none"> <li>• Outpatient mental health care visits for the treatment of severe mental illnesses.</li> <li>• Unlimited visits.</li> </ul>	\$5per visit	\$10 per visit
<b>Serious Emotional Disturbance (SED) Services</b>	<ul style="list-style-type: none"> <li>• Outpatient mental health care visits for the treatment for SED condition.</li> <li>• Unlimited visits. <ul style="list-style-type: none"> <li>▪ The Plan may refer the member to the county mental health department for treatment of SED. The Plan and the county mental health department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with a SED condition.</li> </ul> </li> </ul>	No co-payment	No co-payment

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B &amp; C</i>
	<ul style="list-style-type: none"> <li>▪ The member will remain enrolled in the Healthy Kids 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.</li> </ul>		
<b>Chemical Dependency Services:</b>			
<b>Inpatient</b>	Inpatient detoxification	No co-payment	No co-payment
<b>Outpatient</b>	Crisis intervention and alcohol or drug abuse treatment as medically necessary. Benefit is limited to 20 visits per benefit year.	\$5per visit	\$10 per visit
<b>Home Health Services</b>	Services provided at the home by health care personnel.	No co-payment except <ul style="list-style-type: none"> <li>• \$5 per visit for physical, occupational, and speech therapy</li> </ul>	No co-payment except \$10 per visit for physical, occupational, and speech therapy
<b>Skilled Nursing Care</b>	Services provided in a licensed skilled nursing facility.  Benefit is limited to a maximum of 100 days per benefit year.	No co-payment	No co-payment
<b>Physical, Occupational, and Speech Therapy **</b>	Therapy may be provided in a medical office or other appropriate outpatient setting.	\$5 per visit when performed in an outpatient setting  No co-payment for inpatient therapy	\$10 per visit when performed in an outpatient setting  No co-payment for inpatient therapy
<b>Blood and Blood Products **</b>	Includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings	No co-payment	No co-payment
<b>Health Education</b>	Includes education regarding personal health, behavior, and health care, and recommendations regarding the optimal use of health care services	No co-payment	No co-payment

<b>Benefits*</b>	<b>Covered Services</b>	<b>Member Pays (Co-payment) <i>Income Category A</i></b>	<b>Member Pays (Co-payment) <i>Income Categories B &amp; C</i></b>
<b>Diagnostic X-ray and Laboratory Services</b>	Therapeutic radiological services, ECG, EEG, mammography, other diagnostic laboratory and radiology tests and laboratory tests.	No co-payment	No co-payment
<b>Hospice</b>	Medically necessary skilled care; counseling, drugs and supplies; short-term inpatient care for pain control and system management; bereavement services, physical, speech and occupational therapies; medical social services short-term inpatient and respite care	No co-payment	No co-payment
<b>Organ Transplants</b>	Medically necessary organ and bone marrow transplant; medical and hospital expenses of a donor or prospective donor; testing expenses and charges associated with procurement of donor organ	No co-payment	No co-payment
<b>Reconstructive Surgery **</b>	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 co-payment	No co-payment
<b>Phenylketonuria (PKU) **</b>	Testing and treatment of PKU	No co-payment	No co-payment
<b>Clinical Cancer Trials</b>	Coverage for a member's participation in a cancer clinical trial, phase I through IV, when the member's physician has recommended participation in the trial, and member meets certain requirements	\$5 co-payment per office visit  Co-payment for prescriptions as described in the "Prescription Drug Program" section	\$10 co-payment per office visit  Co-payment for prescriptions as described in the "Prescription Drug Program" section
<b>California Children's Services Program (CCS)</b>	CCS is a California medical program that treats children who have certain physically handicapping conditions and who need specialized medical care. Services provided through the CCS Program are coordinated by the county CCS office.  If the member's condition is determined to be eligible for CCS services, the member remains enrolled in the Healthy Kids Program	No co-payment	No co-payment

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B &amp; C</i>
	and continues to receive medical care from plan providers for services not related to the CCS eligible condition. The member will receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers.		
<b>Biofeedback</b>	Up to 8 visits per Benefit Year with a referral	\$5 per visit	\$10 per visit
<b>Hearing Aids/Services</b>	Audiological evaluations, hearing aids, supplies, visits for fitting, counseling, adjustments, repairs	No co-payment	
<b>Eye Exams/Supplies</b>	Eye examinations, frames and lenses, supplemental care for low-vision benefits	\$5 per visit	\$10 per visit
<b>Cataract Spectacles and Lenses **</b>	Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery	No co-payment	No co-payment
<b>Dental</b>			
<b>Oral Surgery</b>	<ul style="list-style-type: none"> <li>• Bony impaction- per tooth</li> <li>• Root recovery – per tooth</li> </ul>	\$5	\$10
<b>Endodontics</b>	<ul style="list-style-type: none"> <li>• Apicoectomy performed in conjunction with root canal</li> <li>• Retreatment of previous root canal</li> </ul>	\$5 per canal	\$10 per canal
<b>Periodontics</b>	Osseous or muco-gingival surgery	\$5 per quadrant	\$10 per quadrant
<b>Crowns and Bridges</b>	<ul style="list-style-type: none"> <li>• Porcelain crown, porcelain fused to metal crown, full metal crown, and gold onlays or ¾ crowns</li> <li>• Pontics</li> </ul>	\$5 per crown or other pontics	\$10 per crown or other pontics

Benefits*	Covered Services	Member Pays (Co-payment) <i>Income Category A</i>	Member Pays (Co-payment) <i>Income Categories B &amp; C</i>
<b>Dentures</b>	<ul style="list-style-type: none"> <li>• Complete maxillary denture</li> <li>• Complete mandibular denture</li> <li>• Partial acrylic upper or lower denture with clasps</li> <li>• Partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles</li> <li>• Removable unilateral partial denture</li> <li>• Laboratory reline</li> <li>• Denture duplication</li> </ul>	\$5 each	\$10 each

\*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.

# Combined Evidence of Coverage/ Disclosure Form and Plan Agreement

## Evidence of Coverage & Disclosure Form

This Combined Evidence of Coverage (EOC) and Disclosure Form, together with the Summary of Benefits, disclose the terms and conditions of your Health Plan and constitute only a summary of the Health Plan policies and rules. Some of the words used in this EOC have specific definitions. These words are italicized. The meanings of these italicized words are found in the Definitions Section of this EOC. *Members* may also direct questions concerning coverage or specific plan provisions to Member Services.

Please read the following information so you will know from whom or what group of providers you may obtain health care.

You have the right to review this Evidence of Coverage (EOC) prior to enrollment. Please read the Evidence of Coverage and the accompanying Summary of Benefits completely and carefully. Individuals with special health care needs should pay particular attention to sections that apply to them.

Please call Member Services at **(415) 547-7800** (local) or **(800) 288-5555** if you would like additional information about the *benefits* of the Plan. If English is not your main language, or if you are more comfortable speaking in another language, Member Services who speak other languages are available. If they do not speak your language, they will use an interpreter.

### I. 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* the Member will receive are provided by independent *physicians, clinics, hospitals, and other participating providers* that have entered into contracts with either SFHP or with *medical groups* under contract to SFHP. In turn, SFHP contracts with the *medical groups and hospitals*. These individual contracts specify how the Plan works and what it covers. All *members* are required to select a *primary care provider (PCP)* from the many *physicians* who are part of the Plan. The *member's PCP* will

manage his/her care, including preventive care such as checkups and immunizations for children and gynecological examinations for women. The *PCP* will refer the *member* to a *specialist* when necessary and will make arrangements for hospitalization when required. Each *PCP* is connected to a *medical group* and will generally refer the Member to those *specialists, hospitals, and other participating providers* used by that *medical group*. If there are no *appropriately qualified health professionals* to treat the *member's* medical condition who are associated with that *medical group* the *PCP* may refer the Member to a *participating provider* belonging to another *medical group* or who is outside of the *Plan's* network of providers, when necessary.

#### Member ID Card

Once a *member* has enrolled in the Healthy Kids program, he/she 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 the *member* moves, or if the card is lost or stolen, it is important to notify SFHP immediately.

Call Member Services at **(415) 547-7800** (local) or **(800) 288-5555** if you have any questions about your health coverage.

## II. Eligibility and Enrollment

### A. Availability of Funds for Program

The acceptance of any application for enrollment in the Healthy Kids program is contingent upon the availability of public funds from the City and County of San Francisco ("CCSF") to pay the *premium* costs of the program. Upon initial enrollment and payment of one year's premium, *members* shall be guaranteed one year of participation in the program. At or before each *member's anniversary date*, SFHP shall determine whether funds are available from CCSF to cover the *premiums* for the *member's* next year of enrollment.

**B. Requirement for Member Eligibility**

Upon determination that funds are available to cover the potential *member*, an individual shall be all of the following:

<p><b>Healthy Kids Eligibility, less than 19 years of age:</b></p>	<ul style="list-style-type: none"> <li>• Not eligible for 1) no-cost full-scope Medi-Cal 2) Medicare 3) no-cost pregnancy related Medi-Cal (as a new applicant) or 4) the Healthy Families Program at the time application.</li> <li>• A resident of San Francisco County.</li> <li>• In a family with an annual or monthly household income under 300% of the Federal Poverty Level.</li> <li>• The child is not covered by employer-sponsored health insurance or any other publicly sponsored health insurance plan and has not been covered within the last 90 days.</li> </ul> <p>Pregnant minors who are members may be eligible for pregnancy-related <i>services</i> under the Healthy Kids program. If the pregnant minor is a member of the Healthy Kids program, the baby will automatically be covered for the first 30 days of life. After this initial thirty (30) day period, the baby will be eligible to enroll as a <i>member</i>, if the baby meets all of the eligibility criteria. If you are a Healthy Kids program <i>member</i>, and you have a baby, contact Member Services at <b>(800) 288-5555</b> to learn what health coverage options, including the Healthy Kids program, may be available for your baby.</p>
--	---

**C. Application Process**

To apply for the Healthy Kids program, an *applicant* shall submit to the *Plan* all information, documentation, and declarations required to determine eligibility. Such information, documentation and declarations shall include the *applicant's* name and address; name and address of each individual for whom enrollment is being requested, statement of the *member's* household income, and a statement indicating which person(s) is currently enrolled in an employer-sponsored health insurance plan.

The application shall be accompanied by a personal check, cashier's check or money order for one year's required *family contribution* for the Healthy Kids program.

**D. Starting Date of Coverage for Members**

Coverage shall begin for *members* no earlier than the first day of the month following the month in which eligibility for the Healthy Kids program is determined.

**E. Annual Eligibility Review for Members**

The continued eligibility of each *member* is contingent upon the availability of public funds from CCSF to pay for the costs of the program. At or before each *member's anniversary date*, if SFHP determines that such funding is not available to cover the *member's premiums*, the Member shall be disenrolled, as described below.

Except when an *applicant* has applied on behalf of the *member*, each with a unique *anniversary date*, each *member* will be re-evaluated annually prior to his/her *anniversary date* in the program to determine continued eligibility for the program. Applicants shall be notified of the annual eligibility review process at least 60 days prior to the *anniversary date*.

If *members* for whom an *applicant* has applied have different *anniversary dates*, the annual eligibility review will be based on the *anniversary dates* of the last *member* to be enrolled.

**F. Notification of Eligibility Changes**

It is the *member's*, or where *member* is a minor, the *applicant's*, responsibility to notify SFHP within 31 days of all changes in eligibility affecting *member's* enrollment in the Healthy Kids program.

**G. Appealing Enrollment Decisions**

If you believe that the Healthy Kids program made a mistake in deciding whether your child is eligible, you can file an appeal with the San Francisco Health Plan by calling Member Services locally at **(415) 547-7805** or toll-free at **(800) 288-5555**.

**III. Member Financial Responsibilities****Annual Premiums**

The annual *premium* is set by SFHP. The annual *premium* and the *co-payment* responsibilities are set for the Healthy Kids program by the Plan. Depending on your income and family size, you will pay between \$48 to \$189 per year per *member* for each individual enrolled in the Plan. Once you are enrolled in the Healthy Kids program, you will receive an Annual Enrollment Renewal packet in the mail. Your annual payment will be due to the Health Plan on your anniversary date. Use one of the following methods to pay your premiums:

- Cashier's Check
- Money Order
- Personal Check

The Plan shall not increase the amount of the premium unless the applicant has been given 30 days written notice sent by postage prepaid, regular U.S. Mail to the applicant's most current address of record with the Plan.

**Co-payments and Co-payment Limits**

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

Note: There are no *co-payments* for preventive visits or for members under the age of 24 months for well-baby care and office visits. There are no *co-payments* for *members* who are

documented Alaska Natives or Native Americans.

*Members* will not have to pay more than \$250 in *co-payments* during any one *benefit year*. *Members* 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, *members* should contact Member Services at **(415) 547-7800** (local) or **(800) 288-5555** to get a no co-pay card. Present this card at each visit to the doctor's office or pharmacist to provide proof that the maximum *co-payments* amount has been reached for that *benefit year*.

