SAN FRANCISCO HEALTH PLAN℠

Here for you

Combined Evidence of Coverage and Disclosure Form

2016- 2017

HEALTHY KIDS℠ HMO

Contents

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 (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. 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 Customer Service at 1(415) 547-7800 (local) or 1(800) 288-555 (toll free), Monday through Friday, 8:30am to 5:30pm.

Who Should I call?

San Francisco Health Plan (SFHP) at 1(415)547-7800 (local) or 1(800)288-5555 or email us at memberservices@sfhp.org, to:

- To change your PCP
- To get a new member ID card
- To inform us of a change to your name, address, phone number, or social security number
- If you are unhappy with your provider or another healthcare service
- If you need help filling your prescriptions
- To ask questions about getting services or health benefits
- To talk about a problem or file a complaint
- If you need help with nutrition, parenting, breastfeeding, or other topics
- To find out how to get to your PCP's office
- To ask any questions you may have
- If you have medical billing issueswith SFHP
- If you want to check eligibility with SFHP

Call San Francisco Health Plan's Nurse Help Line at 1(877) 977-3397:

- If you cannot reach your PCP during the day or after hours
- To speak with a trained registered nurse who can help to answer your health care questions, give you advice, and instruct you to the urgent care center if needed.

This service is free of charge and available to you in your language, 24-hours a day, 7 days a week.

Help in Other Languages and for the Hearing Impaired

If you prefer to speak a language other than English, our Customer Service team can help. They speak other languages and can help you find a PCP who speaks your language. Call Customer Service at **1(415) 547-7800** (local) or 1(800) 288-5555 (toll free), Monday through Friday, 8:30am to 5:30pm.

Customer Service 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 **1(415) 547-7830** (local), or 1(888) 883-7347 (toll free).

Your Member ID Card

SFHP mails a member ID card to each of its Healthy Kids HMO program members. Check the information on the member ID card to make sure it is correct. Call

Customer Service at **1(415) 547-7800** (local) or 1(800) 288-5555 if:

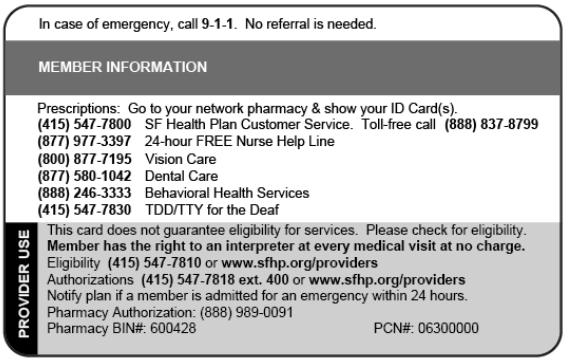
- Any information is not correct
- You move, or any information changes
- The card is lost or stolen

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

Your SFHP ID Card has important information on it including:

- Your PCP's name (or the name of your clinic)
- Your PCP's phone number
- SFHP's 24-hour Nurse Help Line

The picture below shows you what your member ID card will look like.



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 healthy. A PCP will provide all of your basic healthcare, including:

- Wellness check-ups and preventive services, such as immunizations (shots), hearing tests, and laboratory results.
- 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, or a substitute provider, 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 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 Customer Service for help at 1(415) 547-7800 (local) or 1(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 **1(415) 547-7800** (local) or 1(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 PCP

If you are not happy with your PCP for any reason, call Customer Service at **1(415) 547-7800** (local) or 1(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 Customer Service at **1(415) 547-7800** (local) or 1(800) 288-5555. A representative will tell you which PCP to see.

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 (2), 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 the child's 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 you may need. If you need to see a specialist, your PCP will send (refer) you to a specialist after

talking with you. 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" to be referred to another physician 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 HMO Provider Directory under the Pharmacy section, and show your member ID card to the pharmacist.

SFHP has a drug formulary. A drug formulary is a list of brand-name and generic prescription medications approved for coverage unless certain restrictions apply. The drug formulary is reviewed at least four (4) times a year by a chosen group of physicians and pharmacists who work in San Francisco County. The group reviews how safe medications are and how well the medications work before they decide which medications should be included in the drug formulary. A copy of the formulary can be downloaded from the SFHP website at http://www.sfhp.org or you can request information whether a specific drug is on the formulary by calling Customer Service at 1(415) 547-7800 (local) or 1(800)288-5555.

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

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

SFHP formulary does not cover experimental or investigational medication.

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

If your medication is restricted on SFHP formulary or is not a part of the SFHP formulary, your provider must submit a prior authorization form to SFHP for it to review and make a determination if you could use a preferred- drug.

Prior Authorization Process

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

A PA form can be downloaded from the SFHP website at http://www.sfhp.org.

A prior authorization request may be submitted by the prescriber of pharmacist to SFHP in three ways:

1. Download and fax prior authorization request forms to 1(855) 811-9330 for standard requests or 1(855) 811-9331 for urgent requests.
2. Call our Pharmacy Benefits Manager, PerformRx, at 1(888) 989-0091 to submit a verbal request.
3. Submit request online using the Online Pharmacy Prior Authorization Request Form available at: http://sfhp.org/providers/formulary

The pharmacist and/or the SFHP Medical Director review prior authorizations and decides to approve, deny or change the request or ask the doctor for more information. The SFHP pharmacist or Medical Director makes the final decision to deny or change the request or ask the doctor for more information. If the request is complete, standard requests are reviewed within 72 hours and urgent requests are reviewed within 24 hours. Requests that cannot be read or do not have all necessary information may take longer. If the prior authorization is approved, a message is sent by fax to the requesting provider and the claim will be covered by SFHP. If the prior authorization is denied or changed, SFHP will send a letter to the member and requesting provider. This letter includes the reason for SFHP's decision.

