SAN FRANCISCO HEALTH PLAN
Here for you

San Francisco Health Plan
Evidence of Coverage and Disclosure Form
2013-2014

HealthyWorkers

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The San Francisco Health Plan Evidence of Coverage and Disclosure Form should answer your questions about how to use the plan. **This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.** For more detailed information, refer to the Evidence of Coverage section of this booklet. This booklet contains:

Quick Guide: A brief overview about getting started, choosing your Primary Care Physician (PCP), getting care under your new health plan, health plan services and charges, and solving problems, complaints and grievances

Summary of Benefits: A chart to help you compare coverage benefits.

Evidence of Coverage: The terms and conditions of your health plan. Also, this gives details about San Francisco Health Plan.

All references in this document to "Healthy Workers" shall include collectively (i) "As Needed Employees", an eligible class of employees of the City and County of San Francisco classified as "Temporary Exempt As-Needed" workers; (ii) In Home Support Services Workers ("IHSS Workers") who are eligible employees of the IHSS Public Authority; and (iii) IHSS workers who are eligible employees of the IHSS Consortium.

As a Healthy Workers Member, you will have access to medical services through the city's health care network, Community Health Network (CHN). CHN health care providers and *clinics*, San Francisco General Hospital, and your Healthy Workers participating pharmacies understand your health care needs.

This new Evidence of Coverage booklet combines a quick guide of health plan services and how to access them, a Summary of Benefits, and the Evidence of Coverage and Disclosure Form. The Evidence of Coverage is a summary of the *group agreement* between San Francisco Health Plan and your *employer* and also tells you the terms and conditions of your health plan. To find out the exact terms and conditions of coverage, contact your *employer*.

Some of the words used in this Directory have specific definitions. These words are *italicized*. The meanings of these *italicized* words are found in Chapter 12 of this Directory.

Information about our providers and contracted facilities is included in the Provider Directory.

Please be sure to always refer to your Provider Directory when selecting a *primary care provider (PCP)* or other providers you seek services from.

Please call Customer Service at **(415) 547-7800** or **(800) 288-5555** from Monday through Friday, 8:30 am to 5:30 pm if you would like additional information about the *benefits* of *SFHP*.
San Francisco Health Plan is located at:

201 Third Street, 7th Floor
San Francisco, CA 94103

San Francisco Health Plan will provide a copy of the plan contract to you upon request.

SFHP makes it easy for you to get care.

Call your Primary Care Provider (PCP) to:

- Make an appointment
- See a specialist

Call San Francisco Health Plan (SFHP), at **(415) 547-7800** (locally) or **(800) 288-5555** (or email us at **customerservice@sfhp.org)** to:

- Change your primary care provider (PCP)
- Get a new member ID card
- Report a problem with your PCP or other health care services
- Get help filling your prescriptions

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

- If you cannot reach your doctor 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 go to the urgent care center if needed
- This service is free of charge and available to you in your language
- Is available 24-hours a day, 7 days a week

Providers with the In-Home Supportive Services Public Authority (IHSS PA): To find out if you're eligible for Healthy Workers or to apply, contact the IHSS Public Authority at **(415) 243-4477**.

As-needed employees of the City and County of San Francisco: To find out if you're eligible for Healthy Workers or to apply, contact the Department of Human Resources at **(415) 557-4942**.

IHSS Consortium workers: To find out if you're eligible for Healthy Workers or to apply, contact the IHSS Consortium at **(415) 255-2079** or **(800) 283-7000**.

Call San Francisco Community Behavioral Health Services (SFCBHS) at **(415) 255-3737** or **(888) 246-3333** (toll free) or **(888) 484-7200** (TDD), to:

- Get mental health counseling
- Access a substance abuse counselor
- Call Vision Service Plan (VSP) at **(800) 877-7195** to: Get an eye exam or eyeglasses
- IHSS Workers ONLY -- Call Liberty Dental at (888) 703-6999 to: Make an appointment with a dentist

Contents

A. Quick Guide

1. Getting Started

How Managed Care Works

SFHP is a managed care plan. In managed care, your *primary care provider (PCP*), *clinic*, *hospital*, and *specialists* work together to care for you. Your *PCP* provides basic health care needs.

Your *PCP* is part of the Medical Group Community Health Network (CHN), and works at a CHN clinic. CHN consists of doctors, *specialists*, and other providers of health care services, as well as San Francisco General Hospital. Your *PCP*, along with CHN, directs the care for all of your medical needs. This includes *authorizations* to see *specialists*, or receive medical services such as lab tests, x-rays, and/or hospital care. Additionally, as a Healthy Workers *member*, you can access vision services and get your prescriptions filled directly from the vision providers and pharmacies listed in the Healthy Workers Provider Directory. If you have questions about your vision or pharmacy benefits, call Customer Service at **(415) 547-7800** (locally) or **(800) 288-5555**.

Determining Eligibility

IHSS Workers with the IHSS Public Authority (PA):

Most independent IHSS Workers in San Francisco who are recorded with IHSS PA as authorized to work for two consecutive months, and for at least 25 hours in one of those months, are eligible to apply for health care coverage through Healthy Workers.

The IHSS Public Authority determines your eligibility when the signed Enrollment Form/Request for Health Coverage is returned Once you meet these requirements, you will be enrolled in Healthy Workers. *SFHP* will notify you of your new health care coverage at that time.

Each month, the IHSS Public Authority is informed of the number of hours you work. Your eligibility for Healthy Workers will continue as long as you work at least 25 hours per month. If you drop below 25 hours during one month, you will remain a Healthy Workers *member* for three more months, and then your coverage will end, unless you work 25 hours in one of those three consecutive months.

Once enrolled, you will remain a Healthy Workers *member* unless you:

- Work less than 25 hours a month for three months in a row
- Notify *SFHP* that you wish to cancel your health care coverage
- Are no longer living or working in *SFHP's* coverage area (more than a 30-mile or a 30-minute commute to your health care provider)

As-Needed Employees

For the purpose of calculating eligibility for As-Needed Workers, years of service shall be defined as time, calculated in months, from the employee's original start work date with the City and County of San Francisco, regardless of status or classification. The benefit periods will be defined as a minimum of 3 calendar months, with the exception of the initial benefits period of five (5) months from August 1, 2007 to December 31, 2007. Initial eligibility for As-Needed Worker benefits under this Agreement beginning on August 1, 2007 will be based on employee work data for the period April 21, 2006 through April 6, 2007. Beginning January 1, 2008, continuous eligibility will be determined at least on a quarterly basis, based on data collected during the twenty-six (26) bi-weekly pay periods ending the last day of the pay period closest to the first date of the quarter previous to the benefits period. For the benefits period beginning January 1, 2008, the data collection period will be determined from employee data collected for the twenty-six (26) bi-weekly pay periods ending September 30, 2007.

Category A: As-Needed Employees with Less Than 3 Years of City Service

City employees who are included in this category include all As-Needed Workers who have less than three (3) years of City service and who have worked 450 or more hours, based on data collected during the twenty-six (26) bi-weekly pay periods ending the pay date closest to the first date of the quarter previous to the benefit period.

Category B: As-Needed Employees with 3 or more but less than 6 years of City Service
City employees included in this category must have three (3) or more years of City service and have worked 300 hours, based on data collected during the twenty-six (26) bi-weekly pay periods ending the pay date closest to the first date of the quarter previous to the benefit period.

Category C: As-Needed Employees with 6 or more years of City Service
City employees included in this category must have six (6) or more years of City service and have worked 200 or more hours, based on data collected during the twenty-six (26) bi-weekly pay periods ending the pay date closest to the first date of the quarter previous to the benefit period.

Eligibility will be determined by the City pursuant to the terms of this Agreement. Data on hours worked and years of service will be reviewed by the City at the end of each benefit period after August 1, 2007. The City will use that information to determine which employees are eligible for continuous enrollment in the Health Plan's prepaid health care service plan.

Individuals in each category will be notified by the City at least 45 days prior to the date they are newly eligible to begin participation in the Healthy Workers Program. Eligible individuals who enroll at least thirty (30) calendar days prior to the first day of the next benefit period will be eligible for coverage beginning with that benefit period.

Employees enrolled as eligible As-Needed Workers may become ineligible at the end of a benefit period because they have not met eligibility requirements (including, but not limited to requisite hours per Categories A, B or C). Ineligible individuals who remain As-Needed Workers with the City will be offered the option of continuing healthcare coverage through the San Francisco Health Plan for subsequent benefit periods if they assume full responsibility for the monthly premium.

Subscribers may voluntarily withdraw from health care coverage throughout the year. Change requests must be received by the City by the 10th calendar day of the month in order for the change to be effective the first day of the following month.

Reasons for Termination of Coverage
Categories A, B and C

Once enrolled, you will remain a Healthy Workers *member* unless you:

- Are no longer a City employee.
- No longer meet eligibility requirements.
- Fail to pay your quarterly premium, if applicable
- Choose to terminate coverage.
- Become eligible for enrollment as a primary beneficiary in a health plan offered by the City's Health Service System
- Are enrolled as a dependent in a health plan offered by the City's Health Service System
- Are enrolled in another health plan
- Move out of the Health Plan's service area and no longer work in the service area

In all cases involving termination of Healthy Worker benefits listed above, the City will send a notice to workers at least fifteen (15) calendar days prior to the termination date.

Providers with the In-Home Supportive Services Public Authority (IHSS PA): To find out if you're eligible for Healthy Workers or to apply, contact the IHSS Public Authority at **(415) 243-4477**.

As-needed employees of the City and County of San Francisco: To find out if you're eligible for Healthy Workers or to apply, contact the Department of Human Resources at **(415) 557-4942**.

Your spouse and children are not eligible for *benefits* under this plan. Newborns or legally adopted children after 31 days of birth or adoption are also not eligible for *benefits*. However, *SFHP* can help you find coverage for your *dependents* in other healthcare programs. Call Customer Service at **(415) 547-7800** (locally) or **(800)288-5555** for more information.

IHSS Consortium Workers:

IHSS workers with the IHSS Consortium are also eligible for Healthy Workers.

Eligibility Requirements:

Initial Eligibility: A Subscriber must work at least fifteen (15) hours per week within their first thirty (3) days of employment to be eligible on the first day of the following month.

Continuation of Eligibility: A subscriber's eligibility is assessed every three (3) months. The subscriber must have worked, on average, at least fifteen (15) hours per week over a three (3) month period.

Ending of Eligibility: If the Subscriber does not work, on average, at least fifteen (15) hours per week over a three (3) month period, their eligibility will end the first day of the following month.

A Subscriber must also either reside within the San Francisco on a full-time basis or must work within San Francisco in a manner that allows the subscriber to meet the regulatory distance and travel time requirements to access their SFHP primary care provider (15 miles or 30 minutes from your SFHP primary care provider).

IHSS Consortium workers: To find out if you're eligible for Healthy Workers or to apply, contact the IHSS Consortium at **(415) 255-2079** or **(800) 283-7000**.