Except for any applicable *co-payments*, *members* are not financially responsible for *services* provided by their *PCPs*. For all other *services* which are SFHP *benefits*, *members* are not financially responsible for the costs of such *services*, other than for any applicable *co-payments*, if the *services* are referred by the *PCP* and *authorization* has been obtained. In the event SFHP or a *member's medical group* does not pay a *participating provider* for *covered services*, the *member* will not be liable to the provider for any sums owed by SFHP or the *member's medical group*. *Services* which are SFHP *benefits*, but which have not been *authorized*, will not be covered by SFHP and will be the financial responsibility of the *member*. 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 the financial responsibility of the *member*, even if such *services* are referred by the *member's PCP*.

#### **Claims Reimbursement for Emergency Services**

If *emergency services* were received and expenses were incurred by the *member* for such *services*, the *member* must 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. If *emergency mental health services* were received and expenses incurred by the *member* for such *services*, the *member*

must 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 claim is not submitted within this period, SFHP will not pay for those *services*, unless the claim was submitted as soon as reasonably possible as determined by the *medical group* or SFHP. If the *services* are not previously *authorized*, SFHP will review the claim retrospectively for coverage. SFHP will cover *emergency services* as *medically necessary*, or where the *member* reasonably believed that an *emergency 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 the *member* are covered, SFHP will pay the doctor directly or reimburse the *member* if the *services* have been paid for by the *member*.

## **IV. Disability Access**

### **A. Physical Access**

SFHP has made every effort to ensure that our offices and the offices and facilities of the Plan's *participating providers* are accessible to the disabled. If you are not able to locate an accessible *participating provider*, please call **(415) 547-7800** (local) or **(800) 288-5555** and Member Services will help you find an alternate.

### **B. Access for the Vision Impaired**

This Evidence of Coverage (EOC) and other important *Plan* materials will be made available in alternate formats for the vision impaired. Large print and enlarged computer disk formats will be made available and this EOC will be made available on an audiotape. For alternate formats, or for direct help in reading the EOC and other materials, please call Member Services at **(415) 547-7800** (local) or **(800) 288-5555**.

### **C. Help in Other Languages and for the Hearing Impaired**

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 other languages. If we don't have a representative who speaks your language, we have interpreters available by telephone. Call Member Services at

**(415) 547-7800** (local) or **(800) 288-5555**. Member Services can also help you find a doctor who speaks your language. 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.

## V. Member Rights and Responsibilities

### Member Rights

As an SFHP Healthy Kids *member*, I have the right to:

- Be treated respectfully regardless of my gender, culture, language, appearance, sexual orientation, race, presence of disability, or transportation ability.
- Receive information about all health *services* available to me, including a clear explanation of how to obtain them.
- Select a *PCP* to provide or arrange for all the care I need.
- Receive good and appropriate medical care including preventive health *services* and health education.
- Participate actively in decisions regarding my medical care. 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.
- File a complaint or grievance if my linguistic needs are not met.
- Have the meaning and limits of confidentiality explained to me. If I am a minor, I understand that my doctor 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 *PCP*.
- 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 *PCP* 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.

### Member Responsibilities

As a Healthy Kids *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 *physician* 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 *physician* ahead of time when I must cancel.
- Communicate openly with my *physician* 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.
- Treat all SFHP staff and *health care professionals* respectfully and courteously.
- As required by Healthy Kids program, pay any *premiums, co-payments* and charges for non-covered *services* on time.

## VI. Definitions

**Acute Condition** means 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.

**Applicant** is any person over the age of 18 years who is a natural or adoptive parent; a legal guardian; or a caretaker relative, foster parent, or stepparent with whom the child resides, who applies for coverage under the Healthy Kids program on behalf of a child. *Applicant* also means a person 18 years of age who is applying on his or her own behalf for coverage under the Healthy Kids program.

**Appropriately Qualified Health Professional** is a primary care provider, specialist, or other *health professional* who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a *second opinion*.

**Anniversary Date** means the day each year that corresponds to the day and month a *member's* coverage began in the Healthy Kids program.

**Authorization (Authorized)** is the requirement that the *member's PCP* or *medical group*, and in some cases the Health Plan, approve certain *services* before such *services* are actually provided.

**Autologous Blood Donation** is the act of donating the *member's* own blood for storage and future use for a planned surgery that may require a blood transfusion.

**Benefits (Covered Services)** are those *medically necessary services*, supplies, and drugs that a *member* is entitled to

receive according to the terms of the SFHP *contract* and this Evidence of Coverage. Except in an *emergency*, all *services*, to be *benefits*, must be provided by *participating providers* and must be *authorized*.

**Benefit Year** means the twelve (12) month period commencing July 1 of each year at 12:01am.

**California Children's Services (CCS)** is a State and County case management and insurance program for children with certain handicapping medical conditions.

**Clinic** is a place, other than a *hospital* emergency room, where a team of *physicians*, nurses and other health professionals treat patients on an *outpatient* basis.

**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, treatment or medicine you need.
- Your plan denies services and says it is not medically necessary.
- You have to wait too long for an appointment.
- You receive 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 you should not have to pay.

**Co-payment** is the amount that a *member* is required to pay for certain *benefits*.

**Cosmetic Procedure** is any surgery, *service*, drug, or supply designed to alter or reshape normal structures of the body in order to improve appearance.

**Coverage Decision** means a decision made by either the Health Plan or *medical group* to either 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 SFHP *contract* and this Evidence of Coverage.

**Covered Services (Benefits):**  
See benefits.

**Custodial or Maintenance Care** is 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 a *member* who is mentally or physically disabled.

**Dental Care and Services** are services 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** is an injury, an illness, or a condition. 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** means any 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 San Francisco 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** is 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)** is 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 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 any of the following:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part.

*Emergency Services* means medical screening, examination, and evaluation by a *physician*, or to the extent permitted by applicable law, by other appropriate personnel under the supervision of a *physician*, to determine if an *emergency medical condition* or active labor exists and, if it does, the care, treatment, and surgery by a *physician* necessary to relieve or eliminate the *Emergency medical condition*, within the capability of the facility. *Emergency services* also means an additional screening, examination, and evaluation by a *physician*, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a *psychiatric emergency medical condition* exists, and the care and treatment necessary to relieve or eliminate the *psychiatric emergency medical condition*, within the capability of the facility.

**Experimental or Investigational in Nature** includes 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 in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. *Services* which require approval by the federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the *services* or supplies were rendered, shall be considered *experimental* or *investigational in nature*. *Services* or supplies which themselves are not approved or recognized in accordance with accepted professional medical

standards, but nevertheless are pre-authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered *experimental* or *investigational* in nature.

**Federal Poverty Income Guideline** is set each year by the U.S. Department of Health and Human Services (HSS). The guidelines are used to determine eligibility for certain programs such as Healthy Kids, Healthy Families, or Medi-Cal. The poverty guidelines are sometimes referred to as the “federal poverty level” (FPL).

**Health Plan** means San Francisco Health Plan.

**Health Plan Contract** refers to the *combined Evidence of Coverage/Disclosure Form* issued by SFHP to the individual *member* that establishes the *services*, eligibility, and other terms and conditions of coverage which the *members* are entitled to receive from SFHP. Call Member Services at **(415) 547-7800** (local) or **(800) 288-5555** to request a copy.

**Health Professional** means a person holding a license or certificate, appropriate to provide health care *services* in the State of California. *Health professionals* include, but are not limited to, psychologists, podiatrists, nurses, physical therapists, speech therapists, occupational therapists, optometrists, dentists, and laboratory technicians.

- **Hospice Care** is care and *services* provided to a *member* in a home by a licensed or certified home health care agency or licensed hospice, that are:
- Designed to provide palliative and supportive care to individuals who have received a diagnosis of an incurable or irreversible condition that has a high probability of causing death within one year or less;
- Directed and coordinated by medical professionals; and
- Pre-authorized by SFHP.

**Hospital** is a health care facility licensed by the State of California, and accredited by the Joint Commission on Accreditation of Health Care Organizations, as either:

- An acute care *hospital*, or
- A psychiatric *hospital*, or

- A Hospital operated primarily for the treatment of alcoholism and/or substance abuse.

A **Facility** that is principally a rest home, nursing home or home for the aged, or a *skilled nursing facility* that is a distinct part of a *hospital* is not included in this definition.

**Hospital Inpatient Services** 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 *physician’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; or,
- For inpatient rehabilitation provided on an outpatient basis.

SFHP reserves the right to review all *services* to determine whether they are *medically necessary*.

**Inpatient** is an individual who has been admitted to a *hospital* or *skilled nursing facility* as a registered bed patient and is receiving *services* under the direction of a *physician*.

**Life-threatening** 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 point of clinical intervention is survival.

**Medical Group** is the integrated *medical group*, Independent Physician Association (IPA), medical foundation, or similar physician entity with which the *member's PCP* is associated for the provision of *benefits* to SFHP *members* and which has entered into a contract with SFHP to provide *services* to *members*.

**Medically Necessary** are 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** is an individual who satisfies the eligibility requirements of the Healthy Kids program, and who is enrolled and accepted by SFHP as a *member*, and has maintained SFHP membership in accord with the *Health Plan contract*.

**Mental Health** includes psychoanalysis, psychotherapy, counseling, medical management or other *services* most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage, family and child counselor, 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-contracted provider** means a primary care provider, medical group, hospital or other health professional that is not contracted to provide health care services to *SFHP Members*.

**Occupational Therapy** is 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** is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities or to improve the function of movable body parts.

**Outpatient** is an individual receiving *services* under the direction of a *physician* but not incurring overnight charges at the facility where *services* are provided.

**Participating Provider** means a *physician, health professional, institutional health provider, or other provider or supplier of health care services* or supplies who has a currently valid and executed agreement, directly or indirectly, with SFHP to provide *covered services* to *members*.

**Physical Handicap** is a physical or mental impairment that results in anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical or laboratory diagnostic techniques and which are expected to last for a continuous period of time not less than twelve months in duration.

**Physical Therapy** is treatment under the direction of a *physician* and provided by a registered physical therapist, certified occupational therapist or licensed doctor of podiatric medicine, utilizing physical agents, such as ultrasound, heat and massage, to improve a patient's musculoskeletal, neuromuscular, and respiratory systems.

**Physician** is an individual licensed and authorized to engage in the practice of medicine or osteopathic medicine.

**The Plan** means San Francisco Health Plan.

**Premiums** are the monthly family contribution that is made on behalf of each *member* by the *applicant*.

**Primary Care Provider (PCP)** is a general practitioner, family practitioner, internist, obstetrician/gynecologist, nurse practitioner or physician assistant associated with a contracted Physician, or pediatrician who has contracted with SFHP or a Medical Group as a *PCP* to provide primary care to Members and to refer, Authorize, supervise and coordinate the provision of all Benefits to Members in accordance with the Health Plan Contract.

**Prosthesis (Prosthetics)** is (are) an artificial part, appliance or device used to replace a missing part of the body.

**Psychiatric Emergency Medical**

**Condition** is 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.

**Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

- (1) To improve function.
- (2) To create a normal appearance, to the extent possible.

*Rehabilitation* is *medically necessary* care furnished primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury.

**Respiratory Therapy** is treatment under the direction of a *physician* and provided by a trained and certified respiratory therapist to preserve or improve a patient's pulmonary function.

**Second Opinion** is a consultation with a SFHP *medical group physician* other than the *PCP* or referred *Specialist* before scheduling certain *Services*, usually involving surgery.

**Self-Referred** means not provided by, prescribed or referred by the *member's PCP* and not *authorized* in accordance with SFHP procedures except for *emergency services*.

**Serious Chronic Condition** means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following:

- (A) Persists without full cure or worsens over an extended period of time.
- (B) Requires ongoing treatment to maintain remission or prevent deterioration.

**Seriously Debilitating Illness** means diseases or conditions that cause major irreversible morbidity.

**Service Area** is the geographic area served by SFHP, which is the City and County of San Francisco.

**Services** include the *medically necessary benefits* that are covered by SFHP when requested and provided in accordance with the rules set forth in this Evidence of Coverage.

**Severe Mental Illness** shall include all of the following:

1. Schizophrenia.
2. Schizoaffective disorder.
3. Bipolar disorder (manic-depressive illness).
4. Major depressive disorders.
5. Panic disorder.
6. Obsessive-compulsive disorder.
7. Pervasive developmental disorder or autism.
8. Anorexia nervosa.
9. Bulimia nervosa
10. Serious Emotional Disturbances (SED)

**SFHP** means San Francisco Health Plan.

**SFHP Hospital** is a *hospital* licensed under applicable state law contracting specifically with SFHP to provide *benefits* to *members* of SFHP.