If SFHP denies your request for a medication and you are not happy with the decision, you may appeal the decision. For information about the SFHP's Grievance and Appeals Process please refer to page 60.

Hospital Care

If you are sick or hurt, call your PCP. Your PCP will see you, refer you to a specialist, or send you to the hospital. If you have to go to the hospital, it will be the hospital 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

Examples of emergencies include:

- A condition where it looks like your life is in danger
- Extreme or intense pain
- Serious difficulty breathing
- A possible 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're not sure if it is an emergency, call your PCP to find out if you need to go to the emergency room. If you think you have an emergency, you should to go the nearest emergency room. Even if it turns out not to be a real emergency, SFHP will still pay for your care.

Nurse Help Line

You should always go to your doctor for care or call with your questions, but sometimes you can't reach your doctor during the day or after hours. When this happens, call San Francisco Health Plan's Nurse Help Line at 1(877) 977-3397. It is staffed by trained registered nurses who are available 24-hours a day and seven (7) days a week to help answer your health care questions. The service is free of charge and available to you in your language. The nurse can answer your questions, give you helpful advice, instruct you to go to the urgent care center or emergency room, if needed, and more.

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 HMO 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 1(800) 877-7195.

For more information about the dental plan, call Delta Dental toll-free at 1(866) 212-2743 and mention group number "SF60". Or call SFHP at 1(415) 547-7800 (local) or 1(800) 288-5555. Our TDD line for the hearing or speech impaired is 1(415) 547-7830.There is no annual limit on covered dental benefits for members during the benefit year*.

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

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 HMO program at 1(800) 880-5305 for more information.

It is your responsibility to pay your Healthy Kids HMO program premium each year. Call the Healthy Kids HMO program at 1(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.

You will not have to pay more than $250 maximum in co-payments for all children in your household during any one benefit year. You should ask for a receipt whenever a co-payment is made and keep the receipt and a record of all payments so that you may demonstrate that the maximum has been paid if this occurs during the year of membership. When the limit is reached, you should contact SFHP Customer Service at 1(415) 547-7800 (local) or 1(800) 288-5555 to get a non-copay ID card. You will still need to pay copayments until SFHP receives proof that you have paid a total $250 in copayments. If you can show that you paid more than $250 in copayments between October 1 and September 30, SFHP will reimburse you for the amount over $250. 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 medical or mental health 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 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. Members may receive assistance to request reimbursement by calling SFHP Customer Service at 1(415) 547-7800 (local) or 1(800) 288-5555.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 34, 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 23, 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 FranciscoHealth Plan Customer Service department at 1(415) 547-7800 (local) or 1(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 HMO program. If you receive these services, you will remain a member and all health care services will be coordinated.

Children's Services (CCS)

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

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.

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 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.

SFHP is responsible for covering all medically necessary services to treat the member's CCS condition until treatment is authorized by the CCS program, and treatment is provided by a CCS provider.

If the CCS program determines that the condition is a CCS eligible condition, and CCS is covering the eligible condition, the member will remain enrolled in the Healthy Kids HMO 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 providers will be the responsibility of the member's legal guardian.

SFHP will continue to provide primary care and prevention services that are not related to the CCS eligible condition, as described in this booklet. SFHP will also work with the local CCS program, CCS Providers, and SFHP providers, to coordinate services and 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 HMO 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.

If you get services from CCS already, make sure your PCP is aware of this. Additional information about the CCS Program can be obtained by calling SFHP's Customer Service at 1(415) 547-7800 (local) or 1(800) 288-5555. You may call the local county CCS program at 1(415) 575-5700 if you have questions about CCS coverage.

Mental Health Care

As a Healthy Kids HMO member, you are also entitled to mental health and behavioral health benefits. All mental health benefits for the Healthy Kids HMO program are provided by San Francisco Community Behavioral Health Services. For a full description of the mental health benefits available, refer to the Mental Health Care section of this Evidence of Coverage. If you would like assistance obtaining mental health benefits, you may call SFHP Customer Service at 1(415) 547-7800 (local) or 1(800) 288-5555 or you may call Community Behavioral Health Services at 1(888) 246-3333.

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 Customer Service at 1(415) 547-7800 (local) or 1(800) 288-5555 to talk with us about any problems you may have.

Solving Problems

SFHP wants you 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. Customer Service 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 HMO 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 Customer Service and they are also available online at SFHP's website, 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 five (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 60 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 HMO 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 shall pay no more than $5 co-payment for applicable covered services as described in this Benefits Descriptions Section of the EOC/DF.