Information for Members Who Have Trouble Reading

SFHP will get you this Handbook and other important Plan materials in alternate formats like Braille, large size print and audio if you can't see well, or we can read parts to you over the telephone. For alternate formats, or for help in reading SFHP materials, please call SFHP Customer Service at **(415) 547-7830 (TDD)** or toll free at **(888) 883-7347**.

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 many languages. If we don't have a Customer Service representative who speaks your language, we have outside interpreters available by telephone. Call Customer Service also to help you find a doctor who speaks your language. You have a right to interpreter services at no cost to you when you receive medical care or use medical services. You also have a right to ask for face-to-face or telephone interpreter services and to not use friends or family members as interpreters unless you request it.

For Members of San Francisco Health Plan that are hearing impaired, please call **(415) 547-7830 (TDD)** or toll free **(888) 883-7347**.

2. Choosing Your Primary Care Provider (PCP)

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

What is a Primary Care Provider (PCP)?

A *primary care provider (PCP)* is your personal CHN doctor. He or she will work with you to keep you healthy. Your PCP is part of a CHN *clinic*. He or she may be a family practitioner, general practitioner, or an internal medicine *specialist*. Your *PCP* provides all your basic health care, including:

- Regular check-ups and preventive services such as well-woman exams, mammograms, and prostate exams
- Care when you are sick or injured
- Help with on-going health problems like asthma, allergies, or diabetes

What Kind of Provider Can Be a PCP?

Your PCP can be in:

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

Using the Provider Directory

The provider directory is available in English, Spanish, Chinese and Russian

It contains the address and telephone number of each Service Location (e.g., locations of Primary Care Physicians (PCP), clinics, pharmacies and hospital).

It also has the hours and days when each of these are open, the services and benefits available, the telephone number to call after

normal business hours, and identifies providers that are not accepting new patients.

Choosing a Primary Care Provider (PCP)

When you join Healthy Workers, we will assign you to a CHN *clinic* that is near your home. Your PCP is the *clinic* that you are assigned to. Within two weeks of enrollment, you will receive a member ID card with the *clinic* name and phone number for you to call to schedule an appointment. You can either choose to schedule an appointment with a *PCP* at that *clinic*, or you can select another *clinic*. Use the Healthy Workers Provider Directory to help select your *clinic*.

Call Customer Service at **(415) 547-7800** (locally) or **(800) 288-5555** to change your *clinic* or to select a *PCP*.

Review the Healthy Workers Provider Directory to choose a *PCP* from the list of providers. You will find the names of each of the *PCPs* along with their address, telephone number, specialty, and the languages they speak.

PCPs are listed in two ways to help you find the one who is right for you:

- By Alphabet – If you know the name of the provider you would like to see
- By Clinic – If you know the name of the clinic

Some things to think about when choosing a PCP:

- Is the PCP close to home or work?
- Is it easy to get to the PCP clinic by using public transportation?
- Does the PCP speak your language?

Changing Your Primary Care Provider (PCP)

If you are not happy with your PCP for any reason, call Customer Service at **(415) 547-7800** (local) or **(800) 288-5555** to request a change. It's best to call before the 25th 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 **(415) 547-7800** (local) or **(800) 288-5555**. A representative will tell you which PCP to see.

Why a provider may request a change in member's PCP?

- Irreconcilable breakdown in physician-patient relationship
- Physical assault and violent behavior by member including physical threatening and verbal and physical abuse
- Member fraud
- Non-compliance with PCP's care management plan
- Member habitually uses providers not affiliated with SFHP for non-emergency services without required authorizations or communication with the PCP

If Your PCP Leaves SFHP

We will notify you if your provider leaves *SFHP*. We will assign you to another provider or clinic if we are unable to contact you by phone or mail. You can change your provider or clinic anytime by calling Customer Service at **(415) 547-7800** (locally) or **(800) 288-5555**.

Making Appointments with Your Primary Care Provider (PCP)

For most health care needs, see your *PCP* first. Your *PCP* or a doctor-on-call is available by telephone 24 hours a day, 7 days a week. Your *PCP* will make sure you get the health care you need, either by providing treatment or referring you to a *specialist*.

Your *clinic* phone number is listed on your member ID card. If you lose your member ID card, call Customer Service for a replacement card at **(415) 547-7800** (locally) or **(800) 288-5555**, Monday through Friday, 8:30am to 5:30pm.

3. Getting Care Under Your New Health Plan

Schedule Check-Ups and Routine Care. Do not wait until you are sick to see your PCP. Schedule an appointment for a health assessment (check-up) within 120 days of enrollment. Your PCP will advise you about the best time for routine appointments and shots, depending on your age.

Getting a Referral

Your *PCP* provides general medical care. If you need more specialized services, your *PCP* will request a referral from SFHP for certain services you may need. SFHP will approve or deny the request based on medical necessity. You must get a referral for specialty care before you make an appointment. Your *PCP* will start the referral process for you.

Services that do not require a referral are:

- PCP visits
- Emergency services
- OB/GYN visits
- Vision care
- Behavioral Health Services
- Second opinions

You have the right to ask for a *second opinion* about medical treatment or surgeries. If you want a second medical opinion, tell your provider. If you are requesting a Second Opinion about care from your PCP, the Second Opinion shall be provided by an appropriately qualified health care professional of the your choice within the same Medical Group. If there is no participating Provider within the Medical Group who is appropriately qualified to treat your condition or offer a Second Opinion on your behalf, then the Plan shall Authorize a Second Opinion by an Appropriately Qualified Health Professional with another Medical Group, or if necessary, outside of the Plan's provider network.

If you are requesting a Second Opinion about care from your Specialist, the Second Opinion shall be provided by any Appropriately Qualified Health Care Professional of your choice from any Medical Group within the Plan's network. If there is no Appropriately Qualified Health Care Professional within the Plan's network to provide an opinion, then the Plan shall authorize a Second Opinion by an Appropriately Qualified Health Care Professional outside of the Plan's network.

If your condition is such that you face an imminent and serious threat to your health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to your ability to regain maximum function, the second opinion shall be authorized or denied in a timely fashion appropriate to the nature of your condition, not to exceed 72 hours after San Francisco Health Plan receives your request, whenever possible.

If you would like help in obtaining a *second opinion*, call Customer Service at **(415) 547-7800** (locally) or **(800) 288-5555**, Monday through Friday, 8:30am to 5:30pm.

Hospital Care

If you are sick or hurt, call your PCP if possible. He or she will either see you, refer you to a specialist, or send you to San Francisco General Hospital.

Behavioral Health Services

Behavioral Health Services are provided by San Francisco Community Behavioral Health Services. You can call the Plan's Access Help Line to get a referral to a provider who can best serve your needs. To reach the Access Help Line call **(415) 255-3737** or **(888)246-3333** (toll free) or **(888)484-7200** (TDD).

Behavioral health benefits include inpatient and outpatient care as follows:

- Outpatient Behavioral health care for crisis intervention up to 20 visits per year is covered when authorized by your PCP. A psychiatrist, psychologist, or other licensed counselor may provide this treatment
- Inpatient Behavioral health care is covered for an acute phase of a Behavioral health condition if authorized and performed by a participating Behavioral health professional

Pharmacy

As a Healthy Workers *member*, you may have prescriptions filled at San Francisco General Hospital's Outpatient Pharmacy or at the pharmacy associated with your clinic. To find your clinic's pharmacy:

- Refer to section 8 of the Healthy Workers Provider Directory, or
- Call your clinic, or
- Visit our website at www.sfhp.org, and refer to the Pharmacy Services section of the Healthy Workers member area

To activate your Healthy Workers pharmacy benefit, you must register and attend an appointment with your assigned PCP. To keep your Healthy Workers pharmacy benefit active, you must make an appointment and be seen by your assigned PCP every 6 months.

Health Education Programs

As an *SFHP member*, you can receive health education materials and information at no cost. Call Customer Service to request materials on health topics in your language. You can also participate in select health education programs free of charge. Call Customer Service at **(415) 547-7800** (locally) or **(800) 288-5555** for more information, or speak with your *PCP* if you are interested in learning about the programs available to you.

For additional information, call Customer Service at **(415) 547-7800** or **(800) 288-5555**, Monday through Friday, 8:30am to 5:30pm.

4. Health Plan Services and Charges Co-Payments

In addition to your monthly premium, some services require small payments *(co-payments)* at the time of service. There are no deductibles under the program and there are no lifetime financial benefit maximums for any of the covered health benefits. For a full description of *co-payments,* see the Summary of Benefits Section of this Handbook.

Out-of-Network Charges

Providers (CHN doctors, *clinics*, San Francisco General Hospital, vision providers, behavioral health providers, and pharmacies) listed in the Healthy Workers Provider Directory work with

SFHP and are considered to be network providers. You should be able to get appropriate health care within *SFHP's* network of providers. However, if no *SFHP* provider is available to perform the services you need, your PCP will get *authorization* to refer you to an out-of-network provider.

Emergency care is covered anywhere in the United States and does not require prior *authorization*. Remember, **you may be responsible for payment if you obtain services outside of the network and you do not follow the referral process**. Please call Customer Service at **(415) 547-7800** (locally) or **(800)288-5555** if you have any questions about the network of Healthy Workers providers.

B. 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.

Benefit	Covered Service	Member Pays
Deductibles		No deductibles
Lifetime Maximum		Unlimited
Professional Services	In-licensed hospital, skilled nursing facility, hospice, behavioral health facility; office or home physician visit	No co-payment
Outpatient Services	Chemotherapy, dialysis, surgery, anesthesiology, radiation, and associated medically necessary facility charge	No co-payment
Hospitalization Services	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
Emergency Health Coverage	24-hour care for sudden, serious, and unexpected illness, injury, or condition requiring immediate diagnosis in and out of the Plan	No co-payment if services are obtained at San Francisco General Hospital; **$20** co-payment at any other hospital emergency room
Ambulance Services	Ambulance transportation when medically necessary	No co-payment
Prescription Drug Coverage	Prescriptions drug are covered per the DPH Formulary. Call Med Impact at 1(800) 788-2949	**$5** co-payment per prescription for preferred drugs **$10** co-payment per prescription for non-preferred drugs
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
Behavioral Health Services	Inpatient (limited to 30 days per Benefit Year); other services provided through the local behavioral health department with referral. Please note that treatment for the diagnosis of severe emotional disturbances and severe mental illness are excluded from the benefits limitations	No co-payment

