Municipal Executives

Benefits Guide 2010-2011

Health Service System
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

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2010
2011

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- Enroll or re-enroll in a 2010-2011 Healthcare and/or Dependent Care Flexible Spending Account.
- Allocate Flexible Credits (administered by EBS).

The Last Day To Submit Open Enrollment Changes Is April 30, 2010

Open Enrollment is your annual opportunity to make health benefit election changes without any qualifying events. Completed Open Enrollment applications for Plan Year 2010-2011 and required documentation must be received at HSS by 5:30PM, April 30, 2010. Open Enrollment applications can be delivered to HSS in person, sent through the mail or sent by fax to (415) 554-1721. See page 31 for a checklist of required eligibility documentation.

Flexible Credit Allocation and Flexible Spending Account (FSA) Enrollment

Annual allocation of flexible credits and Healthcare or Dependent Care FSA enrollments are handled by EBS. This year during Open Enrollment you can allocate flexible credits and enroll (or re-enroll) in an FSA by telephone/fax. Call EBS at (888) 327-2770 for more information. If you do not allocate flexible credits in April 2010 your credits will be defaulted to Miscellaneous Reimbursement effective July 1, 2010. (See page 24.) FSAs require enrollment every year. If you do not re-enroll in an FSA during April 2010, all current FSA contributions will cease the last pay day in June 2010.

Open Enrollment Events

Health Service System
1145 Market Street, 2nd Floor
San Francisco

April 1-16, 2010
Monday - Friday
8:00AM to 5:00PM

April 19-30, 2010
Monday - Friday
7:30AM to 5:30PM

A limited number of EBS appointments are available at 1145 Market Street. Call (888) 327-2770 to schedule.

San Francisco Airport
Terminal 1, Conf Room A&B
April 5, 2010 9:00AM-4:00PM
HSS Application Drop-off
To meet with HSS call:
(415) 554-1750
A limited number of EBS appointments are available at the Airport. Call (888) 327-2770 to schedule.

850 Bryant
6th Floor Auditorium
April 7, 2010 8:30AM-4:00PM
HSS Application Drop-off
To meet with HSS call:
(415) 554-1750

San Francisco City Hall
Room 421
April 6, 2010 9:00AM-4:00PM
HSS Application Drop-off
To meet with HSS call:
(415) 554-1750

San Francisco General Hospital
Carr Auditorium
April 9, 2010 8:30AM-4:00PM
HSS Application Drop-off
To meet with HSS call:
(415) 554-1750

Laguna Honda Hospital
Room B-104
April 12, 2010 8:30AM-4:00PM
HSS Application Drop-off
To meet with HSS call:
(415) 554-1750

Open Enrollment Alerts

Employee Premium Contributions Increase For Medical Plans Effective July 1, 2010

Twice monthly employee premium contributions for Blue Shield, Kaiser and City Plan will increase in Plan Year 2010-2011. The amount of the increase depends upon the medical plan you elect. Check the rates chart on page 43 before deciding what action to take during Open Enrollment.

Medical Plan Benefit Changes Effective July 1, 2010

Blue Shield HMO:	$20 office visit co-pay $15 co-pay for routine services (physical, well baby, pre/post natal care) $100 emergency room co-pay
Kaiser HMO:	$15 office visit co-pay $100 emergency room co-pay
City Plan PPO:	No plan changes
VSP Vision:	$5 VSP eye doctor visit co-pay for some acute eye conditions

Mental Health Parity Act

Effective July 1, 2010, all Health Service System administered plans are in compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides for parity between some types of mental health and medical benefits. Contact your plan if you have questions.

Selecting a Primary Care Physician

After you are enrolled in either the Blue Shield of California HMO or the Kaiser HMO contact your plan to select your Primary Care Physician (PCP). (You can request a change of Primary Care Physician at any time throughout the year.) If you do not make a change to your PCP after one has been assigned, you will need to use the PCP assigned by your plan until you contact your plan and request a change.

April 2010 Ineligible Dependent Amnesty

It is the responsibility of HSS members to notify the Health Service System when an enrolled dependent becomes ineligible due to divorce, dissolution of partnership, age or any other reason. (See pages 30-31.) Per HSS rules, if a member fails to notify HSS when an enrolled dependent becomes ineligible, the member will be held responsible for the costs of all health premiums and medical service provided, dating back to the date of the dependent's initial ineligibility. Avoid incurring penalties from the dependent audits that are being planned for later this year. Drop ineligible dependents during April 2010 Open Enrollment and HSS will give you amnesty from penalties.

Visit myhss.org to Download Enrollment Applications, Benefits Guides & More

HSS Open Enrollment applications, Benefits Guides and Evidence of Coverage documents for medical, dental and vision plan enrollment are available online at the HSS website myhss.org. Flexible credit allocation and Flexible Spending Account enrollment are handled exclusively through EBS.

Note: The alerts above are highlights only and may not cover every plan change for 2010-2011.

Open Enrollment Rules & Guidelines

Open Enrollment offers you the opportunity to make changes to your healthcare elections without any qualifying event requirements.

Things You Can Do During Open Enrollment

During Open Enrollment you can:

- Elect a different medical or dental plan.
- Add or drop eligible dependents from medical or dental coverage.
- Enroll or re-enroll in 2010-2011 Healthcare and/or Dependent Care Flexible Spending Account (FSA).
- Allocate flexible credits (administered by EBS).

To make changes you must submit a completed Open Enrollment application in person, by mail or by fax to HSS no later than 5:30PM, April 30, 2010.

If you are enrolling new dependents you must provide documentation to HSS proving that your dependents meet eligibility requirements for the upcoming year. See page 31.

You must call EBS at (888) 327-2770 to allocate flexible credits and/or enroll in a Healthcare or Dependent care Flexible Spending Account (FSA) for 2010-2011.

What To Expect If You Make a Change to Your Elections During Open Enrollment

Any changes you elect to make during the April 2010 Open Enrollment period will take effect July 1, 2010 and remain in effect through June 30, 2011.

Dependents deleted from coverage during Open Enrollment are not eligible for COBRA coverage.

If you elect to change your medical plan, the plan will issue you a new medical ID card. You should receive your new ID card before July 1, 2010. If you do not receive your card, contact the plan.

If You Don't Make Any Changes During Open Enrollment

If you are currently enrolled in Blue Shield, Kaiser or City Plan and don't make changes during Open Enrollment, your current medical and dental plan elections and the eligible dependents you have covered will remain the same. Without re-enrollment all current Healthcare and Dependent Care FSAs will end June 30, 2010. And if you don't contact EBS to allocate your flexible credits, credits for this year will be automatically distributed toward any employee premium contributions that you have, with the remainder being allocated to Miscellaneous Reimbursement. (See page 24.)

Payroll Deduction Amounts

The amount deducted from your paycheck will change in accordance with any approved changes to the rates for Plan Year 2010-2011. (See page 43 of this guide for 2010-2011 rates.) Check your pay stub to be sure the correct deduction is being taken. You are responsible for making sure all required healthcare contributions are paid.

No Dual HSS Plan Coverage

HSS members and their dependents cannot be enrolled in two HSS administered medical or dental plans at the same time. For those members who do submit dual enrollment elections, HSS will eliminate dual coverage as follows:

- For any member who is covered both as a member and as a dependent of another member coverage as a dependent will be terminated.
- For dependents who are covered by two different members, the dependent(s) will be covered by the member who covered the dependent(s) first.

Open Enrollment

FREQUENTLY ASKED QUESTIONS

	Flexible Credits	Medical & Dental Coverage	Flexible Spending Accounts
What if I don't want to make any changes to my benefit elections in 2010-2011?	You must allocate your flexible credits every year. To continue your allocations in 2010-2011, call EBS at (888) 327-2770 during Open Enrollment. If you don't take action, flexible credits are automatically distributed. (See page 24)	If you want to keep the same medical and dental plan and are not adding or dropping dependents effective July 1, 2010 you do not need to submit an Open Enrollment application.	FSAs require re-enrollment every year. To continue your FSA for the coming year you must call EBS at (888) 327-2770 during Open Enrollment. If you do not take action, FSA contributions will cease the last pay day of June, 2010.
How do I make changes to my benefit elections in 2010-2011?	Call EBS at (888) 327-2770 during Open Enrollment to make changes to your flexible credit allocations for the coming year. Otherwise, credits are automatically distributed. (See page 24.)	You must submit a completed Open Enrollment application and any required eligibility documentation to HSS no later than 5:30PM, April 30, 2010.	Call EBS at (888) 327-2770 during Open Enrollment to make changes to your FSA contributions for the coming year. If you don't take action, FSA contributions cease the last pay day of June, 2010.
How do I add or drop a dependent from my medical and/or dental plan during Open Enrollment?	If you are adding or dropping dependents during Open Enrollment, this may modify the allocation of your flexible credits. Be sure to discuss these changes with EBS.	Submit a completed Open Enrollment application and required eligibility documentation to HSS no later than 5:30PM, April 30, 2010. No documentation is required when dropping dependents during Open Enrollment.	
May I fax my enrollment information?	Call EBS at (888) 327-2770 to update your flexible credit allocations, then return your signed confirmation to EBS by fax. If you do not take action flexible credits will be automatically distributed. (See page 24.)	You may fax your Open Enrollment application and eligiblity documentation to HSS at (415) 554-1721. Do not fax the same application multiple times; we will email confirmations of fax receipt within two business days.	Call EBS at (888) 327-2770 to enroll in a healthcare and/or dependent care FSA, then return your signed confirmation to EBS by fax. If you do not take action, your FSA contributions will end the last pay period of June, 2010.
Who do I contact if I have questions?	If you have questions about flexible credit allocation, contact EBS by calling (888) 327-2770.	If you have questions about medical and dental enrollment, contact HSS member services at (415) 554-1750.	If you have questions about flexible spending accounts, contact EBS by calling (888) 327-2770.

Choosing a Medical Plan

1 PPO vs. HMO

Learn about the differences between a PPO plan and an HMO plan.
(See the chart on page 8 of this guide.)

2 Plan Service Areas

Find out which plans offer service to you based on the home address of the primary HSS member. See the chart on page 9 of this guide or contact the plan.

3 Medical Groups, Doctors and Hospitals

Identify which doctors, hospitals and other medical services that you and your family prefer. If you are enrolled in the Blue Shield HMO, the Primary Care Physician you select may have an impact on which doctors and hospitals you can access.

4 Vendor Report Cards & Quality Ratings

Visit online resources that can assist you in your decision making process.

HSS Vendor Report Cards
www.myhss.org

California Office of the Patient Advocate
www.opa.ca.gov

Integrated Healthcare Association
www.iha.org

National Committee for Quality Assurance
www.ncqa.org

Agency for Healthcare Research & Quality
www.ahrq.gov/consumer/insuranceqa/

CalHospitalCompare
www.CalHospitalCompare.org

5 Medical Needs & Services Covered

Make sure you understand how your plan works by reviewing the benefits summary and Evidence of Coverage (EOC) documents. Don't wait until you need emergency care to educate yourself about plan details. Here are some common questions to consider when deciding which plan can best meet your particular needs:

- Do you or a family member need to see medical specialists for a particular condition?
- Does someone in your family take regular prescription medication?
- Are the doctors or medical facilities in a plan in a convenient location for you?
- Will you need prior approval to ensure coverage for care if you are hospitalized or require surgery?
- Will you or any family members be seeking mental health care?
- How are benefits paid?

