Retired Employees
2014 Health Benefits

Health Service System
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

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What's New 2014

There are no changes to HSS health plans or covered services in 2014.

2014 Health Benefits

Medical, Dental and Vision. Good news! There are no changes to health plans or covered health services in 2014.

- Same medical, dental and vision plans
- Same covered medical, dental and vision services
- No increase in co-pays, deductibles or out-of-pocket maximums.

Premiums Change in 2014. Health premium contributions will change, effective January 1, 2014. See pages 43–47.

Change of Address–Notify HSS. HSS can terminate health benefits if a retiree's home address and contact information are incorrect and HSS has not been able to contact the retiree for one year.

City Health Plan Optum Rx. As of September 2013, prescription benefits for all City Health Plan enrollees moved to Optum Rx. City Health Plan participants who are enrolled in Medicare now have a separate ID card for prescription benefits, in addition to their UnitedHdealthcare medical ID card.

2013 Open Enrollment

Open Enrollment takes place October 1-31, 2013. Any benefit election changes are effective January 1, 2014. During Open Enrollment you can:

- Change medical and/or dental plan elections.
- Add or drop dependents from medical and/or dental coverage.

Applications Due October 31. Completed Open Enrollment applications must be received at HSS by 5:30 PM, October 31, 2013. Deliver Open Enrollment applications in person, by mail or by fax. The HSS fax number is (415) 554-1721.

Medical, Dental and Vision Elections Roll Forward. If you do not make changes during Open Enrollment, your current plan choices and eligible dependents you have covered will remain the same in 2014.

No COBRA Coverage. Remember, dependents dropped during Open Enrollment are not eligible for COBRA continuation coverage.

Same-Sex Married Couples. As of June 26, 2013 employer premium contributions for any legally married same-sex spouse enrolled on an HSS health plan are not taxable.

New 2014 Wellness Benefits

New HSS Wellness Center. The HSS Wellness Center will open in the first quarter of 2014 on the ground floor of 1145 Market Street. The center will provide classes and workshops to assist retirees and employees in maintaining good health. Get updates on myhss.org.

Free Lunchtime Workshops. EAP provides free behavioral health workshops focused on improving well being. Retirees are invited to attend. To learn more visit myhss.org or call 1-800-795-2351.

Smoking Cessation Programs. Retirees in the Bay area can join a free, 8-week workshop facilitated by an EAP counselor. To learn more or get dates on the next 8-week smoking cessation program call 1-800-795-2351.

Gym Discounts. Get the latest updates on gyms and fitness clubs that offer retirees and employees discounted memberships. Visit myhss.org.

Healthcare Reform 2014

Healthcare Reform 2014

Healthcare reform will provide more Americans with access to health insurance. Provisions which take effect in 2014 include:

Guaranteed Issue. Health plans cannot deny coverage or charge an individual higher premiums due to pre-existing condition or disability.

Individual Mandate. Almost all American citizens over the age of 18 must have health insurance or pay a federal penalty.

Individual Penalties. Federal penalties for individuals without health insurance will be phased in. In 2014, the penalty per person will be 1% of annual income, or $95, whichever is greater. By 2016, the penalty will be 2.5% of income or $695, whichever is greater.

Health Insurance Marketplaces. By October 1, 2013 each state will open a marketplace (or exchange) where individuals can purchase health insurance, with coverage to begin January 2014. However, any individual who is eligible for Medicare, Veteran's Administration benefits or Medicaid cannot purchase health insurance through a state marketplace.

Individual Subsidies. Some individuals who are eligible to purchase health insurance through a state marketplace may qualify for a federal tax credit and/or cost sharing to help pay for premiums and other costs, based on household income. HSS retiree members and dependents do not qualify for federal tax credits because they have access to subsidized coverage through an employer.

Medicaid Expansion. Healthcare reform provides for expansion of Medicaid for many people across the country who are at or below federal poverty levels and aren't currently eligible. In California Medicaid is called Medi-Cal.

The Patient Protection and Affordable Care Act is a federal law passed in 2010 to provide insurance for more Americans.

Covered California

Covered California is the state insurance marketplace created under federal healthcare reform.

Waiving Employer Subsidy. Retirees and dependents who live in California and are not eligible for Medicare or other government-sponsored insurance may be eligible to purchase insurance through Covered California. But review your options carefully. An individual eligible for HSS medical coverage who purchases insurance through Covered California:

- must be disenrolled from HSS medical coverage
- gives up the substantial premium contribution your employer pays for your HSS medical coverage
- may not be eligible for federal subsidy

Also, HSS will not be able to assist members or dependents enrolled in a Covered California plan or help resolve any plan grievances.

Ineligible For HSS Coverage. Individuals who are not eligible for HSS coverage, such as a child over age 26, a grandchild, or an ex-spouse or domestic partner, should consider obtaining health insurance through Covered California.

COVERED CALIFORNIA

Enrolling in Covered California. Covered California starts enrollment in October 2013, with coverage to begin January 2014.

Contact Covered California. For information about Covered California health plans, call 1-888-975-1142 or visit coveredca.com.

Outside California

Every state will have its own health insurance marketplace. If you reside outside of California, use these resources to learn about the health insurance marketplace in your state:
Phone: 1-800-318-2596
Website: healthcare.gov.

Medical Plan Options

These medical plan options are available to retired HSS members and eligible dependents in 2014.

Health Maintenance Organization (HMO)

An HMO is a medical plan that offers benefits through a network of participating physicians, hospitals, and other healthcare providers. For non-emergency care, you access service through your PCP (Primary Care Physician) or an affiliated urgent care center. You do not pay a deductible before accessing benefits, and co-pays at the point of service are set at a flat, contracted rate. This helps to limit out-of-pocket costs. HSS offers retirees the following HMO plans:

Blue Shield of California HMO	
65 Plus (Medicare Advantage)	Medicare-eligible retirees and dependents who live in a 65 Plus service area must enroll in 65 Plus
Access+ (Medicare Coordinated)	Only available to Medicare-eligible retirees and dependents not living in a 65 Plus service area
Access+ (No Medicare)	Only available to retirees and dependents who are not eligible for Medicare

Kaiser Permanente HMO	
Senior Advantage (Medicare Advantage)	Medicare-eligible retirees and dependents must enroll in Senior Advantage
Traditional Plan (No Medicare)	Only available to retirees and dependents not eligible for Medicare

Preferred Provider Organization (PPO)

With City Health Plan PPO, administered by UnitedHealthcare, you are not assigned a primary care physician, so you have more responsibility for coordinating care. You pay an annual deductible. You also usually pay a coinsurance percentage when you access service. Compared to an HMO, a PPO usually has higher out-of-pocket costs.

In-Network Providers

Your out-of-pocket expenses will be less when you receive service from a provider or hospital within the UnitedHealthcare network. If you choose out-of-network service, you will usually pay higher costs.

Out-of-Network Providers

If you seek care outside the network, the plan generally pays benefits at a lower level. The amount in excess of the eligible expense could be significant, and this amount does not apply to your out-of-pocket maximum. You should ask any non-network provider about billed charges before you receive care. (Non-network emergency services are covered at the network level.)

Out-of-Area Providers

If you live in a zip code where UnitedHealthcare in-network providers are not available, the percentage of costs you are responsible for is equivalent to what is paid for an in-network provider. To find out if you live in an out-of-area zip code, contact UnitedHealthcare. Your out-of-area status can change as doctors join (or leave) the network.

Note: You cannot change your plan because a doctor, hospital or medical group chooses not to participate in your plan. Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2014. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. EOCs are available on myhss.org.

Choosing Your Medical Plan

PPO vs. HMO

	Blue Shield HMO	Kaiser Permanente HMO	City Health Plan PPO
Must I select a PCP (Primary Care Physician)?	You can choose your PCP after you enroll, or Blue Shield will assign.	You can choose your PCP after you enroll, or Kaiser will assign.	No PCP– you have more responsibility for coordinating care.
Am I required to use the plan's contracted network of service providers?	Yes. Services must be received from the contracted network.	Yes. Services must be received from Kaiser.	No, but out-of-network providers will cost you more.
Is my access to hospitals and specialists determined by my PCP's medical group?	Yes. PCP referrals to specialists and hospitals will be determined by medical group affiliation.	Yes. All services must be received from a Kaiser facility.	No
Do I have to pay an annual deductible?	No	No	Yes
Do I have to file claim forms?	No	No	Only if you use an out-of-network provider.

Blue Shield of California: Choosing a Primary Care Physician (PCP) and Medical Group

If you enroll in Blue Shield, carefully review your choice of Primary Care Physician. Your PCP affects the network of providers and hospitals that will provide your care. You can change your PCP by calling Blue Shield at 1-800-642-6155.

Blue Shield Provider Networks in San Francisco

Medical Group	Affiliated Hospitals
Hill Physicians hillphysicians.com	UCSF Medical Center
	St. Francis Memorial Hospital
	St. Mary's Medical Center
Brown & Toland brownandtoland.com	California Pacific Medical Center (CPMC)
Chinese Community Health Care Association cchca.com	Chinese Hospital

For more information about Blue Shield physicians and medical groups, including PCPs outside of San Francisco, visit: blueshieldca.com/fap/.

Medical Plan Service Areas

To enroll in Blue Shield or Kaiser, you must reside in a zip code serviced by the plan.

County	Blue Shield of California			Kaiser	County	Blue Shield of California			Kaiser
	65 Plus (MEDICARE ADVANTAGE)	Access+ (MEDICARE COORDINATED)	Access+ (NO MEDICARE)	All Plans (SR. ADV & TRADITIONAL)		65 Plus (MEDICARE ADVANTAGE)	Access+ (MEDICARE COORDINATED)	Access+ (NO MEDICARE)	All Plans (SR. ADV & TRADITIONAL)
Alameda		■	■	■	Orange	■		■	■
Alpine					Placer		❍	❍	❍
Amador				❍	Plumas				
Butte		■	■		Riverside	❍	■	■	❍
Calaveras					Sacramento	■		■	■
Colusa					San Benito				
Contra Costa	■		■	■	San Bernardino	❍	❍	❍	❍
Del Norte					San Diego	■	❍	❍	❍
El Dorado		❍	❍	❍	San Francisco	■		■	■
Fresno	❍	■	■	❍	San Joaquin	■		■	■
Glenn					San Luis Obispo	■		■	
Humboldt					San Mateo	■		■	■
Imperial	❍	■	■	❍	Santa Barbara			■	
Inyo					Santa Clara	■		■	■
Kern	❍	❍	❍	❍	Santa Cruz	■		■	
Kings		■	■	❍	Shasta				
Lake					Sierra				
Lassen					Siskiyou				
Los Angeles	■		■	❍	Solano		■	■	■
Madera	❍	■	■	❍	Sonoma		■	■	❍
Marin		■	■	■	Stanislaus		■	■	■
Mariposa				❍	Sutter				❍
Mendocino					Tehama				
Merced		■	■		Trinity				
Modoc					Tulare		■	■	❍
Mono					Tuolumne				
Monterey					Ventura	■		■	❍
Napa				❍	Yolo		■	■	❍
Nevada	❍	❍	❍		Yuba				❍

■ = Available in this county. ❍ = Available in some zip codes. City Health Plan does not have service area limits.

If you are enrolled in Medicare, the Blue Shield of California Access+ plan is only available to you if you do not live in a service area covered by Blue Shield of California 65 Plus. Contact the plan to confirm service areas. See page 48 for plan contact information.

If you move out of a service area covered by your plan, you must elect a different 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.

Tips to Improve Care and Reduce Costs

1 Mail Order Prescriptions

Mail order prescriptions can save you 30-50% on co-pays, plus there's no trip to the pharmacy. In most cases you can easily order prescription refills by phone or online. Register and get started.