Benefit	Covered Service	Member Pays
Chemical Dependency Services	- Outpatient visits for crisis intervention (up to 20 per benefit year) - Inpatient detoxification - Crisis intervention and outpatient alcohol or drug abuse treatment as medically necessary (up to 20 visits)	**$3**/visit No co-payment No co-payment
Home Health Services	Medically necessary skilled care (not custodial); home visits, physical, occupational and speech therapy	No co-payment
Hearing Aids/Services	Audiological evaluations, hearing aids, supplies, visits for fitting, counseling, adjustments, repairs	No co-payment
Eye Exams/Supplies Covered through your Vision Service Plan	Annual exams to determine the need for corrective lenses	**$10** per eye exam **$25** for frames under **$75** every 24 months (Member is responsible for amount over **$75**)
Diagnostic X-ray and Laboratory Services	Therapeutic radiological services, ECG, EEG, mammography, other diagnostic laboratory and radiology tests, laboratory tests for the management of diabetes	No co-payment
Orthoses and Prostheses	Orthoses and prostheses as prescribed by SFHP providers	No co-payment
Skilled Nursing Facilities	Medically necessary skilled care; room and board; x-ray, laboratory, and other ancillary services; medical social services; drugs, medications, and supplies Skilled nursing services are covered from the day of admission and are limited to 100 days during any benefit year.	No co-payment
Hospice	Medically necessary skilled care; counseling; drugs and supplies; short term inpatient care for pain control and system management; bereavement services; homemaker services; physical, speech and occupational therapies; medical social services; short term inpatient and respite care	No co-payment
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
Rehabilitative Therapies Inpatient	Physical, occupational, speech therapy	No co-payment
Rehabilitative Therapies Outpatient	Physical, occupational, speech therapy as medically necessary	No co-payment
Health Education	Health education materials	No co-payment (no limits)

C. Evidence of Coverage

The Terms and Conditions of your Health Plan

1. About San Francisco Health Plan (SFHP)

San Francisco Health Plan is a licensed managed care health plan (the Plan). It is not a medical provider. Independent doctors, Clinics, Hospitals, and other SFHP providers provide all of the health care services Members receive. In turn SFHP contracts with your Employer who sponsors your health care. These group contracts specify how the Plan works and what it covers.

You have the right to review this Handbook prior to enrollment. Please read the Evidence of Coverage ("EOC") 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. Some of the words used in this EOC have specific definitions. These words are italicized The meanings of these italicized words in bold are found in the Definitions section of the EOC.

(Member Rights and Responsibilities covered in Global Handbook)

2. Definitions

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

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.

Appropriately Qualified Health Professional is a Primary Care Provider, Specialist, or other Health Professional who is acting within his or her scope of license 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.

Arbitration: A way to solve problems using a neutral third party. For problems that are settled through Arbitration, the third party hears both sides of the issue and makes a decision that both sides must accept. Both sides give up the right to a jury or court trial. To learn more, read "Arbitration" in the "Help in Solving Problems" section on page 40.

Authorization (Authorized) is the requirement that certain services be approved by SFHP before they are rendered.

Behavioral health Care or Psychiatric Care is 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 other condition.

Benefits (Covered Services) are those Medically Necessary services, supplies, and drugs that are Benefits of the Group Agreement in which Member is enrolled and for which Medical Group is a contracted provider.

Benefit Year is a period beginning at 12:01am on January 1 and ending at 12:01am January 1 of the following year.

Co-payment is the amount 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.

Covered Services (Benefits) see Benefits.

Custodial Care is care that does not require the regular services of trained medical or Health Professionals and that is designed primarily to assist in activities of daily living including, but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.

Dental Care is any service or appliance customarily provided by dentists or oral surgeons (other than for treatment of tumors of the gum) including: dental x-rays, dental hygiene, hospitalization incident thereto; orthodontia (dental services to correct irregularities or malocclusion of the teeth for any

reason); any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures, dental implants (endosteal, superiosteal or transosteal), treatment of gums, jaw joints, jawbones, or any other dental services.

Disability is an injury, an illness, or a condition. 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 which 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 requested health care service eligible for coverage and payment under the Group Agreement and this Evidence of Coverage that has been denied, modified, or delayed by a decision of the Health Plan, or by one of its Participating Providers, in whole or in part due to a finding that the service is not Medically Necessary.

Domiciliary Care is non-medical 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 meant for repeated use over a prolonged period of time; not considered disposable, with the exception of ostomy bags; ordered by a licensed Health Professional acting within the scope of his or her license; intended for the exclusive use of the enrollee; does not duplicate the function of another piece of equipment or device covered by the carrier for the Member; generally not useful to a person in the absence of illness or injury; primarily serves a medical purpose; and appropriate for use in the home.

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.

Emergency Services means medical screening, examination, and evaluation by a doctor, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a doctor, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery by a doctor 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 doctor, 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.

Employee is an individual who is employed by the Employer group and meets all of the eligibility requirements as described in the Group Agreement.

Employer is defined in the Group Agreement with San Francisco Health Plan.

Evidence of Coverage and Disclosure Form (EOC) is the combined Evidence of Coverage and Disclosure Form that describes your coverage and benefits.

Exclusion is any medical, surgical, hospital or other treatment for which the program offers no coverage.

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.

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

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

Group Agreement is the agreement between San Francisco Health Plan and the Employer pursuant to which Health Plan administers or otherwise pays or arranges for the payment of Benefits under the Healthy Workers program.

Health Plan refers to San Francisco Health Plan.

Health Professional is 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 provided in a home by a licensed or certified provider that is: 1) designed to provide palliative and supportive care to individuals who have received a diagnosis of a Terminal Illness and whose life expectancy is twelve months or less; 2) directed and coordinated by medical professionals, and 3) Authorized by SFHP.

Hospital is a licensed and accredited health facility which is primarily engaged in providing (for compensation from patients) medical, diagnostic and surgical facilities, care and treatment of sick and injured Members on an Inpatient basis, and which provides such facilities under the supervision of a staff of doctors and 24-hour-a-day nursing service by registered nurses.

A facility which is principally a rest home, nursing home, or home for the aged is not included. Nor are any of the following:

- A psychiatric hospital licensed as a health facility accredited by the Joint Commission on Accreditation of Health Care Organizations; or,
- A licensed health facility operated primarily for the treatment of alcoholism and/or substance abuse accredited by the Joint Commission on Accreditation of Health Care Organizations; or,
- A psychiatric health facility as defined in Section 1250.2 of the Health and Safety Code

Inpatient is an individual who has been admitted to a Hospital as a registered bed patient and is receiving Benefits under the direction of a Primary Care Provider.

Life-threatening means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival

Medical Group means the Community Health Network, which is the Medical Group with which the Member's Primary Care Provider is associated for the provision of Benefits to SFHP Members and with whom SFHP is contracted.

Medically Necessary services are those 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 consistent with the symptoms or diagnosis; not furnished primarily for the convenience of the patient, the attending Primary Care Provider 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 entitled to receive Benefits under the Group agreement.

Non-formulary Drug is a drug that is not listed on the DPH Formulary and requires an authorization from DPH in order to be covered.

Non-Participating Provider is a provider who has not contracted with SFHP to provide services to members

Non-preferred Drugs are drugs on the DPH formulary which require the satisfaction of specific clinical criteria before they will be provided through DPH. Preferred drugs may be substituted for non-preferred drugs, if a member does not meet specific clinical criteria indicating the medical necessity for substitution of a non-preferred drug.

Occupational Therapy is treatment under the direction of a Primary Care Provider and provided by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

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

Outpatient Care is the service under the direction of a Primary Care Provider but not incurring overnight charges at the facility where services are provided.

Outpatient Hospital Services are services provided at a Hospital, any other appropriate licensed facility, or any appropriate facility which is not required by law to be licensed, if the professionals delivering such services are licensed to practice, are certified, or practice under the authority of SFHP, a Medical Group, or an individual practice association or other authority authorized by applicable California law.

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 Therapy is treatment under the direction of a Primary Care Provider and provided by a licensed physical therapist, certified occupational therapist or licensed doctor of podiatric medicine, which may utilize physical agents to improve a patient's musculoskeletal, neuromuscular, and respiratory systems.

Plan means San Francisco Health Plan.

Preferred Drugs are drugs on the DPH formulary which are available to a member with a physician prescription. Members do not have to meet additional clinical criteria in order to receive preferred drugs. See definition for non-preferred drugs for additional description of the DPH formulary.

Premium means the contribution required of the Member under the terms of Group Agreement.

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

Program is the Healthy Workers Program.

Prosthesis is an artificial part, appliance, or device used to replace a missing part of the body.

Provider is a physician, hospital, skilled nursing facility or other licensed health professional, licensed facility or licensed home health agency.

Provider Directory is the directory of all the providers contracted with SFHP to provide services to its members.

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:

- To improve function
- To create a normal appearance, to the extent possible

Rehabilitation is care furnished primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation Services may consist of the combined use of medical, social, educational, occupational/vocational treatment modalities and are provided with the expectation that the patient has restorative potential and will realize significant improvement in a reasonable length of time.

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

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 under SFHP.

Second Opinion is an additional consultation with another Primary Care Provider other than the Member's selected Primary Care Provider or a referred Specialist before scheduling certain 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:

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

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

Serious Emotional Disturbances of a Child shall be defined as a child who 1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and 2) who meets the criteria in paragraph 2) of subdivision a) of Section 5600.3 of the Welfare and Institutions Code.

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

Severe Mental Illness is defined as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

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.

Specialist is a doctor other than a Primary Care Provider who has an agreement with SFHP or the Medical Group to provide services to Members on referral by Primary Care Provider.

Speech Therapy is treatment under the direction of a Primary Care Provider and provided by a licensed speech pathologist or speech therapist.

Standing Referral is a referral to a Specialist that allows the Member to visit that Specialist on a repeated basis in order to continue treatment of a Life-threatening, degenerative, or disabling condition.

Terminally Ill means a life expectancy of twelve months or less after a diagnosis of a terminal illness.

Terminated Provider means a provider whose contract with SFHP has terminated. Terminated provider may include an individual practitioner, a medical group or a hospital.

Total Disability is:

- In the case of a Member or employed Dependent, a Disability which prevents the individual 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 Dependent 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.

3. Choice of Primary Care Providers and Facilities

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

Independent Primary Care Providers and Health Professionals/Facilities

Primary Care Providers and other Health Professionals provide all health care services to which you may be entitled. SFHP is not a medical provider. These Primary Care Providers, 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 providers and facilities, see your Healthy Workers Provider Directory that lists the Participating Providers from whom you may receive health care services. Call Customer Service at **(415) 547-7800** or **(800) 288-5555** if you do not have a Provider Directory.

Selecting a Primary Care Provider

Healthy Workers Members are required to have a Primary Care Provider, and are encouraged to select a Primary Care Provider at the time of enrollment. The Primary Care Provider may be a physician, a nurse practitioner, or physician assistant who works closely with a SFHP Provider. To ensure access to services, the Primary Care Provider you select must be within a 30 mile radius of your home or work. If a Primary Care Provider is not selected at the time of enrollment, SFHP will designate one for you. This designation will remain in effect until you select your own Primary Care Provider.

Each Primary Care Provider is affiliated with Community Health Network. Community Health Network (CHN) utilizes only those Specialists and Health Professionals who work with CHN. The Hospital utilized by CHN is San Francisco General Hospital.