6 Plan Costs

Compare the costs of each available medical plan. See page 43 of this guide for rate charts.

Medical Plan Options

These medical plan options are available to active HSS members and eligible dependents. Employee premium contributions are deducted from the member's paycheck twice monthly.

Health Maintenance Organization (HMO)

An HMO is a medical plan that requires you receive all of your care from a network of participating physicians, hospitals, and other healthcare providers. Generally, to be covered for non-emergency benefits, you need to access medical care through your PCP (Primary Care Physician).

HSS offers the following HMO plans:

- **Blue Shield of California HMO**
- **Kaiser HMO**

Preferred Provider Organization (PPO)

A PPO is a medical plan that gives you freedom of choice by allowing you to go to any in-network or out-of-network healthcare provider. When you go to in-network providers the plan pays higher benefits and you pay less out-of pocket. A PPO doesn't assign you a Primary Care Physician, so you have more responsibility for coordinating your care.

HSS offers the following PPO plan:

- **City Health Plan (administered by UnitedHealthcare)**

The healthcare plans administered by HSS do not guarantee the continued participation of any particular doctor, dentist, hospital or medical group during the Plan Year. After Open Enrollment, you won't be allowed to change your healthcare elections because your provider and/or medical group chooses not to participate in a particular plan. You'll be assigned or required to select another provider.

If you move out of the service area covered by your plan, you must elect an alternate medical plan that provides coverage in your area. Failure to change your healthcare elections may result in the non-payment of claims for services received.

This benefits guide cannot cover every detail of your plan contract. The EOC (Evidence of Coverage) contains a complete list of benefits and exclusions in effect for each plan from July 1, 2010 through June 30, 2011. Review your EOC for plan details. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. You can download plan EOCs at myhss.org.

Employee vs. Employer Premium Contribution Costs

On average, an employee contributes 14% of the total cost of a health plan premium. The City pays 86% of the cost of employee and dependent health coverage.

PPO vs. HMO

QUICK COMPARISON CHART

	City Plan PPO	Blue Shield HMO	Kaiser HMO
Do I have to select a Primary Care Physician (PCP) to coordinate my care?	No	You can choose your Blue Shield PCP after you enroll, or Blue Shield will assign.	You can choose your Kaiser PCP after you enroll, or Kaiser will assign.
Do I have to use a contracted network provider?	You can use any licensed provider. Out-of-network providers will cost you more.	Yes. All services must be received from a contracted network provider.	Yes. All services must be received from a Kaiser facility.
Is my access to hospitals and specialists determined by my Primary Care Physician's medical group affiliation?	No	Yes. PCP referrals will in most cases be made within his or her medical group's network of doctors and hospitals.	Yes. All services must be received from a Kaiser facility.
Do I have to pay an annual deductible?	Yes	No	No
Is preventative care covered, such as a routine physical and well baby care?	Yes, after annual deductible is met.	Yes	Yes
Does the plan have a maximum lifetime limit for healthcare services?	Yes. The plan will pay a maximum lifetime benefit of $2 million per covered person.	No	No
Do I have to file claim forms?	Only if you use an out-of-network provider.	No	No

This guide offers general information only. Do not rely solely on this guide when making your health insurance decisions. Before enrolling in a plan, you should consult the Evidence of Coverage (EOC) to get specific information about the benefits, costs and way the plan works. EOCs are available as downloadable PDFs on myhss.org.

Medical Plan Service Areas

To enroll in Blue Shield or Kaiser, you must reside within a zip code serviced by the plan. Refer to the chart below or contact the plan to determine whether or not you live in the plan's service area.

County	City Health Plan	Blue Shield	Kaiser
Alameda	■	■	■
Alpine	■		
Calaveras	■		
Contra Costa	■	■	■
Madera	■	■	❍
Marin	■	■	■
Mariposa	■		❍
Merced	■	■	
Mono	■		
Napa	■		❍
Sacramento	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Clara	■	■	❍
Santa Cruz	■	■	
Solano	■	■	■
Sonoma	■	■	❍
Stanislaus	■	■	■
Tuolumne	■		
Yolo	■	■	❍
Outside of California	■	Urgent Care/ER Only	Urgent Care/ER Only

■ = Available in this County.

❍ = Available in some zip codes; verify your zip code with the plan to confirm availability.

If you do not see your County listed above please contact the medical plan to see if service is available to you.

Medical Plan Benefits-at-a-Glance

	blue of california	KAISER PERMANENTE®
DEDUCTIBLES		
Plan-year deductible	None	None
Lifetime maximum	None	None
PREVENTIVE & ROUTINE CARE		
Routine physical	$15 co-pay	$15 co-pay
Immunizations & inoculations	No charge	No charge
Gynecologic exam	$15 co-pay	$15 co-pay
Well baby care	$15 co-pay	$15 co-pay
PHYSICIAN CARE		
Office & home visits	$20 co-pay	$15 co-pay
Hospital visits	No charge	No charge
PRESCRIPTION DRUGS		
Pharmacy - generic drugs	$5 co-pay 30 day supply	$5 co-pay 30 day supply
Pharmacy - brand-name drugs	$20 co-pay 30 day supply	$15 co-pay 30 day supply
Pharmacy - non-formulary drugs	$35 co-pay 30 day supply	Physician authorized only
Mail order - generic drugs	$10 co-pay 90 day supply	$10 co-pay 100 day supply
Mail order - brand-name drugs	$40 co-pay 90 day supply	$30 co-pay 100 day supply
Mail order - non-formulary drugs	$70 co-pay 90 day supply	Physician authorized only
OUTPATIENT SERVICES		
Diagnostic x-ray & laboratory	No charge	No charge
EMERGENCY		
Hospital emergency room	$100 co-pay waived if hospitalized	$100 co-pay waived if hospitalized
Urgent care facility	$20 co-pay within CA network	$15 co-pay
HOSPITALIZATION		
Inpatient	$100 co-pay per admittance	$100 co-pay per admittance
Oupatient	$50 co-pay	$15 co-pay
SURGERY		
In hospital	$100 co-pay per admittance	$100 co-pay per admittance

This chart provides a summary of benefits. It is not a contract. For a more detailed description of benefits and exclusions for each plan, please review each plan's Evidence of Coverage, available on myhss.org.

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
$250 employee only $500 employee + 1 $750 employee + 2 or more	$250 employee only $500 employee + 1 $750 employee + 2 or more	$250 employee only $500 employee + 1 $750 employee + 2 or more
$2,000,000 per covered person for any combination of In-Network, Out-of-Network and Out-of-Area options utilized.		
85% covered after deductible	Not covered	85% covered after deductible
100% covered no deductible	50% covered no deductible	100% covered no deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
$5 co-pay 30 day supply	50% covered after $5 co-pay; 30 day supply	$5 co-pay 30 day supply
$20 co-pay 30 day supply	50% covered after $20 co-pay; 30 day supply	$20 co-pay 30 day supply
$35 co-pay 30 day supply	50% covered after $35 co-pay; 30 day supply	$35 co-pay 30 day supply
$10 co-pay 90 day supply	Not covered	$10 co-pay 90 day supply
$40 co-pay 90 day supply	Not covered	$40 co-pay 90 day supply
$70 co-pay 90 day supply	Not covered	$70 co-pay 90 day supply
85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	85% covered after deductible; may require prior notification
85% covered after deductible; if non-emergency 50% after deductible	85% covered after deductible; if non-emergency 50% after deductible	85% covered after deductible; if non-emergency 50% after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	85% covered after deductible; may require prior notification
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	85% covered after deductible; may require prior notification

*City Plan Benefits are based on Reasonable & Customary charges. In some cases, billed amounts may exceed Reasonable & Customary fees, resulting in higher out-of-pocket costs for you.

Medical Plan Benefits-at-a-Glance

	blue of california	KAISER PERMANENTE®
REHABILITATIVE		
Physical/Occupational therapy	$20 co-pay	$15 co-pay authorization req.
Acupuncture	$15 co-pay 30 visits/yr; ASH network only	Not covered
Chiropractic	$15 co-pay 30 visits/yr; ASH network only	$15 co-pay 30 visits/yr; ASH network only
PREGNANCY & MATERNITY		
Pre/post-natal physician care For hospital stay, see Hospitalization	$15 co-pay newborn must be enrolled within 30 days of birth	$15 co-pay newborn must be enrolled within 30 days of birth
INFERTILITY		
IVF, GIFT, ZIFT & Artificial Insemination	50% covered of the allowable amount; limitations apply	50% covered limitations apply
TRANSGENDER		
Office visits & outpatient surgery	Co-pays apply authorization req. $75,000 lifetime max	Co-pays apply authorization req. $75,000 lifetime max
DURABLE MEDICAL EQUIPMENT		
Home medical equipment	No charge	No charge as authorized by PCP according to formulary
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary
Hearing aids	No charge 1 per ear every 36 months; $2,500 max	No charge 1 per ear every 36 months; $2,500 max
MENTAL HEALTH		
Inpatient hospitalization	$100 co-pay per admittance	$100 co-pay per admittance
Outpatient treatment	$20 co-pay non-severe and severe	$7 co-pay group $15 co-pay individual
SUBSTANCE ABUSE		
Inpatient	$100 co-pay per admittance for acute short-term detox	$100 co-pay per admittance
Outpatient	$20 co-pay	$5 co-pay group $15 co-pay individual
EXTENDED & END-OF-LIFE CARE		
Skilled nursing facility	No charge up to 100 days per year	No charge up to 100 days per year
Hospice	No charge authorization required	No charge when medically necessary

This chart provides a summary of benefits. It is not a contract. For a more detailed description of benefits and exclusions for each plan, please review each plan's Evidence of Coverage, available on myhss.org.