Blue Shield

Call Blue Shield's online pharmacy partner PrimeMail: 1-866-346-7200

-or-

Log into blueshieldca.com, select the Pharmacy tab, then click Mail-Service Prescriptions.

Kaiser

Call 1-888-218-6245

-or-

Sign up online: kp.org/rxrefill

City Health Plan

Call Optum Rx:
Medicare 1-888-556-6648
No Medicare 1-866-282-0125

-or-

Sign up online: optumrx.org

2 Nurseline 24/7

Not sure if you need to see a doctor? Need health advice after hours? There is no cost to call a nurseline.

Blue Shield

Blue Shield NurseHelp: 1-877-304-0504

-or-

Brown & Toland patients Ask-A-Nurse: 1-855-423-9974

Kaiser

San Francisco Nurse Advice: 415-833-2200

-or-

Other locations call: 1-800-464-4000

City Health Plan

UnitedHealthcare Nurseline: 1-800-846-4678

3 Urgent Care Centers

Need to see a doctor on weekends or during evening hours? If it's not a life-threatening emergency, consider visiting an urgent care center instead of your local hospital emergency room. That will mean a shorter wait time and lower co-pay for you.

Kaiser patients in San Francisco call 415-833-2200. For other locations call 1-800-642-6155.

Brown & Toland patients in San Francisco call 415-876-5762 or visit brownandtoland.com/afterhourscare.

Hill Physicians patients in San Francisco call 415-353-2602. For other locations visit hillphysicians.com.

4 Chronic Condition? Follow Your Doctor's Orders

Based on national data, only 50% of patients follow doctor's orders for managing chronic conditions. If you have a diagnosis of diabetes, heart disease, arthritis, HIV or another chronic condition, make sure you follow your doctor's advice about medication, diet and exercise. This could help you avoid serious complications and hospitalization.

Retired Employees with Medicare Parts A & B

	blue of california **Blue Shield 65 Plus** Medicare Advantage HMO	blue of california **Access+ (Medicare Coordinated)** HMO only for enrollees living outside the 65 Plus plan service area	KAISER PERMANENTE® **Senior Advantage** Medicare Advantage HMO	CITY HEALTH PLAN **UnitedHealthcare Choice Plus PPO and UnitedHealthcare MedicareRx for Groups (PDP)** In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
DEDUCTIBLES						
Deductible and out-of-pocket maximum	No deductible Annual out-of-pocket maximum $6,700/individual	No deductible Annual out-of-pocket maximum $2,000/individual; $4,000 family	No deductible Annual out-of-pocket maximum $1,500/person; $3,000 family	$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $3,750/person	$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $7,500/person	$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $3,750/person
PREVENTIVE CARE						
Routine physical	No charge limits apply; see EOC	No charge	No charge	100% covered no deductible	50% covered after deductible	100% covered no deductible
Immunizations and inoculations	No charge limits apply; see EOC	No charge	No charge	100% covered no deductible	100% covered no deductible	100% covered no deductible
Routine gynecologic wellness exam	No charge limits apply; see EOC	No charge	No charge	100% covered no deductible	50% covered after deductible	100% covered no deductible
Routine pre/post-partum care	No charge visits limited; see EOC	No charge visits limited; see EOC	No charge visits limited; see EOC	85% covered after deductible	50% covered after deductible	85% covered after deductible
PHYSICIAN & OTHER PROVIDER CARE						
Office and home visits	$25 co-pay	$25 co-pay	$20 co-pay	85% covered after deductible	50% covered after deductible	85% covered after deductible
Hospital visits	No charge	No charge	No charge	85% covered after deductible	50% covered after deductible	85% covered after deductible
PRESCRIPTION DRUGS						
Pharmacy: generic drugs	$10 co-pay 30-day supply	$10 co-pay 30-day supply	$5 co-pay 30-day supply	$5 co-pay 30-day supply	Not covered except emergency service; see EOC	$5 co-pay 30-day supply
Pharmacy: brand-name drugs	$25 co-pay 30-day supply	$25 co-pay 30-day supply	$15 co-pay 30-day supply	$20 co-pay 30-day supply	Not covered except emergency service; see EOC	$20 co-pay 30-day supply
Pharmacy: non-formulary drugs non-preferred brands	$50 co-pay 30-day supply	$50 co-pay 30-day supply	Physician authorized only	$45 co-pay 30-day supply	Not covered except emergency service; see EOC	$45 co-pay 30-day supply
Mail order: generic drugs	$20 co-pay 90-day supply	$20 co-pay 90-day supply	$10 co-pay 100-day supply	$10 co-pay 90-day supply	Not covered except emergency service; see EOC	$10 co-pay 90-day supply
Mail order: brand-name drugs	$50 co-pay 90-day supply	$50 co-pay 90-day supply	$30 co-pay 100-day supply	$40 co-pay 90-day supply	Not covered except emergency service; see EOC	$40 co-pay 90-day supply
Mail order: non-formulary drugs non-preferred brands	$100 co-pay 90-day supply	$100 co-pay 90-day supply	Physician authorized only	$90 co-pay 90-day supply	Not covered except emergency service; see EOC	$90 co-pay 90-day supply
Specialty drugs	20% up to $100 co-pay 30-day supply	20% up to $100 co-pay 30-day supply	Same as all above	Same as all above limitations apply; see EOC	Not covered except emergency service; see EOC	Same as all above limitations apply; see EOC
OUTPATIENT SERVICES						
Diagnostic x-ray and laboratory	No charge	No charge	No charge	85% covered after deductible	50% covered after deductible	85% covered after deductible
EMERGENCY						
Hospital emergency room	$50 co-pay	$100 co-pay	$50 co-pay waive if hospitalized	85% covered after deductible; 50% after deductible if non-emergency	85% covered after deductible; 50% after deductible if non-emergency	85% covered after deductible; 50% after deductible if non-emergency
Urgent care facility	$25 co-pay within CA	$25 co-pay within CA	$20 co-pay	85% covered after deductible	50% covered after deductible	85% covered after deductible
HOSPITAL/SURGERY						
Inpatient	$200 co-pay per admission	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible	50% covered after deductible	85% covered after deductible
Outpatient	$100 co-pay per surgery	$100 co-pay per surgery	$35 co-pay	85% covered after deductible	50% covered after deductible	85% covered after deductible

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

Note: Out-of-pocket maximum does not include premium contributions. City Health Plan co-insurance amounts shown reflect what will be covered after Medicare has paid its portion of a claim.
*In some cases, billed amounts may exceed reasonable and customary fees, resulting in higher out-of-pocket costs.

Retired Employees with Medicare Parts A & B

	blue of california **Blue Shield 65 Plus** Medicare Advantage HMO	blue of california **Access+ (Medicare Coordinated)** HMO only for enrollees living outside Blue Shield 65 Plus service area	KAISER PERMANENTE® **Senior Advantage** Medicare Advantage HMO	**CITY HEALTH PLAN** **UnitedHealthcare Choice Plus PPO and UnitedHealthcare MedicareRx for Groups (PDP)** In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
REHABILITATIVE						
Physical/Occupational therapy	$25 co-pay	$25 co-pay	$20 co-pay authorization req.	85% covered after deductible; 60 visits/year	50% covered after deductible; 60 visits/year	85% covered after deductible; 60 visits/year
Acupuncture	$15 co-pay 30 visits/year; ASH network only	$15 co-pay 30 visits/year; ASH network only	Not covered	50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year
Chiropractic	$15 co-pay 30 visits/year; ASH network only	$15 co-pay 30 visits/year; ASH network only	$15 co-pay 30 visits/year; ASH network only	50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year
TRANSGENDER						
Office visits and outpatient surgery	Co-pays apply authorization req. $75,000 lifetime max	Co-pays apply authorization req. $75,000 lifetime max	Co-pays apply authorization req. $75,000 lifetime max	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
DURABLE MEDICAL EQUIPMENT						
Home medical equipment	No charge when medically necessary	No charge when medically necessary	No charge as authorized by PCP according to formulary	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary	No charge when medically necessary	85% covered after deductible; when medically necessary; notification required	50% covered after deductible; when medically necessary; notification required	85% covered after deductible; when medically necessary; notification required
Hearing aids	Eval. no charge $2,500 max per set every 36 months	Eval. no charge $2,500 max per set every 36 months	Eval. no charge 1 aid/ear every 36 months, up to $2,500 each	85% covered after deductible; 1 aid/ear every 36 months, up to $2,500 each	50% covered after deductible; 1 aid/ear every 36 months, up to $2,500 each	85% covered after deductible; 1 aid/ear every 36 months, up to $2,500 each
MENTAL HEALTH						
Inpatient hospitalization	$200 co-pay per admission	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Outpatient treatment	$25 co-pay non-severe and severe	$25 co-pay non-severe and severe	$10 co-pay group $20 co-pay individual	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
CHEMICAL DEPENDENCY						
Inpatient detox	$200 co-pay per admission	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification
Residential rehabilitation	$200 co-pay per admission	$200 co-pay per admission	$100 co-pay per admission; physician approval required	85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
EXTENDED & END-OF-LIFE CARE						
Skilled nursing facility	No charge up to 100 days/year	No charge up to 100 days/year	No charge up to 100 days per year	85% covered after deductible; up to 120 days/year; notification required; custodial care not covered	50% covered after deductible; up to 120 days/year; notification required; custodial care not covered	85% covered after deductible; up to 120 days/year; notification required; custodial care not covered
Hospice	No charge authorization required	No charge authorization required	No charge when medically necessary	85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
OUTSIDE SERVICE AREA						
Care access and limitations	Urgent care $50 co-pay; guest membership benefits for college student dependents in some areas.	Urgent care $50 co-pay; guest membership benefits for college student dependents in some areas.	Only emergency services before condition permits transfer to nearest Kaiser facility. Co-pays apply.	Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. Out-of-area coverage percentages and co-pays apply.

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

City Health Plan co-insurance amounts shown reflect what will be covered after Medicare has paid its portion of a claim.

*In some cases, billed amounts may exceed reasonable and customary fees, resulting in higher out-of-pocket costs.