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

**SFHP Specialist** is a *physician* other than a *PCP* who has an agreement with SFHP or the *medical group* to provide *services* to *members* on referral by a *PCP*.

**Skilled Nursing Facility** is a facility licensed by the California State Department of Health as a "*skilled nursing facility*." A *skilled nursing facility* may be a licensed *skilled nursing facility* portion of a *hospital*.

**Speech Therapy** is *medically necessary* treatment under the direction of a *physician* and provided by a licensed speech pathologist or speech therapist.

**Standing Referrals** are referrals to a *specialist* that allow the *member* to visit that *specialist* on a repeated basis in order to continue treatment of an ongoing problem, or life threatening, degenerative or disabling condition.

**Terminally Ill** means an incurable or irreversible condition that has a high probability of causing death within one year or less.

**Terminated Provider** means any provider, including an individual practitioner, medical group or hospital whose contract with SFHP terminates.

**Total Disability** refers to:

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

**Urgent Care** means those *covered services* provided for the immediate treatment of an unforeseen *acute condition* that requires prompt medical attention but does not require *emergency care*.

## VII. Choice of Physicians and Facilities

All the health care *services* to which *members* may be entitled are provided by *physicians* 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 Kids Provider Directory, which was sent to you in your new *member* packet. If you do not have a copy, call Member Services at **(415) 547-7800** (local) or **(800) 288-5555**. Since the *participating providers* listed in this Directory may change, call Member

Services to find out whether a particular *physician* or other *health professional* is available through SFHP.

### A. Selecting a PCP

*Members* are required to have a *PCP* and are encouraged to select a *PCP* at the time of enrollment. Each *PCP* is affiliated with a *medical group*. Each *medical group* utilizes certain *specialists*, *hospitals*, and other *health professionals* affiliated with that *medical group*, so the *member's* choice of *PCP* will also determine which other *participating providers* will be available for health care *services*.

The *PCP*, along with the *medical group*, is responsible for coordinating and directing all of the *member's* medical care needs, arranging referrals to *specialists* and other providers (including hospitals), and providing the required prior *authorization* the *member* will need to obtain health care *Services*. The *PCP* and *medical group* will also prescribe *medically necessary* lab tests, x-rays and other *covered services*.

If a *member* does not select a *PCP* at the time of enrollment, SFHP will designate one and the *member* will be notified. This designation will remain in effect until the *member* notifies SFHP of his/her own selection.

In order to obtain *benefits*, a *member* must have a *PCP*. If the *member* has not selected a *PCP*, call Member Services at **(415) 547-7800** (local) or **(800) 288-5555**, Monday through Friday, from 8:30am. to 5:30pm. Remember, for all health care needs (other than *emergency services*), including *services* for preventive health, routine health problems, consultation with *specialists*, and for *hospitalization*, the *member* must contact his/her *PCP* to obtain *authorization* for the *services*. If the *member* needs 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 *PCP* and *medical group* must coordinate and *authorize* the *member's* health care.

## B. Changing Your PCP or Medical Group

You may change *PCPs* or *medical groups* by calling Member Services at **(415) 547-7800** (local) or **(800) 288-555**. The change is effective the first day of the next month when the request is received by the 22nd day of the previous month, following notice of approval by SFHP. If we receive your request after the 22nd day of the current month, we may not be able to make the change until the month after the next month.

Please remember, if you change your *PCP* 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 *PCP* discontinues participation in SFHP, SFHP will notify you, so that you may pick another *physician*.

## C. Scheduling Appointments

All health care is coordinated through your *PCP*. New *members* should call their *PCP* to schedule an initial visit once they are enrolled. Routine appointments should be scheduled with your *PCP*. You can call your *PCP's* office 24 hours a day, 7 days a week if you need care. The *member* will be referred to a *specialist* if *medically necessary*, and as determined by the *PCP*.

## D. A Positive Relationship with Your PCP

In order to help your *PCP* 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 *PCP*.

# VIII. How to Use SFHP

## A. Authorization for Services

In this Evidence of Coverage, the words "*authorize*" or "*authorization*" refer to the requirement that the *member* obtain the approval of the *medical group* and, in some cases, SFHP for health care *services* referred by the *PCP* before such *services* are provided. You never need to get an *authorization* or ask your *PCP* before

you receive *emergency services*. Usually the *PCP's* office will obtain the *authorization* when you need it. However, it is always your responsibility to obtain the necessary referral and to make sure that the *authorization* has been obtained before receiving services.

SFHP and your *medical group* are responsible for decisions concerning the *authorization*, modification or denial of *services*. Decisions to *authorize*, modify or deny *services* based on a determination of *medical necessity* consistent with 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 *members, participating providers* and the public upon request.

Except for *services* provided by the *PCP* and *medically necessary emergency services* (see definition of *emergency services* on page 50), all *covered services* which are provided under SFHP to a *member* of SFHP must be referred and coordinated by the *PCP* and *authorized* in accordance with the rules of the *PCP's medical group* and SFHP. Any needed *authorization* from the *medical group* or SFHP will be obtained by the *PCP* on your behalf, but it is always a *member's* responsibility to contact his/her *PCP* to obtain appropriate referrals for *covered services* not provided by the *PCP*. Please note, however, that a referral by your *PCP* 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 the *member's PCP*.

Note: Except for the *services* provided by the *member's PCP* and for *emergency services*, 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 *members* receive appropriate and necessary health care *services*, SFHP allows *members* to obtain a *second opinion*. If the *member* is requesting a *second opinion* about care from his or her *PCP*, the *second opinion* shall be provided by an *appropriately qualified health care professional* of the *member's* choice within the same *medical group*. If there is no *participating provider* within the *medical group* who is appropriately qualified to treat the *member's* condition or offer a *second opinion* on the *member's* 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 the *member* is requesting a *second opinion* about care from his or her *specialist*, the *second opinion* shall be provided by any *appropriately qualified health care professional* of the *member's* 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

A *member's PCP* must refer him/her to a *specialist* for all *authorized, medically necessary covered services* not provided directly by the *PCP*. The *member* will generally be referred to a *specialist* who is affiliated with the same *medical group* as the *PCP*, 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 *services*, the *PCP* will refer him/her to a non-SFHP *provider* for the *services* after obtaining *authorization*.

Note: For all *covered services* not directly provided by the *member's PCP*, including *specialists*, SFHP *hospital*, and lab and x-ray, the *member* must first contact his/her *PCP* and the *services* must be *authorized*. In consultation with the *member*, the *PCP* will designate the *specialist*, SFHP *hospital*, or other *health professional* from whom the *services* will be received.

## D. 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 *PCP*. The OB/GYN or *specialist* must be part of the *member's medical group*. *Covered services* recommended or referred by one of these *physicians*, other than routine visits, must be *authorized* by the *medical group* and/or SFHP to the same extent as other *covered services*.

## E. Emergency Medical Care

An emergency medical condition means a medical condition or psychiatric 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 the member's 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. Or if a pregnant woman is in active labor, meaning labor at a time that either of the following would occur:

- There is inadequate time to affect a safe transfer to another hospital prior to deliver; or
- A transfer poses a threat to the health and safety of the member or unborn child.

*Psychiatric Emergency Medical Condition* means 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.

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 services, it is not necessary to contact your *PCP* before obtaining services. However, you should notify your *PCP* 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 the member 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.

#### **F. Urgent Care or Care After Regular Hours and on Weekends**

If you or a member of your family feels sick, has 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 need attention within 24 to 48 hours. 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.

#### **G. 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 contract 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.**

## IX. SFHP Benefits

SFHP covers the *benefits* described in this section and listed in the Healthy Kids Program Handbook, provided that *services* are obtained as described in Section 8, *authorization for services*. The *co-payments* for these *services* are also listed in the Summary of Benefits.

Note: *Services* are covered as *benefits* only if they are *medically necessary*, provided to a *member* of SFHP and provided either by the *member's PCP*, or with *authorization* as required in this booklet. Remember, except for *emergency services* (please see definition on page 50), all *services* must first be referred by the *member's PCP* and *authorized* by the *member's PCP's medical group* (and in some instances by SFHP).

### A. Linkages to Other Benefit Programs and Coordination of Services

#### 1. California Children's Services (CCS)

As part of the services provided through the Healthy Kids 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 Kids program are deemed to have met the financial eligibility requirements of the CCS Program. Services provided through the CCS Program are coordinated by the 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 condition is determined to be eligible for CCS services, the member will remain enrolled in the Healthy Kids program. He or she will be referred 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 and payment for CCS eligible services obtained from non-CCS paneled provider 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 Kids 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 **(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 Kids 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.

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:

- A. 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.
- B. Shows signs of psychotic behavior, risk of suicide or risk of violence which are related to mental disorder.
- C. 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 and the county mental health department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with a SED condition.

The member will remain enrolled in the Healthy Kids 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 care services and its limitations from SFHP.

When a member is determined 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 (even 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:

- **Outpatient visits** for treatment of SED
- **Inpatient** mental health care after the member has exhausted 30 inpatient days covered through SFHP
- **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".

### 3. 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, 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. A *member's PCP* will connect him or her with GGRC. If you have a family member who is over the age of two (2) with a disability diagnosed prior to the age of eighteen (18) that is likely to continue indefinitely, call GGRC at **(415) 546-9222**. *Members* should see their *PCPs* if they think they may have a disabling condition.

### 4. Early Start

Early Start is a federal program for children from birth to 3 years old who need early intervention services and:

Show a developmental delay in one of the following areas: cognitive, physical, communication, 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**.

### 5. 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. Who is eligible? Children under 5 years of age, pregnant women, women who are breast feeding or who have just had a baby and *members* who meet the Federal Income Guidelines. Eligible clients receive free food vouchers and nutrition education, and breast feeding support. Ask your *PCP* to help you apply or call to make an appointment at **(415) 575-5788** or **(888) WIC-WORKS** or **(888) 942-9675**.

### 6. Schedule of Benefits

Subject to referral by the *member's PCP*, *authorization*, applicable *co-payments*, and all other terms, conditions, limitations and exclusions of this Evidence of Coverage, including those listed in "Exclusions and Limitations," the following *benefits*, when *medically necessary*, are covered by SFHP under the Healthy Kids program.

## B. Preventive Health Services

Scheduled routine physical examinations as follows:

Periodic health exams for, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics; and the most current version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices, (ACIP).

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
- 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 (primary care provider approval not required)
- Mammography for screening for breast cancer or diagnostic purposes and annual cervical cancer screening test as recommended by the *member's PCP* or a qualified *health professional*.
- Medically accepted cancer screening tests including, but not limited to breast, prostate, and cervical cancer screening
- One annual eye refraction (to provide a written lens prescription for eyeglasses) may be obtained from SFHP through Vision Service Plan. Corrective lenses or frames (including the fitting of contact lens), eye exercises, and all other routine eye refractions are also covered through Vision Service Plan.
- 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 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.

#### C. Professional Services

*Medically necessary* professional services and consultations with a *physician* or other *health professional*. 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; and home visits when *medically necessary*. In addition, professional services include:

- Hearing Tests and eye exams, including eye refractions to determine the need for corrective lenses, and dilated retinal eye exams.
- Immunizations consistent with the most current Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices, (ACIP).
- Screening for blood lead levels in children at risk for lead poisoning, as determined by the *PCP*.
- Phenylketonuria (PKU) screening and treatment for PKU.
- Professional services for psychiatric care, alcohol and substance abuse treatment.
- Biofeedback. A maximum of eight visits for biofeedback are covered with a referral from a *PCP* or specialist.
- Screening, diagnosis and treatment for breast cancer.

#### D. Pregnancy and Maternity (Prenatal) Care

Prenatal and Postnatal Physician Office Visits and Delivery. *Medically necessary* professional and *hospital services* including prenatal and postnatal care and care for complications of pregnancy; 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.

- Genetic testing, including Alpha-Fetal Protein Screening (AFP) is covered if *medically necessary*, and must be authorized.
- *Inpatient hospital services.*  
Provided for vaginal and Cesarean Section delivery, and for complications or medical conditions arising from pregnancy or resulting childbirth. The length of *inpatient hospital* stay is based upon the mother's condition. The *Plan* will not restrict its *inpatient hospital* care to less than 48 hours following a normal vaginal delivery and not less than 96 hours following a cesarean section delivery. However, coverage of *inpatient hospital* care may be for a time period less than 48-96 hours if the following two conditions are met:
  1. The discharge decision is made by the treating *physician*, in consultation with the mother; and
  2. The treating *physician* schedules a follow-up visit for the mother and newborn within 48 hours of discharge.
- Nurse Midwife Services. Available to *members* seeking obstetrical care. The chosen nurse midwife must be associated with a *physician* contracted with the Health Plan. Nurse midwives are listed in the Healthy Kids Provider Directory.

Note: All pregnancy and maternity care must be provided or referred by the *member's PCP* and must be *authorized*. *Inpatient hospital services* are covered at the *authorized hospital* and only if the *member* is under the direct care and treatment of her *PCP* or *authorized specialist*. Out-of-area coverage relating to pregnancy (including childbirth) is also available in *urgent* and *emergency* situations.