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
85% covered after deductible; 60 visits / year	50% covered after deductible; 60 visits / year	85% covered after deductible; 60 visits / year
50% covered after deductible; $1,000 / year	50% covered after deductible; $1,000 / year	50% covered after deductible; $1,000 / year
50% covered after deductible; $1,000 / year	50% covered after deductible; $1,000 / year	50% covered after deductible; $1,000 / year
85% covered after deductible; newborn must be enrolled within 30 days of birth	50% covered after deductible; newborn must be enrolled within 30 days of birth	85% covered after deductible; newborn must be enrolled within 30 days of birth
50% covered after deductible; limitations apply; prior notification required	50% covered after deductible; limitations apply; prior notification required	50% covered after deductible; limitations apply; prior notification required
85% covered after deductible; prior notification required; $75,000 lifetime max	50% covered after deductible; prior notification required; $75,000 lifetime max	85% covered after deductible; prior notification required; $75,000 lifetime max
85% covered after deductible; rental not to exceed purchase price	50% covered after deductible; rental not to exceed purchase price	85% covered after deductible; rental not to exceed purchase price
85% covered after deductible; when medically necessary	50% covered after deductible; when medically necessary	85% covered after deductible; when medically necessary
100% covered after deductible; 1 per ear every 36 months; $2,500 max	100% covered after deductible; 1 per ear every 36 months; $2,500 max	100% covered after deductible; 1 per ear every 36 months; $2,500 max
85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible; 120 days per year; prior authorization required; custodial care not covered	50% covered after deductible; 120 days per year; prior authorization required; custodial care not covered	85% covered after deductible; 120 days per year; prior authorization required; custodial care not covered
85% covered after deductible; $10,000 max; prior notification required	50% covered after deductible; $10,000 max; prior notification required	85% covered after deductible; $10,000 max; prior notification required

*City Plan Benefits are based on Reasonable & Customary charges. In some cases, billed amounts may exceed Reasonable & Customary fees, resulting in higher out-of-pocket costs for you.

Medical Plan Wellness Benefits

BLUE SHIELD

www.blueshieldca.com/hw/

LifeReferrals 24/7
Telephone advice and self-directed online decision guides to assist members in making informed healthcare decisions.

Life Stage Health Articles
Topical Information and articles about women's, men's, children's and senior health issues.

Ask the Pharmacist
Email a UCSF pharmacist your drug-related questions and receive a personal, confidential response within 2 business days.

NurseHelp 24/7
Call (877)304-0504. Experienced nurses are available to answer questions, listen to concerns and provide information.

Online Nurse Chat
Chat privately with a registered nurse in a secure online environment.

Healthy Lifestyle Rewards
www.blueshieldca.com/hlr
An interactive, online program that helps you adopt and maintain healthy lifestyle habits like good nutrition, stress management and regular exercise.

Discounts & Savings
www.blueshieldca.com/bsc/hw/hw_375.jhtml
Discounts and savings on Weight Watchers®, 24 Hour Fitness, Drugstore.com as well as reduced rates on massage, chiropractic and acupuncture services from select ASH network practictioners and more.

Online registration is required to take advantage of some of the Blue Shield tools and programs listed.

KAISER PERMANENTE

kp.org/healthyliving

Personalized Health Assessment
Take an in-depth look at the choices you make each day and get a personal plan to help improve your health and quality of life, including:

Classes
Kaiser offers hundreds of classes for all ages on a wide variety of health and wellness topics.

Health Calculators
Use online calculators for healthy weight, calorie counting, fertility, disease risk and more.

Health Encyclopedia
Research health conditions and learn more about treatment options.

Nutrition
Learn how to cook tasty and nutritious food.

Audio Podcasts
Download a wide range of health related audio, including guided meditations on stress reduction, healthy sleep, easing pain and more.

Videos
www.permanente.net/homepage/kaiser/pages/f50506.html

Connect to better health with a variety of Healthy Living videos that you can watch online.

Discounts & Savings
kp.org/healthyroads
Discounts and savings on 10,000 Steps®, ASHN massage, chiropractic and acupuncture services and more.

Online registration is required to take advantage of some of the Kaiser tools and programs listed.

Medical Plan Wellness Benefits

UNITEDHEALTHCARE (CITY PLAN)

www.myuhc.com

Health Information
Conditions A-to-Z Encyclopedia, drug dictionary, health-related articles and a Lifestyles directory, which categorizes information about nutrition, health and mental wellness for men, women and children based on life stage.

Health Calculators
A wide range of online calculators, including healthy weight, target heart rate, calories burned, heart attack risk, smoking risk and drinking risk.

Live Nurse Chat
Via online chat, ask a nurse confidential questions and receive references to additional educational online resources.

Symptom Checker
Access an interactive visual and form-based tool to help you make decisions about first aid and assess common physical symptoms.

Personalized Health Assessment
Take an in-depth look at the health choices you make each day and get a personal plan to help improve well-being and quality of life.

Online registration is required to take advantage of some of the UHC tools and programs listed.

Five Ways To Get Involved In Your Healthcare

1. Get an annual checkup and know your numbers - blood pressure, blood sugar, cholesterol and BMI.
2. Get the recommended health screenings that are appropriate for your age and gender. Early diagnoses often result in better outcomes.
3. Make a list of your health concerns before an office visit so you remember to discuss them with your doctor.
4. If you have a chronic condition, follow your doctor's advice regarding nutrition and physical activity. Take medication as prescribed and monitor your condition with regular check-ups.
5. Make your care wishes known to your family and loved ones by completing an Advance Healthcare Directive.

Mental Health Parity Act

HSS Health Benefits Comply With Federal Legislation

On October 3, 2008, the President signed the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Congress deferred the effective date of the MHPAEA for calendar year plans to January 2010. Effective July 1, 2010, Health Service System health plans, which are on a fiscal year, will be in compliance with this federal law.

The Mental Health Parity Act does not require employers or health insurance plans to provide mental health or substance use disorder benefits. However, for group health plans with 50 or more employees that choose to provide mental health and substance use disorder benefits, like the health plans administered by HSS, the Act does require parity between some types of mental health and medical benefits.

To summarize, under this law, group health plans like those administered by HSS, which provide both medical and surgical benefits and mental health and substance use disorder benefits may not:

- Impose financial requirements and treatment limitations applicable to mental health and substance use disorder benefits that are more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits.
- Requirements such as co-payments and deductibles and limitations such as number of visits or frequency of treatments can be no more restrictive on mental health and substance use disorder benefits than the requirements or limitations imposed on medical and surgical benefits.

For more information visit:
www.cms.hhs.gov/healthinsreformforconsume/04_thementalhealthparityact.asp

Health Service System Wellness Programs

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is a voluntary, confidential, no cost counseling and information program for City employees, their family members and their significant others. EAP staff are licensed counselors who provide assessment, short term therapy (up to six sessions), referrals and follow-up for individuals, couples, families and groups regarding personal or work-related issues such as stress, marital, family and relationship problems, anger management, substance abuse, work performance issues, emotional difficulties, or any concern that becomes a problem in one's life. The EAP staff is also available for mediation/conflict resolution sessions, workplace violence prevention and Critical Incident Debriefing following a traumatic event.

All contact with the EAP is voluntary, confidential and free. Your first appointment with an EAP counselor usually takes place within 48 hours of a phone consult. After a discussion of your concerns, your counselor will help you to identify your issues and make a plan of action to help you resolve your problems. Short-term counseling and referrals may be recommended.

Call the EAP at (800) 795-2351 to make an appointment. The EAP is located at 1145 Market Street, Suite 200. Office hours are 8:00 AM to 5:00 PM, Monday through Friday.

Wellness Seminars

The Health Service System offers a variety of free and low-cost movement classes and wellness-oriented presentations for HSS members throughout the year. Some of these seminars, including Yoga, Stretching, QiGong, Pure Prevention, Five Wishes Advance Healthcare Directives, Chemical Free Home and more are available upon request at any City employee worksite. (There are facility and staffing requirements for some of these offsite classes.) To view the seminar calendar visit myhss.org. To discuss scheduling a seminar at your worksite call (415) 554-0636.

Annual Health Fair

In October the Health Service System presents a health fair, free to all members, including retirees and covered dependents. Free flu shots, health screenings, hearing tests, fitness and nutrition demonstrations and more are offered at the fair. For more information visit www.myhss.org.

eUpdates

In addition to providing important updates about your health benefits, the HSS eNewsletter offers wellness tips and website picks and highlights select Bay area lectures, events and activities that celebrate well being. Health Service System members are invited to sign-up for monthly HSS eNews at www.myhss.org.

Dental Plan Options

Dental benefits are an important part of your healthcare coverage and are key to your overall health. HSS offers a choice of plans, providers and coverage options at no premium cost to most HSS members.

PPO-Style Dental Plans

A PPO-style dental plan gives you the freedom to visit any in-network or out-of-network dentist of your choice. The plan pays higher benefits (and you pay less) when you visit an in-network dentist.

HSS offers you the following PPO-style dental plan:

- **Delta Dental**

The Delta Dental PPO has two different networks of participating dentists and dental care providers:

- Delta preferred In-Network providers offer the highest benefit. Most preventive services are covered at 100%; many other services are covered at 90%.
- The Delta Premier network pays benefits based on a pre-arranged fee agreed to by the network's dentists. Most preventive services are covered at 100%; many other services are covered at 80%.

You may go to any dentist in either network. You may also go to any dentist outside of these networks. When you go to a licensed dentist not in one of the networks described above, the plan pays the same percentage of cost that it pays a Delta network dentist. However, payment is based on what is considered reasonable and customary (R&C) for the geographical area. This means that your share of the expenses will be higher if your out-of-network dentist charges more than R&C. Don't be shy about asking a dentist financial questions before receiving services. Delta can also help you estimate costs before you receive treatment. Call Delta at (888) 335-8227.

HMO-Style Dental Plans

Similar to medical HMO's, Dental Maintenance Organization (DMO) dental plans require that you receive all of your dental care from within a network of participating dental offices. These networks are generally smaller than a dental PPO network.

Please note that you will be required to select a dental office which becomes your primary care office and you must go to this office for all of your dental care. Make sure that the dentist you wish to see is in a DMO plan before selecting it.

HSS offers the following DMO plans:

- **DeltaCare® USA**
- **Pacific Union Dental**

Dental Plan Only?

Yes, you can elect to enroll in an HSS dental plan even if you elect not to enroll in an HSS medical plan.

Dental Plan Service Areas

To enroll in either the DeltaCare USA or Pacific Union Dental DMO, you must reside within a zip code serviced by the plan. Ask your dentist which plan(s) he or she contracts with before making your selection.

County	Delta Dental PPO	Deltacare USA DMO	Pacific Union DMO
Alameda	■	■	■
Alpine	■		
Calaveras	■		
Contra Costa	■	■	■
El Dorado	■	■	
Madera	■	■	■
Marin	■	■	■
Mariposa	■		
Merced	■	■	■
Mono	■		
Monterey	■	■	■
Napa	■	■	■
Sacramento	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Clara	■	■	■
Santa Cruz	■	■	■
Solano	■	■	■
Sonoma	■	■	■
Stanislaus	■	■	■
Tuolumne	■		
Yolo	■	■	■
Outside of California	■		

■ = Available in this County

Refer to the chart above to determine whether or not you live in the plan's service area. If you do not see your County listed above please contact the dental plan to confirm that service is available to you.