Retired Employees Not Eligible for Medicare

	blue of california Access+ HMO	KAISER PERMANENTE® Traditional Plan HMO	CITY HEALTH PLAN UnitedHealthcare Choice Plus PPO In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
DEDUCTIBLES					
Deductible and out-of-pocket maximum	No deductible Annual out-of-pocket maximum $2,000/individual; $4,000 family	No deductible Annual out-of-pocket maximum $1,500/person; $3,000 family	$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $3,750/person	$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $7,500/person	$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $3,750/person
PREVENTIVE CARE					
Routine physical	No charge	No charge	100% covered no deductible	50% covered after deductible	100% covered no deductible
Immunizations and inoculations	No charge	No charge	100% covered no deductible	50% covered after deductible	100% covered no deductible
Routine gynecologic wellness exam	No charge	No charge	100% covered no deductible	50% covered after deductible	100% covered no deductible
Routine pre/post-partum care	No charge visits limited; see EOC	No charge visits limited; see EOC	85% covered after deductible	50% covered after deductible	85% covered after deductible
PHYSICIAN & OTHER PROVIDER CARE					
Office and home visits	$25 co-pay	$20 co-pay	85% covered after deductible	50% covered after deductible	85% covered after deductible
Hospital visits	No charge	No charge	85% covered after deductible	50% covered after deductible	85% covered after deductible
PRESCRIPTION DRUGS					
Pharmacy: generic drugs	$10 co-pay 30-day supply	$5 co-pay 30-day supply	$5 co-pay 30-day supply	50% covered after $5 co-pay; 30-day supply	$5 co-pay 30-day supply
Pharmacy: brand-name drugs	$25 co-pay 30-day supply	$15 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
Pharmacy: non-formulary drugs	$50 co-pay 30-day supply	Physician authorized only	$45 co-pay 30-day supply	50% covered after $45 co-pay; 30-day supply	$45 co-pay 30-day supply
Mail order: generic drugs	$20 co-pay 90-day supply	$10 co-pay 100-day supply	$10 co-pay 90-day supply	Not covered	$10 co-pay 90-day supply
Mail order: brand-name drugs	$50 co-pay 90-day supply	$30 co-pay 100-day supply	$40 co-pay 90-day supply	Not covered	$40 co-pay 90-day supply
Mail order: non-formulary drugs	$100 co-pay 90-day supply	Physician authorized only	$90 co-pay 90-day supply	Not covered	$90 co-pay 90-day supply
Specialty drugs	20% up to $100 co-pay 30-day supply	Same as all above	Same as 30-day supply above limitations apply; see EOC	Same as 30-day supply above limitations apply; see EOC	Same as 30-day supply above limitations apply; see EOC
OUTPATIENT SERVICES					
Diagnostic x-ray and laboratory	No charge	No charge	85% covered after deductible	50% covered after deductible; prior notification	85% covered after deductible
EMERGENCY					
Hospital emergency room	$100 co-pay waived if hospitalized	$100 co-pay waived if hospitalized	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
Urgent care facility	$25 co-pay within CA service area	$20 co-pay	85% covered after deductible	50% covered after deductible	85% covered after deductible
HOSPITAL/SURGERY					
Inpatient	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Outpatient	$100 co-pay per surgery	$35 co-pay	85% covered after deductible	50% covered after deductible	85% covered after deductible

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

Note: Out-of-pocket maximum does not include premium contributions.

*In some cases, billed amounts may exceed reasonable and customary fees, resulting in higher out-of-pocket costs.

Retired Employees Not Eligible for Medicare

	blue of california Access+ HMO	KAISER PERMANENTE® Traditional Plan HMO	CITY HEALTH PLAN UnitedHealthcare Choice Plus PPO In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
REHABILITATIVE					
Physical/Occupational therapy	$25 co-pay	$20 co-pay authorization req.	85% covered after deductible; 60 visits/year	50% covered after deductible; 60 visits/year	85% covered after deductible; 60 visits/year
Acupuncture	$15 co-pay 30 visits/year; ASH network only	Not covered	50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year
Chiropractic	$15 co-pay 30 visits/year; ASH network only	$15 co-pay 30 visits/year; ASH network only	50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000max/year	50% covered after deductible; $1,000 max/year
TRANSGENDER					
Office visits and outpatient surgery	Co-pays apply authorization required	Co-pays apply authorization required	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
DURABLE MEDICAL EQUIPMENT					
Home medical equipment	No charge	No charge as authorized by PCP according to formulary	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary	85% covered after deductible; when medically necessary; notification required	50% covered after deductible; when medically necessary; notification required	85% covered after deductible; when medically necessary; notification required
Hearing aids	Evaluation no charge $2,500 max per set every 36 months	Evaluation no charge 1 aid/ear every 36 months, up to $2,500 each	85% covered after deductible; 1 aid/ear every 36 months, up to $2,500 each	50% covered after deductible; 1 aid/ear every 36 months, up to $2,500 each	85% covered after deductible; 1 aid/ear every 36 months, up to $2,500 each
MENTAL HEALTH					
Inpatient hospitalization	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Outpatient treatment	$25 co-pay non-severe and severe	$10 co-pay group $20 co-pay individual	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
CHEMICAL DEPENDENCY					
Inpatient detox	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Residential rehabilitation	$200 co-pay per admission	$100 co-pay per admission; physician approval required	85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
EXTENDED & END-OF-LIFE CARE					
Skilled nursing facility	No charge up to 100 days/year	No charge up to 100 days/year	85% covered after deductible; up to 120 days/year; notification required; custodial care not covered	50% covered after deductible; up to 120 days/year; notification required; custodial care not covered	85% covered after deductible; up to 120 days/year; notification required; custodial care not covered
Hospice	No charge authorization required	No charge when medically necessary	85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
OUTSIDE SERVICE AREA					
Care access and limitations	Urgent care $50 co-pay; guest membership benefits for college student dependents in some areas.	Only emergency services before condition permits transfer to nearest Kaiser facility. Co-pays apply.	Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. Out-of-area coverage percentages and co-pays apply.

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

*In some cases, billed amounts may exceed reasonable and customary fees, resulting in higher out-of-pocket costs.

Medicare and Your HSS Benefits

HSS rules require all eligible retiree members and their dependents to enroll in Medicare Part A and Part B.

Medicare Basics

Medicare is a federal health insurance program administered by the Centers for Medicare & Medicaid Services (CMS) for people age 65 years or older, under age 65 with Social Security-qualified disabilities, and people of any age with end-stage renal disease (permanent kidney failure requiring dialysis or transplant). The different parts of Medicare help cover specific services:

- Medicare Part A: Hospital Insurance
- Medicare Part B: Medical Insurance
- Medicare Part D: Prescription Drug Coverage

All eligible retired members and covered eligible dependents must enroll in Medicare Part A and Part B. **Failure by a member or dependent to enroll in Medicare by required deadlines will result in a change in or loss of medical coverage.**

If you are receiving Social Security benefits, the Social Security Administration will notify you about Medicare eligibility due to reaching age 65 or meeting disability qualifications. If you are not currently receiving Social Security benefits, it is your responsibility to contact the Social Security Administration to apply for Medicare prior to your 65th birthday or when you become disabled. Failure to do so could result in penalties being assessed by the Social Security Administration and the Health Service System. If you have a Social Security-qualified disability or end-stage renal disease, you should contact the Social Security Administration immediately to apply for Medicare.

An HSS member and his or her covered dependents may not all be eligible for Medicare. In that case, the individual with Medicare will be covered under the insurer's plan for Medicare enrollees, and any individuals without Medicare will be covered by the same insurer's non-Medicare plan.

Medicare Part A: Hospital Insurance

HSS rules require all retired members and dependents to enroll in premium-free Medicare Part A as soon as they are eligible. Most people do not pay a premium for Part A because they made sufficient contributions via payroll taxes while working. Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals and skilled nursing facilities (but not custodial or long-term care). It also helps cover hospice care and some home health care. (Beneficiaries must meet certain conditions to qualify for these benefits.)

You are eligible for premium-free Medicare Part A if you are age 65 or older and have worked and contributed to Social Security for at least 10 years (40 quarters). You may also qualify for Medicare Part A through a current, former, or deceased spouse. If you are under age 65 and have end-stage renal disease (permanent kidney failure requiring dialysis or transplant) or a Social Security-qualified disability, you may also qualify for Medicare Part A. If you are under age 65 with a qualifying disability, Medicare coverage generally begins 24 to 30 months following eligibility. If you have questions about your eligibility for premium-free Medicare Part A, contact Social Security.

What if I'm not eligible for premium-free Medicare Part A?

If you are not eligible for premium-free Medicare Part A, you are not required to enroll in Medicare Part A. But you must submit a statement to HSS from the Social Security Administration verifying that you are not eligible for premium-free Medicare Part A. HSS still requires you to enroll in Medicare Part B, even if you are not eligible for Medicare Part A.

Medicare Part B: Medical Insurance

HSS rules require that all retired members and their dependents enroll in Medicare Part B as soon as they are eligible. Medicare Part B helps cover the cost of doctors' services and outpatient medical services. Most people pay a monthly premium to the federal government for Part B. The Medicare Part B monthly premium, which is based on your income per CMS regulations, is usually deducted from your Social Security check. If your income falls after you enroll in Part B, you may be eligible for a Part B premium reduction. For information on Medicare Part B premiums, or to request a Part B premium reduction, contact the Social Security Administration. If you do not enroll in Medicare Part B when you first become eligible, your Part B premium will be higher and penalties may be charged when you do enroll. This higher premium and/or penalty will continue for the entire time you are enrolled in Medicare.

What if either I or my dependent did not enroll in Medicare Part A and/or Part B when originally eligible?

If you or a dependent were eligible at age 65, or sooner due to a disability, but did not enroll in Medicare Part A and/or Part B, the Social Security Administration may assess a late enrollment penalty for each year in which the individual was eligible but failed to enroll. HSS members and dependents are required to enroll in Medicare in accordance with HSS rules, even if they are paying a federal penalty for late Medicare enrollment.

What is the HSS penalty for not enrolling in Medicare Part A and B when eligible, or failing to pay Medicare premiums after enrollment?

For eligible HSS members without Medicare, existing HSS medical plan coverage will be terminated and the member will be automatically enrolled in City Health Plan 20. For eligible dependents without Medicare, HSS medical coverage will be terminated. Full HSS coverage for a member or dependent may be reinstated the beginning of the next available coverage period after HSS receives proof of Medicare enrollment.

What is the City Health Plan 20 for Medicare-eligible HSS members who do not enroll in Medicare, or who fail to pay Medicare premiums?

An HSS member who does not enroll in Medicare when eligible, or who loses Medicare coverage due to non-payment of Medicare premiums, will lose existing HSS medical coverage and be automatically enrolled in City Health Plan 20. City Health Plan 20 significantly increases premium and out-of-pocket costs. Under City Health Plan 20, you will be responsible for paying the 80% that Medicare would have paid for a covered service, plus any amounts above usual and customary fees. In addition, under City Health Plan 20, yearly out-of-pocket limits increase to $10,950.

Medicare and Your HSS Benefits

Do not enroll in any individual Medicare Part D plan. Doing so could result in the termination of your HSS medical coverage.

Medicare Part D: Prescription Drug Insurance

There are two types of Medicare Part D prescription plans: individual and group. Individual Part D prescription drug coverage is purchased directly by an individual from an insurer or pharmacy. HSS members should not enroll in any individual Medicare Part D plan. HSS members are automat-ically enrolled in group Medicare Part D when they enroll in any medical plan offered through HSS.
HSS medical plans offer enhanced group Medicare Part D coverage.

Should either I or my dependents enroll in Medicare Part D?

Do not enroll in an individual Medicare Part D prescription drug plan. If you are Medicare-eligible, HSS retiree medical coverage includes enhanced group Medicare Part D prescription drug coverage. You may receive marketing information from private insurers, pharmacies and other entities trying to sell individual Medicare Part D prescription coverage plans. Ignore these solicitations.

As of January 2011, Medicare enrollees with income exceeding certain thresholds are charged a Part D premium, also known as the Income Related Monthly Adjusted Amount (IRMAA). In most cases, this Part D premium will be deducted from the individual's Social Security check. For information on Medicare Part D premiums, please contact the Social Security Administration at 1-800-772-1213.

Is there a premium for Medicare Part D?

Most people are not required to pay a Medicare Part D premium. However, if your income exceeds a certain threshold, you may be required to pay a Part D premium to the Social Security Administration. If you are charged a Part D premium, but your income changes and falls below the threshold, contact the Social Security Administration to request an adjustment.

What is the HSS penalty if either I or my dependent fails to pay a Part D premium to the Social Security Administration?

Failure to pay a required Part D premium will result in Part D coverage being terminated by the Social Security Administration. Consequently, HSS medical coverage must also be terminated. HSS members who have lost Part D eligibility due to lack of payment will be automatically enrolled in City Health Plan 20. (See page 17.) Dependents' coverage will end. Full HSS medical coverage for a member or dependent may be reinstated the beginning of the next available coverage period after HSS receives proof of Medicare Part D reinstatement.

Medicare Enrollment Is Optional for Retirees Residing Permanently Outside the U.S.

Retiree members and dependents who reside outside the United States must either enroll in City Health Plan PPO or waive HSS coverage.