#### E. Family Planning

Family planning benefits, counseling, professional *services* for sterilization as permitted by State and Federal Law, prescription contraceptives and non-prescription contraceptives if the *PCP* determines that none of the

methods of contraception designated by the *Plan* as covered or preferred are medically appropriate for the patient.

#### F. Abortion Services

Therapeutic abortions are covered when *medically necessary*. Elective abortions are covered.

#### G. Infertility Treatment

Treatments for medical conditions of the reproductive system are covered if Medically Necessary. Infertility treatment such as in-vitro fertilization, G.I.F.T. (Gamete Interfallopian Transfer) or any other form of induced fertilization, artificial insemination, or *Services* incident to or resulting from procedures for or the *services* of a surrogate mother are not *covered services*.

#### H. Health Facilities

The following *hospital services* are SFHP *benefits* when *authorized* and provided at the SFHP *hospital* in accordance with SFHP rules:

- *Hospital services* in connection with dental procedures are covered when due to an underlying medical condition or because of the severity of the procedure.
- *Services* of the dentist or oral surgeon are covered under the dental benefit through Delta Dental Plan.

Note: *Hospital benefits* are not covered if the *member* refuses to be under the direct care and treatment of a *medical group physician* or other *physician* whose *services* have been *authorized*.

##### 1. Inpatient Hospital Admissions

Inpatient *hospital services* during an *authorized* admission include:

- Semi-private room and board, unless a private room is *medically necessary* and *authorized*. If a private room is used without *authorization*, the *member* will be responsible for the difference between the *hospital's* customary charge for a two-bed room and the private room.
- General nursing care and special duty nursing when *medically necessary* and *authorized*.
- Intensive care *services*.

- Operating room, special treatment rooms, delivery room, newborn nursery and related facilities.
- Meals (and special diets when *authorized*).
- *Hospital* ancillary services including diagnostic laboratory, x-ray services, and *short-term therapy* services, subject to the visit limitation (described on page 59). Drugs, medications, IV fluids, biologicals, and oxygen administered in the *hospital* and approved by the Food and Drug Administration (FDA). Up to three days' supply of drugs as directed upon discharge by the Physician during transition from the *hospital* to home.
- Surgical and anesthetic supplies, dressings and cast materials, surgically implanted devices and *prosthesis* (not including surgically implanted hearing aids), other medical supplies, medical appliances, and equipment administered in the *hospital*, and *prosthetic* devices for a patient having a mastectomy (to restore and achieve symmetry for the patient) or a patient having a laryngectomy (to restore speech). (See *short-term therapy benefits*, page 45).
- Administration of blood and blood plasma including *hospital* blood processing, the cost of blood, blood plasma, and other blood products. Includes the collection and storage autologous blood when medically indicated.
- Radiation therapy, chemotherapy and renal dialysis.
- *Inpatient* alcohol and substance abuse admissions are covered only for *medically necessary* detoxification. All other *inpatient* alcohol and substance abuse treatments and services are not *benefits*.
- Mastectomy length of stay associated with a mastectomy or lymph node dissection is determined by the *member's physician* and surgeon in consultation with the *member*.

## 2. Outpatient Hospital Services

*Services* and supplies for treatment (including radiation and chemotherapy) or surgery in an *outpatient hospital* setting or ambulatory surgery center. *Hospital outpatient psychiatric care/alcohol and drug abuse* treatment are not covered. Other *outpatient services* laboratory, x-ray, major diagnostic *services*. Diagnostic and therapeutic radiological services include: electrocardiography; electroencephalography; mammography; and laboratory *services* including: tests for management of diabetes, cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (glycohemoglobin).

- Renal Dialysis. *Outpatient* renal dialysis. Equipment, training and medical supplies required for home dialysis are also covered.
- Radiation Therapy. Treatment of a condition through application of a radioactive substance.
- Supplies, equipment, and *services* for treatment and/or control of diabetes. Supplies, *equipment*, and *services* for treatment and/or control of diabetes even when such items, tests, and *services* are available without a prescription, including:
- Supplies and equipment such as:
  - Blood glucose monitors and blood glucose testing strips.
  - Blood glucose monitors designed to assist the visually impaired.
  - Insulin pumps and all related supplies
  - Ketone urine testing strips.
  - Lancet and lancet puncture devices.
  - Pen delivery systems for the administration of insulin.
  - Podiatric devices to prevent or treat diabetes-related complications.
  - Insulin syringes.
- Visual aids, excluding eye ware, to assist the visually impaired with proper dosing of insulin.
- Diabetes Outpatient self-management training, education, and medical nutrition therapy.

- Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).
- Dilated retinal eye exam.
- Additionally, the following prescription items are covered if they are determined to be *medically necessary*:
  - Insulin;
  - Prescription medications for the treatment of diabetes (per the Healthy Kids formulary);
  - Glucagon.

### 3. Skilled Nursing Facility Services

A *skilled nursing facility* is a facility which contracts with SFHP, provides continuous skilled nursing services, and is licensed as a *skilled nursing facility* by the State of California. A *skilled nursing facility* may be a distinct part of a *hospital* and use of such distinct part shall be counted towards the maximum number of days described in this section. This benefit is limited to 100 days during any *benefit year*. Subject to this limitation, the following *skilled nursing facility benefits* are provided when *medically necessary* and *authorized* and not primarily for *custodial* or *convalescent* or *domiciliary care*:

- Semi-private room and board, unless a private room is *medically necessary* and *authorized*. If a private room is used without *authorization*, the *member* will be responsible for the difference between the *skilled nursing facility's* customary charge for a two-bed room and the private room.
- General nursing care and special duty nursing when *authorized*.
- Special diets, when *authorized*.
- Physical therapy, occupation therapy, speech therapy, and other rehabilitative *services* up to SFHP maximums.
- Oxygen administered in the *skilled nursing facility*.
- Administration of blood and blood plasma including *hospital* blood processing, the cost of blood, blood plasma, and other

blood products. Includes the collection and storage of *autologous blood* when medically indicated.

- Durable medical equipment utilized by the member during an authorized stay in the skilled nursing facility.

Note: Skilled nursing benefits are not provided for custodial or domiciliary care services (custodial services) as defined by SFHP.

Exception: *Custodial services* are covered for *members* who have been diagnosed with a *terminal illness* (high probability of causing death within one year or less, as determined by the *member's PCP*), where medically necessary, skilled nursing benefits may be *authorized*. In the event that *services* are partially *custodial services* and partially *skilled nursing benefits*, SFHP will cover a pro rata portion of the costs directly attributable to the provision of the *skilled nursing services*.

### I. Home Health Care Services

*Home health care services* are the provision of skilled medical *services* by SFHP contracted Health Professionals to a homebound *member*. The purpose of *home health care* is to transition the *member* from institutionalization or to prevent institutionalization when the *member* does not require continuous skilled *services* in the home. A homebound *member* is unable to leave his or her home due to a medical condition except with considerable effort and assistance.

*Home health care services* are provided pursuant to an *authorized* home health treatment plan and only when *medically necessary* and *authorized*. *Home health care services* must be provided under the direct care and supervision of the *member's PCP* within the *medical group's service area*.

*Home health benefits* include intermittent and part-time home visits by a home health agency to provide the skilled *services* of the *health care professionals* described in this section. As *authorized*, home health visits are made by: a registered nurse; licensed vocational nurse; physical therapist,

occupational therapist, speech therapist or respiratory therapist (*physical therapy, occupational therapy, speech therapy, and other rehabilitative therapy* provided in this section are counted towards, and subject to, SFHP maximums described in *short-term therapy*); certified home health aide in conjunction with the *services* of the nurses and/or the therapists listed in this section; medical social services provided by a licensed medical social worker for consultation and evaluation. The following *home health care services* are also included:

- In conjunction with the professional *services* rendered by a home health agency, medical supplies, and medications administered by the home health agency necessary for the home health care treatment plan and related pharmaceutical and laboratory *services* to the extent that these *services* would have been provided if the *member* was an *inpatient* of a *hospital*.
- Medically necessary home visits by a physician.
- *Durable medical equipment* if medically necessary under the *member's* home health treatment plan. *Durable medical equipment* shall be rented or purchased, as determined by SFHP, and must be Authorized. *Durable medical equipment* does not include equipment that is primarily for the convenience of the *member* or person providing care to the *member*. Replacement because of loss and repair due to misuse and damage of home medical equipment are not covered.

In no event will home health care be provided by SFHP for services, which are not skilled services. Services that are custodial in nature (Custodial Care) or that can be appropriately provided by a non-skilled or non-licensed family member are not covered. This limitation does not apply to Hospice Services.

#### J. Hospice Care

SFHP also provides *hospice care* for its *members* who are *terminally ill* through periodic visits to the *member* at home by licensed hospice staff

under contract to SFHP, if they elect this home based treatment instead of the other *benefits for terminal illness* which are provided by the *Plan*. The *member* may change the decision to receive *hospice care* at any time and request the other *services* offered by SFHP instead.

When ordered by a *physician*, the hospice *benefits* include *physician services*, nursing care, medical social services, home health aide *services*; drugs, medical supplies and appliances, counseling and bereavement *services*, *physical/occupational/ speech therapy*; short-term *inpatient* care for pain control and symptom management; homemaker and short term respite care.

#### K. Short-Term Therapy Benefits

Short-term therapy benefits are: physical therapy, occupational therapy, speech therapy, and respiratory therapy. The short-term therapy services and benefits, whether provided on an inpatient or outpatient basis (including when provided in an acute care hospital, rehabilitation unit, skilled nursing facility, outpatient office, or as part of home health care or hospice services), may be provided up to a combined maximum of 60 consecutive calendar days following the first such therapy treatment for any single illness or injury. Short-term therapy past the initial sixty (60) day period will be authorized as medically necessary. All short-term therapy services must be medically necessary and authorized by the medical group or the Plan.

#### L. Cancer Clinical Trials

Routine patient care costs related to the *member's* participation in a cancer clinical trial which meets the requirements of Health and Safety Code Section 1370.6. The *member* must be diagnosed with cancer and accepted into a phase I, II, III or IV clinical trial for cancer after recommendation by the *member's primary care provider* that the *member's* participation in the trial has a meaningful potential to benefit the *member*. The treatment must be provided in a clinical trial that either involves a drug that is exempt under federal regulation from a new drug application or is approved by one

of the following:

(1) One of the National Institutes of Health; (2) The federal Food and Drug Administration; (3) The U.S. Department of Defense; or (4) the U.S. Veterans' Administration.

Coverage for treatment in a clinical trial is limited to participating *hospitals* and *participating providers* in California, unless the protocol for the clinical trial is not provided for at a California *hospital* or by a California physician.

Routine patient care costs include:

- Drugs, items, devices and services that would otherwise be a covered benefit under the Plan if those drugs, items, devices and services were not provided in connection with an approved clinical trial program.

Routine patient care costs do not include:

- A drug or device that has not been approved by the federal FDA
- Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses
- 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 *member*
- Services customarily provided by the research sponsors free of charge
- Any health care service that is otherwise excluded under the Healthy Kids Program.

#### **M. Prescription Drugs**

Medically necessary prescription drugs (including injectables) and nutritional supplements and formulas for the treatment of phenylketonuria (PKU) are covered when prescribed by a licensed physician acting within the scope of his or her license. Coverage includes needles and syringes when medically necessary for the administration of the covered injectable medication. For diabetics, coverage includes medically necessary insulin, glucagon, syringes

and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, and lancets and lancet puncture devices in medically necessary quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes. Prenatal vitamins and fluoride supplements are covered only if medically necessary and require a prescription.

SFHP shall, in consultation with the prescribing physician, determine the supply of drugs to be prescribed. SFHP's formulary includes FDA-approved brand name and generic drugs. There is no co-payment for prescription drugs provided in an inpatient setting, drugs administered in the doctor's office, or in an outpatient facility setting during a member's stay at the facility. Refer to the Prescription Drug Coverage section of the Healthy Kids Program Summary of Benefits Matrix on page 16 for co-payment information. Generic substitution is required, unless a generic equivalent for a brand name drug does not exist or it is medically necessary for the member to receive the non-generic equivalent; up to a 30-day supply of these drugs will be given. If you require a non-generic drug, your physician must specifically request that no substitutions be made by writing "no substitutions" on your prescription form and an authorization request must be submitted.

Up to a 90-day supply of maintenance drugs, including oral and injectable contraceptives and insulin supplies (maintenance drugs are those prescribed for 60 days or longer and are usually for chronic conditions) are covered. Tobacco cessation drugs must include proof of the member's participation in a tobacco cessation program.

Emergency contraception may be obtained from a participating pharmacist or from a non-participating provider, in the event of a medical emergency. There is no co-payment for FDA-approved contraceptive drugs and devices.