Unless you have an Emergency Medical Condition, you should contact your Primary Care Provider for all health care needs, including preventive services, routine health problems, consultations with Specialists, and hospitalization. In order to receive medical services covered by SFHP, the Primary Care Provider and SFHP must coordinate and authorize your health care. The Primary Care Provider and SFHP are responsible for coordinating and directing all of your medical care needs, arranging referrals to Specialist and other providers (including Hospitals), and providing the required Authorization needed to obtain services. The Primary Care Provider will also prescribe Medically Necessary lab tests, X-rays and other services.

Changing Your Primary Care Provider

If you are not happy with your PCP for any reason, call Customer Service at **(415) 547-7800** (local) or **(800) 288-5555** to request a change. It's best to call before the 25th 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.

IMPORANT 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

(415) 547-7800 (local) or **(800) 288-5555**. A representative will tell you which PCP to see.

If your PCP discontinues their participation with SFHP, we will notify you and help you select a new PCP.

Scheduling Appointments

All non-emergent health care is coordinated through your Primary Care Provider. New Members should call their Primary Care Provider to schedule an initial visit once they are enrolled. Routine appointments should also be scheduled with your Primary Care Provider. In the event you must cancel a scheduled appointment, it must be done at least 24 hours in advance whenever possible.

A Positive Relationship with your Primary Care Provider

In order to help your Primary Care Provider provide you with all Medically Necessary and appropriate professional services in a manner compatible with your wishes, it is important that you and your Primary Care Provider maintain a cooperative provider-patient relationship. If a cooperative and professional relationship cannot be maintained, SFHP will assist you in the selection of another Primary Care Provider.

For example, your Primary Care Provider may regard the refusal of recommended procedures and treatments as incompatible with fostering a positive provider-patient relationship and providing proper medical care. He or she may request that you be re-assigned to another Primary Care Provider. In addition, a Primary Care Provider or Medical Group may refuse to accept you as a patient if you were previously terminated from the doctor-patient relationship for cause. In these cases, Customer Service will assist you in choosing another Primary Care Provider.

4. How to Use San Francisco Health Plan

Authorization for Services

In this Evidence of Coverage, we use the words “Authorize” or “Authorization” to refer to the requirement that you obtain the approval of SFHP, for health care services referred by your Primary Care Provider before such services are provided.

Note: Except for the services provided by your Primary Care Provider 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 Covered Services, even if the services are needed.

The Primary Care Provider, on your behalf, will obtain any needed Authorization from SFHP, but it is always your responsibility to contact your Primary Care Provider to obtain appropriate referrals for Covered Services not provided by the Primary Care Provider. Please note that a referral by the Primary Care Provider does not guarantee coverage for these services. The eligibility provisions, Benefits, exclusions, and limitations described in this Evidence of Coverage will apply, whether or not the services are referred by your Primary Care Provider.

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 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 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 delivery; 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 *primary care provider* before obtaining services. However, you should notify your *primary care provider* within 24 hours after care is received unless it is determined that it was not reasonably possible to communicate with the physician within 24 hours. In this case, notice should be given as soon as possible. *SFHP* will cover services rendered in the situation that 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.

Post Stabilization:

Post-Stabilization and Follow-up Care After an Emergency. Once your emergency medical condition is stabilized, your health care provider may believe that you require additional medically necessary services prior to your being safely discharged. If the hospital is not part of San Francisco Health Plan's contracted provider network, the hospital will contact your assigned medical group or San Francisco Health Plan to obtain timely authorization for these post-stabilization services. If San Francisco Health Plan determines that you may be safely transferred to a plan contracted hospital, and you refuse to consent to the transfer, the hospital must provide you written notice that you will be financially responsible for 100% of the cost for services provided to you once your emergency condition is stable. Also if the hospital is unable to determine your name and contact information at the San Francisco Health Plan in order to request prior authorization for services once you are stable, it may bill you for such services.

IF YOU FEEL THAT YOU WERE IMPORPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTED PROVIDER, PLEASE CONTACT SAN FRANCISCO HEALTH PLAN AT **(415) 547-7800** OR **(800) 288-5555**

Urgent Care or Care After Regular Hours and on Weekends

If you feel sick, have a fever, or some other urgent medical problem, call your *primary care provider's* office, even during the hours that your *primary care provider's* office is normally closed. Your *primary care provider* or a doctor-on-call will always be available to tell you how to handle the problem at home or if you should go to an *urgent care* center or a hospital emergency room. Problems that may be urgent but not true emergencies are problems that can usually wait 24 to 48 hours for treatment. Call your *primary care provider* if you have an urgent medical need. Your *primary care provider* will give you advice on what to do.

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

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.

Follow-Up Care After Emergency Services or Urgent Care

Follow-up care received after *emergency services* or *urgent care* must be coordinated by your *primary care provider*. If you require follow-up care after you have received *emergency services* or *urgent care*, you should call your *primary care provider* so that he or she can coordinate the care that you need. Your *primary care provider* may see you or may refer you to a *specialist* who can provide you with the care that you need. If you receive follow-up care after receiving *emergency services* or *urgent care* from any provider who is not a *participating provider* and *SFHP* has not *authorized* the services, you may be liable for the cost of those

services. Contact your *primary care provider* after receiving *emergency services* or *urgent care* to find out what you should do.

Referrals to Specialists

Members are referred to Specialists as Medically Necessary and as determined by the Member's Primary Care Provider. The Primary Care Provider must refer you to a Specialist for all Authorized, Medically Necessary Covered Services not provided directly by the Primary Care Provider. You will generally be referred to a Specialist who is affiliated with the same Medical Group as your Primary Care Provider, but you 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 no Participating Provider is available to perform the needed service, the Primary Care Provider will refer you to a non-SFHP Provider for the services after obtaining Authorization.

Services Not Requiring Referrals

Services that do not require a referral are:

- PCP Services
- OB/GYN visits
- Emergency services
- Vision Care
- Behavioral Health Services

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

Direct Access to OB/GYNs

You can seek obstetrical and gynecological Covered Services directly from a Specialist who is an obstetrician and/or gynecologist, directly from a Primary Care Provider who is a family practice doctor and surgeon, or directly from a nurse practitioner who is designated by SFHP as providing obstetrical and gynecological services without a referral from a Primary Care Provider. SFHP must Authorize Covered Services recommended or referred by these Primary Care Providers, other than an office visit, to the same extent as other Covered Services.

Standing Referrals to Specialists

You may receive a Standing Referral to a Specialist, or to one or more Specialist, pursuant to a treatment plan from your Primary Care Provider developed in consultation with the Specialist. The Standing Referral must be approved by SFHP, and may limit the period of time that the visits are Authorized, or require that the Specialist provide the Primary Care Provider with regular reports on the health care provided. This Standing Referral (subject to time and visit limitations) allows you to see the Specialist on a repeated basis to continue treatment of an ongoing problem, or for Life Threatening, degenerative, or disabling conditions.

Second Opinions

To ensure that you receive appropriate and necessary health care services, SFHP allows you to obtain a Second Opinion. If you are requesting a Second Opinion about care from your PCP, the Second Opinion shall be provided by an Appropriately Qualified Health Care Professional of your choice within the same Medical Group. If there is no Participating Provider within the Medical Group who is appropriately qualified to treat your condition or offer a Second Opinion on your behalf, then the Plan shall Authorize a Second Opinion by an Appropriately Qualified Health Professional with another Medical Group, or if necessary, outside of the Plan's provider network.

If you are requesting a Second Opinion about care from your Specialist, the Second Opinion shall be provided by any Appropriately Qualified Health Care Professional of your choice from any Medical Group within the Plan's network. If there is no Appropriately Qualified Health Care Professional within the Plan's network to provide an opinion, then the Plan shall Authorize a Second Opinion by an Appropriately Qualified Health Care Professional outside of the Plan's network.

Requests for Second Opinions will be Authorized in an expeditious manner. In urgent/emergent cases, a Second Opinion will be Authorized as soon as possible, consistent with good professional practice and whenever possible, within 72 hours. Follow-up care provided subsequent to a Second Opinion will

be provided through Participating Providers whenever possible.

Liability of Member for Payment

Members are financially responsible for Co-payments as listed in the Summary of Benefits. However, in no event will you, during any one calendar year, have to pay more than the maximum annual Co-payment amount that is set forth in the Summary of Benefits. Co-payments for Benefits not provided by SFHP (such as your dental plan) are not included in the calculation of this annual maximum.

Except for any applicable Co-payments, you are not financially responsible for services provided by your Primary Care Providers. For all other services which are SFHP Benefits, you are not financially responsible for the costs of such services, other than for any applicable Co-payments, if the services are referred by the Primary Care Provider and Authorization has been obtained.

Services which are SFHP Benefits, but which have not been Authorized, will not be covered by SFHP and will be your financial responsibility, unless such services are Emergency Services, as defined by SFHP.

Services that are not SFHP Benefits under your SFHP Benefit program are your financial responsibility, even if your Primary Care Provider refers such services.

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

5. SFHP Benefits

SFHP covers the Benefits described in this section provided that services are obtained as described in Authorization for services. Please consult the Summary of Benefits for your Benefit schedule. The Co-payments for these services are also listed in the Summary of Benefits section of this Handbook.

Important Information

Services are covered as SFHP Benefits only if they are Medically Necessary and provided to you as a Member of SFHP. Decisions to Authorize, modify or deny services based on a determination of Medical Necessity are based upon criteria and 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. The determination of Medical Necessity will be subject to appeal in accordance with the procedures outlined in “Grievance and Appeal Procedures.” It is your responsibility, as a Member, to notify SFHP of any denial of service by your Primary Care Provider or Medical Group if you wish for SFHP to review such determination. Subject to referral by the Primary Care Provider, Authorization, and applicable Co-payments, and all other terms, limitations and exclusions of this Evidence of Coverage, including those listed in “Exclusions and Limitations” the following Benefits are covered by SFHP when Medically Necessary:

Professional Services

Primary Care Provider office visits for examination, diagnosis and treatment of a medical condition, disease or injury, including referred Specialist office visits, consultations or Second Opinions; office surgery with applicable Co-payment; Outpatient chemotherapy and radiation therapy. In addition, Professional Services include:

- Allergy Testing and Treatment. Office visits for the purpose of allergy testing and treatment, including allergy injections and serum.
- Injectable Medications. Office visits for administration of injectable medications and its usage for the condition approved by the Food and Drug Administration (FDA) are covered for Medically Necessary treatment of medical conditions when prescribed by a Primary Care Provider and Authorized in accordance with SFHP rules
- Screening, Diagnosis and Treatment of Breast Cancer
- Phenylketonuria (PKU) Screening and testing for PKU
- Doctor services in a Hospital or Skilled Nursing Facility for examination, diagnosis, treatment, and consultation including the services of a surgeon, assistant surgeon, anesthesiologist, pathologist, and radiologist. Inpatient professional services are covered only when Authorized and the

Primary Care Provider has referred the services of the Hospital or Skilled Nursing Facility.