Benefits*	Covered Services	Member Pays (Co-payment) Income Category A	Member Pays (Co-payment) Income Categories B & C
Alaskan Native/Native American Enrollees		$0	$0
Deductible	No deductibles will be charged for covered benefits	$0	$0
Yearly Co-Payment Maximum		$250	$250
Lifetime Maximum	No lifetime maximum limits on benefits apply under this plan	$0	$0
Hospitalization Services Inpatient	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
Hospitalization Services Outpatient	Medically necessary facility charges, general nursing care, ancillary services including operating room, prescribed drugs, laboratory, chemotherapy, and radiology	No co-payment except $5 per visit for physical, occupational and speech therapy performed on an outpatient basis. $5 per visit for emergency health care services (waived if the member is hospitalized)	No co-payment except $10 per visit for physical, occupational and speech therapy performed on an outpatient basis. $15 per visit for emergency health care services (waived if the member is hospitalized

Benefits*	Covered Services	Member Pays (Co-payment) Income Category A	Member Pays (Co-payment) Income Categories B & C
Professional Services	Doctor visits, inpatient and outpatient medical and surgical services	$5 per office or home visit except No co-payment for hospital inpatient professional services No co-payment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments No co-payment for members 24 months of age and younger No co-payment for vision or hearing testing, or for hearing aids	$10 per office or home visit except No co-payment for hospital inpatient professional services No co-payment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments No co-payment for members 24 months of age and younger No co-payment for vision or hearing testing, or for hearing aids
Outpatient Services	In a doctor 's office, surgery center, or other designated facility	$5	$10
Preventive Health Care Services	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
Diagnostic, X-Ray, and Laboratory Services **	Laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, and treat members.	No co-payment	No co-payment
Diabetic Care **	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
Emergency Health Coverage	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
Ambulance Services	Ambulance transportation when medically necessary	No co-payment	No co-payment

Benefits*	Covered Services	Member Pays (Co-payment) Income Category A	Member Pays (Co-payment) Income Categories B & C
Prescription Drug Coverage **	Drugs prescribed by a licensed practitioner	$5 per prescription for up to 30 day supply for brand name drugs. $5 per prescription for up to 90 day supply of generic drugs. No co-payment for prescription drugs provided in an inpatient setting. No co-payment for drugs administered in the doctor's office or in an outpatient facility. No co-payment for FDA-approved contraceptive drugs and devices.	$10 co-payment per prescription for up to 90 day supply for generic drugs. $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. No co-payment for prescription drugs provided in an inpatient setting. No co-payment for drugs administered in the doctor's office or in an outpatient facility No co-payment for FDA-approved contraceptive drugs and devices.
Contraceptives	FDA approved drugs and implanted devices.	No co-payment	No co-payment
Durable Medical Equipment **	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
Orthotics and Prosthetics **	Original and replacement devices as prescribed by a licensed practitioner.	No co-payment	No co-payment
Maternity Care	Professional and hospital services relating to maternity care	No co-payment	No co-payment
Family Planning Services	Voluntary family planning services	No co-payment	No co-payment
Inpatient Mental Health Care Services:	Mental health care in a participating hospital when ordered and performed by a participating mental health professional for the treatment of a mental health condition.		

Benefits*	Covered Services	Member Pays (Co-payment) Income Category A	Member Pays (Co-payment) Income Categories B & C
Mental Health Care	Diagnosis and treatment of a mental health condition. This includes, but is not limited to inpatient mental health care services for the treatment of Severe Mental Illnesses (SMI).	No co-payment	No-co-payment
Serious Emotional Disturbance (SED) Services	Inpatient mental health care services for the treatment for a member determined by the county to have a SED condition. The plan shall provide all medically necessary covered services until the county mental health department establishes eligibility for a subscriber child with SED and the county mental health department provides the medically necessary services to treat the SED The Plan and the county mental health department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with SED. The member will remain enrolled in the Healthy Kids HMO program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED from the Plan.	No co-payment	No co-payment
Basic Mental Health Care Services	This includes, but is not limited to, the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement. Family members may be involved in the treatment when medically necessary for the health and recovery of the child. This includes, but is not limited to outpatient mental health care services for the treatment of Severe Mental Illnesses (SMI).	$5 per visit	$10 per visit

Benefits*	Covered Services	Member Pays (Co-payment) Income Category A	Member Pays (Co-payment) Income Categories B & C
Outpatient Mental Health Care Services:	Mental health care when ordered and performed by a participating mental health professional.		
Serious Emotional Disturbance (SED)	Outpatient mental health care visits services for the treatment of a member determined by the county to have a SED condition. The plan shall provide all medically necessary services until the county mental health department establishes eligibility for a member child with SED and the county mental health department provides the medically necessary services to treat the SED. The Plan and the county mental health department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with SED. The member will remain enrolled in the Healthy Kids HMO program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED from the Plan.	No co-payment	No co-payment
Chemical Dependency Services:			
Inpatient Alcohol/ Drug Abuse Treatment	Hospitalization to remove toxic substances from the system	No co-payment	No co-payment
Outpatient Alcohol/ Drug Abuse Treatment	Crisis intervention and alcohol or drug abuse treatment as medically necessary.	$5 per visit	$10 per visit
Home Health Services	Services provided at the home by health care personnel.	No co-payment except $5 per visit for physical, occupational, and speech therapy	No co-payment except $10 per visit for physical, occupational, and speech therapy
Skilled Nursing Care	Services provided in a licensed skilled nursing facility. Benefit is limited to a maximum of 100 days per benefit year.	No co-payment	No co-payment