Medicare enrollment is not required for retired members residing outside the United States. However, healthcare services within the United States will not be covered for foreign residents who are not enrolled in Medicare. Members who choose this option must complete an HSS form certifying that they are waiving Medicare enrollment and waiving health coverage within the United States.

If you are a foreign resident, please contact the Social Security Administration for more information before choosing to disenroll from Medicare. The federal government may charge you significant penalties if you disenroll from Medicare now but decide to re-enroll in the future.

For retiree members and dependents who reside outside the United States, are enrolled in City Health Plan and continue Medicare enrollment, services within the United States will be covered and HSS premium contribution rates for Medicare enrollees will apply. Services outside the United States will be covered by the City Health Plan PPO at the out-of-area reimbursement rate.

What are the financial penalties I can incur if I move out of my plan's service area but fail to notify HSS of my new address?

If you move out of your plan's service area, you must notify HSS before your move and enroll in a different HSS plan that offers coverage at your new address. Medicare does not allow retroactive termination of coverage. If you do not contact HSS and enroll in a different plan before your move, you can be held responsible for paying the costs of any medical services that you or your dependents obtained after you moved out of your plan's service area.

Medicare Contact Information

The Social Security Administration administers Medicare eligibility, Medicare enrollment and Medicare premium payments.

Social Security Administration (SSA)
1-800-772-1213
TTY 1-800-325-0778
Seven days a week; 7:00AM to 8:00PM
ssa.gov

The Centers for Medicaid & Medicare Services (CMS) administers Medicare benefits.

Centers for Medicaid & Medicare Services
1-800-633-4227
TTY 1-877-486-2048
Seven days a week; 7:00AM to 8:00PM
medicare.gov

This guide offers general information and does not include everything you need to know about Medicare, including updates to federal law affecting Medicare that may have taken effect after this guide was published.

Blue Shield Enrollees and Medicare

Blue Shield of California HMO Enrollees and Medicare

Upon Medicare enrollment, Blue Shield members who reside in a Blue Shield 65 Plus plan zip code are enrolled in Blue Shield 65 Plus, which is a Medicare Advantage plan. With this plan, the enrollee assigns Medicare benefits to Blue Shield. Medicare is the primary payer for medical services and Blue Shield coordinates payments. Be aware that doctors and hospitals in the Blue Shield 65 Plus plan network may be different than the Blue Shield plan which covers members without Medicare. Blue Shield 65 Plus includes enhanced group Medicare Part D prescription drug coverage. Members in this plan must obtain service within the 65 Plus plan network, and they use one Blue Shield medical ID card for doctor, hospital and pharmacy services.

Some Medicare-eligible Blue Shield enrollees reside in a service area not covered by Blue Shield 65 Plus. These members and their dependents will be enrolled in the Blue Shield Access+ (Medicare Coordinated) HMO and will not assign Medicare benefits to Blue Shield. In this case, both the Medicare card and Blue Shield Access+ ID card must be presented to the service provider. For services obtained outside the Blue Shield Access+ HMO network, Medicare benefits will apply. Medicare will pay its share and the enrollee will be responsible for costs not covered by Medicare. Blue Shield Access+ (Medicare Coordinated) HMO includes Blue Shield Medicare Rx, which is enhanced group Medicare Part D prescription drug coverage.

Blue Shield and Medicare: At-A-Glance	
Medicare Eligibility	A retiree member or dependent enrolled in Blue Shield is eligible for Medicare at age 65, or due to a Social Security-qualified disability or end-stage renal disease.
Plan Enrollment	Medicare-eligible Blue Shield enrollees who live in the 65 Plus service area can only be covered by the 65 Plus Medicare Advantage HMO. The 65 Plus provider network is different than the Access+ network.
	Medicare-eligible Blue Shield enrollees living outside the 65 Plus service area can only be covered by the Blue Shield Access+ (Medicare Coordinated) HMO.
Medicare Part A	Retiree member and dependents must enroll in premium-free Medicare Part A if eligible.
Medicare Part B	Retiree member and dependents must enroll Medicare Part B when eligible and pay premiums to maintain continuous enrollment.
Group Medicare Part D	Blue Shield retiree plans include enhanced employer group Medicare Part D. Do not enroll in any individual Part D plan. Federal Part D premiums must be paid, if required, based on income.

If you change plans, make sure Medicare assignment is transferred from Blue Shield to the new medical plan. Complete any forms required by Blue Shield and your new plan. If your Medicare is not properly assigned you could be held responsible for the costs that Medicare would have paid. Medicare does not allow retroactive terminations and re-assignments.

Kaiser Enrollees and Medicare

Kaiser HMO Enrollees and Medicare

Upon Medicare enrollment, Kaiser members are enrolled in Kaiser Senior Advantage, which is a Medicare Advantage plan. With this plan, the enrollee assigns Medicare benefits to Kaiser. Medicare is the primary payer for medical services and Kaiser coordinates payments. Kaiser Senior Advantage includes enhanced group Medicare Part D prescription drug coverage. Most retirees qualify for both premium-free Medicare Part A and Part B (for which you must pay a premium). However, if you are not eligible for Medicare Part A per the Social Security Administration, but qualify only for Part B, you will still be enrolled in Kaiser Senior Advantage.

Kaiser and Medicare: At-A-Glance	
Medicare Eligibility	A retiree member or dependent enrolled in Kaiser is eligible for Medicare at age 65, or due to a Social Security-qualified disability or end-stage renal disease.
Plan Enrollment	A Medicare-eligible Kaiser enrollee can only be covered by the Kaiser Senior Advantage HMO plan.
Medicare Part A	Retiree member and dependents must enroll in premium-free Medicare Part A if eligible.
Medicare Part B	Retiree member and dependents must enroll Medicare Part B when eligible and pay premiums to maintain continuous enrollment.
Group Medicare Part D	The Kaiser Senior Advantage plan includes enhanced employer group Medicare Part D. Do not enroll in any individual Part D plan. Federal Part D premiums must be paid, if required, based on income.

If you change plans, make sure Medicare assignment is transferred from Kaiser to the new medical plan. Complete a Kaiser disenrollment form and any forms required by your new plan. If your Medicare is not properly assigned you could be held responsible for the costs that Medicare would have paid. Medicare does not allow retroactive terminations and re-assignments.

Medicare and Your Health Plan: City Health Plan

City Health Plan PPO Enrollees and Medicare

For City Health Plan members enrolled in Medicare, Medicare is the primary payer. With City Health Plan, you do not assign Medicare benefits to UnitedHealthcare. (This is called Medicare COB, or Coordination of Benefits.) For medical service, present both your Medicare card and UnitedHealthcare ID card to your provider. You will be responsible for costs that are not covered by either Medicare or the plan, including deductibles, co-pays, your co-insurance percentage, and billed amounts that exceed reasonable and customary fees. The UnitedHealthcare PPO plan for Medicare-eligible retirees is combined with an enhanced group Medicare Part D prescription drug plan called UnitedHealthcare Medicare Rx for Groups (PDP). You will be issued a separate prescription benefits ID card in addition to your UnitedHealthcare medical plan ID.

City Health Plan and Medicare: At-A-Glance	
Medicare Eligibility	A retiree member or dependent enrolled in City Health Plan is eligible for Medicare at age 65, or earlier due to a Social Security-qualified disability or end-stage renal disease
Plan Enrollment	A Medicare-eligible City Health Plan enrollee can only be covered by the UnitedHealthcare Medicare COB (Coordination of Benefits) plan called UnitedHealthcare Choice Plus PPO.
Medicare Part A	Retiree member and dependents must enroll in premium-free Medicare Part A if eligible.
Medicare Part B	Retiree member and dependents must enroll Medicare Part B when eligible and pay premiums to maintain continuous enrollment.
Group Medicare Part D	City Health Plan PPO is combined with UnitedHealthcare MedicareRx for Groups (PDP), administered by Optum Rx, which issues a separate prescription plan ID card. Do not enroll in any individual Part D plan. Federal Part D premiums must be paid, if required, based on income.

If you change plans to an HMO, make sure your Medicare is assigned to the new medical plan. Complete any forms required by your new plan. If your Medicare is not properly assigned you could be held responsible for the costs that Medicare would have paid. Medicare does not allow retroactive terminations and re-assignments.

Creditable Coverage Disclosure Notice

An important notice about prescription drug coverage and Medicare.

Federal Medicare Part D regulations require the Health Service System (HSS) to provide this Notice of Credible Coverage on an annual basis to:

- participants enrolled in an HSS medical plan that includes prescription drug coverage

and

- participants who are not enrolled, but are eligible to enroll, in an HSS medical plan that includes prescription drug coverage.

Retirees and dependents who are not eligible for Medicare can disregard this notice.

The prescription drug coverage that you have through your HSS medical plan is creditable coverage under Medicare Part D. Creditable coverage means that the amount that the plan expects to pay for prescription drugs for individuals covered by the plan on average is the same or more than what standard Medicare prescription drug coverage would be expected, on average, to pay. This means that your current HSS creditable prescription drug coverage is better than the standard level of coverage set by the federal government under the Medicare Part D program that became available on January 1, 2006.

It is important that you retain this notice because Medicare Part D was set up to encourage eligible participants to either be enrolled in creditable coverage (as you currently are) or be enrolled in Medicare Part D. The incentive to do one or the other is created by assessing late enrollment penalties for anyone who, after May 15, 2006, goes without either creditable coverage (like yours) or enrollment in Part D of Medicare.

You only need to worry about this rule if, in the future, you or a Medicare-eligible dependent terminates or loses the healthcare coverage administered through the Health Service System. At that point, your evidence of creditable coverage will prevent you from incurring any late enrollment penalties, as long as you enroll in Medicare Part D no more than 62 days after your coverage terminates. Anyone who fails to act within that time period will incur the late enrollment penalty of at least 1% per month for each month after May 15, 2006 that he or she did not have creditable coverage or enrollment in Part D.

For example, if nineteen months passed between the time a person terminated creditable coverage with the Health Service System and that person's enrollment in Medicare Part D, that person's premium would always be at least 19% higher than what most other people pay. That person might also be required to wait until the following November, when the federal government conducts Open Enrollment for Medicare, in order to sign up for Medicare Part D coverage.

If an individual (either you or a dependent) loses current creditable prescription drug coverage through no fault of his or her own, that individual may also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

Issue Date: January 1, 2014

Behavioral Health Benefit Highlights

Behavioral Health Services

Blue Shield

LifeReferrals 24/7

Speak on the telephone to a counselor at any time at no cost. Three face-to-face visits with a licensed therapist in each six-month period are also included. Call 1-800-985-2405.

Non-Emergency Therapy Services

Call 1-877-263-9952 to schedule a visit with a mental health professional in the Blue Shield network for non-emergency therapy or to discuss concerns about substance abuse.

Residential Substance Abuse Treatment

To access residential treatment for substance abuse, you do not need a referral from your Blue Shield Primary Care Physician. Call 1-877-263-9952.

Kaiser

Behavioral Health Classes

Kaiser offers classes on depression, anxiety, insomnia, couples communication, anger management, parenting, and more. healthy.kaiserpermanente.org

Wellness Coaching

Speak with a wellness coach on the phone about issues like stress management and life balance. Call 1-866-251-4514, 6:00 AM to midnight, to schedule.

Therapy and Substance Abuse Treatment

San Francisco Kaiser members call (415) 833-2292 for information or to schedule service. You do not need a referral from your Kaiser PCP. If you live outside San Francisco, contact the mental health department of your regional Kaiser facility.

City Health Plan

Locate Network Therapists and Facilities

To find behavioral health therapists, visit myuhc.com and click on "Find Mental Health Clinician" under Links and Tools. Or call 1-866-282-0125.