Diagnostic Laboratory and X-ray Services

Diagnostic and therapeutic radiological services, and other diagnostic services, which shall include, but are not limited to: electrocardiography, electroencephalography, and mammography. Any radiology other than X-rays, if Medically Necessary, must be referred by the Member's Primary Care Provider or treating Specialist, and Authorized by SFHP.

Preventive Health Services

Preventive Health Services shall include, under a doctor's supervision:

- Reasonable health appraisal examinations on a periodic basis;
- A variety of voluntary family planning services;
- Prenatal care;
- Venereal disease tests, including HIV tests
- Cytology examinations on a reasonable periodic basis;
- Health education and promotion services provided by SFHP. Call Customer Service at (415) 547-7800 or (800) 288-5555 for information on current, available classes; and
- Screening and diagnosis for all types of cancers; annual cervical cancer screening test including the conventional Pap test and the option of any cervical cancer screening test approved by the federal Food and Drug Administration, upon the referral of the Primary Care Provider.

Hospital Services

The following Hospital services are Benefits when Authorized and provided at a SFHP Hospital in accordance with SFHP rules:

Inpatient Hospital Services means short-term general Hospital services, including:

- A semi-private room with customary furnishings and equipment;
- Meals (including special diets as Medically Necessary);
- General nursing care and special duty nursing as Medically Necessary;
- Use of operating room, special treatment rooms, delivery room newborn nursery, and related facilities;
- Intensive care unit and services;
- Drugs, medications, and biologicals;
- Anesthesia and oxygen services;
- Diagnostic laboratory and X-ray services;
- Physical Therapy and therapeutic and rehabilitative services as medically appropriate;
- Respiratory Therapy;
- Administration of blood, blood products, including the cost of in-Hospital blood processing;
- Coordinated discharge planning including the planning of such continuing care as may be Medically Necessary, and as a means of preventing possible early rehospitalization;
- Inpatient alcohol and substance abuse admissions for Medically Necessary detoxification;
- Inpatient Mastectomy Length of Stay. The length of Hospital stays associated with a mastectomy or lymph node dissection shall be determined in consultation with the Member's attending doctor and surgeon; and
- Inpatient Maternity Length of Stay. See Pregnancy and Maternity Care.

Outpatient Hospital Services (Ambulatory Care Services)

Outpatient Hospital Services include:

- Laboratory, X-ray and major diagnostic and treatment services;
- Physical Therapy, Speech Therapy, and Occupation Therapy services as medically appropriate; and
- Hospital Services including but not limited to Outpatient surgery, which can reasonably be provided on an ambulatory basis.

Short-Term Rehabilitative Services

Short-term neuromuscular rehabilitative services, including physical, occupational, speech, and inhalation therapies for the treatment of Acute Conditions or the acute phase of chronic conditions as Medically Necessary.

Neuromuscular rehabilitative services beyond the two-month period are covered only if the Member's Primary Care Provider and SFHP Medical Group, in accordance with procedures established by SFHP, determine that such therapy is Medically Necessary.

Pregnancy and Maternity Care

Prenatal and postnatal Primary Care Provider office visits and delivery which are Medically Necessary professional and Hospital Services including prenatal and postnatal care and care for complications of pregnancy; newborn examinations and nursery care while the mother is hospitalized. These services are provided under SFHP to the newborn only within the first 31 days after birth.

Inpatient Hospital Services are 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 does 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:

- The discharge decision is made by the treating provider, in consultation with the mother;
- and the treating doctor schedules a follow-up visit for the mother and newborn within 48 hours of discharge.

Nurse-midwife services are available to Members seeking obstetrical care. The chosen nurse-midwife must be associated with the Member's Primary Care Provider and contracted with the Health Plan.

Family Planning

- Family Planning Counseling;
- Prescription contraceptive devices such as diaphragms and fitting (Norplant is excluded.);
- Abortion;
- Tubal ligation;
- Vasectomy;
- In the event of an Emergency Medical Condition, emergency contraception may be obtained directly from a participating pharmacist or from a non-Participating Provider.

Infertility Services

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.

Home Health Care Services

Home health care services are the provision of skilled medical services by SFHP-contracted licensed providers to a homebound Member when Medically Necessary. A homebound Member is one who 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 a Medically Necessary, Authorized home health treatment plan. Except for a home health aide, each visit by a representative of a home health agency shall be considered as one home health care visit. A visit of 4 hours or less by a home health aide shall be considered as one home health visit. As Authorized, home health visits include up to a maximum of 4 visits per day with each visit being no more than 2 hours in duration for a daily maximum of 8 hours. Each visit by a nurse, vocational nurse, or other home Health Professional or therapist (other than a Primary Care Provider), even if for less than 2 hours is, at a minimum, counted as 1 visit.

Home health care services include diagnostic and treatment services that can reasonably be provided in the home. Home health care services must be provided under the direct care and supervision of the Member's Primary Care Provider and within SFHP's Service Area.

Home Health Benefits include:

- Intermittent and part-time home visits by a home health agency to provide the skilled services of these professional providers:
    - registered nurse;

- licensed vocational nurse;
- physical therapist, occupational therapist, speech therapist, or respiratory therapist;
- certified home health aide in conjunction with the services above.

- Medical social services provided by a licensed medical social worker for consultation and evaluation;
- 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;
- Home visits by a SFHP Provider;
- Medically Necessary Durable Medical Equipment;

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.

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 with SFHP.

When ordered by a Primary Care Provider, the Hospice Benefits include doctor services, nursing care, medical social services, home health care services; drugs, medical supplies and appliances, counseling and bereavement services, Physical/Occupational/Speech Therapy; homemaker and short-term respite care.

Emergency Health Care Services

Covered Emergency Services are any services provided in any Emergency Room for an Emergency Medical Condition, including psychiatric screening, examination, evaluation, and treatment by a qualified doctor. 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.

If you become injured or suddenly ill, and it is reasonably believed that the medical condition is an Emergency Medical Condition, you should call 911 and go to the closest Hospital 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.

If it is not medically possible to notify your Primary Care Provider before receiving Emergency Services, you should notify your Primary Care Provider by phone within 24 hours of the start of the Emergency Services or as soon as it is medically possible for you to provide notice.

Emergency Hospitalization

If a Member is admitted to a SFHP Hospital as the result of an Emergency Medical Condition that is not used by the Primary Care Provider's Medical Group, the Health Plan may elect to transfer him or her to the Hospital used by his or her Primary Care Provider's Medical Group. This transfer will occur when it is medically safe to do so. Any service provided by the Hospital after the time that the Health Plan has notified the Member and the Hospital to which the Member was admitted that the transfer is medically safe are not Covered Services, and may be the financial responsibility of the non-affiliated Hospital.

Out-of-Network Emergency Services.

SFHP will provide care in a non-Plan Hospital only for as long as the Member's medical condition prevents transfer to a Plan Hospital in SFHP's Service Area, as approved by the Plan, subject to applicable co-payments listed in the Summary of Benefits. Unauthorized continuing or follow-up care after the initial Emergency has been treated in a non-Plan Hospital or by a non-Plan Provider is not a Covered Service.

Ambulance Services

Emergency Ambulance Services. Ambulance transportation to the nearest Hospital which can provide the necessary services is covered only if the transportation was reasonably required for the Member to receive Emergency Services for an Emergency Medical Condition.

Non-Emergency Ambulance Services

Non-Emergency ambulance transportation of a Member from a Hospital to another Hospital or facility; or facility to home when:

- Medically Necessary, and
- Requested by a Primary Care Provider; and
- Authorized in advance

Treatment of the Gums

Hospital and professional services provided for conditions of the teeth, gums, or jaw joints and jawbones, including adjacent tissues are a Covered Benefit only to the extent that these services are:

- Provided for the treatment of tumors of the gums;
- Provided for the treatment of damage to the natural teeth caused solely by an accidental injury. This Benefit does not include damage to the natural teeth that is not accidental.
- Medical treatment of temporomandibular joint syndrome which is non-surgical and is Medically Necessary; (TMJ)
- Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;
- Surgery to reposition the upper and/or lower jaw that is Medically Necessary to correct skeletal deformity

This Benefit does NOT include:

- Services customarily provided by dentists and oral surgeons, including hospitalization;
- Orthodontia (dental services to correct irregularities or mal-occlusion of the teeth) for any reason;
- Any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
- Dental implants (endosteal, subperiosteal or transosteal).

Plastic and Reconstructive Surgical Services

Reconstructive Surgical Services are limited to the following: Reconstructive surgery to restore and achieve symmetry and 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:

- improve function
- create a normal appearance to extent possible

Includes Reconstructive Surgery to restore and achieve symmetry incident to mastectomy.

Exclusion: Cosmetic Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

Cancer Clinical Trials

Routine patient care costs related to the Member's participation in a cancer clinical trial. 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:

- One of the National Institutes of Health
- The federal Food and Drug Administration
- The U.S. Department of Defense, or
- The U.S. Veterans' Administration

Coverage for treatment in a clinical trial is limited to participating Hospitals and Participating Providers in California, unless the protocol for the clinical trial is not provided for at a California Hospital or by a California physician.

Routine patient care costs include:

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

Routine patient care costs DO NOT include:

- A drug or device that has not been approved by the federal FDA;
- Services other than health care Services, such as travel, housing, companion expenses, and other non-clinical expenses;
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the Member;

- Services customarily provided by the research sponsors free of charge;
- Any health care Service that is otherwise excluded under the Healthy Workers Program.

Prescription Drugs

Prescription drug benefits are administered by the San Francisco Department of Public Health ("DPH). The DPH pharmacy provides comprehensive pharmaceutical services for inpatients and outpatients of the hospital and clinics. For more information on pharmacy services available from DPH, call **Med Impact at (800) 788-2949**.

Outpatient and discharge prescription services are provided through the DPH outpatient pharmacy. Healthy Worker Members may use the outpatient pharmacy or the community pharmacy affiliated with their primary care clinic. Refer to your Healthy Workers Provider Directory for information on which pharmacy you may access.

Medically Necessary prescription drugs, including injectables, nutritional supplements and formulas for the treatment of Phenylketonuria (PKU), will be covered when prescribed by a Primary Care Provider or Specialist 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. Prenatal vitamins and fluoride supplements are covered only if Medically Necessary and requiring a prescription.

DPH shall, in consultation with the Member's prescribing Physician and consistent with professionally recognized standards of practice, determine the supply of drugs to be prescribed. DPH's Formulary includes FDA-approved brand name and generic drugs. The formulary also includes Preferred and non-Preferred drugs. Co-payments are less for Preferred Drugs. If your physician prescribes a Preferred drug and determines that the non-Preferred drug equivalent may not be substituted you will only be required to pay the Preferred drug copayment. The physician must specifically request that no substitutions be made by writing "no substitutions" on your prescription form.