Dental Plan Benefits-at-a-Glance

	DELTA DENTAL		DELTACARE USA	PACIFIC UNION DENTAL
	Preferred In-Network Providers	Premier & Out-of-Network Providers		
Types of Service				
Cleanings & Exams	100% covered Limit 2x per plan year	100% covered Limit 2x per plan year	100% covered Limit 1 every 6 months	100% covered Limit 1 every 6 months
X-rays	100% covered	100% covered	100% covered	100% covered
Extractions	90% covered	80% covered	100% covered	100% covered
Fillings	90% covered	80% covered	100% covered Limitations apply to resin materials.	100% covered
Crowns	90% covered	80% covered	100% covered Limitations apply to resin materials.	100% covered
Dentures, Pontics & Bridges	50% covered 6 month wait for new enrollees	50% covered 6 month wait for new enrollees	100% covered Full and partial dentures 1x every 5 yrs; fixed bridgework; certain limitations apply.	100% covered Full and partial dentures 1x every 5 yrs; fixed bridgework; certain limitations apply.
Root Canals	90% covered	80% covered	100% covered Excluding the final restoration.	100% covered
Orthodontia	50% covered Adults and children; up to $2,500 lifetime max; 6 month wait for new enrollees	50% covered Adults and children; up to $2,500 lifetime max; 6 month wait for new enrollees	Employee pays: $1,600/child $1,800/adult Adult limitations apply.	Employee pays: $1,600/child $1,800/adult $350 startup fee. Limitations apply.
Annual Maximum				
Total Dental Benefits	$2,500 per year Excluding orthodontia benefits.	$2,500 per year Excluding orthodontia benefits.	None	None
Annual Deductible				
Before Accessing Benefits	None	None	None	None

This guide offers general information only. Do not rely solely on this guide when making your health insurance decisions. Before enrolling in a plan, read the Evidence of Coverage to get specific details about benefits, costs and way the plan works. Plan EOCs are available on myhss.org.

Dental Plan Comparison

DENTAL PLAN QUICK COMPARISON

	Delta Dental PPO	DeltaCare USA DMO	Pacific Union Dental DMO
Can I choose to receive services from any dentist?	Yes. You can use any licensed dental provider.	No. All services must be received from a contracted network provider. These networks are generally quite small.	No. All services must be received from a contracted network provider. These networks are generally quite small.
Must my primary care dentist refer me to a specialist for certain kinds of dental work?	No	Yes	Yes
Is there a waiting period before I can access treatment?	No waiting period, except for dentures, pontics, bridges and orthodontia which require a 6 month wait.	No waiting period.	No waiting period.
Will I pay a flat rate for most services?	No. Your out-of-pocket costs are based on a percentage of applicable charges.	Yes	Yes
Must I live in a certain service area to enroll in the plan?	No	Yes. You must live in this DMO's service area to enroll.	Yes. You must live in this DMO's service area to enroll.

Vision Plan Benefits

All HSS members and eligible dependents who are enrolled in an HSS medical plan receive vision benefits, including an annual eye exam.

VSP Vision

All HSS members and eligible dependent(s) who enroll in the City Health Plan, Blue Shield HMO or Kaiser HMO can access vision benefits administered by Vision Service Plan (VSP). The vision plan provides you and your eligible dependents with one eye exam with a VSP network doctor every 12 months; helps you and your eligible dependents cover the cost of visual correction eyewear, such as glasses or contacts; and offers limited coverage for some acute eye conditions.

Choice of Providers

Under the vision plan, you have the choice of using a VSP network doctor or a non-VSP doctor. It may be to your advantage financially to use a VSP network doctor because covered services are provided to you at a higher benefit and you may have lower out-of-pocket costs.

You can find a VSP network doctor in your area by visiting www.vsp.com or contacting VSP Member Services at (800) 877-7195.

Accessing Your Vision Benefits

There are no ID cards issued for the vision plan. When you wish to receive service from a VSP network doctor, contact the doctor, identify yourself as a VSP member, and make an appointment. VSP will provide benefit authorization to the doctor. Services must be received prior to the benefit authorization expiration date. If you receive services from a VSP network doctor without benefit authorization or obtain services from an out-of-network provider, you are responsible for payment in full to the provider. You can then submit an itemized bill directly to VSP for partial reimbursement. Download a claim form at www.vsp.com.

Plan Benefits, Limits and Exclusions

- The vision plan covers one set of contacts or eyeglass lenses every 24 months, based on your last date of service. If retractor examination reveals an Rx change of .50 diopter or more after 12 months, replacement lenses are covered.
- Eligible dependent children are covered in full for polycarbonate prescription lenses.
- Cosmetic extras such as progressive lenses, tinted lenses or oversize lenses will cost you extra. If you use a VSP network doctor, you'll pay the VSP discounted price for these cosmetic extras. If you're using an out-of-network provider, you'll pay the retail price.
- The vision plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, the plan will pay the basic cost of the allowed lenses and you'll be responsible for any additional cost for the options, unless the extra is defined in the VSP Schedule of Benefits.
    - Blended or UV protected lenses
    - Contact lenses (except as noted in the Schedule of Benefits)
    - Oversize lenses
    - Photochromic and tinted lenses
    - Progressive multi-focal lenses
    - Coatings of the lens or lenses, except scratch resistant coatings
    - Laminating of the lens or lenses
    - A frame that costs more than the Plan allowance
    - Certain limitations on low vision care
    - Cosmetic lenses
    - Optional cosmetic processes

VISION PLAN BENEFITS AT-A-GLANCE		
	VSP Network Benefit	**Out-Of-Network Benefit**
Vision Exam	Covered in full once every 12 months* after the $10 co-pay	up to $40 every 12 months* after the $10 co-pay
Single Vision Lenses	Covered in full once every 24 months* after the $25 co-pay	up to $45 every 24 months* after the $25 co-pay
Lined Bifocal Lenses	Covered in full once every 24 months* after the $25 co-pay	up to $65 once every 24 months* after the $25 co-pay
Lined Trifocal Lenses	Covered in full once every 24 months* after the $25 co-pay	up to $85 once every 24 months* after the $25 co-pay
Frames	Covered up to $150 every 24 months* after the $25 co-pay; there may be a network discount for amount exceeding allowance	up to $55 once every 24 months* after the $25 co-pay
Contact Lenses	Covered up to $150 every 24 months* no co-pay; in lieu of frames/lenses; allowance applies toward contact lens fitting, evaluation exam and contacts	Covered up to $105 every 24 months* no co-pay; in lieu of frames/lenses; allowance applies toward contact lens fitting, evaluation exam and contacts
Urgent Eye Care	$5 co-pay limited coverage for urgent and acute eye conditions	Not covered

*Based on your last date of service.

Acute and Urgent Eye Care

With a $5 co-pay, VSP now offers limited coverage for urgent and acute eye conditions, including treatment of pink eye, sudden onset of flashers and floaters and diagnosis of eye pain or sudden changes in vision. You can visit any VSP network doctor; no appointment is necessary. VSP acute eye care does not cover chronic conditions like diabetes-related eye disease or glaucoma. VSP doctors will refer you to your primary medical doctor for treatment of uncovered eye conditions.

Vision Expenses Not Covered

- Orthoptics or vision training and any associated supplemental testing, plano (non-prescription) lenses or two pairs of glasses in lieu of bifocals.
- Replacement of lenses or frames furnished under this plan that are lost or broken, except at the contracted intervals.
- Medical or surgical treatment of the eyes, except for limited acute eye care described above.
- Corrective vision treatments such as, but not limited to, LASIK and PRK laser surgery. (You may be eligible for discounts when services are provided by a VSP network doctor – call VSP.)

Coordinating Vision Benefits with Medical Plan Benefits

Some HMOs also offer optometry and eyecare services such as eye exams, glasses and lenses. HSS recommends that you compare the out-of-pocket cost you will incur using HMO vision services to out-of-pocket costs when using a VSP network doctor.

No Medical Plan, No Vision Benefits

If you don't enroll in an HSS medical plan, you and your dependents will not have the vision benefits available through VSP.

Flexible Credits

Dollar Value of Credits

In lieu of dependent coverage subsidized by the City, MEA and unrepresented managers are allocated a dollar value in credits that they can apply to a variety of pre- and post-tax options. In 2010-2011, eligible **City and County of San Francisco enrollees** will receive **$329.85** in credits **twice monthly** to purchase from the options listed on page 25. Eligible **Superior Court enrollees** will receive **$620.75** in credits **twice monthly** to purchase from the options listed on page 25.

Initial Enrollment

Eligible employees may allocate available flexible credits to any combination of available pre- or post-tax benefit options based on the actual cost of each benefit. Enrollment is handled through EBS.

Flexible credit allocation options include putting credits toward employee contributions to health insurance premiums. If 100% of flexible credits are applied toward employee health premium contributions and the cost of the required contribution exceeds the total credits available, the additional amount will be covered by twice monthly payroll deduction.

Credits applied to post-tax benefits will result in imputed income.

Denied Coverage

Members who allocate flexible credits toward an insurance benefit but are then denied coverage may elect one of the following:

- The member may reallocate 100% of the flexible credit amount that was allocated to the denied benefit option(s) to the Miscellaneous Reimbursement option. (Imputed income will be calculated.)

OR

- The member may elect to forfeit 100% of the flexible credit amount that was allocated to the denied benefit option(s) for the duration of the plan year.

Members who elect to reallocate flexible credits to the Miscellaneous Reimbursement option will not receive the retroactive value of the applicable flexible credits but will have the applicable amount applied to the Miscellaneous Reimbursement account on a prospective basis.

Miscellaneous Reimbursement

If you allocate credits to Miscellaneous Reimbursement you must provide proof of qualifying expenses incurred between July 1, 2010 and June 30, 2011 to EBS by September 30, 2011. All options with no payroll deduction require paper claim forms and proof of expenditures to be filed directly with EBS for reimbursement. Download claim forms at myhss.org.

Miscellaneous Reimbursement Forfeiture

If you elect to allocate credits toward Miscellaneous Reimbursement but do not submit sufficient eligible claims to EBS against your credits by the required deadlines you will forfeit those flexible credit dollars.

Family Status Changes

Members may only elect to reallocate flexible credits if the reallocation relates directly to a qualified change in family status. (See pages 32-33.)

Open Enrollment

Members must allocate flexible credits annually during Open Enrollment. Call EBS at (888) 327-2770.

Any member who does not take action to make a flexible credit allocation during Open Enrollment will be subject to the following:

- If the member currently has medical plan coverage through Kaiser, Blue Shield or City Plan, flexible credits for the 2010-2011 Plan Year will be automatically applied to the actual cost of the medical plan at the same level of coverage currently in place. Any additional amount required to cover the actual cost of the medical plan will be covered by payroll deductions. All remaining credits, if any, will be allocated to the Miscellaneous Reimbursement Account and subject to imputed income.
- If the member currently has no medical plan coverage, all credits will be allocated to the Miscellaneous Reimbursement Account and subject to imputed income.

Flexible Credit Options

More detailed benefit summaries for these flexible credit options are available online at myhss.org. You must contact EBS at (888) 327-2770 during Open Enrollment to allocate flexible credits.