Health Service System EAP

Group Lunchtime Workshops

Free EAP group workshops offer City retirees and employees the opportunity to share, learn and grow, with the goal of becoming more flexible and knowledgeable at all stages of life. Workshops include:

- Creating a Meaningful Retirement
- Stress Management
- Managing Anger Effectively
- Communication and Conflict Resolution
- Dealing with Difficult People
- Smoking Cessation

For current EAP workshops calendar visit myhss.org/events/seminars.html or call 1-800-795-2351.

Emergency?

Take advantage of behavioral health benefits before issues escalate to a crisis. But in the case of a life-threatening emergency, call 911 or go immediately to the nearest emergency room.

Wellness Benefits

Health Plan Wellness Tools

Blue Shield of California

Wellness discounts and savings:
blueshieldca.com/hw

Quit For Life smoking cessation:
1-866-784-8454
quitnow.net

Symptom checker and wellness information:
blueshieldca.com/bsca/health-wellness/tools

NurseHelp 24/7: 1-877-304-0504

Silver Sneakers access to gyms nationwide
(65 Plus plan enrollees only):
silversneakers.com
1-800-776-4466

Kaiser Permanente

Hundreds of classes, Health Risk Assessment, audio podcasts and more:
kp.org/healthyliving

ChooseHealthy discounts and savings:
kp.org/healthyroads

Free one-on-one telephone wellness coaching to help you set and reach personalized health goals:
1-866-862-4295

Nurse Advice 24/7: (415) 833-2200
Outside San Francisco go to kp.org
and click Locate Our Services.

UnitedHealthcare

Health4Me Phone App to find a doctor, check claims and estimate costs:

Conditions A–Z, online symptom checker, Health Risk Assessment and more:
myuhc.com

Nurseline 24/7: 1-800-846-4678

HSS Wellness

HSS eUpdates

The HSS monthly email newsletter offers information about events, benefits and wellness information. Sign up at myhss.org.

City Fitness Classes

Retirees can participate in a variety of free and low-cost movement classes offered by the Health Service System and other City departments. Current classes include yoga, Qigong, Zumba, bellydance and more.

Civic Center area: myhss.org/events/seminars.html

SFGH: sfghwellness.org/calendar

Fitness Club Discounts

HSS offers gym discounts at many Bay area clubs, including 24 Hour Fitness, Crunch, Planet Fitness, LiveFit and Sonora Sports. You must show proof of retirement from the City, SFUSD or SFCCD to participate in these special offers. See myhss.org for the most updated list of fitness club discounts.

Community Wellness

San Francisco Recreation & Parks

San Francisco Recreation & Parks offers a full schedule of events, programs and classes, as well as opportunities to join volunteer groups working n City parks and gardens. For information visit:
sfrecpark.org.

Always Active

Free exercise programs and health education for adults 60 years of age and older throughout San Francisco. Classes are taught in English, Spanish and Cantonese. For information visit:
alwaysactive.org.

Dental Plan Options

Dental care is an important part of maintaining your health. HSS offers retirees a choice of dental plans.

PPO-Style Dental Plans

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

HSS offers the following PPO-style dental plan:

- **Delta Dental**

If You Enroll in Delta Dental, Save Money By Choosing PPO Dentists

The Delta Dental plan has two different networks. Ask your dentist if he or she is PPO or Premier. Both networks are held to the same quality standards. But choosing a PPO dentist will save you money.

With Delta Dental PPO dentists you pay less out-of-pocket costs. Most preventive services are covered at 100%; many other services are covered at 80% or 50%.

Delta Dental Premier dentists charge higher out-of-pocket fees. Covered charges are based on pre-arranged charges with each contacted dentist. Most preventive services are covered at 80%; many other services are covered at 50%.

You can also choose any dentist outside of the PPO and Premier networks. When you receive service from an out-of-network dentist, many services are covered at a lower percentage, so you pay more. (See page 28.) Also, payment is based on reasonable and customary fees for the geographic area. Your out-of-pocket costs will be higher if your out-of-network dentist charges more than reasonable and customary fees.

Ask your Delta Dental dentist about costs before receiving services. You can request a pre-treatment estimate of costs before you receive care. For more information call Delta Dental at 1-888-335-8227.

HMO-Style Dental Plans

Similar to medical HMOs, Dental Maintenance Organization (DMO) 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. Before you elect a DMO plan, make sure that the plan's network includes the dentist of your choice.

HSS offers the following DMO plans:

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

Dental Plan Only?

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

Dental Plan Service Areas

To enroll in either DeltaCare USA or Pacific Union Dental, you must reside in a zip code serviced by the plan.

■ = Available in this county

County	Delta Dental	DeltaCare USA	Pacific Union	County	Delta Dental	DeltaCare USA	Pacific Union
Alameda	■	■	■	Orange	■	■	■
Alpine				Placer	■	■	■
Amador	■	■		Plumas	■		
Butte	■	■	■	Riverside	■	■	■
Calaveras	■			Sacramento	■	■	■
Colusa	■			San Benito	■	■	■
Contra Costa	■	■	■	San Bernardino	■	■	■
Del Norte	■			San Diego	■	■	■
El Dorado	■	■	■	San Francisco	■	■	■
Fresno	■	■	■	San Joaquin	■	■	■
Glenn	■			San Luis Obispo	■	■	
Humboldt	■	■		San Mateo	■	■	■
Imperial	■	■	■	Santa Barbara	■	■	■
Inyo	■			Santa Clara	■	■	■
Kern	■	■	■	Santa Cruz	■	■	■
Kings	■	■	■	Shasta	■	■	
Lake	■	■		Sierra	■		
Lassen	■			Siskiyou	■		
Los Angeles	■	■	■	Solano	■	■	■
Madera	■	■	■	Sonoma	■	■	■
Marin	■	■	■	Stanislaus	■	■	■
Mariposa	■			Sutter	■	■	
Mendocino	■			Tehama	■		
Merced	■	■	■	Trinity	■		
Modoc	■			Tulare	■	■	■
Mono	■			Tuolumne	■		
Monterey	■	■	■	Ventura	■	■	■
Napa	■	■	■	Yolo	■	■	■
Nevada	■			Yuba	■		
				Outside California	■		

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, contact the dental plan to see if service is available to you:

Delta Dental: 1-888-335-8227

DeltaCare USA: 1-800-422-4234

Pacific Union Dental: 1-800-999-3367

Dental Plan Benefits-at-a-Glance

	DELTA DENTAL PPO		DELTACARE USA DMO	PACIFIC UNION DENTAL DMO
	PPO In-Network Providers	Premier and Out-of-Network Providers		
Types of Service				
Cleanings and exams	100% covered Max 2x per year; 3x pregnant women; periodontal clean 50%	80% covered Max 2x per year; 3x pregnant women; periodontal clean 50%	100% covered Limit 1 every 6 months	100% covered Limit 1 every 6 months
X-rays	100% covered Some limitations apply	80% covered Some limitations apply	100% covered Some limitations apply	100% covered certain limitations apply
Extractions	80% covered	80% covered	100% covered	$5 co-pay
Fillings	80% covered	80% covered	100% covered Limitations apply to resin materials.	$5 co-pay
Crowns	50% covered	50% covered	100% covered Limitations apply to resin materials.	$85 co-pay
Dentures, pontics and bridges	50% covered	50% covered	No charge Full and partial dentures 1x every 5 yrs; fixed bridgework; certain limitations apply.	$85–$100 co-pay
Endodontic/ Root Canals	50% covered	50% covered	100% covered Excluding the final restoration	$50 co-pay
Oral surgery	80% covered	80% covered	100% covered	Co-pays vary
Implants	50% covered	50% covered	Not covered	Not covered
Orthodontia	Not Covered	Not Covered	Member pays: $1,600/child $1,800/adult $350 startup fee; limitations apply.	Member pays: $1,660/child $1,880/adult $350 startup fee; limitations apply.
Annual Maximum				
Total dental benefits	$1,000 per person	$1,000 per person	None	None
Annual Deductible				
Before accessing benefits	None	$50 per person $150 for family for all services except diagnostic and preventative care.	None	None

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.

Dental Plan Comparison

Dental Plan Quick Comparison

	Delta Dental PPO	Pacific Union DMO	DeltaCare USA 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	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. To enroll, you must live in this DMO's service area.	Yes. To enroll, you must live in this DMO's service area.

Vision Plan Benefits

All HSS members and dependents who are enrolled in an HSS medical plan are also enrolled in vision benefits.

Vision Plan Benefits

All HSS members and eligible dependent(s) who enroll in the City Health Plan PPO, Blue Shield HMO or Kaiser HMO can access vision coverage administered by Vision Service Plan (VSP).

Choice of Providers

You have the choice of using a VSP network doctor or a non-VSP doctor. You can find a VSP network doctor in your area by visiting vsp.com or contacting VSP Member Services at 1-800-877-7195.

Accessing Your Vision Benefits

No ID cards are issued for the vision plan. 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 prior authorization or obtain services from a vision care service provider outside of the VSP network (including Kaiser), you are responsible for payment in full to the provider. You may then submit an itemized bill directly to VSP for partial reimbursement. Compare the costs of out-of-network vision services to VSP in-network costs before choosing. Download claim forms at vsp.com.

Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every 24 months, per last date of service. If examination reveals Rx change of .50 diopter or more after 12 months, replacement lenses covered.
- Eligible dependent children are covered in full for polycarbonate prescription lenses.
- Cosmetic extras, including progressive, tinted or oversize lenses, will cost you more.

Vision Plan 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 below.
- Corrective vision treatments such as, but not limited to, LASIK and PRK laser surgery. (You may be eligible for discounts from a VSP doctor.)

Acute and Urgent Eye Care

With a $5 co-pay, VSP offers limited coverage for urgent and acute eye conditions, including pink eye, sudden onset of flashers and floaters, and diagnosis of eye pain or sudden changes in vision. Visit any VSP network doctor; no appointment is necessary.

VSP acute eye care does not cover chronic eye conditions like diabetes-related eye disease or glaucoma. Chronic eye disease may be covered by your medical plan. (Check your medical plan's Evidence of Coverage, available on myhss.org.)

No Medical Plan, No Vision Benefits

If you do not enroll in an HSS medical plan, you and your enrolled dependents cannot access VSP vision benefits.

Vision Plan Benefits-at-a-Glance

	VSP Network	Out-of-Network
Types of Service		
Well vision exam	$10 co-pay Every 12 months*	up to $50 After $10 co-pay; every 12 months*
Single vision lenses	$25 co-pay Every 24 months*	Up to $45 After $25 co-pay; every 24 months*
Lined bifocal lenses	$25 co-pay Every 24 months*	Up to $65 After $25 co-pay; every 24 months*
Lined trifocal lenses	$25 co-pay Every 24 months*	Up to $85 After $25 co-pay; every 24 months*
Scratch-resistant coating	Fully covered Every 24 months*	Not covered
Frames	Up to $150 After $25 co-pay; 20% off total over $150; every 24 months*	Up to $70 After $25 co-pay; every 24 months*
Contact lenses, fitting and evaluation	Up to $150 Every 24 months*; fitting and evaluation exam fully covered after a maximum $60 co-pay	Up to $105 Every 24 months*
Urgent eye care	$5 co-pay Limited coverage for urgent and acute eye conditions	Not covered
Savings and Discounts		
Non-covered lens options (progressives, anti-reflective coating, photochromic, polycarbonate)	Average 20–25% off Of provider's usual and customary charges; every 24 months*	Not applicable
Laser Vision Correction	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities	Not applicable

*Based on your last date of service.

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.

Eligibility

These rules govern which employees and dependents may be eligible for retiree health benefits.