Benefits*	Covered Services	Member Pays (Co-payment) Income Category A	Member Pays (Co-payment) Income Categories B & C
Physical, Occupational, and Speech Therapy **	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
Blood and Blood Products **	Includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings	No co-payment	No co-payment
Health Education	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
Diagnostic X-ray and Laboratory Services	Therapeutic radiological services, ECG, EEG, mammography, other diagnostic laboratory and radiology tests and laboratory tests.	No co-payment	No co-payment
Hospice	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
Organ Transplants	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
Reconstructive Surgery **	Performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors, or disease and are performed to improve function or create a normal appearance	No co-payment	No co-payment
Phenylketonuria (PKU) **	Testing and treatment of PKU	No co-payment	No co-payment

Benefits*	Covered Services	Member Pays (Co-payment) Income Category A	Member Pays (Co-payment) Income Categories B & C
Clinical Cancer Trials	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 trail, 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
California Children's Services Program (CCS)	CCS is a California medical program that treats children who have certain physically handicapping conditions and who need specialized medical care. Services provided through the CCS Program are coordinated by the county CCS office. If the member's condition is determined to be eligible for CCS services, the member remains enrolled in the Healthy Kids HMO Program and continues to receive medical care from plan providers for services not related to the CCS eligible condition. The member will receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers.	No co-payment	No co-payment
Biofeedback	Up to 8 visits per Benefit Year with a referral	$5 per visit	$10 per visit
Hearing Aids/Services	Audiological evaluations, hearing aids, supplies, visits for fitting, counseling, adjustments, repairs	No co-payment	
Eye Exams/Supplies	Eye examinations, frames and lenses, supplemental care for low-vision benefits	$5 per visit Frame allowance up to $100	$5 per visit Frame allowance up to $100

Benefits*	Covered Services	Member Pays (Co-payment) Income Category A	Member Pays (Co-payment) Income Categories B & C
Contact Lenses	Medically necessary contact lenses shall be covered in full.	No co-payment for medically necessary contact lenses. An allowance of $110 will be provided toward the cost of an examination, contact lens evaluation, fitting costs and materials for elective contact lenses. Contact lenses are limited to once each twelve month benefit period, beginning October 1st of each year.	No co-payment for medically necessary contact lenses. An allowance of $110 will be provided toward the cost of an examination, contact lens evaluation, fitting costs and materials for elective contact lenses. Contact lenses are limited to once each twelve month benefit period, beginning October 1st of each year.
Cataract Spectacles and Lenses **	Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery	No co-payment	No co-payment
Dental			
Oral Surgery	Bony impaction- per tooth Root recovery – per tooth	$5	$10
Endodontics	Apicoectomy performed in conjunction with root canal Retreatment of previous root canal	$5 per canal	$10 per canal
Periodontics	Osseous or muco-gingival surgery	$5 per quadrant	$10 per quadrant
Crowns and Bridges	Porcelain crown, porcelain fused to metal crown, full metal crown, and gold onlays or ¾ crowns Pontics	$5 per crown or other pontics	$10 per crown or other pontics

Benefits*	Covered Services	Member Pays (Co-payment) Income Category A	Member Pays (Co-payment) Income Categories B & C
Dentures	Complete maxillary denture Complete mandibular denture Partial acrylic upper or lower denture with clasps Partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles Removable unilateral partial denture Laboratory reline Denture duplication	$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 Customer Service at 1(415) 547-7800 (local) or 1(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, Customer Service who speak other languages are available. If they do not speak your language, they will use an interpreter.

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.

Eligibility and Enrollment

Availability of Funds for the Program

The acceptance of any application for enrollment in the Healthy Kids HMO 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 (1) year's premium, members shall be guaranteed one (1) 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.

Requirement for Member Eligibility

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

Healthy Kids HMO Eligibility, less than 19 years of age:	• 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. • A resident of San Francisco County. • In a family with an annual or monthly household income at or under 322% of the Federal Poverty Level. • 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. Pregnant minors who are members may be eligible for pregnancy-related services under the Healthy Kids HMO program. If the pregnant minor is a member of the Healthy Kids HMO 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 member, if the baby meets all of the eligibility criteria. If you are a Healthy Kids HMO program member, and you have a baby, contact Customer Service at 1(800) 288-5555 to learn what health coverage options, including the Healthy Kids HMO program, may be available for your baby.

Application Process

To apply for the Healthy Kids HMO 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 HMO program.

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 HMO program is determined.

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.

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 ineligibility affecting member's enrollment in the Healthy Kids HMO program.

Appealing Enrollment Changes

If you believe that the Healthy Kids HMO program made a mistake in deciding whether your child is eligible, you can file an appeal with the San Francisco Health Plan by calling Customer Service locally at 1(415) 547-7805 or toll-free at 1(800) 288-5555

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 HMO 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 HMO 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 Customer Service at 1(415) 547-7800 (local) or 1(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 orNative 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 Customer Service at 1(415) 547-7800 (local) or 1(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 medical or mental health 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 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.

Disability Access

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 1(415) 547-7800 (local) or 1(800) 288-5555 and Customer Service will help you find an alternate.