Up to a 30-to-34 day supply of Preferred or non-Preferred drugs may be prescribed, as Medically Necessary. Up to a 90-day supply of Preferred on non-Preferred maintenance drugs, including oral and injectable contraceptives and insulin supplies are covered. Maintenance drugs are those prescribed for 60 days or longer and are usually for chronic conditions. Tobacco cessation drugs are covered. The Member for whom the treatment is prescribed must also attend a tobacco cessation program.

Formulary

SFHP Providers may prescribe a range of prescription drugs listed on DPH's Formulary. SFHP's Formulary is DPH's list of approved prescription drugs. DPH's Formulary is developed and regularly reviewed on a quarterly basis and updated by DPH. A Member may obtain a copy of DPH's Formulary by calling Customer Service at **(415) 547-7800** or **(800) 288-5555**, Monday through Friday, 8:30am to 5:30pm. Except as described in this Evidence of Coverage, only prescription drugs that are listed on the DPH Formulary are covered. The presence of a drug on the Formulary does not guarantee that you will be prescribed that drug by your provider. A prescription drug that is not listed on DPH's Formulary, however, will be covered if:

- If the PCP determines it is medically necessary, (and DPH authorizes the non-formulary prescription drugs); or
- The Prescription drug not on DPH's Formulary had been previously approved by SFHP for the Member to treat the Member's medical condition and the Member's Primary Care 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 Primary Care Provider may decide to prescribe a drug that is a DPH Formulary medication and that is medically appropriate for treating the enrollee's condition; or
- It is a drug approved by the federal Food and Drug Administration as a Treatment Investigational New Drug or classified as a Group C cancer drug by the National Cancer Institute to be used only for the purposes approved by the federal Food and Drug Administration or the National Cancer Institute.

A Member or his/her Primary Care Provider may request a non-formulary prescription drug. The Primary Care Provider must submit a pharmacy Authorization Request to DPH. The pharmacy Authorization Request form can be obtained by calling Med Impact at **(800) 788-2949**. Urgent Authorization requests, as indicated by the Primary Care Provider, will be processed within twenty-four business hours.

Exclusion: Prescriptions for drugs and medicines which have not received the marketing approval of the U.S. Food and Drug Administration (FDA) are excluded. 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 have been 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 for treatment of the life-threatening or chronic and seriously debilitating conditions by one of the following:
- The American Medical Association *Drug Evaluations*,
- The American Hospital Formulary Service *Drug Information,*
- The United States Pharmacopoeia Dispensing Information, Volume 1,
- Or in two articles from major peer-reviewed medical journals that present data supporting the proposed Off-Label Drug Use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

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 36 months, and surgically implanted hearing devices are excluded.

Behavioral Health Care

Behavioral Health Benefits are provided through San Francisco Community Behavioral Health Services (“SFCBHS”). *Members* should call SFCBHS 's Access Help Line for a referral to a Mental Health provider, or a substance abuse treatment counselor. *Members* can also receive a referral to SFCBHS from their Physician or the Plan. SFCBHS's Access Help Line is **(415) 255-3737** (local), **(888) 246-3333** (toll free), **(888) 484-7200** (TDD).

Behavioral Health Benefits are limited to the following:

- Inpatient care in a licensed health facility, for a total of thirty (30) days in each Benefit Year;
- Residential treatment may be substituted for Inpatient care days at a ratio of two (2) residential treatment days to one (1) Inpatient day; and
- Intensive Outpatient treatment may be substituted for Inpatient care days at a ratio of three (3) intensive Outpatient days to one (1) Inpatient day;
- Twenty (20) Outpatient visits in each Benefit Year.

Severe Mental Illness

The following conditions are considered to be Severe Mental Illness conditions and are excluded from the Inpatient and Outpatient Benefit limitations noted above: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa. Coverage for conditions meeting the Severe Mental Illness definition includes Inpatient Hospital care, Outpatient Hospital care, partial

hospitalization services, professional services, and Medically Necessary prescription drugs.

Substance Abuse Treatment

Outpatient chemical dependency and alcoholism Benefits are limited to 20 visits per Benefit Year.

Inpatient detoxification Services are covered for Medically Necessary Inpatient Hospital Services for acute medical alcohol and detoxification only.

Durable Medical Equipment

Durable Medical Equipment (DME) are prosthetic devices, orthotic devices, oxygen, and oxygen equipment, limited to equipment and devices which:

- Are intended for repeated use over a prolonged period;
- Are not considered disposable, with the exception of ostomy bags;
- Are ordered by a licensed Health Professional acting within the scope of his or her license;
- Are intended for the exclusive use of the enrollee;
- Do not duplicate the function of another piece of equipment or device covered by the carrier for the enrollee;
- Are generally not useful to a person in the absence of illness or injury;
- Primarily serve a medical purpose; and
- Are appropriate for use in the home.

Medically Necessary repair or replacement of covered DME, prosthetic devices, and orthotic devices is a Benefit when prescribed by a Primary Care Provider or ordered by a licensed Health Professional acting within the scope of his or her license, and when not caused by misuse or loss.

Human Organ Transplant Benefits

Human organ transplants, including reasonable medical and Hospital expenses of a donor or individual identified as a prospective donor if the expenses are directly related to the transplant, other than corneal, shall be subject to the following restrictions:

- Preoperative evaluation, surgery, and follow-up care shall be provided at centers that have been designated by the participating carrier as having documented skills, resources, commitment and record of favorable outcomes to qualify the centers to provide such care.
- The patient-selection committee of the designated centers selects patients and are then subject to Authorization.
- Only anti-rejection drugs, biological products, and other procedures that have been established as safe and effective, and no longer investigational, are covered.

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:
  - Insulin,
  - Syringes,
  - Lancets,
  - Insulin pumps and all related necessary supplies,
  - Ketone urine testing strips for type I diabetes,
  - Blood glucose meters, and
  - Blood glucose meter testing strips in medically appropriate quantities for:
  - The monitoring and treatment of insulin dependent diabetes
  - The monitoring and treatment of non-insulin dependent diabetes
  - The monitoring and treatment of diabetes in pregnancy
- Diabetes education programs,
- Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin), and
- Dilated retinal eye exam.

- Additionally, the following prescription items are covered if they are determined to be Medically Necessary:
    - Insulin,
    - Prescriptive medications for the treatment of diabetes,
    - Glucagon

Skilled Nursing Facility Services

Short-term skilled nursing care provided in a Skilled Nursing Facility or a skilled nursing bed in an acute care Hospital, limited to a maximum of one hundred (100) days in each Benefit Year.

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.

Claims Reimbursement for Emergency Services

If *emergency service* 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 SFHP within 90 days after the date of the services for which payment is requested, or as soon as possible. If emergency behavioral health services were received and expenses incurred by the member for such services, the member should submit a complete claim with the service record for payment to SFCBHS within 90 days after the date of services for which payment is requested. If the claim is not submitted within this period, SFHP may not pay for those services, unless the claim was submitted as soon as reasonably possible. If the services are not previously authorized, SFHP will review the claim retrospectively for coverage as set forth on p. 18. 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 services 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. The *member* must provide proof of payment along with the submitted claim.

Benefit Program Changes

Benefits, exclusions, and limitations are subject to change, cancellation, or discontinuance at any time either by the Program or by SFHP, following at least thirty-one (31) days written notice by SFHP. 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 obtain Benefits. Benefits for services or supplies furnished after the effective date of any Benefit modification, limitation, exclusion, or cancellation shall be provided.

6. Exclusions of Limitations

General Exclusions and Limitations

You should read all descriptions under the Benefits section of this Evidence of Coverage to get the full details of your coverage and non-coverage under SFHP. Such services are Covered Benefits only if obtained in accordance with the procedures described in this document, including all Authorization requirements and referral and coordination by your Primary Care Provider.

Specific Exclusions and Limitations

Certain services listed below are limited in duration or number, as described in “SFHP Benefits.” Other services listed below in this Section are excluded and are not Covered Benefits from SFHP:

- Acupuncture
- Alcoholism services for alcoholism treatment and rehabilitation on an Inpatient or day care basis, whether or not court-ordered, except for Medically Necessary Inpatient detoxification. Outpatient treatment and Rehabilitation is limited to 20 visits per Benefit Year;
- Alternative Therapies
- Chiropractic care
- Conception by artificial means including gamete intra-fallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), in-vitro fertilization (IVF), or any other process that

involves the harvesting or manipulation (physical, chemical, or by any other means) of the human ovum to treat infertility. Any service, procedure, or process that prepares the Member to receive conception by artificial means is not covered.

- Contraceptives and contraceptive devices that do not require a prescription unless the Member's Primary Care 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, private room in a Hospital and personal items;
- Custodial Care incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, or to control or change a person's environment;
- Dental Care services or appliances
- Disabling Conditions including services that are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. SFHP will provide services in the time of need, and the Member shall cooperate to assure that the SFHP is reimbursed for such Benefits.
- Drug Abuse Treatment including 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. Outpatient treatment is limited to 20 visits per Benefit Year.
- Emergency Facility Services for non-Emergency conditions;
- Experimental Care which is any health care service, drug, device, or treatment that is determined by SFHP to be Experimental or Investigational in Nature. A drug is not excluded under this section on the basis that the drug is 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. Please refer to page 28 of this Handbook, under the Formulary description of Off-Label Drug Use for a complete description of when SFHP will cover these drugs. Services denied as experimental or investigational are subject to review by the Department of Managed Health Care's IMR process. Please refer to page 37 of this Handbook for a description of how to access the Department's IMR process.
- Routine foot care including callus, cornparing, or excision or toenail trimming.
- Home/Vehicle Improvements including 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;
- Implants, except those that are Medically Necessary and are not cosmetic, Experimental or Investigational in Nature;
- Infertility Treatments such as in-vitro fertilization, G.I.F.T. (Gamete Interfallopian Transfer) or any other form of induced fertilization, artificial insemination. Services incident to or resulting from procedures for or the services of a surrogate mother are also not Covered Services.
- Long-Term Care, unless SFHP determines that it is a less costly, satisfactory alternative to Covered Benefits. Short-term, Skilled Nursing Facility, and Hospice Care are Covered Benefits but only when Medically Necessary and only for Benefits described under "Hospice Care" and "Skilled Nursing Facility Services."
- Medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices that are either:
    - Experimental or Investigational in Nature or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question; or
    - Outmoded or not efficacious.

- If services are 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 11 of this handbook. You do not need to participate in the Plan's Grievance Process before having your case heard through DMHC's IMR process. You may apply directly to DMHC for participation in the IMR process.