Retiree Member Eligibility

An employee must meet age and minimum service requirements and have been enrolled in HSS health benefits at some time during active employment to be eligible for retiree health coverage. (HSS calculates service.) If hired on or after January 10, 2009, an employee with only five years of service may be eligible for health benefits but will have no employer contributions toward premiums. Individuals who qualify for disability retirement do not have to meet the five year service requirement to be eligible. If a retiree chooses to take a lump sum pension distribution, retiree health premium contributions will be unsubsidized, and paid at full cost. Other restrictions may apply.

Newly eligible retirees must enroll in retiree medical and/or dental coverage within 30 days of their retirement effective date, by providing HSS with a completed enrollment application and all required eligibility documentation, including retirement system paperwork. Members eligible for Medicare at the time of retirement must also provide proof of Medicare enrollment. If you fail to meet required deadlines, you must wait until the next Open Enrollment.

New retiree coverage will take effect on the first day of the month following the retirement effective date. Depending on your retirement date, there can be a gap between when employee coverage ends and retiree coverage begins. Setting a retirement date at the end of the month will help avoid a coverage gap.

Contact HSS Member Services at (415) 554-1750 three months before your retirement date to prepare for enrollment in retiree benefits. You must notify HSS of retirement even if you are not planning to elect HSS coverage on your retirement date.

For more information, visit:
myhss.org/member_services/new_retirees.html

Dependent Eligibility

Spouse or Domestic Partner

A retiree member's legal spouse or domestic partner may be eligible for HSS health coverage. Proof of Medicare enrollment must also be provided for a spouse or domestic partner who is Medicare-eligible due to age or disability. Enrollment in HSS benefits must be completed within 30 days of the date of marriage or partnership. Coverage will begin on the first day of the month after a completed application and eligibility documentation is filed with HSS. Legal spouses and domestic partners can also be added to a member's coverage during annual Open Enrollment.

Natural Children, Stepchildren, Adopted Children

A member's natural child, stepchild, adopted child (including child placed for adoption), and the natural or adopted child of a member's enrolled domestic partner are eligible for coverage up to 26 years of age. Coverage terminates at the end of the coverage period in which the child turns 26. Eligibility documentation is required upon initial enrollment.

Legal Guardianships and Court-Ordered Children

Children under 19 years of age who are placed under the legal guardianship of an enrolled member, a member's spouse, or domestic partner are eligible. If a member is required by a court's judgement, decree or order to provide health coverage for a child, that child is eligible up to age 19. Coverage terminates at the end of the coverage period in which the child turns 19. The member must provide HSS with proof of guardianship, court order or decree by required deadlines.

Eligibility

Adult Disabled Children

Children who are disabled may be covered beyond the age limits stated previously, provided all of the following criteria are met. (A newly hired employee who enrolls an adult disabled child age 26 or older must meet all requirements below except 1 and 2.)

1. Adult child was enrolled in an HSS medical plan on the child's 19th birthday and continuously for at least one year prior to the child's 19th birthday;
2. Adult child was continuously enrolled in an HSS medical plan from age 19 to 26;
3. Adult child is incapable of self-sustaining employment due to the disability;
4. Adult child is unmarried;
5. Adult child permanently resides with the employee member;
6. Adult child is dependent on the member for substantially all of his economic support, and is declared as an exemption on the member's federal income tax;
7. Member submits to HSS acceptable medical documentation–a certification that an adult child is enrolled in Medicare due to a Social Security-qualifying disability, or HSS disabled dependent forms completed and signed by a physician–at least 60 days prior to child's attainment of age 26 and every year thereafter as requested;
8. All enrolled dependents who qualify for Medicare due to a disability are required to enroll in Medicare. Members must notify HSS of any dependent's eligibility for, and enrollment in, Medicare;
9. Once enrolled, the member must continuously enroll the disabled adult child in HSS coverage and Medicare (if eligible) to maintain future eligibility.

Financial Penalties for Failing to Disenroll Ineligible Dependents

Members must notify HSS within 30 days and cancel coverage for a dependent who becomes ineligible. If a member fails to notify HSS, the member may be held responsible for the costs of ineligible dependent health premiums and any medical service provided.

Required Eligibility Documentation

	Proof of Retirement	Marriage Certificate	Domestic Partner Cert	Birth Certificate	Adoption Certificate	Proof Of Placement	Court Order Or Decree	Medical Evidence	Social Security #	Medicare Card
Retiree	■								■	■
Spouse		■							■	■
Domestic Partner			■						■	■
Child: Natural				■					■	
Child: Adopted					■				■	
Child: Placed for Adoption						■			■	
Stepchild: Spouse		■		■					■	
Stepchild: Domestic Partner			■	■					■	
Child: Legal Guardianship							■		■	
Child: Court Ordered							■		■	
Adult Child: Disabled				■				■	■	■

Note: Proof of Medicare enrollment is not required for a retiree, spouse, partner or disabled child who is not eligible for Medicare per federal Social Security Administration eligibility rules.

Changing Elections Outside of Open Enrollment

A member may make a benefits election change due to a qualifying event a maximum of two times during the January–December 2014 plan year. For changes to benefit elections due to a qualifying event the member must notify the Health Service System and complete the enrollment process. This includes the submission of all required documentation **no later than 30 calendar days** after the qualifying event. A Social Security number is required for all newly enrolled individuals.

Family Status	Enrollment Change	Documentation	Coverage
Marriage Legal Domestic Partnership	Add new spouse or partner to medical and/or dental coverage	• HSS enrollment application • Legal marriage certificate or certification of partnership • Proof of Medicare enrollment for Medicare-eligible domestic partner of either gender	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.
	Add new stepchild to medical and/or dental coverage	• HSS enrollment application • Legal marriage certificate or certification of partnership • Child's birth certificate	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.
	Waive member's medical and/or dental coverage	• HSS enrollment application • Legal marriage certificate or certification of partnership • Proof of member enrollment in other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.
Divorce Legal Separation Dissolution of Partnership Annulment	Drop former spouse, partner and associated stepchilden from coverage	• HSS enrollment application • Divorce decree or legal documents proving separation, dissolution of partnership or annulment	These individuals are no longer eligible for HSS coverage; failure to drop may result in penalties. Coverage terminates the last day of the coverage period in which the legal divorce, dissolution or separation was granted.
Birth of a Child Adoption of a Child Child Placed for Adoption	Add child to medical and/or dental coverage	• HSS enrollment application • If newborn, birth verification letter from hospital; birth certificate when issued • If adopted, adoption certificate or proof of placement	Coverage is effective the day of the child's birth, or, for an adoption, the date of legal custody. Documentation must be submitted within 30-day deadline.
Legal Guardianship of a Child	Add child to medical and/or dental coverage	• HSS enrollment application • Court decree	Coverage effective the date guardianship takes effect, if documentation submitted within 30-day deadline.
Court-Ordered Coverage for a Child	Add child to medical and/or dental coverage	• HSS enrollment application • Court order to add child	Coverage effective the date of court order, if documentation submitted within 30-day deadline.
	Drop child from medical and/or dental coverage	• HSS enrollment application • Court order for other coverage • Proof child has other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.

A member or eligible dependent who loses other coverage due to termination of employment, a change from full-time to part-time employment, dropping other employer coverage during an Open Enrollment, ineligibility for Medicare or Medicaid, or the commencement of an unpaid leave of absence may enroll in HSS coverage **within 30 calendar days** of these qualifying events.

Loss of Coverage	Enrollment Change	Documentation	Coverage
Member Loses Other Coverage	Enroll member (and dependents who also lost coverage) in medical and/or dental coverage	• HSS enrollment application • Proof of loss of coverage • All required dependent eligibility documentation. (See page 33.)	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.
Spouse or Partner Loses Other Coverage	Enroll spouse or partner in medical and/or dental coverage	• HSS enrollment application • Proof of loss of coverage • Legal marriage certificate or certification of partnership	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.
Dependent Child or Stepchild Loses Other Coverage	Enroll child or stepchild in medical and/or dental coverage	• HSS enrollment application • Proof of loss of coverage • Child's birth certificate • Legal marriage certificate or certification of partnership (if stepchild)	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.

A member or dependent who gains other coverage due to commencement of employment, a change from part-time to full-time employment, adding other coverage during another employer's Open Enrollment, eligibility for Medicare or Medicaid, or return to work from an unpaid leave of absence may drop HSS coverage **within 30 calendar days** of these qualifying events. A retiree member may only waive dental coverage outside of Open Enrollment with proof of obtaining other coverage. A retiree may waive medical coverage at any time.

Gain of Coverage	Enrollment Change	Documentation	Coverage
Member Gains Other Coverage	Waive member's medical and/or dental coverage	• HSS enrollment application • Proof of other coverage (only required to waive dental)	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.
Spouse or Partner Gains Other Coverage	Drop spouse or partner from medical and/or dental coverage	• HSS enrollment application • Proof of other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.
Dependent Child or Stepchild Gains Other Coverage	Drop child or stepchild from medical and/or dental coverage	• HSS enrollment application • Proof of other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.

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Changing Elections Outside of 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** of the date of death. Coverage for your deceased dependent will terminate the day after the dependent's death.

Death of a Member

In the event of a member's death, the surviving dependent or survivor's designee should contact HSS to obtain information about eligibility for survivor health benefits. To be eligible for health benefits, the surviving spouse or domestic partner of a retiree must have been legally married to the member, or registered as the member's domestic partner, for at least one year prior to the death of the member. Other restrictions apply.

After being notified of a member's death, HSS will send instructions to the spouse or partner, including a list of documentation required for enrolling in surviving dependent health coverage. To avoid a break in coverage for survivors who were enrolled in HSS benefits at the time of the member's death, the following must be submitted to HSS **within 30 days** of the member's death date of death:

- Completed surviving dependent enrollment form
- Copy of member's death certificate
- Copy of certificate of marriage or partnership (if not already on file at HSS)
- Copy of survivor's Medicare card (if survivor is Medicare-eligible)

A surviving spouse or partner who is not enrolled on the deceased member's health plan at the time of the member's death may be eligible for coverage, but must wait until Open Enrollment to enroll. Surviving dependent children of a member must meet eligibility requirements for dependent children. (See pages 32–33.)

Moving Out of a Plan's Service Area

If you move your primary residence to a location outside your health plan's service areas, you will no longer be able to obtain services through that plan. You will need to enroll in a different HSS plan that offers service based on your new address. You must complete an HSS application to elect a new plan **within 30 days** of your move. Coverage under the new plan will be effective the first day of the coverage period following the date HSS receives your completed enrollment application. If you do not enroll in a new plan **within 30 days** of your move, you must wait until the next Open Enrollment.

Note: If you do not notify HSS of your new home address and HSS is unable to contact you for a period of one year, your health coverage may be terminated by HSS.

Financial Penalties for Failing to Disenroll Ineligible Dependents

Members must notify HSS within 30 days and cancel coverage for a dependent who becomes ineligible. If a member fails to notify HSS, the member may be held responsible for the costs of ineligible dependent health premiums and any medical service provided.

Domestic Partner Health Benefits Taxation

Health coverage for a domestic partner and a partner's children is typically a taxable benefit.

Tax Treatment of Health Benefits

The federal government does not recognize domestic partnership for tax purposes. Employer contributions to health premiums for an retiree's domestic partner and children of a domestic partner are taxable (imputed) income. By comparison, if a retiree is legally married, no taxable imputed income results from employer contributions to the spouse's health premiums.

Note: Effective June 26, 2013 health premium contributions for all married spouses (including same-sex) and their families is no longer taxable imputed income. (Proof of legal marriage is required.) This is due to the Supreme Court ruling which declared the federal Defense of Marriage Act unconstitutional.