### SFHP Formulary

Participating providers may prescribe a range of prescription drugs listed on the SFHP Drug Formulary. The SFHP formulary is SFHP's list of approved prescription drugs. The SFHP Drug Formulary is developed, and regularly reviewed and updated on a quarterly basis by the SFHP Pharmacy and Therapeutics Committee, which is made up of SFHP's Medical Director, pharmacists, providers, and other health consumer representatives. A member may obtain a copy of the SFHP Drug Formulary by contacting SFHP at **(415) 547-7800** (local) or **(800) 288-5555**. Except as described in this Evidence of Coverage, only prescription drugs that are listed on SFHP Drug Formulary list are covered. The presence of a drug on the formulary does not guarantee that you will be prescribed that drug by your provider. A prescription drug that is not listed on the formulary will be covered:

- If SFHP, in consultation with the *PCP* or prescriber, determines it is medically necessary, (SFHP requires a prior authorization for non-formulary prescription drugs); or
- The prescription drug not on SFHP's *formulary* had been previously approved by *SFHP* for the *member* to treat the Member's medical condition and the Member's *participating provider* continues to prescribe the drug for the Member's medical condition, provided that the prescription drug is appropriately prescribed and is considered safe and effective for treating the Member's medical condition. The Member's *participating provider* may decide to prescribe a drug that is a SFHP Formulary medication and that is medically appropriate for treating the enrollee's condition; or
- It is a drug approved by the federal Food and Drug Administration as a Treatment Investigational New Drug or classified as a Group C cancer drug by the National Cancer Institute to be used only for the purposes approved by the federal Food and Drug Administration or the National Cancer Institute.

A member or physician may request a non-formulary prescription drug. A physician must submit a request form to SFHP's pharmacy benefit management company (Informed Rx) at **(516) 403-2151** or **(800) 945-1815** (which can be obtained from SFHP). Once this form has been obtained, SFHP will make an authorization determination. An authorization determination that the physician indicates is an urgent medication will be processed within twenty four hours.

Exclusion: Prescriptions for drugs and medicines which have not received the marketing approval of the U.S. Food and Drug Administration (FDA). However, coverage for drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the following conditions are met:

- The drug is approved by the FDA;
- The drug is prescribed by a Plan Provider to treat a life-threatening condition or for a chronic and seriously debilitating condition,
- The drug is Medically Necessary to treat the condition, and;
- The drug is recognized by a specified pharmaceutical professional publication for treatment of the life-threatening or chronic and seriously debilitating conditions.

### N. Durable Medical Equipment

*Durable medical equipment* includes, when *medically necessary*, oxygen and equipment for its administration, blood glucose monitors, apnea monitors, pulmonaides and related supplies, nebulizer machines, tubing and related supplies, spacer devices for metered dose inhalers, insulin pumps and necessary related supplies, colostomy bags, urinary catheters and supplies. SFHP may determine whether to rent or purchase such equipment.

### O. Orthotics and Prosthetics

When *medically necessary* and *authorized*, *orthotics* and *prosthetics*, including *medically necessary* replacement *prosthetic* devices are covered. Replacement is only following

the useful life of the *orthotic* or *prosthetic*. *Benefits* also include the initial and subsequent *prosthetic* devices and installation accessories to restore a method of speaking incident to a laryngectomy; *prosthetic* devices incident to mastectomy and to achieve symmetry, and therapeutic footwear for diabetics. Surgically implanted hearing aids are not covered.

The following are not covered *benefits*: Corrective shoes and arch supports (except therapeutic footwear for diabetics), non-rigid devices (such as elastic knee supports, corsets, elastic stockings, and garter belts), dental appliances, electronic voice producing machines, or more than one device for the same part of the body. If there are two or more professionally recognized appliances equally appropriate for a condition, SFHP will provide *benefits* based on the most cost-effective appliance. Surgically implanted devices, such as pacemakers are covered.

#### **P. Health Education**

Our health education programs can help you protect and improve your health. SFHP encourages you to make changes for better health and emphasize active participation, informed decision-making and self-care skills.

The following services are available at no charge:

- Health education publications on how to use your Health Plan are available in English, Spanish and Chinese.  
All Healthy Kids members will receive our quarterly *member* newsletter, Your Health Matters. Call Member Services to request other materials.
- Health education classes for children and adults are available throughout SFHP's *service area*. Call Member Services at **(415) 547-7800** (local) or **(800) 288-5555** for information on the current classes available.

#### **Q. Hearing Care**

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. Monaural or binaural hearing aids including ear molds, the hearing aid instrument, the initial battery, cords and other ancillary equipment. Visits for fitting, counseling, adjustments and repairs at no charge for one year following the provision of a covered hearing aid.

Exclusions: The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase, and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss. Replacement parts for hearing aids, repair of a hearing aid more than once in any period of thirty-six months, and surgically implanted hearing devices are excluded.

#### **R. Organ Transplant Benefits**

*Hospital* and professional *services* provided in connection with *medically necessary* and *authorized* human organ transplants are covered for *members*. All transplants must be pre-authorized by SFHP and SFHP may require that the transplant be performed at a transplant center selected by SFHP. Should a request for *services* related to organ transplantation be denied due to the *experimental* or *investigational nature* of the treatment, you may immediately have this decision reviewed by the Department of Managed Health Care ("DMHC") through the IMR process, as set forth in section 1370.4 of the Health and Safety Code. You do not need to participate in the Plan's Grievance Process before having your case heard through the DMHC's IMR process. You may apply directly to the DMHC for participation in the IMR process. Please see page 65 of this EOC/DF for a complete description of the IMR process and how the *Plan* will assist you with application. *Members* will be referred to CCS to determine if they are eligible to receive *services* through CCS. If the *member* qualifies for CCS, they will remain enrolled in SFHP but will receive all organ transplant *services* through CCS. SFHP will continue to provide all *medically necessary* care for conditions unrelated to the CCS eligible condition. For more information on CCS services, please refer to section IX-A-1 of this handbook.

The costs of any transplant *services* are not covered when the recipient of the transplant is not a *member*.

The following *services* are covered when the recipient is a *member*:

- *Services* incident to obtaining the transplanted material from a living donor or an organ transplant bank will be covered for the covered transplant.
- Prescribed post-surgical immune suppressive *outpatient* drugs following the transplant.

Note: Bone marrow and organ donor searches are covered *benefits*. However, SFHP is not responsible for assuring the availability of, or locating a bone marrow donor or donor organ.

#### **S. Cosmetic and Reconstructive Surgery**

*Medically necessary cosmetic and reconstructive surgery* performed to correct or repair abnormal structures of the body caused by congenital defects, severe burns and other medical conditions, such as developmental abnormalities, trauma, infection, tumors, or disease, as well as *services* related to *cosmetic and reconstructive surgery*, to repair or alleviate bodily damage caused by illness or injury or following surgery are covered *benefits* for *members*.

Additionally, cosmetic *services* provided in connection with *reconstructive surgery* after a mastectomy to restore and achieve symmetry for the patient are a *benefit*. Any such *services* must be received while the *member* is enrolled in and eligible for SFHP coverage.

#### **T. Alcohol/Substance Abuse Treatment**

*Inpatient hospitalization as medically necessary* to remove toxic substances from the system. Up to 20 *outpatient* visits per *benefit year* each are also covered for medically appropriate crisis intervention and treatment of alcoholism or substance abuse. Alcohol and substance abuse treatment (except for *inpatient* detoxification) are covered through San Francisco Mental Health Plan. See section U, below for a description of how to contact San Francisco

Mental Health for more information on the services they provide.

### **U. Mental Health Care**

#### **1. Inpatient**

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

#### **Basic Mental Health Services**

(Community Behavioral Health Services is SFHP's Mental Health Service provider).

Diagnosis and treatment of a mental health condition.

#### **Limitations**

Basic mental health care services are limited to thirty (30) days per benefit year. Additional days may be authorized by SFHP. SFHP, with the agreement of the subscriber or applicant or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following:

- 2 days of residential treatment,
- 3 days of day care treatment, or
- 4 outpatient visits.

#### **Severe Mental Illness (SMI)**

Inpatient mental health care services for the treatment of Severe Mental Illnesses. 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

#### **Limitations**

Unlimited days.

#### **Serious Emotional Disturbance (SED) Services (Provided by the Community Behavioral Health Services)**

Diagnosis and treatment for SED condition.

**Limitations**

**Unlimited days.** On or before day 30; SFHP may refer the member to their county mental health department for continued treatment of the SED condition. The Plan and the county mental health department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with a SED condition.

**2. Outpatient**

Mental health care services when ordered and performed by a participating Plan mental health provider.

**Basic Mental Health Care Services**

- 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.

**Limitations**

Basic outpatient mental health care services are limited to twenty (20) visits per benefit year, except that the number of treatment days may be increased when outpatient treatment days are substituted for inpatient hospitalization days as described in the *Inpatient Mental Health Services* benefit description section of this Evidence of Coverage (EOC) booklet.

**Severe Mental Illness (SMI)**

Outpatient mental health care services for the treatment of severe mental illnesses. 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

**Limitations**

Unlimited visits.

**Serious Emotional Disturbance (SED) Services**

Diagnosis and treatment for SED condition provided by the county mental health department.

For members with a Serious Emotional Disturbance (SED) condition, outpatient and related professional services pertaining to the SED condition will be provided by the county mental health department. The Plan and the county mental health department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with a SED condition.

The member will remain enrolled in San Francisco Health Plan and will continue to receive primary care, specialty care, and all other covered services for medical conditions not related to the SED condition from the Plan. For more information about SED diagnosis and treatment benefits, see information on page 39.

**Limitations**

Unlimited visits.

**V. Emergency Services**

*Services* in any emergency room for an *emergency medical condition*, including psychiatric screening, examination, evaluation, and treatment by a qualified *physician*. Follow-up care for an illness, injury or condition which caused the *emergency medical condition* must be provided by, referred or *authorized* according to the rules described in this Evidence of Coverage.

**W. Emergency Hospitalization**

If a *member* is admitted to a SFHP *hospital* as the result of an emergency medical condition that is not used by the *PCP'S medical group*, the Health Plan may elect to transfer him or her to the Hospital used by his or her *PCP's medical group*. This transfer will occur

when it is medically safe to do so. Any *service* provided by the *hospital* after the time that the Health Plan has notified the *member* and the *hospital* to which the *member* was admitted that the transfer is medically safe, are not *covered services*, and may be the financial responsibility of the non-affiliated *hospital*.

#### **X. Medical Transportation Services**

Emergency ambulance transportation in connection with a medical condition requiring *emergency services* to the first *hospital* or *urgent care* center that accepts the *member* for *emergency care*.

Non-emergency transportation for the transfer of a *member* from a *hospital* to another *hospital* or facility; or facility to home, when:

- Medically necessary, and
- Requested by a physician, and
- Authorized in advance.

#### **X. Dental Benefits**

Dental Benefits are provided through Delta Dental of California.

Upon enrollment you will receive a dental provider directory that lists Delta Dental dentists participating in the Healthy Kids program. This directly will assist you in choosing a dentist that is accessible and who speaks your language. We encourage you not to wait until you have a problem to see your dentist, but to see him/her on a regular basis. When you choose a network dentist from the list of participating dentists, you can receive any necessary covered preventative or corrective dental care *services* at that location.

If you have a question or grievance regarding eligibility, covered *services*, the denial of dental *services* or claims, policies, procedures and operations of the dental program, or the quality of dental *services* performed by a network dentist, you may contact Delta Dental's Healthy Kids Member Services toll free number at **(866) 212-2743**, Monday through Friday, 6:00am to 5:15pm For emergency situations they are available 24 hours a day, seven days a week. Please refer to Group Number SF60.

#### **A. Choice of Physician and Provider**

The Delta Dental provider directory provides you with the names of

network dentists in the City and County of San Francisco. The directory also gives you information about office facilities including wheelchair accessibility and languages spoken within each office. You can select any dentist listed in the directory. If you have special health care needs, contact Delta's Member Services department for assistance in finding a dentist who can best meet your needs.

#### **B. Scheduling Appointments**

After you have selected a network dentist, call the dentist to schedule an appointment. Tell the dentist you are covered by Delta under the Healthy Kids program and ask the dentist to confirm that he or she is a network dentist. During your first appointment, be sure to give your dentist the following information:

1. Your group number (can be found on your *member* identification card: SF60);
2. The name of your program: Healthy Kids program;
3. The *member's* client identification number; and,
4. Any other dental coverage you have.

#### **C. Referrals to Specialists**

our network dentist may refer you to another dentist for a consultation or specialized treatment. If this is done, be sure that the dentist you are referred to is a network dentist. You can do this simply by asking the specialist when you make your appointment. *Specialists* are also listed in the Delta Dental - Healthy Kids Provider Directory. Remember if the dentist is not a network dentist, you will be responsible for the cost of treatment.