PRE-TAX FLEXIBLE CREDIT OPTIONS

	Tax Status	Flexible Credit	Payroll Deduction
Employee Health Premium Contributions	Pre-Tax	Yes	Yes
Healthcare Flexible Spending Account FBMC	Pre-Tax	Yes	Yes
Dependent Care Flexible Spending Account FBMC	Pre-Tax	Yes	Yes
Cancer Insurance Allstate Workforce Division	Pre-Tax	Yes	Yes
Heart and Stroke Insurance Allstate Workforce Division	Pre-Tax	Yes	Yes
Accident Insurance Allstate Workforce Division	Pre-Tax	Yes	Yes
Long Term Disability Insurance UNUM	Pre-Tax	Yes	No

POST-TAX FLEXIBLE CREDIT OPTIONS

	Tax Status	Flexible Credit	Payroll Deduction
Universal Life Insurance ING	Post-Tax	Yes	Yes
Short Term Disability Insurance ING	Post-Tax	Yes	Yes
Long Term Care Insurance MetLife	Post-Tax	Yes	Yes
Pet Insurance PetCare	Post-Tax	Yes	Yes
Group Legal Plan Pre-Paid Legal	Post-Tax	Yes	Yes
Supplemental Group Term Life Insurance Reliastar $50,000 Group Term Life Insurance provided at no cost to all employees eligible for flexible credit benefits.	Post-Tax	Yes	No
Commuter Transit Reimbursement EBS Note: a separate pre-tax Commuter Check benefit administered by FBMC is also available to all City employees.	Post-Tax	Yes	No
Miscellaneous Reimbursement Account Submit receipts to EBS for qualifying expenses, including: • MEA dues • Auto insurance • Prior service buyback • Professional coaching • Health club dues and fitness items • Homeowners insurance • Pension system contributions • PERS long term care plan • Tuition reimbursement when an employee has exceeded the $2,000 allocation from the MEA training fund. • Memberships or tickets to cultural events at institutions funded or operated by the City of San Francisco Hotel Tax Fund. Visit myhss.org for details about these and other qualifying expenses. Note: Contributions to 457(b) deferred comp accounts do not qualify.	Post-Tax	Yes	No

Flexible Spending Accounts

An FSA is an IRS-approved tax favored account you can use to pay for eligible medical and dependent care expenses not covered by insurance. Funds are set aside from your salary pre-tax.

How an FSA Works

Flexible Spending Accounts (FSAs) let you set aside money pre-tax to pay for eligible healthcare and/or dependent care expenses. You can enroll in either a Healthcare FSA, a Dependent Care FSA or both.

It is possible to realize tax savings with an FSA, but keep in mind that any unused FSA dollars at the end of the year will be forfeited according to IRS rules. So you need to plan ahead to make the most of an FSA. To calculate potential FSA tax savings, visit myfbmc.com/ccsf and click on the tax calculator. You should also consult your tax adviser or the IRS for information about your specific situation.

The following information provides an overview of your FSA benefits. To get details about this benefit contact FBMC, the FSA administrator, or visit myfbmc.com/ccsf. You can also request an FSA resource guide from HSS Member Services.

Healthcare FSA

- Set aside from $120 up to $5,000 pre-tax per household in a Plan Year. Depending on the annual amount that you elect, deductions of between $5.00 and $208.33 will be taken twice monthly from your paycheck in Plan Year 2010-2011. No deduction is taken from the 3rd paycheck in any month.
- Submit reimbursement forms to FBMC for eligible out-of-pocket expenses, including healthcare deductibles, prescriptions and select over-the-counter medical items.
- When you sign-up for a Healthcare FSA the total annual amount you designate becomes available for eligible healthcare expenses at the start of the Plan Year. You do not have to wait for your contributions to accumulate in your account.

Dependent Care FSA

- Set aside from $120 up to $5,000 pre-tax per household in a Plan Year. Deductions will be taken twice monthly from your paycheck throughout Plan Year 2010-2011. Depending on the annual amount that you specify, deductions of between $5.00 and $208.33 will be taken twice monthly from your paycheck in 2010-2011. No deduction is taken from the 3rd paycheck in any month.
- If you have a stay-at-home spouse, you may not enroll in the Dependent Care FSA.
- Submit reimbursement forms to FBMC for eligible out-of-pocket expenses, such as certified day care, pre-school and elder care for your qualifying dependents. (Children in day care must be under age 13.)
- The funds for a Dependent Care FSA are available after they have been deducted from your paycheck and received by FBMC. Unlike a Healthcare FSA, the entire annual amount for a Dependent Care FSA is not available at the start of the Plan Year.

Estimating FSA Expenses

Before enrolling in an FSA make sure to work out a detailed estimate of the eligible expenses you are likely to incur for the year ahead. Budget conservatively. Any unreimbursed funds are forfeited at the end of the Plan Year and cannot be returned to you. You can find FSA calculation tools on myfbmc.com. For a list of eligible expenses, the definition of qualfying family members and how to submit reimbursements, visit myfbmc.com/ccsf. FSA expenses must meet Internal Revenue Service (IRS) eligibility criteria. Please refer to IRS publications502 and 503: irs.gov/pub/irs-pdf/p502.pdf and irs.gov/pub/irs-pdf/p503.pdf.

FSA Administrator FBMC

The Flexible Spending Account benefit is administered by FBMC. Visit myfbmc.com/ccsf or call (800) 865-3262 on Monday-Friday, 4 AM-7 PM Pacific Time to get detailed information about your FSA.

- Learn more about FSAs.
- View a list of eligible expenses.
- Review the status of your reimbursement requests.
- Review your account balance and available funds.
- Download reimbursement forms.

Direct Deposit Reimbursement

To apply for direct reimbursement, complete the Direct Deposit Enrollment Form on myfbmc.com/ccsf or contact FBMC Customer Service at (800) 865-3262. Processing your direct deposit enrollment may take four to six weeks.

- After your reimbursement claim is reviewed and approved, reimbursement funds are deposited into your checking or savings account.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement. (However, you will receive notification that the claim has been processed.)

Annual Re-enrollment Required

You must re-enroll in your Flexible Spending Accounts every Open Enrollment period.

No Transferring Between Accounts

You cannot transfer money between Healthcare and Dependent Care Flexible Spending Accounts.

Changing Contribution Amounts

You cannot change the amounts you contribute to your Flexible Spending Account(s) during the Plan Year unless the change is consistent with a qualifying change in family status. See pages 32-33.

Termination or Retirement

If your employment ends during the Plan Year, you can only file claims for FSA eligible expenses that were incurred while you were actively employed.

Leaves of Absence

During an unpaid leave of absence, no deductions can be taken for an FSA if paychecks are not issued. Also, FSA claims cannot be filed for qualifying expenses incurred while an employee was on leave. Accounts that remain unpaid for three consecutive pay periods will be terminated retroactively to the first missed pay period. You may only reinstate your Flexible Spending Account upon your return to work by contacting HSS and requesting a reinstatement. At that time you have the option of making up the contributions that were missed due to your leave.

Eligibility Time Period

Expenses for services incurred before July 1, 2010 or after June 30, 2011 are not eligible for reimbursement. For example, a medical expense incurred in June 2010 isn't eligible for reimbursement from a Healthcare Flexible Spending Account because your account is not open until July 1, 2010.

Avoid Forfeiting FSA Contributions

FSA expenses for Plan Year 2010-11 must be incurred between July 1, 2010 and June 30, 2011. The IRS requires that claims be postmarked no later than September 30, 2011. Per IRS rules, you will forfeit any money left in your FSA(s) after the end of this claim filing period. There are no exceptions.

FSAs & Federal Health Care Reform

Allowed contribution amounts, eligible expenses and other information listed here may change as a result of pending federal health care legislation. For details, contact FBMC at (800) 865-3262.

New Hires, Promotions & Returning Employees

Municipal Executive Benefits

Eligible Muncipal Executives Association members and unrepresented City managers may enroll in medical, dental, vision and Flexible Spending Account benefits. Instead of subsidized employee premium contributions for dependents, these managers are also allocated flexible credits that can be applied to a variety of pre- and post-tax benefits, including employee premium contributions. For this year's flexible credit value and credit allocation options, see pages 24-25 of this guide. To allocate flexible credits new hires must meet in person with a representative from EBS at the HSS office within 30 days of the date of hire or promotion. Appointments are available on Wednesdays. Call HSS at (415) 554-1750 to schedule your EBS appointment.

New or Rehired Employees Must Enroll Within 30 Days

Eligible new and rehired employees must enroll in an HSS medical and/or dental plan within 30 calendar days of their appointment date. If you do not enroll within this 30 day period, you must wait until the next Open Enrollment or when you have a qualifying change in family status. (See pages 32-33 for details about qualifying events.)

How To Enroll

To enroll in an HSS medical and/or dental plan, new or returning employees must submit a completed enrollment application and any required eligibility documentation to HSS. For a checklist of required eligibility documentation see page 31. Please submit copies of eligibility documentation – not your original documents. If you choose not to hand in an application during your orientation, applications and supporting documentation can be mailed, faxed or dropped off at the HSS office withing 30 calendar days of your official start date. See page 44 for HSS phone, fax and address details. You must also meet with EBS to allocate your flexible credits. If you do not meet with EBS, your flexible credits will be automatically distributed. (See page 24 for more information.)

When Coverage Begins

Coverage starts on the first day of the month following your eligibility date, provided you have submitted the required application and eligibility documentation to HSS within the 30 day deadline. Contact HSS Member Services at (415) 554-1750 if you have questions about when your coverage will begin.

Responsibility For Employee Premium Contributions

Healthcare contributions are taken from active employee paychecks twice monthly. No healthcare contribution deductions are taken from any third paycheck in a month. You should carefully check your paycheck stub to verify that the correct healthcare contribution is being deducted. If the deduction is incorrect or does not appear on your paycheck stub, contact HSS Member Services. You are responsible for all required healthcare contributions, whether they are deducted from your paycheck or not.

Healthcare Contribution Calendar

Payroll Deductions Taken Twice Monthly

Employee premium contributions are deducted from paychecks twice monthly–a total of 24 payroll deductions per year. (There will be no employee premium contribution deductions taken from the third paychecks of the month – August 31, 2010 and March 29, 2011.) All required employee premium contributions for any monthly coverage period must be paid in full for a member and any dependents to be covered during that period.

2010 Pay Dates	Coverage Period	2011 Pay Dates	Coverage Period
July 6, 2010 July 20, 2010	July 1-30, 2010	January 4, 2011 January 18, 2011	January 1-31, 2011
August 3, 2010 August 17, 2010	August 1-31, 2010	February 1, 2011 February 15, 2011	February 1-28, 2011
September 14, 2010 September 28, 2010	September 1-30, 2010	March 1, 2011 March 15, 2011	March 1-31, 2011
October 12, 2010 October 26, 2010	October 1-31, 2010	April 12, 2011 April 26, 2011	April 1-30, 2011
November 9, 2010 November 23, 2010	November 1-30, 2010	May 10, 2011 May 24, 2011	May 1-31, 2011
December 7, 2010 December 21, 2010	December 1-31, 2010	June 7, 2011 June 21, 2011	June 1-30, 2011

If you take an approved leave of absence you may need to pay HSS directly for the employee premium contributions that were being deducted from your paycheck. Your employee premium contributions are due no later than the pay dates listed above. If you decide to continue healthcare coverage during a leave you can sign-up for easy, secure Auto-Pay. With Auto-Pay your required employee premium contribution can be charged automatically to your VISA or Mastercard while you are on leave. If you fail to make a required employee premium contribution within 45 days from the date it is due, your coverage will be terminated and you will not be permitted to re-enroll in coverage until Open Enrollment in spring 2011, with coverage to begin July 1, 2011. See page 34 for more information about HSS healthcare coverage and leaves of absence.