IRS Exemption for Enrolled Health Plan Dependents Who Meet Certain Requirements

The Internal Revenue Service (IRS) offers a tax break for health-related expenses incurred by a "qualifying relative." Under IRS code section 152, a domestic partner (of either gender), and children of a domestic partner qualify for favorable tax treatment if:

1. Partner or child receives more than half of his or her financial support from the *retiree*; and
2. Partner or child lived with the employee as a member of his or her household for the entire calendar year (January 1–December 31), with the exception of temporary absences due to vacation, education or military service; and
3. Partner or child is a citizen of the United States, or a resident of the United States, Canada or Mexico.

If an enrolled dependent meets all requirements the retiree may submit an annual declaration to HSS, and there will be no imputed income for the employer contribution to dependent health premiums. To receive favorable tax treatment, you must file the declaration annually with HSS by required deadlines.

Equitable California State Tax Treatment

If a domestic partner and associated dependents do not meet the IRS code section 152 requirements for favorable tax treatment under federal law, you may be able to take advantage of equitable California state tax treatment. This California law only applies to same-sex domestic partners–not opposite-sex domestic partners. To obtain equitable tax treatment under California state law, you are required to have a Declaration of Domestic Partnership issued by the Secretary of the State of California. You will need to deduct the value of the employer-paid health insurance premiums for your same-sex domestic partner, and his or her children, when filing your California state income tax return.

Consult with Your Tax Advisor

This is a brief overview regarding the tax treatment of health benefits for domestic partners and their children at the time this guide was printed. Laws are subject to change. Please consult with a professional tax advisor before taking any action. It is your responsibility to comply with state and federal tax law.

COBRA

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted in 1986 allows retirees and their covered dependents to elect temporary extension of healthcare coverage in certain instances where coverage would end. These include:

- Children who are aging out of HSS coverage.
- Retiree's spouse, domestic partner or stepchildren who are losing HSS coverage due to legal separation, divorce or dissolution of partnership.
- Covered dependents who are not eligible for survivor benefits and are losing HSS coverage due to the death of an HSS member.
- New retirees who opt to enroll in COBRA dental coverage when they first lose active employee dental benefits.

Time Limits for COBRA Elections

The COBRA administrator will notify you of the opportunity to elect COBRA coverage. You have 60 days from the notification date to complete COBRA enrollment. Coverage will be retroactive to the date of the COBRA qualifying event, so there is no break in healthcare coverage. While covered under COBRA, you have 30 days to add newly eligible dependents (spouse, domestic partner, newborn or adopted child) to COBRA coverage, based on the date of the qualifying event (marriage, partnership, birth, adoption).

In the case of a dependent losing coverage (due to divorce or aging out of a plan) the retiree or dependent must notify the COBRA Administrator within 30 days of the qualifying event. Dependents dropped from coverage during Open Enrollment are not eligible for COBRA.

Duration of COBRA Continuation Coverage

Group COBRA coverage is generally available for a maximum of 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a coverage extension for up to 36 months.

COBRA enrollees who are disabled on the date of their qualifying event, or at any time during the first 60 days of COBRA coverage, are eligible for 29 months of coverage. Beginning the 19th month of coverage, the cost will rise to 150 percent of the group rate. Retirees and dependents who are eligible for less than 36 months of federal COBRA may be eligible for Cal-COBRA. Continuation coverage under both federal and California state COBRA will not exceed 36 months.

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 individuals to remit the required healthcare premium payments directly lto the COBRA administrator. For COBRA rate information, visit myhss.org or contact HSS.

COBRA Continuation Coverage Alternatives

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

All retirees and dependents who were covered under an HSS-administered health plan are entitled lto a certificate showing evidence of prior health coverage. This certificate of prior coverage may assist the retiree and/or dependents in purchasing new health coverage that excludes pre-existing medical conditions.

This is only a summary. For more details information about COBRA benefits, contact WageWorks, at 1-877-502-6272.

Privacy

Use and Disclosure of Your Personal Health Information

The Health Service System maintains policies to protect your personal health information, in accordance with HIPPA, the federal Health Insurance Portability and Accountability Act. These policies are designed to avoid disclosure of your health information, except for the following uses:

- To make or obtain payments from plan vendors contracted with the Health Service System;
- To facilitate administration of health insurance coverage and services for Health Service System members;
- To assist actuaries in making projections and soliciting premium bids from health plans;
- To provide you with information about health benefits and services;
- When legally required to disclose information by federal, state or local law (including Worker's Compensation regulations), law enforcement investigating a crime, and court order or subpoena;
- To prevent a serious or imminent threat to individual or public health and safety.

Other than the uses listed 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 disclose your health information, you may revoke that authorization in writing at any time.

Your Rights With Regard To Your Health Information

You may request restrictions on the use and disclosure of your health information by sending your request in writing to the Health Service System. The Health Service System will evaluate and reply to your request. For example, you may:

- Ask that the Health Service System only communicate with you at a certain phone number or at a certain email address;
- Ask for a copy of your health information on file with the Health Service System (a fee may be charged for paper copies);
- Ask that incorrect records held by the Health Service System be corrected;
- Request a list of Health Service System disclosures of your personal health information for reasons other than facilitating treatment, or maintaining business and finance operations.

You have the right to express complaints to the Health Service System and the federal Health and Human Services agency if you feel your privacy rights have been violated. Any privacy complaints made to the Health Service System should be made in writing.

Written requests or complaints should be send to:

Health Service System
1145 Market Street 2nd Floor
San Francisco, CA 94013
Attn: Privacy Officer

Full Legal Notice

This is a summary of a legal notice which details Health Service System privacy policy. The full legal notice is available at:
myhss.org/health_service_board/privacy_policy.html

You may also contact the Health Service System to request a written copy of the full legal notice.

Glossary of Healthcare Terms

Accountable Care Organization (ACO)
A payment and healthcare delivery model that aligns provider reimbursements with meeting quality and cost targets.

Brand-Name Drug
FDA approved prescription drugs marketed under a specific brand name by manufacturers.

COBRA
This federal law allows individuals 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 services, after required deductible has been paid. It is often specified by a percentage. For example, retiree pays 15% and insurance company pays 85%.

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

Deductible
Specified amount you must pay for healthcare in a contracted benefits period before plan will begin to cover all or a portion of your costs. Some plans have no deductible.

Dependent
A family member who meets HSS eligibility criteria for enrollment.

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 begins. You are not covered until the effective date.

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

Employer-Subsidized Benefits
Benefits that are paid for, all or in part, with money contributed by the employer.

Enrollee
Individual enrolled in a health plan.

Explanation of Benefits (EOB)
Written, formal statement sent to PPO enrollees that lists medical services provided and costs billed.

Evidence of Coverage (EOC)
A legal document that gives details about a plan's benefits and exclusions and how to get care. It explains your rights and responsibilities and the plan providers' responsibilities to you.

Exclusions
The list of conditions, injuries, or treatments that are not covered under your health insurance policy.

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.

Generic Drug
FDA-approved prescription drugs that contain the same active ingredient as a brand-name drug, and cost less than the brand-name drug.

Health Maintenance Organization (HMO)
Provides health services through a closed network. 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 or retiree's domestic partner, be reported as taxable income on a federal income tax return.

In-Network
These providers and facilities contract with a health plan to provide services at pre-negotiated fees. Enrollees usually pay less when using an in-network providers.

Glossary of Healthcare Terms

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

Medicare Advantage Plan
A health plan where a participant signs Medicare over to a private insurer that administers Medicare and added benefits. These plans may include a group Medicare Part D prescription drug benefit.

Medicare Coordinated Plan
A health plan offered by a private insurer, where Medicare remains the primary payer and the private insurer is the secondary payer of supplemental or enhanced coverage. May include group Medicare Part D prescription drug coverage.

Medicare Part A
Hospital insurance provided by the federal government to individuals who are eligible based on age or certain qualifying disabilities.

Medicare Part B
Outpatient medical insurance provided by the federal government to eligible individuals based on age or qualifying disabilities.

Medicare Part D
Prescription drug insurance provided by the federal government to eligible individuals based on age or qualifying disabilities. There are individual Part D plans and employer group Part D plans.

Member
An employee or retiree designated as the primary plan subscriber, per HSS rules.

Non-Formulary Drug
Prescription drug which is not on a health plan's list of covered drugs.

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

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

Out-of-Network
Providers or healthcare facilities that 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.

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

Out-of-Pocket Maximum
The highest total amount you will spend in a year on out-of-pocket medical costs. Once you reach out-of-pocket maximum, your plan pays 100% of covered service costs.

PDP
A prescription drug plan.

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 or retiree.

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

Privacy
HSS maintains standards for protecting your health information: myhss.org/health_service_board/privacy_policy.html

Qualifying Event
A change in your life situation that allows you to make a change in your benefit elections outside Open Enrollment. (See page 34.)

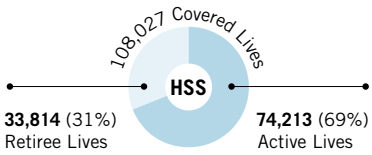
Reasonable and Customary
The average fee charged by a practitioner within a geographic area. If the fees are higher than reasonable and customary, the individual receiving service may be responsible for paying the difference.

Retiree Premium Contribution
The amount a retiree must pay toward the cost of retiree health premiums.

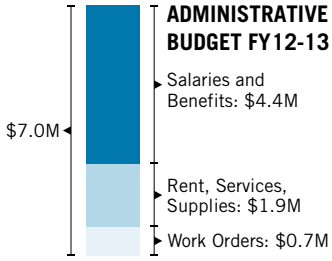
Health Service System Overview

Governed by the Health Service Board, the Health Service System designs health and wellness benefits for employees, retirees and their families, and works to improve care while controlling premium costs.

COVERED LIVES

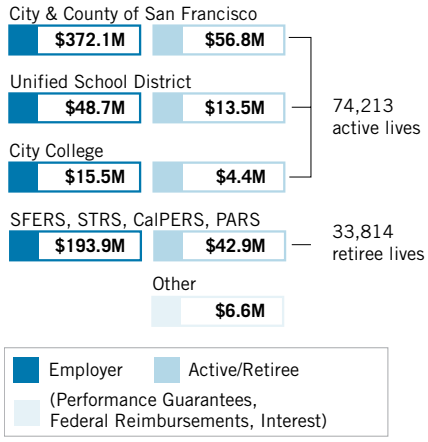


ADMINISTRATIVE BUDGET FY12-13



FUNDING and GOVERNANCE

$754M TRUST FUND CONTRIBUTIONS FY12-13



HEALTH SERVICE SYSTEM FY12-13

Health Service Board

7 Commissioners:
- 3 Elected Members
- 3 Appointees
- 1 City Supervisor

28 Plans From 10 Vendors

Medical: 6 HMO; 4 PPO
Dental: 2 DMO; 2 DPO
Vision: 1
FSA: 2
Group Life: 6
Long-Term Disability: 2
Flex Credits: 2
COBRA: 1

Health Service Staff

Operations
22 staff members
10,000 annual enrollment transactions
53,000 annual member interactions

Finance
7 staff members
12,500 annual financial transactions
2,740 annual rate calculations

Administration
3 staff members
15 annual public meetings

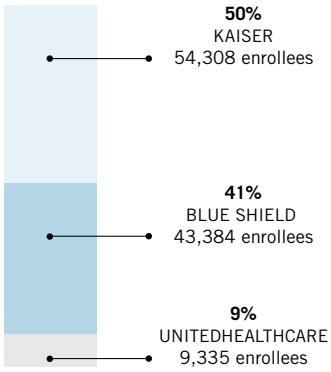
IT/PeopleSoft
4 staff members
500 annual data queries

Wellness/EAP
3 staff members
7,490 employees in depts w/wellness councils
3,314 EAP visits