#### **D. Changing Your Dentist**

You can choose any network dentist at any time. If you wish to change dentists, simply review the directory of network dentists in your area and call to schedule an appointment. If your dentist stops participating in Delta's Healthy Kids provider network, you will be notified 90 days in advance. Delta's Healthy Kids Member Services department is available to assist you in choosing a new dentist.

## E. Second Opinions

Second Opinions are performed by a regional consultant, who conducts clinical examinations, prepares objective reports of dental conditions and evaluates treatment that is proposed or has been provided.

A *second opinion* may be required prior to treatment when necessary to make a *benefit* determination.

*Authorizations* for *second opinions* after treatment can be made if a *member* has a grievance regarding the quality of care provided. You and the treating dentist will be notified when a *second opinion* is necessary and appropriate. When a *second opinion* is *authorized* through a regional consultant, all charges will be paid by Delta Dental. Enrollees may otherwise obtain a *second opinion* about treatment from a network dentist they choose, and claims for the examination or consultation may be submitted for payment. Such claims will be paid in accordance with the *benefits* of the program.

This is a summary of the Delta Dental policy on *second opinions*. A copy of the formal policy is available upon request by contacting the Delta Dental Healthy Kids Member Services department at toll free **(866) 212-2743** and refer to Group Number SF60.

## F. Emergency and Urgent Dental Care Services

An emergency or urgently needed dental *service* is a dental *service* required for, or under the circumstances, reasonably believed to be required for, treatment of severe pain, swelling or bleeding or the immediate diagnosis and treatment of unforeseen dental conditions which, if not immediately diagnosed and treated, would lead to serious deterioration in health, disability or death.

## G. How to Get Emergency or Urgent Dental Care Services

Prior approval from Delta Dental is not required for emergency or urgently required dental Services. You can receive emergency dental *services* 24 hours a day, seven days a week. In the case of an emergency, you should call your regular network dentists or any other network dentist. If you need additional assistance call Delta's

Healthy Kids Member Services department at toll free **(866) 212-2743** and refer to Group Number SF60.

If you are outside California, you still have 24 hours, seven days a week emergency coverage. You can get emergency dental *services* from any licensed dentist without prior approval from Delta. All emergency *services* by out-of-state dentists are paid at the allowable rate by Delta for emergency treatment. The treating dentist should call toll free at **(866) 212-2743** for payment and *benefits* information.

## H. Follow-Up Care

Instructions for follow-up care after an emergency or urgently needed *service* will be provided by the treating dentist. Follow the directions provided by the treating dentist on follow-up care or call your network dentist for more information.

## I. Dental Services That Are Not Covered

If you receive non-emergency *services* from a dentist who is not a network dentist, you are responsible for payment to the dentist.

## J. Payment Responsibilities

Delta pays network dentists directly. Delta Dental's agreement with your dentist makes sure that you will not be responsible to the dentist for any money for a *covered service* other than *other charges (co-payments)*. There are no other charges (co-payments) required for preventative *services*.

## K. Your Dental Benefits

Delta Dental covers several categories of *benefits* when those *services* are provided by a network dentist, and when they are necessary and customary under the generally accepted standards of dental practice

### 1. Diagnostic and Preventative Benefits

Diagnostic - initial and periodic oral examinations, x-rays, palliative emergency office visits, and consultation by a specialist.

Preventative - prophylaxis (cleaning), fluoride treatment, dental sealants, preventative dental education and oral hygiene instruction.

Space Maintainers - covered *benefits* include space maintainers, include removable acrylic and fixed band type.

## 2. Restorative, Oral Surgery, Endodontic and Periodontic Benefits

Restorative - amalgam, composite resin, acrylic, synthetic or plastic restorations (fillings) for treatment of cavities (decay). Related pin and pin build up in conjunction with a restoration.

Sedative bases and sedative fillings are also included as *benefits*.

Oral Surgery - extractions, surgical removal of impacted teeth, biopsy of oral tissues, and other surgical procedures, such as: alveolectomies, excision of cysts and neoplasms, treatment of palatal and mandibular torus, frenectomy, incision and drainage of abscesses, root recovery (separate procedure) and post-operative *services* including exams, suture removal and treatment of complications.

Endodontic - direct pulp capping, pulpotomy and vital pulpotomy, apexification filling with calcium hydroxide, root amputation, root canal therapy, apicoectomy and vitality tests.

Periodontic - emergency treatment, including treatment for periodontitis; periodontal scaling and root planning, and sub-gingival curettage; gingivectomy and osseous or muco-gingival surgery.

## 3. Crown and Fixed Bridge Benefits

Crowns - including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel as necessary to treat cavities that cannot be directly restored with amalgam, composite resin, acrylic, synthetic, or plastic fillings. Related dowel pins and pin build-up are also included.

Fixed Bridges - which are cast, porcelain baked with metal, or plastic processed to gold. Benefit Includes:

- (1) Recommendation of crowns, bridges, inlays, and onlays as a covered benefit,
- (2) Cast post and core, including cast retention under crown, and
- (3) Repair or replacement of crowns, abutments or pontics as a covered benefit.

## 4. Removable Prosthetic Benefits

Dentures - *Covered benefits* include construction or repair of partial dentures and complete dentures when provided to replace missing, natural teeth. *Benefits* also include office or laboratory relines or rebases; denture repair; denture adjustments; tissue conditioning; stayplates; and denture duplication. Implants are considered an optional benefit.

## 5. Orthodontic Benefits

Orthodontic treatment is not a benefit of this dental plan. However, orthodontic treatment will be provided by the California Children Services (CCS) Program if the *member* meets the eligibility requirement for *medically necessary* orthodontia coverage under the CCS Program.

## 6. Other Dental Benefits

Other dental *benefits* include (1) Local anesthetics, (2) Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure, (3) Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure, and (4) Coordination of *benefits* with the Health Plan in the event hospitalization or *outpatient* surgery setting is medically appropriate for dental *services*.

## L. Dental Benefit Exclusions and Limitations

The covered dental benefit for each member will be limited to fifteen hundred dollars (\$1,500) per benefit year. This means that the SFHP Healthy Kids program will pay for covered dental services up to \$1,500 per benefit year\*. Once the limit is reached, you will have to pay for all dental services. The requirements for co-pays stay the same.

**\*Benefit Year** means the twelve (12) month period commencing July 1 of each year at 12:01 am.

If you have any questions, please call the San Francisco Health Plan Member Services Department at **(415) 547-7800** or **(800) 288-5555**. The TDD line for the hearing or speech impaired is **(415) 547-7830**.

**Dental X-rays are limited as follows:**

- **Bitewing x-rays** are limited to one set of four films in any consecutive SIX month period. However, isolated bitewing or periapical films are allowed on an emergency or episodic basis.
- **Full mouth x-rays** in conjunction with a periodic exam are limited to once every 24 months.
- **Panoramic film x-rays** are limited to once every 24 consecutive months.
- Prophylaxis Services (cleanings) are limited to two in a 12-month period.
- Dental sealant treatments are limited to permanent first and second molars only.

**Restorations are limited as follows:**

- If the tooth can be adequately restored with amalgam, composite resin, acrylic, synthetic or plastic restorations materials, any other restoration such as a crown or jacket is considered optional.
- Composite resin or acrylic restorations in posterior teeth are considered optional.
- Only micro filled resin restorations that are non-cosmetic are allowed.
- Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

**Root canal therapy, including culture of canal is limited as follows:**

- **Retreatment of root canals** is a covered benefit only if clinical or

radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms.

- **Removal or retreatment of silver points**, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

Periodontal scaling and root planting, and subgingival curettage are limited to five quadrant treatments in any 12 consecutive months.

**Crowns are limited as follows:**

- **Replacement of each unit is limited** to once every 36 consecutive months, except when the crown is no longer functional.
- **Only acrylic crowns and stainless steel crowns are a benefit** for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.
- **Crowns will be covered only if** there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- **Veneers** posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

**Fixed bridges are limited as follows:**

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case, it is considered optional treatment.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.

- **Fixed bridges used to replace missing posterior teeth** are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- **Fixed bridges** are optional when provided in connection with a partial denture on the same arch.
- **Replacement of an existing fixed bridge** is covered only when it cannot be made satisfactory by repair.

Five units of crown or bridgework per arch are allowed. The sixth unit is considered full mouth reconstruction and is an optional treatment.

Dentures (full maxillary, full mandibular, partial upper, partial lower), teeth, clasps, denture repair, adjustment and duplication, tissue conditioning (two per denture) and stress breakers are limited as follows:

- **Partial dentures** will not be replaced within 36 consecutive months, unless:
  - It is necessary due to **natural tooth loss** where the addition or replacement of the teeth to the existing partial is not feasible, or
  - **The denture is unsatisfactory** and cannot be made satisfactory.
  - **The covered dental benefit for partial dentures** will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborated or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the *applicant* will be responsible for all additional charges.
- **A removable partial denture** is considered an adequate restoration of a case when teeth are missing on both sides of the same dental arch. Other treatments of such cases are considered optional.
- **Full upper and/or lower dentures** are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory

and cannot be made satisfactory by reline or repair.

- **The covered dental benefit for complete denture(s)** will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the *applicant* will be responsible for all additional charges.
- **Office of laboratory** relines or rebases are limited to one per arch in any 12 consecutive months.
- **Stayplates** are a benefit only when used as anterior space maintainers for children and to replace extracted anterior teeth for adults during a healing period.

#### M. Dental Benefit Grievances

If you have a concern or a grievance regarding any dental *service* you have received you should contact a Member Services representative at Delta Dental at

**(877) 580-1042**, Monday through Friday from 6:00am through 5:15pm.

**To submit a grievance electronically, please visit Delta Dental's web-site at <http://www.deltadentalca.org>.**

1. At the Main Menu please select "Contact Us",
2. Please select "State, County and Local Dental\_Programs"
3. Under "To file a grievance", please select "Patient grievance form".

Members who have a grievance involving the *services* received from Delta Dental may also contact San Francisco Health Plan at **(415) 547-7800** (local) or **(800) 288-555**.

If you have questions about the *services* you receive from a network dentist, first discuss the matter with your dentist. If you continue to have concerns, call Delta Dental's Member Services department. If appropriate, an arrangement can be made for you to be examined by another dentist in your area. If the dentist recommends that the work be replaced or corrected, Delta Dental will intervene with the original dentist to either have the *service* replaced or corrected at no additional cost to you. In the latter

case, you are free to choose another network dentist to receive your full benefit.

The representative will try to resolve the problem immediately; however, sometimes more than one day is needed to investigate and gather information. In this case, the representative will contact you within 30 days to tell you of the results of the review. You may contact a Delta Dental Member Services representative or your network dentist's office to file a grievance. Grievance forms are available from Delta Dental Member Services, on-line at the Delta Dental web site or from your network dentist's office. A Delta Dental Member Services representative will fully explain the grievance instructions and procedures. A network dentist staff member can also help you fill out the form and file it, but we strongly encourage you to contact a Delta Dental Member Services representative to ensure that the form is accurately completed.

If you file a grievance in writing, include the group name and number SF60, the *member's* name and *member* identification number and a telephone number on all correspondence. You should also include a copy of the treatment form (available from your dentist) and any other relevant information. Delta Dental's address and telephone number are as follows:

Delta Dental-Healthy Kids

P.O. Box 537010  
Sacramento, CA 95853-7010  
Toll Free **(866) 212-2743**

Delta Dental will acknowledge receipt of the grievance form within five (5) business days of its receipt. Resolution will occur within 30 days of filing. To file a grievance, take one of these actions:

- Complete a grievance form and send it to Delta Dental's Member Services,
- Call a Delta Dental Healthy Kids Member Services representative at toll free **(866) 212-2743** and state your grievance,

- Submit a grievance electronically on Delta Dental's web-site at <http://www.deltadentalca.org>. or,
- Visit your network dentist's office and request a grievance form in person. Dental office staff may assist you in filling out the form.

You will receive a letter from Delta Dental concerning the disposition of the grievance.

If your grievance involves a serious and imminent threat to the patient's health, please call Delta Dental's Member Services department and state you want to file an urgent grievance. Your urgent grievance will be assigned highest priority and resolved within three (3) business days from receipt.

If you have a grievance involving dental *services*, you should first contact Delta Dental at toll free **(866) 212-2743** and use Delta Dental's grievance process. However, if within 30 days after filing your grievance you need help, a grievance has not satisfactorily resolved by Delta Dental, or you are not satisfied with the result of Delta Dental's grievance process, you have the option to contact the Department of Managed Health Care as described in Section 15 of this Combined Evidence of Coverage/Disclosure Form or you may use the grievance process administered by San Francisco Health Plan.