Eligibility

These rules govern which employees can become members of the Health Service System and which member dependents may be eligible for coverage.

Member Eligibility

The following are eligible to participate in the Health Service System as defined in San Francisco Administrative Code Section 16.700:

- City and County Employees
  - All permanent employees of the City and County of San Francisco whose normal work week is not less than 20 hours;
  - All regularly scheduled provisional employees of the City and County of San Francisco whose normal work week is not less than 20 hours;
  - All other employees of the City and County of San Francisco, including temporary exempt "as needed" employees, who have worked more than 1040 hours in any consecutive 12 month period and whose normal work week is not less than 20 hours.
- Elected Officials
- All members of designated boards and commissions during their time in service to the City and County of San Francisco as defined in San Francisco Administrative Code Section 16.700(c).
- All officers and employees as determined eligible by the governing bodies of the San Francisco Transportation Authority, San Francisco Parking Authority, San Francisco Redevelopment Agency, Treasure Island Development Authority, San Francisco Superior Court and any other employees as determined eligible by ordinance.

Dependent Eligibility

Spouse/Domestic Partner

A member's legal spouse or domestic partner may be eligible for HSS healthcare coverage. Proof of marriage or registered domestic partnership is required. Enrollment must occur within 30 days of the date of marriage or partnership; in that case coverage begins on the first day of the month after the completed application is filed with HSS. Legal spouses and partners can also be added to coverage during annual Open Enrollment.

Natural Children, Step-Children, Adopted Children

To be eligible, a natural child, step-child or adopted child of a member, or a member's spouse or domestic partner, must meet all of the following criteria:

1. Child must be under 25 years of age.
2. Child must be unmarried.
3. Child cannot be working full time.
4. Child must reside in the member's home (except for full-time college students and children living with a divorced spouse).
5. Child must be declared as an exemption on the member's federal income tax return. (Some exceptions are allowed in the event of a member's divorce or dissolution if natural or adopted child is declared by a former spouse/partner.)

Legal Guardianships and Other Children Residing in a Member's Home (IRS Exemption)

Children under legal guardianship and other children residing full time in a member's home may be eligible if they meet all of the following criteria:

1. Child must be under 19 years of age.
2. Child must be unmarried.
3. Child cannot be working full time.
4. Child must reside in the member's home and be economically dependent on the member.
5. Child must be declared as an exemption on the member's federal income tax return. A copy of the member's federal income tax return must be submitted to HSS annually.

Court Ordered Children

Children covered by a National Medical Support Notice (Court Order) can be covered to age 19.

Disabled Children

Children who are disabled may be covered beyond the age limits stated previously provided all of the following criteria are met:

1. Child was continuously enrolled in an HSS administered medical plan from age 19-25.
2. Child was enrolled in an HSS administered medical plan on the child's 19th birthday and continuously for one year prior to age 19.
3. Child sustained a qualifying disability prior to reaching age 25.
4. Child is incapable of self-sustaining employment due to the qualifying disability.
5. Child is unmarried.
6. Child permanently resides with the member.
7. Child is economically dependent on the member for all of his or her economic support and is declared on member's IRS tax return.
8. Member submits required documentation of the disability at least 60 days prior to the child's attainment of age 25 and every year thereafter.

Social Security Numbers Required

Members and dependents who do not have a Social Security number on file at HSS risk having benefits terminated. Social Security numbers for newborns must be provided within 6 months of the date of birth. Visit www.ssa.gov/pubs/10023.html for more information. If your dependent does not qualify for a Social Security number, please contact HSS at (415) 554-1750.

Financial Penalties for Failing to Disenroll Ineligible Dependents

It is the responsibility of the member to notify HSS within 30 days and cancel coverage for a dependent who becomes ineligible due to divorce, dissolution of partnership, age or any other reason. If a member fails to notify HSS when an enrolled dependent becomes ineligible, the member may be held responsible for payment of the costs of all health premiums and any medical service provided, dating back to the date of ineligibility.

REQUIRED ELIGIBILITY DOCUMENTATION

	EVIDENCE OF HIRE	BENEFIT AUTH. FORM	MARRIAGE CERTIFICATE	DOMESTIC PARTNER REG.	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	COURT ORDER	INCOME TAX RETURN	MEDICAL EVIDENCE	SOCIAL SECURITY #
Employee: Permanent/Provisional	■									■
Employee: Temporary/Exempt		■								■
Spouse			■							■
Domestic Partner				■						■
Child: Natural					■					■
Child: Step-child			■	■	■			■		■
Child: Domestic Partner				■	■					■
Child: Adopted						■				■
Child: Legal Guardianship							■			■
Child: IRS Exemption					■			■		■
Child: Court Ordered							■			■
Child: Disabled								■	■	■

Changing Benefit Elections

You can only change your benefits elections during annual Open Enrollment, unless there is a qualifying change in your family status.

Marriage or Domestic Partnership

To enroll a new spouse or domestic partner and his or her eligible child(ren) in your HSS healthcare coverage you must submit a completed HSS enrollment application and a copy of your marriage license or certificate of domestic partnership and birth certificates for the child(ren) to the Health Service System **within 30 days** from the date of your marriage or certification of domestic partnership. (HSS also requires a Social Security number for all enrolled members.) Coverage for your spouse or domestic partner and his or her eligible children is effective on the first day of the month following the submission of the required application and documentation within the 30 day time frame. If you do not complete the enrollment process **within 30 days** from the date of your marriage or certification of domestic partnership, you must wait until the next annual Open Enrollment period to add your new family members.

Domestic Partner Tax Alert: In keeping with IRS requirements, when you elect healthcare coverage for your domestic partner or same sex spouse (and any dependent(s) of that partner or spouse), you will be taxed by the federal government on the value of the City and County of San Francisco's contribution toward the cost of healthcare coverage for these dependents. This is referred to as imputed income and may increase your net pay. The State of California does not tax these benefits.

Birth or Adoption

Coverage for your newborn child is effective on the child's date of birth provided you meet the deadline and documentation requirements stated below. Coverage for your newly adopted child is effective on the date the child is placed with you provided you meet the deadline and documentation requirements stated below. To enroll your newborn or newly adopted child you must submit a completed HSS enrollment application and a copy of the birth certificate or adoption documentation **within 30 days** from the date of birth or placement for adoption. If you do not complete the enrollment process **within 30 days** from the date of birth or placement for adoption of a new child, you must wait until the next annual Open Enrollment period. A Social Security number must be provided within 6 months of the date of birth or adoption, or your child's coverage may be terminated. Visit ssa.gov/pubs/10023.html for more information.

Loss of Other Healthcare Coverage

Employees and eligible dependents who lose other coverage may be enrolled by submitting a completed HSS enrollment application and proof of the loss of coverage (for yourself and/or your dependents) **within 30 days** from the date other coverage terminates. Coverage for your dependent will be effective on the first day of the coverage period following the date HSS receives a completed HSS enrollment application, provided you meet the 30 day deadline and eligibility documentation requirements. There may be a break in healthcare coverage between the date that other coverage terminates and the date that HSS coverage begins. If you do not complete the enrollment process **within 30 days** from the date that other coverage terminates, you must wait until the next annual Open Enrollment period to add your dependent.

Divorce, Separation and Dissolution of Partnership

Termination of HSS health coverage for your ex-spouse/domestic partner due to divorce, legal

separation or dissolution of domestic partnership is required by law. You must submit a completed HSS enrollment application and a copy of your divorce decree, legal separation documents or dissolution of domestic partnership documents **within 30 days** from the date of divorce, legal separation or dissolution of domestic partnership. Coverage for your ex-spouse/domestic partner will terminate on the last day of the coverage period in which the divorce, legal separation or dissolution of domestic partnership occurred, provided you meet the deadline and documentation requirements stated above. If you do not complete the coverage termination process **within 30 days** from the date of your divorce, legal separation or dissolution, coverage for your ex-spouse/domestic partner will terminate on the last day of the coverage period in which you submit a completed HSS enrollment application and required documentation. You will be responsible for paying all required premium contributions up to the coverage termination date. Failure to notify HSS of a divorce or dissolution of partnership may result in financial penalties equal to the total cost of premiums and services provided for the ineligible ex-partner or ex-spouse covered on your plan.

Obtaining Other Coverage

You may terminate healthcare coverage for yourself and/or your enrolled dependents if you or they become eligible for other healthcare coverage. Submit a completed HSS enrollment application and proof of other healthcare coverage enrollment (for yourself and/or your dependents) **within 30 days** from the date of your enrollment in another healthcare plan. Your HSS healthcare coverage will terminate on the last day of the coverage period in which HSS receives a completed HSS enrollment application provided you meet the deadline and documentation requirements stated above. Please note that there may be an overlap of healthcare coverage between the date your other coverage begins and the date your HSS coverage terminates. You are responsible for paying all required contributions up to the termination date of your HSS healthcare coverage. If you do not complete the coverage termination process **within 30 days** from the date of your enrollment in another healthcare plan, you must wait until the next annual Open Enrollment.

Death of a Dependent

If an enrolled dependent dies, you should notify HSS as soon as possible and submit a copy of the death certificate **within 30 days** from the date of death. Coverage for your deceased dependent will terminate at midnight on the date of the dependent's death.

Death of a Member

In the event of a member's death, surviving dependent(s) or another designee should contact HSS **within 30 days** from the date of the member's death to obtain information about eligibility for survivor healthcare benefits.

Whenever you update your coverage because of a qualifying change in family status, carefully check your paycheck to verify that the correct employee premium contribution is being deducted. If the deduction is incorrect or doesn't appear on your paycheck, contact HSS Member Services at (415) 554-1750. If an employee premium contribution is not made within 30 days from the date it is due, coverage will be terminated and you will not be permitted to re-enroll until Open Enrollment in spring 2011, with coverage to begin July 1, 2011.

Ineligible Dependent Penalty

Members who fail to notify HSS when an enrolled dependent becomes ineligible are responsible for paying the total cost of premiums and services provided back to the original date of the dependent's ineligibility.

