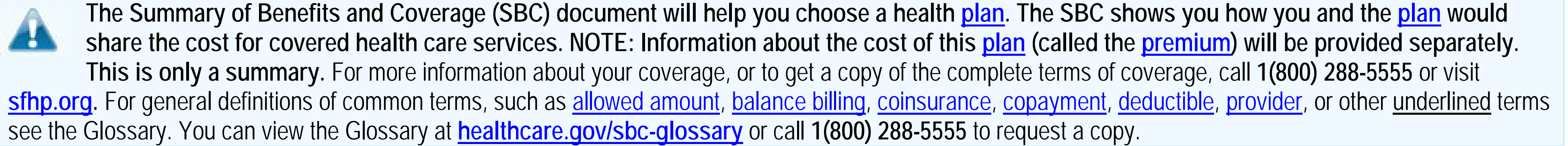

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call **1(800) 288-5555** or visit sfhp.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call **1(800) 288-5555** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$ 250 individual / $ 250 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balance-billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See sfhp.org or call **1(800) 288-5555** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	Not Covered	None
	Specialist visit	$10 copay/visit	Not Covered	Preauthorization may be required.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Depending on the service, preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Depending on the service, preauthorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at sfhp.org	Generic drugs	$10 copay/prescription	Not Covered	Preauthorization may be required. Covers 90-day supply for most generic drugs; 30-day supply for opiate pain drugs. No copay for up to 12-month supply of FDA-approved contraceptive drugs and devices.
	Preferred brand drugs	$10 copay/prescription	Not Covered	Preauthorization may be required. Covers 30-day supply for most brand drugs; 90-day supply for brand drugs used to treat chronic conditions. No copay for up to 12-month supply of FDA-approved contraceptive drugs and devices.
	Non-preferred brand drugs	$15 copay/prescription	Not Covered	Preauthorization may be required. Applies when a medication on the formulary is available in both a brand name and generic form, but your provider requests the brand name drug.
	Specialty drugs	$10 copay/prescription for generic/preferred brand drugs $15 copay/prescription for non-preferred brand drugs	Not Covered	Preauthorization may be required. Covers 30-day supply for most brand drugs; 90-day supply for generic and brand drugs used to treat chronic conditions. No copay for up to 12-month supply of FDA-approved contraceptive drugs and devices.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Preauthorization may be required.
	Physician/surgeon fees	No Charge	Not Covered	Preauthorization may be required.
If you need immediate medical attention	Emergency room care	$15 copay	$15 copay	Copay waived if admitted to the hospital.
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$15 copay	$15 copay	Preauthorization may be required for out-of-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Preauthorization may be required.
	Physician/surgeon fees	No Charge	Not Covered	Preauthorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit	Not Covered	No charge if determined to have Serious Emotional Disturbance condition
	Inpatient services	No Charge	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	None
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	None
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 100 days per benefit year. Rehabilitation services and habilitation services copays and limitations may apply.
	Rehabilitation services	$10 copay/visit	Not Covered	Preauthorization may be required. Copays do not apply in inpatient settings. Combined maximum of 60 consecutive calendar days following first therapy treatment for any single illness or injury.
	Habilitation services	$10 copay/visit	Not Covered	Preauthorization may be required. Copays do not apply in inpatient settings. Combined maximum of 60 consecutive calendar days following first therapy treatment for any single illness or injury.
	Skilled nursing care	No Charge	Not Covered	Up to 100 days per benefit year. Rehabilitation services and habilitation services copays and

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				limitations may apply.
	Durable medical equipment	No Charge	Not Covered	Preauthorization is required.
	Hospice services	No Charge	Not Covered	Preauthorization may be required. Rehabilitation services and habilitation services copays and limitations may apply.
If your child needs dental or eye care	Children's eye exam	$5 copay/visit	Not Covered	Limited to one exam per year.
	Children's glasses	Frame allowance up to $100 Contact lens allowance up to $110	Not Covered	Limited to one per year.
	Children's dental check-up	No Charge	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Private-duty nursing
- Bariatric surgery
- Infertility treatment
- Routine foot care
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Dental care (Adult)
- Routine eye care (Adult)
- Hearing aids
- Long-term care

Premiums: The Healthy Kids HMO premium is $189 per year per member, with a maximum of $567 per family. Premium assistance is available by contacting San Francisco Health Plan Customer Service at **1(415) 547-7800** or toll-free at **1(800) 288-5555** from Monday through Friday, 8:30am to 5:30pm. If you are hearing impaired, call TDD **1(888) 883-7347.**

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at **1(877) 267-2323 x61565** or **cciio.cms.gov.** Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit **HealthCare.gov** or call **1(800) 318-2596.**

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the California Department of Managed Health Care, at **1(888) 466-2219** or **dmhc.ca.gov.**

* For more information about limitations and exceptions, see the plan or policy document at sfhp.org.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1(800) 288-5555.**

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1(800) 288-5555.**

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码 1(800) 288-5555.**

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1(800) 288-5555.**

––––––––––––––––––––––To see examples of how this plan might cover costs for a sample medical situation, see the next section.––––––––––––––––––––––

* For more information about limitations and exceptions, see the plan or policy document at sfhp.org.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible $0
- Specialist copayment $10
- Hospital (facility) copayment $0
- Other copayment $10/$15

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$50**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible $0
- Specialist copayment $10
- Hospital (facility) copayment $0
- Other copayment $10/$15

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$310**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible $0
- Specialist copayment $10
- Hospital (facility) copayment $15
- Other copayment $10/$15

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$45
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$45**

The plan would be responsible for the other costs of these EXAMPLE covered services.