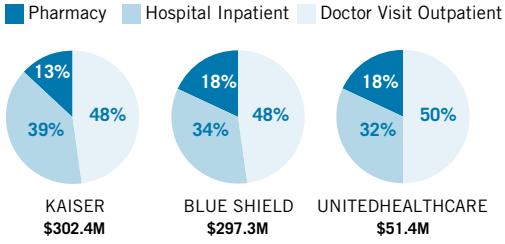
Communications
1 staff member
65,000 open enrollment packets mailed
56,000 website visits

HEALTH PLANS

MEDICAL PLAN ENROLLMENT FY12-13



HEALTH PREMIUM COSTS BY VENDOR FY 12-13



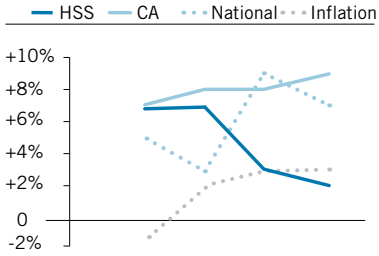
Dental and Vision

Delta Dental: $54.8M
DeltaCare USA: $1.0M
Pacific Union: $0.4M
VSP: $4.4M

Other

WageWorks (FSA/COBRA): $5.8M
UNUM (LTD): $7.1M
ING (Group Life): $0.4M
EBS (Flex Credits): $4.7M

YEAR-OVER-YEAR HEALTH PREMIUM BENCHMARKING



	09–10	10–11	11–12	12–13
HSS Premiums	+7%	+7%	+3%	+2%
CA Premiums	+7.5%	+8%	+8%	+9%
Ntl Premiums	+5%	+3%	+9%	+7.5%
Ntl Inflation	-2%	+2%	+3%	+3%

Dollar amounts are unaudited totals, available as of August 1, 2013 for FY 2012-2013.
As of January 1, 2013, LTD and Group Life insurance plans are administered by Aetna.

Rates: Retiree Not Eligible for Medicare

MONTHLY CONTRIBUTIONS EFFECTIVE JANUARY 1–DECEMBER 31, 2014

MEDICAL	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	1,393.62	42.57	1,132.09	2.58	1,097.46	331.51
Retiree + 1 Dependent with no Medicare	1,718.26	363.30	1,415.80	281.95	1,790.62	1,024.63
Retiree + 2 or More Dependents with no Medicare	1,717.67	899.52	1,414.78	750.32	1,788.55	2,022.78
Retiree + 1 Dependent with Medicare Part A Only	1,718.87	362.69	1,418.12	279.63	1,578.54	808.08
Retiree + 1 Dependent with Medicare Part B Only	1,718.87	362.69	1,311.81	173.32	1,316.90	546.43
Retiree + 1 Dependent with Medicare Part A and Part B	1,587.47	231.29	1,311.81	173.32	1,264.97	494.48
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,718.28	898.91	1,417.10	748.00	1,576.47	1,806.23
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,718.28	898.91	1,310.79	641.69	1,314.83	1,544.58
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,586.88	767.51	1,310.79	641.69	1,262.90	1,492.63

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	42.37	0	16.47	0	32.85
Retiree + 1 Dependent	0	84.80	0	27.20	0	54.21
Retiree + 2 or more Dependents	0	128.10	0	40.22	0	80.19

Required retiree premium contributions, if any, will be deducted from the member's monthly pension check. If the pension check does not fully cover premium payments, the member must contact HSS to make payment arrangements.

All rates published in this guide are subject to approval by the Health Service Board and the San Francisco Board of Supervisors.

Rates: Retiree Eligible for Medicare Part A and Part B

MONTHLY CONTRIBUTIONS EFFECTIVE JANUARY 1–DECEMBER 31, 2014

MEDICAL	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	384.60	0	352.49	0	364.18	0
Retiree + 1 Dependent with no Medicare	709.24	320.73	636.20	279.37	1,057.34	693.12
Retiree + 2 or More Dependents with no Medicare	708.65	856.95	635.18	747.74	1,055.27	1,691.27
Retiree + 1 Dependent with Medicare Part A Only	709.85	320.12	638.52	277.05	845.26	476.57
Retiree + 1 Dependent with Medicare Part B Only	709.85	320.12	532.21	170.74	583.62	214.92
Retiree + 1 Dependent with Medicare Part A and Part B	578.45	188.72	532.21	170.74	531.69	162.97
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	709.26	856.34	637.50	745.42	843.19	1,474.72
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	709.26	856.34	531.19	639.11	581.55	1,213.07
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	577.86	724.94	531.19	639.11	529.62	1,161.12

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	42.37	0	16.47	0	32.85
Retiree + 1 Dependent	0	84.80	0	27.20	0	54.21
Retiree + 2 or more Dependents	0	128.10	0	40.22	0	80.19

Required retiree premium contributions, if any, will be deducted from the member's monthly pension check. If the pension check does not fully cover premium payments, the member must contact HSS to make payment arrangements.

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Rates: Retiree Eligible for Medicare Part A Only

MONTHLY CONTRIBUTIONS EFFECTIVE JANUARY 1–DECEMBER 31, 2014

MEDICAL	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	1,392.33	43.86	1,131.94	2.73	893.60	107.24
Retiree + 1 Dependent with no Medicare	1,716.97	364.59	1,415.65	282.10	1,586.76	800.36
Retiree + 2 or More Dependents with no Medicare	1,716.38	900.81	1,414.63	750.47	1,584.69	1,798.51
Retiree + 1 Dependent with Medicare Part A Only	1,717.58	363.98	1,417.97	279.78	1,374.68	583.81
Retiree + 1 Dependent with Medicare Part B Only	1,717.58	363.98	1,311.66	173.47	1,113.04	322.16
Retiree + 1 Dependent with Medicare Part A and Part B	1,586.18	232.58	1,311.66	173.47	1,061.11	270.21
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,716.99	900.20	1,416.95	748.15	1,372.61	1,581.96
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,716.99	900.20	1,310.64	641.84	1,110.97	1,320.31
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,585.59	768.80	1,310.64	641.84	1,059.04	1,268.36

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	42.37	0	16.47	0	32.85
Retiree + 1 Dependent	0	84.80	0	27.20	0	54.21
Retiree + 2 or more Dependents	0	128.10	0	40.22	0	80.19

Required retiree premium contributions, if any, will be deducted from the member's monthly pension check. If the pension check does not fully cover premium payments, the member must contact HSS to make payment arrangements.

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Rates: Retiree Eligible for Medicare Part B Only

MONTHLY CONTRIBUTIONS EFFECTIVE JANUARY 1–DECEMBER 31, 2014

MEDICAL	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	1,436.19	0	352.49	0.00	475.65	0
Retiree + 1 Dependent with no Medicare	1,760.83	320.73	636.20	279.37	1,168.81	693.12
Retiree + 2 or More Dependents with no Medicare	1,760.24	856.95	635.18	747.74	1,166.74	1,691.27
Retiree + 1 Dependent with Medicare Part A Only	1,761.44	320.12	638.52	277.05	956.73	476.57
Retiree + 1 Dependent with Medicare Part B Only	1,761.44	320.12	532.21	170.74	695.09	214.92
Retiree + 1 Dependent with Medicare Part A and Part B	1,630.04	188.72	532.21	170.74	643.16	162.97
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,760.85	856.34	637.50	745.42	954.66	1,474.72
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,760.85	856.34	531.19	639.11	693.02	1,213.07
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,629.45	724.94	531.19	639.11	641.09	1,161.12

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	42.37	0	16.47	0	32.85
Retiree + 1 Dependent	0	84.80	0	27.20	0	54.21
Retiree + 2 or More Dependents	0	128.10	0	40.22	0	80.19

Required retiree premium contributions, if any, will be deducted from the member's monthly pension check. If the pension check does not fully cover premium payments, the member must contact HSS to make payment arrangements.

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Rates: Eligible Surviving Spouse/Domestic Partner

MONTHLY CONTRIBUTIONS EFFECTIVE JANUARY 1–DECEMBER 31, 2014

MEDICAL	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Survivor Not Eligible for Medicare	1,393.62	42.57	1,132.09	2.58	1,097.46	331.51
Survivor + 1 Dependent with no Medicare	1,718.26	363.30	1,415.80	281.95	1,790.62	1,024.63
Survivor + 1 Dependent with Medicare Part A and Part B	1,587.47	231.29	1,311.81	173.32	1,264.97	494.48
Survivor + 2 or More Dependents with no Medicare	1,717.67	899.52	1,414.78	750.32	1,788.55	2,022.78
	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
Survivor with Medicare Part A and B	384.60	0	352.49	0	364.18	0
Survivor with Medicare A and B + 1 Dependent no Medicare	709.24	320.73	636.20	279.37	1,057.34	693.12
Survivor with Medicare A and B + 1 Dependent with Medicare A and B	578.45	188.72	532.21	170.74	531.69	162.97
Survivor with Medicare A and B + 2 or more Dependents with no Medicare	708.65	856.95	635.18	747.74	1,055.27	1,691.27

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	42.37	0	16.47	0	32.85
Retiree + 1 Dependent	0	84.80	0	27.20	0	54.21
Retiree + 2 or More Dependents	0	128.10	0	40.22	0	80.19

Required retiree premium contributions, if any, will be deducted from the member's monthly pension check. If the pension check does not fully cover premium payments, the member must contact HSS to make payment arrangements.

All rates published in this guide are subject to approval by the Health Service Board and the San Francisco Board of Supervisors.

Key Contact Information

HEALTH SERVICE SYSTEM

Member Services
1145 Market Street
San Francisco, CA 94103
(Civic Center station between 7th and 8th)
Tel: 415-554-1750
1-800-541-2266 (outside 415)
Fax: (415) 554-1721
myhss.org

MEDICAL PLANS

City Health Plan (UnitedHealthcare)
Tel: 1-866-282-0125
Medicare Medical Group: 752103
Medicare Rx Group: 23689
Non-Medicare Medical and Rx Group: 752103
myuhc.com

Blue Shield of California
65 Plus (Medicare Advantage)
Tel: 1-800-776-4466
TTY/TDD call 1-800-794-1099,
seven days a week, 7:00AM to 8:00PM
Group: MA0002
blueshieldca.com/sfhss

Blue Shield of California
Access+
Tel: 1-800-642-6155
Medicare A and B Group: H12188
Medicare A or B only Group: H12195
Non-Medicare Group: H12189
blueshieldca.com/sfhss

Kaiser Permanente
Tel: 1-800-464-4000
Group: 888 (Northern California)
Group: 231003 (Southern California)
my.kp.org/ca/cityandcountyofsanfrancisco

VISION PLAN

Vision Service Plan
(VSP)
Tel: 1-800-877-7195
Group: 12145878
vsp.com

DENTAL PLANS

Delta Dental
Tel: 1-888-335-8227
Group: 1673-0001
deltadentalins.com/ccsf

DeltaCare USA Dental
Tel: 1-800-422-4234
Group:. 1797-0003
deltadentalins.com/ccsf

Pacific Union Dental (UnitedHealthcare)
Tel: 1-800-999-3367
Group: 705287-0048
myuhcdental.com

COBRA

WageWorks
Tel: 1-877-502-6272
wageworks.com

OTHER AGENCIES

San Francisco Employees' Retirement System
Tel: 415-487-7000
sfers.org

CalPERS
Tel: 1-888-225-7377
calpersca.org

CalSTRS
Tel: 1-800-228-5453
calstrs.org

PARS
Tel: 1-800-540-6369
parsinfo.org

Social Security Administration
Tel: 1-800-772-1213
TTY/TDD 1-800-325-0778
ssa.gov

Medicare
Tel: 1-800-633-4227
TTY/TDD 1-877-486-2048
medicare.gov