- Non-skilled care that can be performed safely and effectively by family members (whether or not such family members are available to provide such services) or persons without licensure certification or the presence of a supervising licensed nurse, except for Authorized homemaker services for Hospice Care.
- Obesity including treatment of obesity by medical and surgical means, except for treatment of morbid obesity. In no instance shall treatment for morbid obesity be provided primarily for cosmetic reasons.
- Organ donors including any services to a Member in connection with organ or tissue donor transplant services when the recipient of the transplant is not a Member.
- 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 enhancer, voice prosthesis or any other language assistance devices, except as provided under Orthotics and Prosthetics.
- Over-the-counter drugs, supplies, and devices including air filters or medications not requiring a prescription, vitamins, minerals, food supplements, or food items for special diets or nutritional supplements, except those required for the treatment of Phenylketonuria (PKU).
- Confinement in a pain management center to treat or cure chronic pain.
- Penile implant devices and surgery, and related services or any resulting complications, except as penile devices and surgery are 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."
- Private duty nursing of any sort. Special duty nursing, if Authorized as Medically Necessary, may be covered as part of an Authorized Hospital or Skilled Nursing Facility admission.

Self-referral referred care that is not provided by, prescribed or referred by the member's primary care provider and not authorized in accordance with SFHP procedures except for emergency service, out of area urgent services, OB/GYN services, acupuncture and chiropractic care.

- Services received prior to the Member's effective date of coverage or after the date the Member ceases to be a Member, except as provided with respect to an extension of benefits.
- Sexual Dysfunction incident to non-physically related sexual dysfunction, sexual inadequacies, except as Medically Necessary.
- Skin aging relating to the diagnosis and treatment to retard or reverse the effects of aging of the skin.
- Speech Therapy unless Medically Necessary, and then subject to the limits described in the Benefits Section.
- Substance (Drug) abuse includes substance abuse admissions (whether or not court-ordered), unless Medically Necessary for Inpatient medical detoxification. Outpatient substance abuse treatment is limited to 20 visits per Benefit Year.
- Transportation other than provided under Ambulance Services including coverage for transportation by commercial airplane, passenger car, taxi, or other form of public transportation is excluded.
- Vasectomy and tubal ligation reversal or incident to the reversal of a vasectomy or tubal ligation, 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.

- Workers' compensation Benefits including any injury arising out of, or in the course of, any employment for salary, wage or profit, or any disease covered, with respect to such employment, by any workers' compensation law, occupational disease law or similar legislation. If SFHP pays for such services, it shall be entitled to establish a lien upon such other Benefits up to the reasonable cash value of Benefits provided by SFHP for the treatment of the injury or disease as reflected by the providers' usual billed charges. Also, SFHP may recover the cash value of its Benefits from the Member, up to an amount equal to what was actually paid by the Plan, to the extent that such Benefits would have been covered or paid for as Workers' Compensation Benefits if the Member had diligently tried to establish his or her rights thereto.

7. Eligibility and Enrollment

An *employee* is eligible for enrollment and continuing coverage under this group plan as described below. This group plan does not cover any dependents.

- A *member* must either live or work in *SFHP's service area*. This *service area* is the City and County of San Francisco.
- The individual effective date of coverage for each *member* shall be at 12.01am Pacific Time on the first (1st) day of the month following the month in which the *member* meets all of the *employer's* eligibility requirements, provided that *SFHP* receives the *member's* enrollment application and eligibility information from the *employer* within the time period described in the *group service agreement*. The *member* must meet and continue to meet all of the *employer's* eligibility requirements throughout the period of coverage under this group plan. You should contact your *employer* for questions regarding your *employer's* eligibility requirements.
- Except in respect to a member who is entitled to an extension of *benefits* from other health insurance because of injury or illness, coverage will take effect as described above. This provision delaying the effective date of coverage shall not apply in the event SFHP provides *benefits* within sixty (60) days of the date of discontinuance of the Employer Group's previous group health plan and if a *member* was validly covered (on the date of such discontinuance) under such previous group health plan. In addition, this provision delaying the effective date of coverage shall not apply to the extent prohibited by any state or federal law.

If a *member* is totally disabled on the date of discontinuance of the *employer group's* previous group health plan and if such *member* is entitled to an extension of *benefits*, such *member* will not be entitled to any *benefits* under this group plan for services or expenses directly related to the *disabling condition* until the expiration of such extension of benefits. The *member* will be enrolled in this group plan for all other *benefits* not related to the disabling condition covered by the extension of *benefits*. No individual will be eligible to enroll under this group plan if that individual has had coverage terminated for cause under this or any other SFHP health coverage plan for any reason.

8. Termination, Cancellation and Change in Benefits, and Charges

Termination of Benefits

Except as provided under the Group Continuation Coverage or State Continuation Benefits Coverage provisions below, there is no right to receive *benefits* for services provided following termination or cancellation of the *group service agreement* or the end of the *member's* individual eligibility. This provision applies even if the *member* is hospitalized or undergoing treatment for an ongoing condition. To obtain an Extension of Benefits, Group Continuation Coverage (COBRA), or State Continuation Benefits Coverage, the person seeking such coverage must qualify and apply for such continued coverage. See Group Continuation Coverage, page 36.

Coverage for the *member* terminates at 12:01am Pacific time on the earliest of these dates:

- The date the *group service agreement* ends. This contract may be terminated by either your group *employer* or *SFHP*. You will be given written notice of such termination or cancellation.
- The date you are no longer employed by your *employer* or you no longer meet all the requirements of your *employer* as defined in the *group service agreement* and as approved by *SFHP*.
- The end of the period for which *premium* payments were paid to *SFHP* by the *employer*.
- You no longer live or work within San Francisco so that you no longer meet the regulatory distance and travel time requirements to access your SFHP primary care provider (15 miles or 30 minutes from your SFHP primary care provider).
- Immediately upon written notice if *SFHP* terminates coverage of a *member* for cause if the *member* did any of the following:
- a) provide information that is materially false or misrepresented on any enrollment application or any other health plan form;
- b) permit a non-member to use his or her member ID to obtain service and *benefits*;
- c) obtain or attempt to obtain services or *benefits* under *SFHP* by means of false, materially misleading, or fraudulent information, acts or omissions;
- d) engage in disruptive behavior or threaten the life or well-being of *SFHP* personnel or the providers of services when such conduct is not corrected after written notice by the *SFHP*. In addition, the *SFHP* may terminate coverage of a *member* for cause upon 31 days written notice for the following:
- e) inability to establish a satisfactory physician-patient relationship after following the procedures on page 20;
- f) failure to pay any *co-payment* or supplemental charge when such failure to pay is not remedied following written notice by *SFHP*;
- g) violation of any material provision of the *group service agreement* although not specifically mentioned in this Section, if such violation persists after written notice by *SFHP*.

Cancellation of Group Service Agreement

SFHP may cancel the *group service agreement,* or any part thereof (including any *benefits* rider), at any time after having given at least thirty (30) days' written notice to the *employer*, or 15 days after the end of any period for which *premiums* have not been paid, stating when such cancellation will become effective.

The *group service agreement* also may be canceled by the *member's employer* at any time, provided that the *employer* gives written notice to *SFHP*. This notice may specify that cancellation is effective upon *SFHP's* receipt of the notice or at a later date as specified on the notice.

In the event the *group service agreement* is canceled either by *SFHP* or by a group *employer*, it is the *employer's* responsibility to notify the *member* of the cancellation.

Reinstatement

In the event your group coverage is canceled, only the *employer* may reinstate coverage to the extent permitted in the *employer's group service agreement* and as approved by *SFHP*.

Individual's Right of Cancellation

Please see any specific cancellation rules for your coverage provided in the Summary of Benefits, Eligibility, and Enrollment Rules.

Change in Benefits and Charges

SFHP reserves the right to change the *benefits* and charges of this group plan. The *employer* or *members* will be given thirty-one (31) days' written notice for any change in *benefits* and charges.

9. Group Continuation Coverage

Group Continuation Coverage (COBRA or Cal-COBRA)

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), Group Continuation Coverage is available, under certain conditions, to *employees* of most *employers*. If an *employer* sponsors membership in *SFHP*, the *member* can apply for Group Continuation Coverage. Contact Customer Service at **(415) 547-7800** (locally) or **(800) 288-5555** for further information.

You can continue being covered by *SFHP* when your job ends, for any reason other than gross misconduct; when your hours are reduced; or when you retire and your benefits are canceled or reduced because the *employer* filed for Chapter 11 bankruptcy. Your *employer* will let you know that you have a right to keep your health plan under COBRA for any of these reasons.

If you want to keep your health coverage with *SFHP* you must tell your *employer* within 60 days of the date you get your notice of your right to keep your health coverage. If you don't choose COBRA during those 60 days, you cannot have it later. Your *employer* must send your payment and the COBRA forms to keep you covered within 45 days after you choose to keep it.

You will have to pay the whole cost of staying with *SFHP*. You must send your payment to the *employer* every month. This will keep your coverage going.

You can go on being covered until the first of the following events takes place:

- The end of eighteen months if you lost your job or your hours were lowered.
- The date the *group agreement* between *SFHP* and the *employer* terminates.
- The date you stop paying the monthly charges.
- The date you first become covered under another group health plan unless there is a pre-existing condition limitation that applies.
- The date you first become entitled to Medicare.

10. Duplicate Coverage, Third Party Liability, and Coordination of Benefits

Duplication Coverage

If a 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, because he or she is entitled to these other Benefits. This exclusion is applicable to Benefits received from any of the following sources:

- Benefits provided under the Medicare program. If a Member receives services he or she is entitled to under Medicare and those services are also covered under SFHP, the SFHP Provider may seek compensation for the services provided under Medicare. This exclusion for Medicare does not apply when the sponsoring group and the services provided to the Member are subject to the Medicare Secondary Payer laws.
- Benefits provided by any other federal or state government agency, or by any county or other political subdivision. Also excluded are the reasonable costs of services provided at a Veterans' Administration facility for a condition unrelated to military service or at a Department of Defense facility, provided the person is not on active duty.
- Benefits provided free of charge or without expectation of payment.
- Benefits provided under workers' compensation coverage.

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 in writing to reimburse SFHP the reasonable cash value of Benefits provided as reflected by the provider's usual billed charges, but not to exceed the amount actually paid by the Plan, immediately upon

collection of damages by the Member, whether by action at law, settlement, or otherwise; and,

- Provides SFHP with a lien, in the amount of the reasonable cash value of Benefits provided by SFHP, as reflected by a percentage of the provider's usual billed charges but not exceeding the amount actually paid by the Plan, as set forth in California Civil Code section 3040. The lien may be filed with the third party, the third party's agent, or the court.

Coordination of Benefits

If a Member is covered by more than one group health plan or group insurance coverage, SFHP will coordinate Benefits with the other carrier. If another carrier covering the Member under a group health plan is primary, then SFHP or its SFHP Providers will seek compensation from that carrier for Benefits provided under SFHP coverage. The Member will receive all of the Benefits to which they are entitled under this Plan, but no more than these Benefits. This coordination of Benefits will be done by SFHP in accordance with the rules of the California Department of Managed Health Care.

When coordinating Benefits, if the patient is the Member, then the coverage that the patient obtains through employment is primary.

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.