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 Customer Service at 1(415) 547-7800 (local) or 1(800) 288-5555.

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, Customer Service can help. Our Customer Service representatives speak other languages. If we don't have a representative who speaks your language, we have interpreters available by telephone. Call Customer Service at 1(415) 547-7800 (local) or 1(800) 288-5555. Customer Service 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 minors, friends or family members as interpreters unless you request it.

Member Rights and Responsibilities

Member Rights

As an SFHP Healthy Kids HMO 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 from the SFHP Healthy Kids HMO Program Provider Directory to provide or arrange for all the care I need.
- Receive good and appropriate medical care including preventive health services and health education.
- 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 HMO 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 HMO program, pay any premiums, co-payments and charges for non-covered services on time.

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 HMO 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 HMO 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 HMO 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 October 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.

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

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 HMO, Healthy Families, or Medi-Cal. The poverty guidelines are sometimes referred to as the "federal poverty level" (FPL).

Health Insurance Portability and Accountability Act (HIPAA) A law that protects your rights to get health insurance and keep your medical records private.

Health Plan 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 Customer Service at 1(415) 547-7800 (local) or 1(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.

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

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

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 HMO 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 Care Services 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 licensed and 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, licensed and 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 to develop and restore an individual's ability to function as normally as possible due to 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:

1. Persists without full cure or worsens over an extended period of time.
2. Requires ongoing treatment to maintain remission or prevent deterioration.

Serious Emotional Disturbance (SED) refers to a diagnosed condition in a child that is not a "substance abuse disorder" or "developmental disorder". A child with SED also behaves in a way that is not appropriate for the child's age. A county mental health department decides if a child has SED based on California Law. In making the decision, the county will consider whether a child has certain problems. These could include trouble taking care of him/herself, problems at school, or problems with family relationships. The child might also have other

problems such as being at risk of suicide or violence. Or, the child might meet the state's Special Education requirements. The county may also look at whether the child is at risk of being removed from the home and at how long the condition is expected to last.

Seriously Debilitating Illness 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 (SMI) is defined as a mental health condition that shall include all of the following:

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

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.

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 HMO Provider Directory, which was sent to you in your new

member packet. If you do not have a copy, call Customer Service at 1(415) 547-7800 (local) or 1(800) 288-5555. Since the participating providers listed in this Directory may change, call Customer Service to find out whether a particular physician or other health professional is available through SFHP.

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 Customer Service at 1(415) 547-7800 (local) or 1(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.

Changing Your PCP or Medical Group

You may change PCPs or medical groups by calling Customer Service at 1(415) 547-7800 (local) or 1(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.

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.

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.

How to Use SFHP

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 27), 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.

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.

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.

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.

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.

Urgent Care or Care After Regular Hours and on Weekends

If you feel sick, have a fever, or 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 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.

Post Stabilization and Follow-up Care After an Emergency

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

If the hospital where you 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 you to stay in the non-contracted hospital.

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

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

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

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR POST-STABILIZATION SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTED HOSPITAL, PLEASE CONTACT SAN FRANCISCO HEALTH PLAN CUSTOMER SERVICE DEPARTMENT AT 1(415) 547-7800 or 1(800) 288-5555, Monday to Friday from 8:30AM to 5:30PM.

SFHP Benefits

SFHP covers the benefits described in this section and listed in the Healthy Kids HMO 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 28), 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 HMO 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 HMO 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 HMO 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 HMO 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 Customer Service at 1(415) 547-7800 (local) or 1(800) 288-5555 or by calling the local county CCS program at 1(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 HMO 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:

- 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:
  - The child is at risk of removal from the home or has already been removed; or
  - 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.
- Shows signs of psychotic behavior, risk of suicide or risk of violence which are related to mental disorder.
- Meets special education eligibility requirements not related to developmental disorders.

If a member is determined to have a SED condition, care for the SED condition will be provided by the county mental health department. The plan may refer the member to the county mental health department for treatment of SED. The plan shall provide all medically necessary covered services until the county mental health department establishes eligibility for a member child with SED and the county mental health department provides the medically necessary services to treat the SED. The Plan and the county mental health department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with a SED condition.

The member will remain enrolled in the Healthy Kids HMO 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, but not limited to:

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

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

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, pervasive developmental disorder (PDD), 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 1(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 1(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 1(415) 575-5788 or 1(888) WIC-WORKS or 1(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 HMO program.

B. Preventive Health Services

Scheduled routine physical examinations as follows:

We cover a variety of preventive care services, which are health care services to help keep you healthy or to prevent illness. The following preventive services are covered by SFHP with no Member cost sharing (meaning services are covered at 100% of Eligible Expenses without deductible, coinsurance or copayment):

- Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive

guidelines supported bythe Health Resources and Services Administration.
- Additional preventive care and screenings for women supported by the Health Resources and Services Administration guidelines.

The current recommendations of theUnited States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention.

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, including taking your child to a dentist before the first tooth comes through (before age 2) and recommendations on how to get the most out of your health coverage.

Limitations

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

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 HMO 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

Abortions are covered services.

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 56). 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 43).
- 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 HMO 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 conjunct-

tion 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) federal Food and Drug Administration; (3) U.S. Department of Defense; or (4) 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 HMO 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 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, folic acid, 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 HMO Program Summary of Benefits Matrix on page 14 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 prior authorization request must be submitted.