Leaves of Absence & Your Benefits

Type of Leave	Eligibility	Your Responsibilities
Family and Medical Leave (FMLA) Worker's Compensation Leave Family Care Leave	If you notify HSS before your leave begins, you may be eligible to continue (or waive) your healthcare coverage for the duration of your approved leave of absence. You may have additional rights under an approved FMLA leave. Contact your departmental personnel representative for details.	1. Notify your department's personnel officer. They will provide HSS with important information about your leave. 2. Contact HSS before leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits. 3. Contact HSS 30 days before returning to work to request that your premium contributions be returned to active status.
Personal Leave Following Family Care Leave	If you have been on an approved Family Care Leave and elect to extend your leave period as a Personal Leave, you may be eligible to continue (or waive) your healthcare coverage for the duration of your approved Personal Leave, if: - The reason for the Personal Leave is the same as the reason for the prior Family Care Leave. - Your required employee premium contribution payments, if any, are current - You notify HSS before your leave begins.	1. Notify your department's personnel office. They will provide HSS with important information about your leave. 2. Contact HSS before leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits. 3. Contact HSS 30 days before returning to work to request that your premium contributions be returned to active status.
Educational Leave Personal Leave Leave for Employment as an Employee Organization Officer or Representative	If you notify HSS before your leave begins, you may be eligible to continue (or waive) your healthcare coverage for the duration of your approved leave of absence.	1. Notify your department's personnel office. They will provide HSS with important information about your leave. 2. Contact HSS before leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits. 3. If your leave lasts beyond 12 weeks, you must pay the total cost of medical and dental coverage for yourself and any covered dependents. This includes your employee premium contribution amount plus the City and County of San Francisco's contribution. Contact HSS for details. 3. Contact HSS 30 days before returning to work to request that your premium contributions be returned to active status.

Approaching Retirement

Contact HSS three months before your retirement date for important information about continuing healthcare coverage after you leave active employment.

Transitioning to Retirement

If you choose to retire, the transition of your health benefits from active employment to retiree status does not happen automatically. You must elect to continue healthcare coverage in retirement by completing and submitting the required retiree enrollment forms and supporting documents to the Health Service System. You should contact HSS Member Services at (415) 554-1750 and speak to a Benefits Analyst three months before your retirement date so that we can advise you about the actions you must take to enroll in retiree healthcare coverage. You must notify HSS of your retirement even if you are not planning to elect HSS coverage at the time of your retirement date.

SFERS Pre-Retirement Seminars

If you are a member of SFERS (San Francisco Employee Retirement System) you may be eligible to attend a pre-retirement planning seminar with speakers from SFERS, HSS and Social Security. You must pay a fee and register in advance. Contact SFERS at (415) 487-7000.

Eligibility

The San Francisco City Charter requires that to be eligible for retiree healthcare coverage the retiree must have been a member of the Health Service System at some time during their active employment. Other restrictions may apply.

Health Benefit Contributions For Retirees

If you choose to continue your medical and/or dental coverage through the Health Service System after you retire your required premium contribution may be higher than your active employee contributions. Costs will depend on your plan choice, the number of dependents covered on your plan and your Medicare status. Also note, if you choose to take a lump sum pension distribution, your retiree healthcare premium contributions will be unsubsidized and full cost. As a retired member you will also be required to pay for dental coverage. Premium contributions are deducted from your pension check. If required monthly contributions are greater than the total amount of your pension check you must contact HSS to make payment arrangements. Premium contribution rates are updated every Plan Year. If you have questions call HSS Member Services at (415) 554-1750.

Medicare & Your HSS Benefits

All retired members and their dependent family members who have reached the age of 65 are required to apply for Medicare Parts A and B. Failure to enroll in Medicare as required if you are age 65 or older and retired can result in penalties and limitations in your healthcare coverage.

Active Employees Over Age 65

If you are over age 65 and an active employee of the City & County of San Francisco you have the option, but are not required, to enroll in premium free Medicare Part A. Upon retirement, you must enroll in both Medicare Part A and Part B.

This information offers a brief overview of important topics related to healthcare benefits in retirement. It does not include all the information you may need to know. If you are planning to retire, please contact HSS Member Services at (415) 554-1750 for guidance about your individual situation.

Holdover & COBRA Health Coverage

If you are placed on an eligible holdover roster you may be eligible to continue your enrollment in HSS health coverage.
If you are not on a holdover list, you may be eligible for COBRA.

Employees with Holdover Rights

Employees placed on an eligible holdover roster may be eligible to continue HSS administered medical, dental and vision coverage for themselves and their covered dependents. HSS holdover eligibility requirements include:

1. Employees must certify, on an annual basis, that they are unable to obtain healthcare coverage from another source.
2. Premium contributions must be paid. (Rates are subject to increase each Plan Year).
3. COBRA may be available when holdover benefits have been exhausted.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted in 1986 offers employees and their covered dependents the opportunity to elect a temporary extension of healthcare coverage in certain instances where coverage would otherwise end.

Employees with No Holdover Rights

Under COBRA, employees with no holdover rights, or whose holdover rights have ended, may be eligible to continue medical, dental and vision coverage for themselves and eligible dependents. Active employee healthcare coverage ends on the last day of the coverage period in which employment terminates.

COBRA Qualifying Events

Employees have the right to elect continuation of coverage if healthcare coverage is lost due to any of the following qualifying events:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct.
- Reduction in number of hours of employment that makes the employee ineligible for healthcare coverage.

Covered spouses or domestic partners have the right to elect continuation coverage if healthcare coverage is lost due to any of the following qualifying events:

- Voluntary or involuntary termination of the employee's employment for reasons other than gross misconduct.
- Divorce, legal separation or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

Covered dependent children have the right to elect continuation coverage if healthcare coverage is lost due to any of the following qualifying events:

- Loss of dependent child status under the plan rules.
- Voluntary or involuntary termination of the employee's employment for reasons other than gross misconduct.
- Reduction in number of hours of employment that makes the employee ineligible for healthcare coverage.
- Parent's divorce, legal separation or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

Dependents dropped from coverage during Open Enrollment are not eligible for COBRA.

COBRA Notification & Time Limits for COBRA Elections

When a qualifying event occurs, the COBRA Administrator FBMC will notify you of the opportunity to elect COBRA coverage. You have 60 days from the date of this notification to complete enrollment for yourself and any dependents who were covered on your employer-provided plan at the time of your termination. The coverage will be retroactive to the date of the COBRA qualifying event so you will not have a break in your healthcare coverage. While covered under COBRA, you have 30 days from the date of the qualifying event to add any newly eligible dependent (spouse, domestic partner, newborn or adopted child) to your COBRA coverage.

Duration of COBRA Continuation Coverage

COBRA beneficiaries are generally eligible for group coverage for a maximum of 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to be covered for up to 36 months.

In the case of a dependent losing coverage (divorce or aging out of a plan) the employee or dependent must notify the COBRA Administrator within 30 days of the qualifying event.

Employees who are disabled on the date of their qualifying event or at any time during the first 60 days of continuation coverage, are eligible for 29 months of COBRA coverage. The cost will be 150% of the group rate, beginning in the 19th month of coverage.

Termination of COBRA Continuation Coverage

COBRA coverage will end if:

- You obtain coverage under another group plan if no pre-existing condition limitation under the new plan applies to the covered individual.
- You fail to pay the premium required under the plan within the grace period.
- The applicable COBRA period ends.

Paying for COBRA

Once COBRA continuation coverage is elected, it is the responsibility of the covered individual(s) to remit the required healthcare premium payments directly to the COBRA Administrator.

COBRA Continuation Coverage Alternatives

As an alternative to COBRA continuation coverage, you may be able to purchase individual health coverage, if available, from your healthcare plan or other insurers. Contact plans directly for details and costs.

All employees and dependents who were covered under a Health Service System administered health plan are entitled to a certificate that will show evidence of prior health coverage. This certificate of prior coverage may assist the employee and/or dependents in purchasing new health coverage that excludes pre-existing medical conditions.

Recent Federal Legislation & COBRA

This information does not reflect all the changes to COBRA resulting from the 2009 federal American Recovery and Reinvestment Act and subsequent federal legislation that temporarily expands and/or subsidizes COBRA coverage for some participants. For more information about how federal legislation may impact your COBRA benefits contact FBMC.

COBRA Questions?

For questions about COBRA continuation coverage contact the COBRA Administrator FBMC at (800) 342-8017.

Glossary of Healthcare Terms

Brand Name Drug
FDA approved prescription drugs marketed under a specific brand name by the manufacturer.

COBRA
This federal law allows employees and dependents who are enrolled in an employer-sponsored plan to temporarily continue receiving health coverage after certain qualifying events like termination or divorce.

Co-Insurance
Co-insurance refers to the amount of money that a member is required to pay for healthcare services, after any required deductible has been paid. Co-insurance is specified by a percentage. For example, the employee pays 15% toward the charges for a covered service and the insurance company pays 85%.

Co-payment
The flat fee you pay each time you utilize a healthcare service or fill a prescription.

Deductible
The specified amount you must pay for healthcare in a Plan Year before the plan will begin to cover all or a portion of your costs. Some plans have no deductible.

Dependent
A family member or other individual who meets the eligibility criteria established by HSS for enrollment in an available healthcare plan.

Dental Maintenance Organization (DMO)
An entity that provides dental services through a closed network. DMO participants can only obtain service from network dentists and typically need pre-approval from a primary care dentist before seeing a specialist.

Effective Date
The actual date your healthcare coverage is scheduled to begin. You are not covered until the effective date.

Employee Premium Contribution
The amount you must pay toward the cost of your health plan premiums.

Employer Premium Contribution
The amount your employer pays toward the cost of your health plan premiums.

Explanation of Benefits (EOB)
Written, formal statement sent to PPO enrollees that lists the services provided and costs billed by their health plan.

Evidence of Coverage (EOC)
The Evidence of Coverage gives details about the benefits and exclusions of your health plan and explains how to get the care you need. The EOC is an important legal document and is your contract with your Plan provider. It explains your rights, benefits and responsibilities as a member of your Plan. It also explains the Plan Providers responsibilities to you. The EOC should be reviewed in conjunction with this benefits guide because the guide does not list every service, limitation or exclusion of your plan. EOCs are available on myhss.org.

Exclusions
The list of conditions, injuries, or treatments that are not covered under your health insurance policy. Exclusions can be found in your plan document called the Evidence of Coverage.

Formulary
A comprehensive list of prescription drugs that are covered by a medical plan. The formulary is designed to assist physicians in prescribing drugs that are medically necessary and cost effective for members. The formulary is updated periodically.

Flexible Spending Account (FSA)
An account that you contribute to pre-tax and reimburses you for qualified healthcare and dependent care expenses.

Generic Drug
FDA approved prescription drugs that are a therapeutic equivalent to the Brand Name Drug, contain the same active ingredient as the Brand Name Drug, and cost less than the Brand Name Drug equivalent.

Health Maintenance Organization (HMO)
An entity that provides health services through a closed network. Unlike PPOs, HMOs either employ their own staff or contract with groups of providers. HMO participants typically need pre-approval from a primary care provider before seeing a specialist.

Imputed Income
Federal IRS regulations require that the value of non-cash compensation, such as an employer's contribution to the health insurance of an employee's domestic partner, be reported as taxable income on federal returns.

In-Network
These providers or facilities are contracted with a health plan to provide services at pre-negotiated fees. Enrollees usually pay less when using an in-network provider, because these networks provide services at lower cost to the insurance companies with which they have contracts.

Medical Group
An independent group of physicians and other healthcare providers that contract to provide services to members of an HMO.

Lifetime Maximum Benefit
The maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime.