11. Grievances and Appeal Procedures

Grievance Process

Members are encouraged to bring grievances to the attention of *physician* office staff first in order to resolve the issue directly. If this approach fails to resolve the problem, or if you wish to immediately file a grievance, please notify SFHP as soon as possible. The Health Plan may be able to resolve your problem or answer your questions informally at that time or shortly thereafter. You can also ask for a copy of the complete Complaint/Grievance Protocols. Please contact Customer Service at **(415) 547-7800** (locally) or **(800)288-5555** 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 39.

Filing a Grievance

You can file a grievance about the provision of health *services* or *benefits* by calling Customer Service at **(415) 547-7800** (locally) or **(800) 288-5555**, or you may make a written complaint to San Francisco Health Plan, Attn:

Grievance Coordinator
201 Third Street, 7th Floor,
San Francisco, CA 94103.

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

Complaint/Grievance Process

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

Step 1.You file your complaint over the telephone, in writing or in person. SFHP's Grievance Coordinator will be available to help you with your complaint if you wish.

Step 2. In most cases, SFHP will send you a letter within 5 calendar days to confirm receipt of your *grievance*. The letter will also give you information about the *grievance* procedure and about your rights as an SFHP *member*.

Step 3. SFHP will write to you with our proposed resolution within 30 calendar days. If you haven't received a letter from SFHP within 30 calendar days or if you do not accept the resolution SFHP proposes, you can ask either for an appeal hearing with SFHP or you can immediately contact the Department of Managed Health Care as described on page 39.

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

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

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

Appeal Hearing

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

Expedited Medical Review and Appeals

You can ask that the *Plan* review your *grievance* or *appeal* within 72 hours when you have an Urgent Grievance. An Urgent Grievance is when a delay in getting medical care would pose an imminent and serious threat to your health including, but limited to loss of life or limb, major bodily function or severe pain.

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

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.

Where to Write

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

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

A grievance may also be submitted through our website at **www.sfhp.org.**

Independent Medical Review of Grievances Involving a Disputed Health Care Service

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

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

- 1. (A) Your Physician has recommended a health care *service* as *medically necessary*, or

- 1. (B) You have received *urgent care* or *emergency services* that a provider determined was *medically necessary*, or
- 1. (C) You have been seen by a *physician* for the diagnosis or treatment of the medical condition for which you seek an IMR;
- 2. The disputed health care service has been denied, modified, or delayed by SFHP or your *medical group*, based in whole or in part on a decision that the health care *service* is not *medically necessary*; and
- 3. You have filed a grievance with SFHP or your *medical group* and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you may bring it immediately to the Department's attention. The DMHC may waive the requirement that you follow SFHP's *grievance* process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialis*t* 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 **(415) 547-7800** (locally) or **(800)288-5555**.

Experimental/Investigational IMRs

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

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

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.

Complaints to the Department of Managed Health Care

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

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

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 30 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 (30) 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 of the neutral arbitrator may be obtained from Customer Service. 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.

12. Other Provisions

Review by the Director of the Department of Managed Health Care

Should SFHP cancel or refuse to renew enrollment for you and you feel that such action was due to reasons of health or utilization of Benefits, you may request a review by the Director of the Department of Managed Health Care by calling **(800) 466-2219** or **(877) 688-9891** (TTD).

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 to advise its Governing Board on policy decisions. Two members of this committee are also members of the Governing Board and one is a member of SFHP's Quality Improvement Committee. In conformance with Health and Safety Code, Section 1369, 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 **(415) 547-7800** (locally) or **(800) 288-5555**. If you are interested in participation in the future, please contact Customer Service.

Non-Assignability

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

Independent Contractors

SFHP providers are neither agents nor employees of SFHP but are independent contractors. SFHP regularly credentials the Primary Care Providers who provide services to Members. However, in no instance shall SFHP be liable for negligence or wrongful acts or omissions of any person who provides services to you, including any Primary Care Provider, Hospital, or other provider or their employees.

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. If the provider does not agree to provide care according to the Plan's policies and procedures, then continuity of care will not be available to the member. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Continuity Of Care For New Members By Non-Contracting Providers

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*. If the provider does not agree to provide care according to the Plan's policies and procedures, then continuity of care will not be available to the member. 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 **(415) 547-7800** (local) or **(800)288-5555**, for more information.

Payment of Providers

SFHP generally pays its contracted Medical Groups and its contracted Hospitals by a method called capitation. Under this method, each SFHP Medical Group and Hospital is paid a fixed monthly fee for the Members assigned to that Medical Group and 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. As required by law, our contracts with Medical Groups and Hospitals do not allow them to collect any payments from Members if SFHP were to fail to pay providers.

While SFHP does not enter into incentive arrangement with Medical Groups regarding the cost of Hospital care, Hospitals may enter into such incentive arrangements with affiliated Medical Groups. Under such incentive arrangements, the Hospital and Medical Group may share in the cost of Hospital services and the Medical Group may receive a bonus if the cost of such services is below a fixed amount.

Call SFHP at **(415) 547-7800** (locally) or **(800) 288-5555**, or your Primary Care Provider or Medical Group for more information on payment of providers.

Confidentiality of Medical Information

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

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

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

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

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

Benefit Program Participation

SFHP shall have the authority, in accordance with the governing rules of the program, to construe and interpret the provisions of the Health Plan Contract and this Evidence of Coverage, to determine the Benefits of SFHP and to determine eligibility to receive Benefits under the Health Plan Contract and this Evidence of Coverage. SFHP shall exercise this authority for the Benefit of all persons entitled to receive Benefits under the contract and this Evidence of Coverage.

Governing Law

SFHP 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 Subchapter 5.5 of Chapter 2 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 they are not included in this Evidence of Coverage or the Group Agreement between SFHP and your Employer.

Natural Disasters, Interruptions, and Limitations

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.sfhp.org** or by calling **(800)288-5555**.

Important Questions	Answers		Why this Matters:
	Member Pays (Co-payment) Income Category A	**Member Pays (Co-payment) Income Category B & C**	
What is the overall deductible?	$0.00	$0.00	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always January 1st). See the chart on page 45 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	No	You don't have to meet deductibles for specific services, but see the chart starting on page 45 for other costs for services the plan covers.
Is there an out–of–pocket limit on my expenses?	$0.00	$0.00	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Not applicable	Not applicable	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	No	The chart starting on page 45 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see http://www.sfhp.org/members/programs/healthy_workers/change_doctors.aspx or call **(800) 288-5555**.	Yes. For a list of preferred providers, see http://www.sfhp.org/members/programs/healthy_workers/change_doctors.aspx or call **(800) 288-5555**.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart on page 9 how this plan pays different kinds of providers.

Important Questions	Answers		Why this Matters:
Do I need a referral to see a specialist?	Yes. All services outside of primary care with the exception of obstetrics and gynecology, mental health, and chemical dependency require a referral.	Yes. All services outside of primary care with the exception of obstetrics and gynecology, mental health, and chemical dependency require a referral.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Yes	See your policy or plan document for additional information about excluded services.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 Copay	Not covered	None
	Specialist visit	$0 Copay	Not covered	None
	Other practitioner office visit	$0 Copay	Not covered	None
	Preventive care/ screening/ immuni-zation	No Charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.sfhp.org.	Generic drugs	$5 Copay	Not Covered	$5 copay for up to a 30-day supply at a Plan Pharmacy. Prescribed contraceptives are no charge.
	Preferred brand drugs	$10 Copay	Not Covered	$5 and $10 copay for up to a 30-day supply at a Plan Pharmacy. Prescribed contraceptives are no charge.
	Non-preferred brand drugs	$10 Copay	Not Covered	$5 and $10 copay for up to a 30-day supply at a Plan Pharmacy. Prescribed contraceptives are no charge.
	Specialty drugs	$10 Copay	Not Covered	$5 and $10 copay for up to a 30-day supply at a Plan Pharmacy. Prescribed contraceptives at no charge. Prescriptions drug are covered per the DPH Formulary. Call Med Impact at **(800)788-2949**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0	Not Covered	No Copay
	Physician/ surgeon fees	$0	Not Covered	Copay is per procedure and includes the outpatient facility fee and the outpatient surgery physician and surgical service fee.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$0	$20	Copay is waived if admitted to hospital as inpatient. No co-payment if services are obtained at San Francisco General Hospital; $20 co-payment at any other hospital emergency room.
	Emergency medical transportation	$0	$0	Copay is per trip.
	Urgent care	$0 Copay	$20	Urgent care from non-participating providers is covered if a reasonable person would believe that your health would seriously deteriorate if you delayed treatment. No co-payment if services are obtained at San Francisco General Hospital; $20 co-payment at any other hospital emergency room.
If you have a hospital stay	Facility fee (e.g., hospital room)	$0	Not Covered	Copay is per day and includes inpatient hospital services fee and inpatient physician and surgical services fee.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Physician/ surgeon fee	$0	Not Covered	Copay is per day and includes inpatient hospital services fee and inpatient physician and surgical services fee.
If you have mental health, behavioral health, or substance abuse needs	Mental/ Behavioral health outpatient services	$0	Not Covered	None
	Mental/ Behavioral health inpatient services	$0	Not Covered	None
	Substance use disorder outpatient services	$3 per visit	Not Covered	None
	Substance use disorder inpatient services	$0	Not Covered	None
If you are pregnant	Prenatal and postnatal care	$0	Not Covered	Normal prenatal visits and first post-natal visit is $0 cost share.
	Delivery and all inpatient services	$0	Not Covered	No Copay

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$0	Not Covered	Up to 100 visits per calendar year.
	Rehabilitation services	$0	Not Covered	No Copay
	Habilitation services	$0	Not Covered	Cost share applies to outpatient services.
	Skilled nursing care	$0	Not Covered	Up to 100 days per benefit period.
	Durable medical equipment	$0	Not Covered	See details on p. 19
	Hospice service	$0	Not Covered	None
If your child needs dental or eye care	Eye exam	$10 per eye exam	Not Covered	Annual exams to determine the need for corrective lenses
	Glasses	$25 for frames under $75 every 24 months (Member is responsible for amount over $75)	Not Covered	$25 for frames under $75 every 24 months (Member is responsible for amount over $75)
	Dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Hearing Aids
- Infertility Treatment
- Long-Term/Custodial Nursing Home Care
- Non-Emergency Care when Traveling Outside the U.S.
- Private-Duty Nursing
- Weight Loss Program

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Routine Eye Exams (Adult) with limits
- Routine Foot Care with limits
- Routine Hearing Tests

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at **(800) 278-3296**. You may also contact your state insurance department at **(888) 466-2219**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: San Francisco Health Plan's Customer Service at **(415) 547-7800** (locally) or **(800) 288-5555**.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **(800) 288-5555** or TTY/TDD **(415) 547-7830**

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **(800) 288-5555** or TTY/TDD **(415) 547-7830**

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

About these Coverage

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different. See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,340
- **Patient pays** $2,200

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
\Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$500
Coinsurance	$0
Limits or exclusions	$200
Total	**$2,200**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,120
- **Patient pays** $1,280

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$700
Coinsurance	$300
Limits or exclusions	$80
Total	**$1,280**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national
- averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Neighborhoods Covered by SFHP