Up to a 90-day supply of generic maintenance drugs and insulin, and up to 100-day supply of formulary test strips and lancets is covered.

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 formulary 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 on our website at http://www.sfhp.org/providers or by contacting SFHP at 1(415) 547-7800 (local) or 1(800) 288-5555. Except as described in this Evidence of Coverage, only prescription drugs that are listed on SFHP Drug Formulary list are covered unless restrictions apply. 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;

A member or physician may request a non-formulary prescription drug. A physician or pharmacy must submit a prior authorization request to SFHP's pharmacy benefit management company as described in PRIOR AUTHORIZATION PROCESS section above.

Exclusion:

- Drugs or medications prescribed solely for cosmetic purposes
- Patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc,. even if prescribed by your provider
- Medicines not requiring a written prescription (except insulin and smoking cessation drugs as previously described)
- Experimental or investigational drugs
- Any special food or diet items
- When a generic equivalent is available for a brand name drug, only generic drugs are covered unless it is medically necessary to receive the non-generic equivalent. The physician must submit a prior authorization request explaining why the generic equivalent cannot be used.
- Drugs used for the treatment of sexual or erectile dysfunction, unless one of these drugs is used to treat a condition other than sexual or erectile dysfunction and is medically necessary.
- 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 HMO members will receive our quarterly member newsletter, Your Health Matters. Call Customer Service to request other materials.
- Health education classes for children and adults are available throughout SFHP's service area. Call Customer Service at 1(415) 547-7800 (local) or 1(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 61 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.

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

T. Alcohol/Substance Abuse Treatment (Provided by Community Behavioral Health Services, SFHP's Mental Health Services provider.)

Diagnosis and treatment of a substance abuse condition. If you think your child may have a substance abuse condition, SFHP will give you information on how to get services for your child. Call SFHP's Customer Service Department at 1(415) 547-7800 to get information on how to get services for your child.

Inpatient hospitalization as medically necessary to remove toxic substances from the system. Medically appropriate crisis intervention and treatment of alcoholism or substance abuse is covered. Alcohol and substance abuse treatment (except for inpatient detoxification) are covered through San Francisco Behavioral Health Services. See section U, below for a description of how to contact San Francisco Behavioral Health Services for more information on the services they provide.

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

Diagnosis and treatment of a mental health condition. If you think your child may have a mental health condition, San Francisco Health Plan will give you information on how to get services for your child. Call SFHP's Customer Service Department at 1(415) 547-7800 to get information on how to get services for your child.

Inpatient Mental Health

Cost to Member: No Copayment

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

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

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

The treatment for PDD and autism includes medically necessary inpatient, outpatient, urgent and emergency services.

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

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

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

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

The member will remain enrolled in the Healthy Kids HMO Program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED from the Plan. For more information about SED diagnosis and treatment benefits, see "Coordination of Services" on page 36.

Outpatient Mental Health

Cost to Member: $10 per visit
(not applicable to SED)

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

Mental Health Care:

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

Serious Emotional Disturbance (SED)
Outpatient mental health care visits for the treatment of a member determined by the county to have a SED condition.

For members with a Serious Emotional Disturbance (SED) condition, outpatient and related professional services pertaining to the SED may be provided by the county mental health department. The plan may refer the member to the county mental health department for treatment of SED. The plan shall provide all medically necessary covered services until the county mental health department establishes eligibility for a subscriber child with SED and the county mental health department provides the medically necessary services to treat the SED. The Plan and the county mental health department will coordinate services to ensure that all medically necessary services and treatment are provided to a member with SED.

The member will remain enrolled in the Healthy Kids HMO Program and will continue to receive primary care, specialty care, and all other covered services for medical conditions not related to the SED from the Plan. For more information about SED diagnosis and treatment benefits, see information on page 47.

The treatment for PDD and autism includes medically necessary inpatient, outpatient, urgent and emergency services.

Inpatient Alcohol/Drug Abuse Treatment

Cost to Member: No Copayment

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

Outpatient Alcohol/Drug Abuse Treatment

Cost to Member :$10 per visit

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

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 you are admitted to a SFHP hospital as the result of an emergency medical condition that is not used by your PCP'S medical group, the Health Plan may elect to transfer you to the Hospital used by your 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 you and the hospital to which you were 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.

Y. Sexual Reassignment Surgery

SFHP covers the change of anatomical sex, which is the surgical conversion of the penis or vagina. SFHP does not cover other reassignment surgeries or related surgical procedures such as facial or neck feminization and/ or breast enhancement/reduction, unless medically necessary. If not medically necessary, these procedures are considered cosmetic and therefore are not a covered benefit.

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 HMO 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 HMO Customer Service toll free number at 1(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 Customer Service 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 HMO 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:

- Your group number (can be found on your member identification card: SF60);
- The name of your program: Healthy Kids HMO program;
- The member's client identification number; and,
- 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 HMO 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 HMO provider network, you will be notified 90 days in advance. Delta's Healthy Kids HMO Customer Service 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 HMO Customer Service department at toll free 1(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 HMO Customer Service department at toll free 1(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 1(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:

- Recommendation of crowns, bridges, inlays, and onlays as a covered benefit,
- Cast post and core, including cast retention under crown, and
- 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

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 very 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 crows 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 Customer Service representative at Delta Dental at 1(877) 580-1042, Monday through Friday from 6:00am through 5:15pm. To submit a grievance electronically, please visit Delta Dental's website at http://www.deltadentalins.com.