Non-Formulary Drug
A drug that is not on the insurer's list of approved medications. Non-formulary drugs can usually only be prescribed if a doctor's special request is submitted and approved.

Open Enrollment
The period of time when you can change your health benefit elections without a qualifying event.

Out-of-Network
Providers or healthcare facilities which are not in your health plan's provider network. Some plans do not cover Out-of-Network service costs. Others charge a higher co-payment for this type of service.

Out-of-Pocket Costs
The actual costs you pay–including premiums, co-payments and deductibles–for your healthcare.

Out-Of-Pocket Maximum
The amount of money that an individual must pay out of their own pocket, before an insurance company will pay 100% for an individual's healthcare expenses.

Out-of-Area
A location outside the geographic area covered by a health plan's network of providers.

Preferred Provider Organization (PPO)
An entity that contracts to provide healthcare services to subscribers at negotiated, often discounted, rates.

Premium
The amount charged by an insurer for healthcare coverage. This cost is usually shared by employer and employee.

Primary Care Physician (PCP)
The doctor (or nurse practitioner) who coordinates all your medical care and treatment. HMOs require all plan participants be assigned to a PCP.

Qualifying Event
A change in your life situation that allows you to make a change in your benefit elections outside Open Enrollment. This includes marriage, domestic partnership, separation, divorce or dissolution of partnership, the birth or adoption of a child and the death of a dependent as well as obtaining or losing other healthcare coverage.

Reasonable and Customary Charges
The average fee charged by a particular type of healthcare practitioner within a geographic area. Often used by medical plans as the amount of money they will pay for a specific test or procedure. If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference.

Privacy Policy

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Use and Disclosure of Health Information

The City & County of San Francisco Health Service System (the "Health Service System") may use your health information, that is, information that constitutes Protected Health Information (PHI) as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Health Service System has established a policy to guard against unnecessary disclosure of your health information.

The following is a summary of the circumstances under which your healthcare information may be used and disclosed.

To Make or Obtain Payment

The Health Service System may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the City Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate the payment of benefits.

To Conduct Healthcare Operations

The Health Service System may use or disclose health information for its own operations to facilitate administration and as necessary to provide coverage and services to all Health Service System members. A health care operation includes:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guidelines and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of City Health Plan, including customer service and resolution of internal grievances.

For example, the Health Service System may use your health information to conduct case management, quality improvement and utilization review and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment Alternatives

The Health Service System may use and disclose your health information to tell you about or recommend treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services

The Health Service System may use or disclose your health information to provide you information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Actuaries

The Health Service System may provide summary health information to the plan sponsor; may solicit premium bids from other health plans; or may modify, amend or terminate the plan.

When Legally Required

The Health Service System will disclose your health information when it is required to do so by any federal, state or local law or by court order.

To Conduct Health Oversight Activities

The Health Service System may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Health Service System, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings

As permitted or required by state law, the Health Service System may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Health Service System makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information, or to obtain your consent for disclosure.

For Law Enforcement Purposes

As permitted or required by state law, the Health Service System may disclose your health information to a law enforcement official for certain law enforcement purposes, but not limited to, if the Health Service System has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety

The Health Service System may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Health Service System, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions

In certain circumstances, federal regulations may require the Health Service System to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, Medicare and other similar entities and correctional institutions and inmates.

For Worker's Compensation

The Health Service System may release your health information to the extent necessary to comply with Workers' Compensation laws or similar programs.

Authorization To Use Or Disclose Health Information

Other than as related above, the Health Service System will not disclose your health information other than with your written authorization. If you authorize the Health Service System to use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights With Respect to Your Health Information

You have the following rights regarding your health information that the Health Service System maintains:

Right to Request Restrictions

You may request restrictions on certain uses and disclosures of your health information. You have the right to request in writing a limit on the Health Service System's disclosure of your health information to someone involved in the payment of your care. However, the Health Service System is not required to agree to your request.

Right to Receive Confidential Communications

You have the right to request in writing that the Health Service System communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Health Service System only communicate with you at a certain telephone number or by email. The Health Service System will make every attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information

You have the right to inspect and copy your health information. A written request to inspect and copy records containing your health information must be sent to the Health Service System. If you request a copy of your health information, the Health Service System may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information

If you believe that your health information records are inaccurate or incomplete, you may request in writing that the Health Service System amend the records. The request may be made as long as the information is maintained by the Health Service System. The Health Service System may deny the request if it does not include a reason to support the amendment. The request may be denied if your health information records were not created by the Health Service System, if the health information you are requesting to amend is not part of the Health Service System's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy or if the Health Service System determines the records containing your health information are accurate and complete.

Right to an Accounting

You have the right to request in writing a list of Health Service System disclosures of your health information for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Health Service System will provide you one accounting during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. If applicable, the Health Service System will inform you in advance of the fee.

Right to a Paper Copy of this Notice

You have a right to request in writing and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. You also may obtain a copy of the current version of this notice from the Health Service System website at www.myhss.org.

Duties of the Health Plan

The Health Service System is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Health Service System reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Health Service System changes its policies and procedures, a revised copy of this Notice will be provided to you within 60 days of the change. You have the right to express complaints to the Health Service System and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Health Service System should be made in writing. The Health Service System encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Written Authorizations & Requests

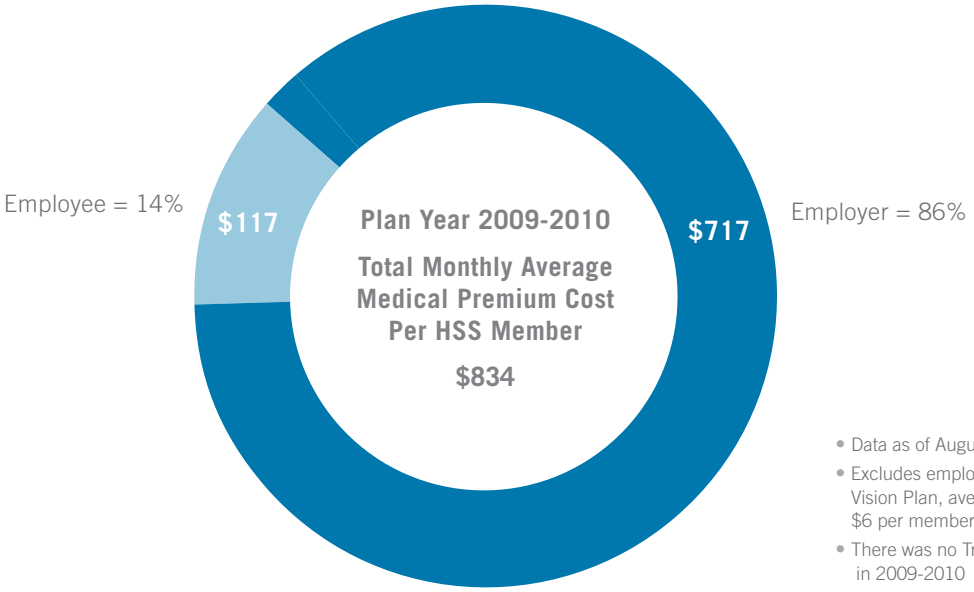
Any written authorizations or requests regarding your health information as described above should be directed to:

Health Service System
1145 Market Street, Suite 200
San Francisco, CA 94103
Attn: Privacy Officer

Effective Date

Original Effective Date: April 14, 2003
Revised January 1, 2010

Medical Plan Costs



The San Francisco Health Service System provides medical and other non-pension benefits to City and County employees, City College and San Francisco Unified School District employees, San Francisco Superior Court employees, and retirees and dependents. The Health Service System is responsible for designing healthcare benefits, selecting and managing plan providers and determining some aspects of benefit eligibility to supplement the eligibility rules contained in the City Charter and applicable ordinances. In addition, the Health Service System is responsible for administration of health benefits, including maintaining employee membership and financial accounting records. Additional financial information, including audited Health Service System Trust Fund Financial Statements, is available online at myhss.org.

Twice Monthly Medical Plan Rates

EMPLOYEE PREMIUM CONTRIBUTION RATES FOR PLAN YEAR JULY 1, 2010 - JUNE 30, 2011

CITY HEALTH PLAN PPO

	CCSF	Superior Court
Employee Only	226.91	463.33
Employee + 1 Dependent	669.58	906.00
Employee + 2 or More Dependents	1,034.96	1,271.38

BLUE SHIELD OF CALIFORNIA HMO

	CCSF	Superior Court
Employee Only	60.44	296.87
Employee + 1 Dependent	356.81	593.23
Employee + 2 or More Dependents	602.78	839.20

KAISER HMO

	CCSF	Superior Court
Employee Only	4.42	240.85
Employee + 1 Dependent	244.75	481.17
Employee + 2 or More Dependents	444.22	680.65

See pages 24-25 for information about flexible credits which can be allocated toward employee premium contributions.

All medical plan rates published in this Benefits Guide are subject to the final approval of the San Francisco Board of Supervisors.

The employee premium contribution rates may change subject to union contract negotiations.

Key Contact Information

HEALTH SERVICE SYSTEM

Member Services
1145 Market Street, Suite 200
San Francisco, CA 94103
(Civic Center Station between 7th & 8th)
Tel: (415) 554-1750
(800) 541-2266 (outside 415)
Fax: (415) 554-1721
www.myhss.org

EAP (Employee Assistance Program)
Tel: (800) 795-2351

MEDICAL PLANS

City Health Plan (UnitedHealthcare)
Tel: (866) 282-0125
Group No. 705287
www.myuhc.com

Blue Shield of California
Tel: (800) 642-6155
Group No. H11054
www.blueshieldca.com/sfhss

Kaiser Foundation Health Plan, Inc.
Tel: (800) 464-4000
Group No. 888
my.kp.org/ca/cityandcountyofsanfrancisco

VISION PLAN

Vision Service Plan (VSP)
Tel: (800) 877-7195
Group No.12145878
www.vsp.com

FLEXIBLE SPENDING ACCOUNTS

Fringe Benefits Management Company (FBMC)
Tel: (800) 342-8017
Customer Service M-F 4AM-7PM
(800) 865-3262
Automated Interactive Benefits 24 hrs
www.myfbmc.com/ccsf

DENTAL PLANS

Delta Dental
Tel: (800) 765-6003
Group Number 9502-0003
www.deltadentalins.com/ccsf

DeltaCare USA Dental
Tel: (800) 422-4234
Group Number 01797-0001
www.deltadentalins.com/ccsf

Pacific Union Dental
Tel: (800) 999-3367
(925) 363-6000
Group Number 705287-0046
www.myuhcdental.com

FLEXIBLE CREDITS

Employee Benefit Specialists (EBS)
Tel: (800) 229-7683
www.ebsbenefits.com

COBRA

Fringe Benefits Management Company (FBMC)
Tel: (800) 342-8017
www.myfbmc.com

CITY AGENCIES

Department of Human Resources
Tel: (415) 557-4800
www.sfgov.org/dhr

San Francisco Employees' Retirement System (SFERS)
Tel: (415) 487-7000
www.sfers.org