## XI. Vision Benefits

### A. Vision Benefits

Vision Benefits are provided through Vision Service Plan (VSP). VSP and its network of providers provide professional vision care to *members* covered under the Healthy Kids program. When you need vision *benefits* from a VSP doctor, contact VSP at **(800) 877-7239** or the VSP doctor directly. If you are eligible for *services* VSP will provide a *benefits authorization* to the doctor. When such *authorization* is received and *services* are performed prior to the expiration date of the *authorization*, the *services* will be covered. Should you receive *services* from a VSP doctor without such *authorization* or obtain *services* from an out-of-network provider, you

are responsible for payment in full to the provider.

If you do not have a list of VSP doctors you may obtain one by calling VSP at **(800) 877-7195**, or SFHP at **(415) 547-7800** (local) or **(800) 288-555**. Following is a list of your covered vision *benefits*:

An annual eye exam is covered in full, after applicable exam co-payment, to determine the presence of vision problems or abnormalities.

The annual exam shall include:

- Case history
- Evaluation of the health status of the visual system
- Evaluation of refractive status
- Binocular function test
- Diagnosis and treatment plan, if needed
- Lenses – Basic lenses are covered in full, after applicable material co-payment. The member doctor will order the proper lenses necessary for the Member's visual welfare. Lenses are limited to once each 12-month period.

Frames. A frame allowance of \$75 will be provided by VSP toward the purchase of your frames, after an applicable material co-payment. Frames are limited to once each 12-month period.

- **Contact Lenses.** An allowance of \$110 will be provided by VSP towards costs of an exam, contact lens evaluation fitting costs and materials. This allowance will be in lieu of all *benefits* including exam and material costs. The *member* is responsible for any costs exceeding this allowance. Contact lenses are limited to once each 12-month period.
- **Low vision.** Limitations: A low vision benefit shall be provided to *members* who have severe visual problems that are not correctable with regular lenses. This *benefit* requires prior *authorization* from VSP. With this prior *authorization*, supplementary testing and supplemental care, including low vision therapy as visually necessary

or appropriate shall be provided. Low vision *benefits* include:

- Supplementary testing; No Co-payment; and
- **Supplementary care:** Low vision *benefits* obtained from an out-of-network provider will be reimbursed in accordance with what VSP would pay a provider included in VSP's panel of approved Co-payments or this benefit.

#### **Co-payments:**

Refer to the Eye Exams/Supplies section of the Healthy Kids Program Summary of Benefits Matrix on page 22 for co-payment information.

- Exam co-payment due at time of eye exam
- Material co-payment (frames and lenses only)
- Supplemental care for low-vision benefits

#### **B. Vision Benefit Exclusions and Limitations**

Vision Service Benefits shall exclude:

- Benefits that are neither necessary nor appropriate.
- Benefits that are not obtained in compliance with the rules and policies of the *member's* vision plan.
- Vision training.
- Aniseikonic lenses.
- Plano lenses, less than +/- .38 diopter.
- Two pair of glasses in lieu of bifocals, unless *medically necessary* and with the prior *authorization* of the vision plan.
- Replacement or repair of lost or broken lenses or frames.
- Medical or surgical treatment of the eyes.
- *Services* or materials for which the *member* is covered under a workers' compensation policy.
- Eye exams or any corrective eyewear, required as a condition of employment.

- *Services* or materials provided by any other group benefit providing for vision care.

There is no benefit for professional services or materials connected with:

- Blended lenses (bifocals which do not have a visible dividing line).
- Contact lenses except as specified above.
- Oversized lenses (larger than standard lenses blank to accommodate prescriptions).
- Progressive multifocal lenses.
- Coated or laminated lenses.
- UV protected lenses.
- Other optional cosmetic processes.
- Photochromic or tinted lenses.

#### C. Payment Responsibilities

The *member* pays the *co-payment* to the VSP doctor for the *services* covered under the vision benefit. VSP will reimburse the VSP doctor directly according to its agreement with the doctor.

#### D. Provisions for Out-of-Network Vision Services

There are no out-of-network vision *benefits*.

#### E. Vision Claim Appeals

If a claim submitted by a *member* for reimbursement is denied, in whole or in part, VSP shall notify the *member* in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice, a *member* may make an oral or written request for such review of such denial, by addressing such request to VSP. In contacting VSP, the *member* should state the reason the *member* believes that the denial of the claims was in error and may provide any pertinent documents that the Member wishes to be reviewed. VSP will review the claim and give the *member* the opportunity to review any pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. The determination of VSP, including specific reasons for the decision, or a notice regarding VSP's expected resolution date, shall be provided and

communicated to the *member* in writing within thirty (30) days after receipt of request for review.

If the *member* chooses not to pursue this process with VSP, the *member* may file a grievance with the Health Plan by following the instructions in Section 15, Grievance and Appeal Procedures in this Combined Evidence of Coverage/Disclosure Form.

#### F. Vision Benefit Grievances

*Members* who have a grievance involving *Services* received from VSP should contact VSP Member Services Department at **(800) 877-7239**. If you are unable to resolve your grievance with VSP, you may call San Francisco Health Plan for additional help at **(415) 547-7800** (local) or **(800) 288-555**. Please refer to Section 15, Grievance and Appeal Procedures in this Combined Evidence of Coverage/Disclosure Form.

#### G. Charges

For non-preventive *services*, the *member* is 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. There are no deductibles under the program and there are no lifetime financial benefit maximums for any of the covered health *benefits*.

#### H. Vision Benefit Program Changes

*Benefits*, exclusions, and limitations are subject to change, cancellation, or discontinuance at any time either by the Healthy Kids program or by SFHP, following at least thirty-one (31) days' written notice by SFHP to the *member*. *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.

## XII. Exclusions and Limitations

### A. 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 the *member's PCP*.

Note: No *service* is covered unless it is *medically necessary*. 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*.

### B. Specific Exclusions and Limitations

Certain services are limited and are noted in the *benefits* description and Summary of *benefits*. Other *services* listed in the section below are excluded under this coverage.

- Acupuncture and Chiropractic are not covered *benefits*.
- **Alcoholism services** for alcoholism treatment and *rehabilitation* on an *inpatient* or day care basis, whether or not court-ordered, except for *inpatient* detoxification.
- **Contraceptives and contraceptive devices** that do not require a prescription unless the patient's *participating provider* determines that none of the methods designated by the Plan as covered or preferred are medically appropriate for the patient.
- **Convenience items** such as telephones, TVs, guest trays, and personal hygiene items.
- **Cosmetic surgery** that is performed to alter or reshape normal structures of the body solely for the purpose of improving appearance.
- **Custodial care** incident to *services* rendered in the home or *hospitalization* or confinement in a health facility primarily for custodial, maintenance, or *domiciliary care*, rest, or to control or change a person's environment.
- **Drug addiction**, or drug abuse treatment or *rehabilitation* on an *inpatient*, or day care basis, except as *medically necessary* to remove toxic substances from the body.
- **Durable medical equipment** including coverage for comfort or convenience items; disposable supplies except colostomy bags and 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; or more than one piece of equipment that serve the same function are excluded. Diabetic equipment and supplies are covered as set forth under Section 9: SFHP *benefits*.
- **Experimental care**, except for drugs prescribed for a use that is different from the use for which the drug has been approved for marketing by the federal Food and Drug Administration, provided that each of the conditions set forth in Section 1367.21 of the California Health and Safety Code are met. Should a request for *services* be denied due to the *experimental* or *investigational nature* of the treatment, you may immediately have this decision reviewed by the Department of Managed Health Care (DMHC) through the IMR process, as set forth in section 1370.4 of the Health and Safety Code. You do not need to participate in the Plan's *grievance process* before having your case heard through the DMHC's IMR process. You may apply directly to the DMHC for participation in the IMR process.
- **Routine Foot Care** including callus, corn paring or excision, toenail trimming, and foot *orthotics*, except for surgery and therapeutic footwear required to prevent or treat diabetes-related complications.
- **Hearing aids and services** including the purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and

- charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss. Replacement parts for hearing aids, repair of a hearing aid more than once in any period of thirty-six months, and surgically implanted hearing devices are excluded.
- **Home/vehicle improvements** or any modifications or attachments made to dwellings, property, or motor vehicles including ramps, elevators, stair lifts, swimming pools, air\filtering systems, environmental control equipment, spas, hot tubs, or automobile hand controls.
  - **Infertility treatment** such as in-vitro fertilization, G.I.F.T. (*gamete interfallopian transfer*) or any other form of induced fertilization, artificial insemination, or *services* incident to or resulting from procedures for or the *services* of a surrogate mother are not covered *services*.
  - **Learning and self improvement programs** including the treatment of hyperkinetic syndrome, learning disability, behavioral problems, or for or incident to reading, vocational, educational, recreational, art, dance or music therapy, weight control, or exercise program.
  - **Long-term care** including long-term care in a **skilled nursing facility**, unless SFHP determines that it is a less costly, satisfactory alternative to covered *benefits*. Short-term, *skilled nursing facility* and *hospice* care are covered.
  - **Non-skilled care** that can be performed safely and effectively by family members or persons without licensure, certification or the presence of a supervising licensed nurse, except for *authorized* homemaker services for *hospice care*.
  - **Obesity** including surgery for morbid obesity, unless determined *medically necessary* by SFHP.
  - **Organ donor services** to a *member* in connection with donor transplant services when the recipient of the transplant is not a *member*.
  - **Orthopedic devices/other supplies**, orthopedic shoes (except for diabetics), elastic supports (see Exclusions under *orthotics* and *prosthetics* on page 47). Disposable medical supplies home testing devices, comfort items, environmental control equipment, exercise equipment, self help/educational devices, home monitoring equipment, any type of communicator, voice
  - **Over-the-counter drugs**, supplies, and devices such as air filters or medications not requiring a prescription, vitamins, minerals, food supplements, or food items for special diets or nutritional supplements, except for diagnosis of Phenylketonuria (PKU). Confinement in a pain management center to treat or cure chronic pain. SFHP covers pain management *services* in a SFHP *hospital* for intractable cancer pain or traction and pain management medications for *terminally ill* patients when *medically necessary*.
  - **Physical exams** and immunizations required for licensure, employment, insurance, participation in school or participation in recreational sports, ordered by a court, or for travel, unless the examination corresponds to the schedule of routine physical examinations and immunizations provided in Preventive Health Services, page 40.
  - **Services received outside of the United States**, except for *emergency, urgent or authorized services*.
  - **Sex-change surgeries** for or incident to intersex surgery (transsexual operations) are excluded. *Medically necessary services* relating to complications of sex change surgery are a covered *benefit*.
  - **Sexual dysfunction** incident to non-physically related sexual dysfunction, including all *services* excluded under **infertility treatment** described in this section and penile implant devices and surgery, and related services

except as penile devices and surgery are *medically necessary* for a non-psychiatric condition.

- **Skin aging** relating to the diagnosis and treatment to retard or reverse the effects of aging of the skin.
- **Substance (Drug) abuse** substance abuse admissions (whether or not court-ordered), unless *medically necessary* for acute medical detoxification, page 49.
- **Transportation** other than provided under medical transportation, page 51.
- **Vasectomy and tubal ligation reversal or repeat vasectomy or tubal ligation** (unless due to non-successful initial vasectomy or tubal ligation), or the infertility resulting thereof. The Plan covers *medically necessary services* necessary to treat complications arising out of any reversal or sterilization procedure.

### XIII. Coordination of Benefits and Third Party Liability

#### A. Coordination of Benefits

In an effort to avoid duplicative payment for the same services, when the *member* is eligible for *benefits* from other payers, the Plan will coordinate its benefits with those of the other payers. If an SFHP *member* is 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 the *member*. This *coordination of benefits* will apply when the *member* is entitled to the following other *benefits*:

- *Benefits* to which a *member* is entitled from any other insurer, healthcare service plan, or union healthcare trust fund.
- *Benefits* provided by any other federal or state government agency, including CCS, or by any county or other political subdivisions including any *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 as a result of a *worker's compensation* claim.
- *Benefits* provided for treatment directly related to any totally *disabling condition*, illness or injury for which the *member* has coverage under a contract or policy providing *hospital*, medical or surgical expense or service benefits.

Note: Even if you have other coverage, *benefits* will only be covered under SFHP if provided by SFHP providers and *authorized* in accordance with SFHP rules.

#### B. Third Party Liability

If a *member* is injured through the act or omission of another person (a third party), SFHP shall, with respect to *services* required as a result of that injury, provide the *benefits* under SFHP only on the condition that the *member*:

- Agrees to reimburse SFHP the reasonable cash value of *benefits* provided as reflected by the physician's usual and customary charges and as allowed by law, immediately upon collection of damages by the *member*, whether by action at law, settlement, or otherwise.
- Provides SFHP with a lien, in an amount equal to the value of benefits provided by SFHP, as reflected by an amount not to exceed eighty (80) per cent of the provider's usual and customary charges or the amount actually paid by SFHP. The lien may be filed with the third party, the third party's agent, or the court.

All liens filed by SFHP for the recovery of payments made by SFHP on behalf of a *member* entitled to medical *services* under the Plan shall be in accordance with Civil Code section 3040.