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 1(415) 547-7800 (local) or 1(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 Customer Service 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 Customer Service 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 Customer Service 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 Customer Service 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 HMO
P.O. Box 537010
Sacramento, CA 95853-7010
Toll Free: 1(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 HMO Customer Service representative at toll free 1(866) 212-2743 and state your grievance,
- Submit a grievance electronically on Delta Dental's website at http://www.deltadentalins.com. 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 Customer Service 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 1(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.

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 HMO program. When you need vision benefits from a VSP doctor, contact VSP at 1(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 1(800) 877-7195, or SFHP at 1(415) 547-7800 (local) or 1(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 and Lenses

Cost to member: $5 copayment, for frames with lenses, or for frames or for lenses when purchased separately.

Description: When the vision examination indicates that corrective lenses are necessary, the member is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, and lenticular lenses as appropriate. Benefit also includes tinted lenses, Photochromic lenses, and polycarbonate lenses.

A frame allowance of $100 is provided by the vision plan and the plan will provide the member a selection of frames that do not cost more than $100. The member is responsible for any costs exceeding this allowance for the following options:

- Blended lenses (bifocals which do not have a visible dividing line)
- Contact lenses except as specified in the Contact Lenses section below;
- Oversized lenses (larger than standard lens blank to accommodate prescriptions);
- Progressive multifocal lenses;
- Coated or laminated lenses;
- UV protected lenses.
- Other optional cosmetic processes.
- A frame that costs more than the plan allowance.

Frames are limited to once each 12-month period.

Contact Lenses

Cost to member: Medically necessary contact lenses: no co-payment

Elective contact lenses: An allowance of $110 will be provided by the vision plan toward the cost of an examination, contact lens evaluation, fitting costs and materials. This allowance will be in lieu of all benefits, including examination 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 and Supplementary Testing

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;

Supplementary care: $10 co-payment. 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 HMO Program Summary of Benefits Matrix on page 14 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 Section15, 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 Customer Service Department at 1(800) 877-7239. If you are unable to resolve your grievance with VSP, you may call San Francisco Health Plan for additional help at 1(415) 547-7800 (local) or 1(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 HMO 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.

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. Learning and self-improvement programs to provide that medically necessary treatment for PDD or autism, is not excluded.

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, for custodial 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 45). 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 (except insulin and smoking cessation products), vitamins (except prenatal vitamins and folic acid), minerals (except fluoride preparations), 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 38.

Services received outside of the United States, except for emergency, urgent or authorized services.

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 47.

Transportation other than provided under medical transportation, page 48.

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.

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.

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 HMO 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 HMO benefits. Healthy Kids HMO 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 HMO 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 Customer Service at 1(415) 547-7800 or 1(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 HMO 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, 1(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 1(800) 735-2929 (TTY), or 1(888) 877-5379 (TYY), to contact the Department. The Department's Internet website (http://www.hmohelp.ca.gov) contains forms and instructions online.

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. You can also ask for a copy of the complete Complaint/Grievance Protocols. Please contact Customer Service at 1(415) 547-7800 (local) or 1(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 62.

Filing a Grievance

You can file a grievance about the provision of health services or benefits by calling Customer Service at 1(415) 547-7800 (local) or 1(800) 288-555, or you may make a written complaint to:

San Francisco Health Plan
Attn: Grievance Coordinator
P.O. Box 194247
San Francisco, CA 94119

You can also submit your grievance in person at the following address:

San Francisco Health Plan
Service Center
7 Spring Street
San Francisco, CA 94104

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.

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 on page 62.

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 1(888) HMO-2219, or a TDD line 1(877) 688-9891.

B. 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 1(800) 288-555 or 1(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.

C. 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.

D. Where to Write

The written grievance or any correspondence or information regarding the member grievance should be mailed:

Grievance Coordinator
San Francisco Health Plan,
P.O. Box 194247
San Francisco, CA 94119

You can also submit your grievance in person at the following address:

San Francisco Health Plan
Service Center
7 Spring Street
San Francisco, CA 94104

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.

E. 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:

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;

The disputed health care service has been denied, modified, or delayed by SFHP or your medical group, based in whole or in part on a decision that the health care service is not medically necessary; and

You have filed a grievance with SFHP or your medical group and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you 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 Customer Service at 1(415) 547-7800 (local) or 1(800) 288-555.

F. Experimental/Investigational IMRs

If you 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.

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

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

G. Complaints to the Department of Managed Health Care

The California Department of Managed Health Care (DMHC) 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 1(800) 288-5555 or 1(415) 547-7800 or the TDD number at 1-888-883-7347 and use your health plan's grievance process before contacting the DMHC. Using this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by 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

DMHC also has a toll-free telephone number, 1(888) HMO-2219, and a TDD line, 1(877) 688-9891, for the hearing and speech impaired. The DMHC's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

H. 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 cannot 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.

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 Customer Service at 1(415) 547-7800 (local) or 1(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 received continued care from the terminated provider. Contact Customer Service 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 received continued care from the non-contracted provider. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a non-contracting provider.

Call Customer Service at 1(415) 547-7800 (local) or 1(800) 288-5555, 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 1(415) 547-7800 (local) or 1(800) 288-5555, 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 sent to you every year pursuant to the Federal Health Insurance Portability and Accountability Act (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 Compliance & Regulatory Affairs Officer at 1(415) 547-7800, or 1(800) 288-5555 or by visiting SFHP's website at www.sfhp.org.

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 Compliance & Regulatory Affairs 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

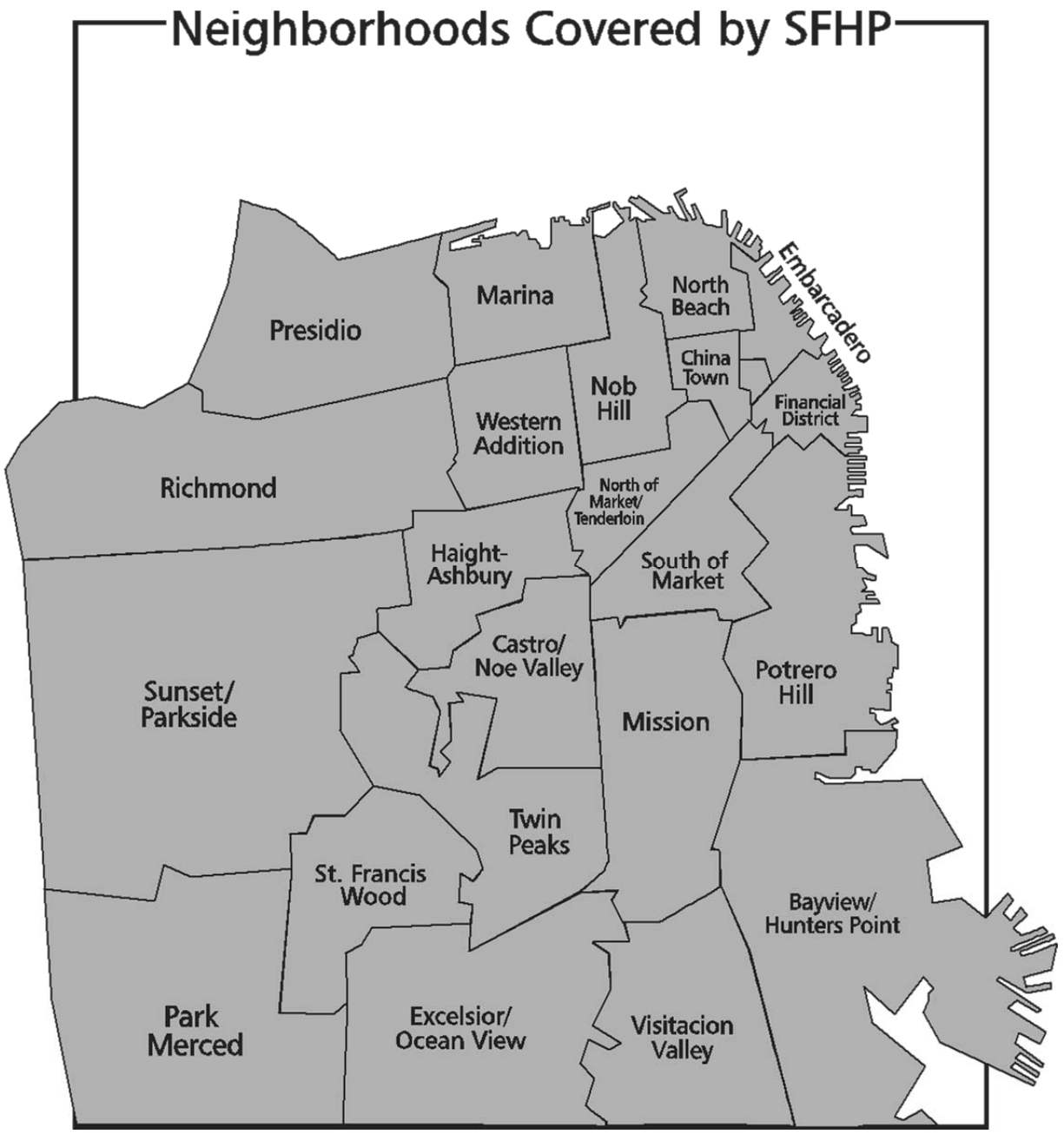
SFHP shall have the power and discretionary authority to construe and interpret the provisions of the Health Plan Contract and the Evidence of Coverage and to determine the benefits of SFHP. SFHP shall exercise this authority for the benefit of all persons entitled to receive benefits under the contract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

I. Governing Law

SFHP's Healthy Kids HMO 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.


Neighborhoods Covered by SFHP
Presidio
Marina
North Beach
Embarcadero
China Town
Nob Hill
Financial District
Western Addition
Richmond
North of Market/ Tenderloin
Haight-Ashbury
South of Market
Castro/ Noe Valley
Potrero Hill
Sunset/ Parkside
Mission
Twin Peaks
St. Francis Wood
Bayview/ Hunters Point
Park Merced
Excelsior/ Ocean View
Visitacion Valley