## XIV. Benefit Changes, Disenrollment and Cancellation

### A. Right of San Francisco Health Plan to Change Benefits and Charges

San Francisco Health Plan reserves the right to change *benefits* and charges of the Healthy Kids Plan Benefit program. *Members* will be given at least thirty (30) days' notice prior to the effective date of any change in *benefits* or charges.

### B. Disenrollment

SFHP will provide at least 15 days prior written notice to any member before disenrollment becomes effective, except in cases where a member is being disenrolled due to fraudulent use of Healthy Kids benefits. Healthy Kids coverage will not end sooner than 15 days after the date the cancellation notice is mailed. A *member* shall be disenrolled from participation in the program if any of the following occur:

- The *member* is found by the Health Plan to no longer be eligible
- The *member* attains the age of 25. Disenrollment for this reason shall be effective on the last day of the month the *member* attains the age of 25.
- The required annual *premium* is not paid for the *member* for 30 consecutive days after the due date. Disenrollment for this reason shall be effective 45 days from the date of the non-payment notice.
- The *member* or his/her legal representative so requests in writing. Disenrollment for this reason shall be effective at the end of the month in which the request is made.
- The *applicant* or *member* has intentionally made false statements in order to establish eligibility with the Health Plan for any person or has obtained or attempted to obtain *services* by means of false, materially misleading, or fraudulent information, acts or omissions. Disenrollment for these reasons shall be effective upon mailing of the notice to the *member*.

- The *member* or *applicant* has allowed a *non-member* to use a *member* identification card to obtain *services* or otherwise permits another person to fraudulently or deceptively use Health Plan *services* or facilities. Disenrollment for this reason shall be effective upon mailing of the notice to the *member*.
- The *member*, or *applicant* on behalf of the *member*, fails to provide the necessary information to be re-qualified during the annual eligibility review. Disenrollment for this reason shall be effective after one year of coverage.
- Death of a *member*. Disenrollment for this reason shall be effective at the end of the month in which death occurred.
- SFHP terminates the program. Disenrollment for this reason shall be effective no sooner than 90 days after the date of mailing the notice to *members* of termination of the program.

### Disenrollment for Non-Payment

Prior to disenrolling a *member* for failure to pay the required annual *premium*, SFHP shall provide a "Notice of Non-Payment" to the *member* if payment has not been received within 30 days after the payment due date. The Notice of Non-Payment will advise the *member* that if payment is not received the *member* will be disenrolled effective 45 days from the date the Notice of Non-Payment is mailed. If the Plan does not receive payment 30 days after the Notice of Non-Payment is mailed, the Plan will send a Notice of Cancellation. The Notice of cancellation will inform the member that their Healthy Kids coverage will be discontinued effective 12:00am on the last day of the month, but no less than 15 days from the date the Notice of Cancellation is mailed. Such notice shall clearly indicate the circumstances under which enrollment is being cancelled, the effective date of disenrollment and the *applicant* or other responsible individual's financial responsibility for *services* provided after the effective date of disenrollment.

The notice shall be in writing, sent by regular U.S. Mail to the *applicant's* current address on file with the Plan. A *member* who is disenrolled may ask the Plan to review the decision for disenrollment. Contact Member Services at **(415) 547-7800** or **(800) 288-555** if you have been disenrolled and would like to request a review of the Plan's decision. A Member Service representative will help you.

*Members* who are disenrolled for non-payment may reapply for coverage. SFHP requires a full year of premium payment or premium assistance (if eligible) for reinstatement. Members eligible due solely to their "age-out" status who disenroll or are disenrolled who are over the age of 24 are not eligible to reapply.

#### C. Return of Premium

In the event of disenrollment prior to the last day of the period for which payment has been received, the *Plan* shall within 30 days return to the *applicant* the pro rated portion of the *premium* paid to the Health Plan which corresponds to any unexpired period for which payment has been received by the Health Plan.

#### D. Individual's Right of Cancellation

Healthy Kids program *members* can cancel at any time, with 31 days written notice.

#### E. Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans, including the *Plan's* enrollment and disenrollment decisions. An *applicant* or *member* who alleges that an enrollment has been cancelled or not renewed because of the *member's* health status or requirements for health services may request a review by the Department. The Department of Managed Health Care has a toll-free telephone number, **(888) HMO-2219**, to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(800) 735-2929** (TTY), or **(888) 877-5379** (TYY), to contact the Department. The Department's Internet website

(<http://www.hmohelp.ca.gov>) contains forms and instructions online.

## XV. Grievance and Appeal Procedures

### A. Grievance Process

*Members* are encouraged to bring grievances to the attention of *physician* 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. The Health Plan 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 Complaint/Grievance Protocols. Please contact Member Services at **(415) 547-7800** (local) or **(800) 288-555** and a copy will be sent to you.

Filing a *grievance* or *appeal* is your right and is a confidential process. SFHP cannot discriminate against you or disenroll 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*.

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 "Complaints to the Department of Managed Health Care" on page 66.

### Filing a Grievance

You can file a grievance about the provision of health *services* or *benefits* by calling Member Services at **(415) 547-7800** (local) or **(800) 288-555**, or you may make a written complaint to:

**San Francisco Health Plan  
201 Third Street, 7th Floor  
San Francisco, CA 94103**

Complaint forms and *member* grievance procedures can be obtained from SFHP, your provider's office, your provider's Medical Group or online at SFHP's website at **[www.sfhp.org](http://www.sfhp.org)**.

## Complaint/Grievance Process

When you file a grievance or complaint this is what happens:

- Step 1. You file your complaint over the telephone, in writing or in person. SFHP's Grievance Coordinator will be available to help you with your complaint if you wish.
- Step 2. In most cases, SFHP will send you a letter within 5 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 write to you with our proposed resolution within 30 calendar days. If you haven't received a letter from SFHP within 30 calendar days or if you do not accept the resolution SFHP proposes, you can ask either for an appeal hearing with SFHP or you can immediately contact the Department of Managed Health Care as described in section B on page 65.

If, for some reason, your mail is returned as undeliverable and we cannot reach you by telephone, SFHP will not be able to continue to work on your *grievance* until SFHP hears from you and will suspend your *grievance*. However, SFHP can start working on your *grievance* if SFHP hears from you within 6 months of your filing of the *grievance*. If SFHP does not hear from you, your *grievance* will be closed after 6 months.

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, regardless of whether you file a second-level appeal or not. 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 **(888) HMO-2219**, or a TDD line **(877) 688-9891**.

## B. Appeal Hearing

If you are not happy with the way SFHP has resolved your grievance, you can either file an appeal with SFHP or you can immediately contact the Department of Managed Health Care at **(888) HMO-2219** or a TTD line **(877) 688-9891**.

- Step 1. You can request an appeal hearing with SFHP in writing, by phone or in person. The Grievance Coordinator can help you file your *appeal* or, if you wish, you can ask an advocate to help you.
- Step 2. The Grievance Coordinator will schedule your *appeal* hearing. You will receive a notice with the date, time, and place of the meeting. You or your advocate will be able to present any other facts about your *appeal* at the hearing. The *appeal* hearing will be scheduled within 7 calendar days after you file your *appeal*. The hearing committee will review all the records of the *grievance* and meet with you to hear your statement and the Health Plan's statement.
- Step 3. After the hearing a determination regarding your *grievance* will be made and the hearing committee will notify the Grievance Coordinator of the determination. The Grievance Coordinator will send you a letter within 3 business days to let you know of the outcome of your *appeal*.

If you are not satisfied with the hearing committee's recommendation(s), or if it has been longer than 30 days since you first filed your initial grievance, you can file an *appeal* with the Department of Managed Health Care.

## C. 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 limited to loss of

life or limb, major bodily function or severe pain.

To initiate an Urgent Grievance, call SFHP at **(800) 288-555** 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. See section H below for information on how to contact the Department of Managed Health Care.

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

#### **D. Member Cooperation with the Grievance Process**

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

#### **E. Where to Write**

The written *grievance* or any correspondence or information regarding the *member grievance* should be mailed or hand delivered to:

**Grievance Coordinator  
San Francisco Health Plan,  
201 Third Street, 7th Floor,  
San Francisco, CA 94103**

#### **F. 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* resolution 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 (B) You have received *urgent care* or *emergency services* that a provider determined was *medically necessary*, or (C) 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
3. 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 may bring it immediately to the Department's attention. 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 **(800) 288-555**.

#### **G. Experimental/Investigational IMRs**

If your doctor 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 doctor 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 doctor 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.

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.

#### **H. Complaints to the Department of Managed Health Care**

The California Department of Managed Health Care requires that we advise our *members* of the following:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800) 288-5555** or **(415) 547-7800** and use your health plan's grievance process before contacting the department. Utilizing 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 your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department 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 a health plan 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 department also has a toll-free telephone number, **(888) HMO-2219**, and a TDD line, **(877) 688-9891**, for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

#### **I. Arbitration of Disputes**

If there is any dispute or disagreement between a *member* and SFHP (other than a claim of medical malpractice) that exceeds the jurisdiction of Small Claims Court, the *member* and the Plan shall settle the dispute by final and binding arbitration. The arbitration shall take place in San Francisco, California. A *member* shall request arbitration by written notice to the *Plan* within the applicable statute of limitations provided by California law, including, but not limited to the Tort Claims Act, that would apply if the *member* were to file a civil lawsuit regarding the same matter.

If the total amount of damages claimed by the *member* 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 the *member's* request for arbitration, or if the parties cannot 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 the *member* exceeds \$200,000, then within thirty (30) calendar days of the date the *Plan* receives the *member's* request for arbitration, the *member* and the *Plan* shall attempt to agree

upon a single arbitrator. If the parties can not agree upon a single arbitrator within this thirty day period, then one arbitrator will be named by SFHP and one arbitrator shall be named by the *member*, and a third neutral arbitrator will be named by the arbitrators within thirty (30) calendar days of the *member's* 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 the *member's* 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 the *member* 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 the *member* 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 the *member* 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

the *member*, 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 a *member's* right to a jury trial for claims of medical malpractice.

## XVI. 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 Beneficiary Committee (BC) 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. SFHP encourages its *members* 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 Beneficiary Committee and of the Governing Board may be obtained by calling Member Services at **(415) 547-7800** (local) or **(800) 288-555**. If the *member* is 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 *members*, including any *physician*, *hospital* or other provider or their employees.

#### **D. Continuity of Care by A Terminated Provider**

*Members* who 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. The *terminated provider* must agree to a rate of payment and to abide by *SFHP's* reasonable policies and procedures, as applicable to the *terminated provider*. If the *terminated provider* does not agree to a rate of payment or to abide by *SFHP's* policies, then the *member* will not be able to receive continued care from the *terminated provider*. Contact Member Services to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

#### **E. Continuity of Care for New Members by Non-Contracted Providers**

Newly covered *members* who 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 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 the *member* at the time the *member's* coverage became effective under this *Plan*. The *non-contracted provider* must agree to a rate of payment and to abide by *SFHP's* reasonable policies and procedures, as applicable to the *terminated provider*. If the *non-contracted provider* does not agree to a rate of payment or to abide by *SFHP's* policies, then the *member* will not be able to receive continued care from the *non-contracted provider*. 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 **(800) 288-555**, for more information.

#### **F. Payment of Providers**

SFHP generally pays its contracted *medical groups* and 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 doctors get paid for the services that they provide to *members*. 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 doctors exceed this amount, they must pay the Plan back. If the doctors do not get paid at least what they would receive under capitation, then the Plan will pay the doctors an extra amount to equal the capitation amount.

While SFHP does not enter into incentive arrangements with *medical groups* regarding the cost of *hospital* care, hospitals may enter into such 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 **(800) 288-555**, your *PCP*, or your *medical group* for more information on payment of providers.

#### **G. Notice of Information Practices**

SFHP follows its Notice of Privacy Practices. This letter was sent to you in April of 2009, pursuant to the Federal law HIPAA, which regulates the use of protected health information. You may receive a copy

of this letter at any time by contacting the Plan's Privacy Officer at **(415) 547-7800**, or **(800) 288-555**.

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.

The *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.

Note: A statement describing SFHP's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

#### **H. 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.

#### **I. Governing Law**

SFHP's Healthy Kids 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 Sections 1300.43 through 1300.826 of Title 28 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.

#### **J. Natural Disasters, Interruptions, Limitations**

SFHP will have no liability to the *member* if *services* of either SFHP or any SFHP physician are not provided or arranged or are delayed because of a reason beyond SFHP's reasonable control. Examples of reasons beyond SFHP's control include natural disaster, war, riot, labor dispute involving an SFHP or other *health care professional*, civil insurrection, or epidemic. In such event, SFHP's obligation to the *member* shall be limited to SFHP's good faith effort to provide or arrange for the provision of *benefits* within the limitations imposed by the natural disaster or such other reason beyond SFHP's control.

