2011-2012

MUNICIPAL EXECUTIVES

BENEFITS GUIDE

Health Service System

CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

Contents

Open Enrollment Overview

Open Enrollment takes place April 1–29, 2011. Review your choices and make informed decisions.

Things You Can Do During Open Enrollment

- Change medical or dental plan elections.
- Add or drop dependents from medical and/or dental coverage.
- Allocate municipal executive flex credits, which includes annual Flexible Spending Account (FSA) enrollment. Flex credit allocation and FSA enrollment is administered by EBS.

Open Enrollment Deadline: April 29, 2011

If you wish to change your medical or dental plan elections, completed Open Enrollment applications and required documentation must be received at HSS by 5:30PM, April 29, 2011. (See page 29 for a documentation checklist.) Open Enrollment applications can be delivered to HSS in person, sent through the mail or sent by fax. The HSS fax number is (415) 554-1721. Any changes you make during April 2011 Open Enrollment will be in effect from July 1, 2011 through June 30, 2012.

EBS Flex Credit Allocation and Flexible Spending Account (FSA) Enrollment

Allocation of 2011-2012 flex credits, including annual Flexible Spending Account (FSA) enrollment, is administered by Employee Benefits Specialists (EBS). If you wish to roll forward your current flex credit allocations no EBS appointment is required. EBS will contact you by mail with instructions. To change your current flex credit allocations, you must confer with EBS by phone or in person. If you do not complete your flex credit allocation with EBS during April 2011 Open Enrollment, your flex credits will be automatically distributed, effective July 1, 2011. (See page 22.) Questions? Call EBS at (800) 229-7683.

FSAs require re-enrollment every year. To make FSA contributions in 2011-2012, you must enroll or re-enroll in an FSA during April 2011, via your flex credit allocations with EBS. If you do not take action during Open Enrollment, current FSA contributions will cease the last pay day in June 2011.

Open Enrollment Events

Health Service System
April 1-29, 2011
1145 Market Street, 2nd Floor
8:00AM to 5:00PM
EBS appointments available:
April 18-29, 2011

San Francisco Airport
April 5, 2011
Terminal 1
Conf Rm A & B
9:00AM to 4:00PM
EBS appointments available

San Francisco General Hospital
April 6, 2011
Main Cafeteria
8:30AM to 4:00PM
HSS only, no EBS

850 Bryant
April 7, 2011
5th Floor, Room 551
8:30AM to 4:00PM
HSS only, no EBS

Laguna Honda Hospital
April 12, 2011
Pavilion Conf Rm P1192
9:00AM to 4:00PM
HSS only, no EBS

City Hall
April 13, 2011
Room 034
9:00AM to 4:00PM
EBS appointments available

Medical, dental and vision plan benefit changes– take note of these important updates.

Summary of Changes Effective July 1, 2011:	
All medical, dental and vision plans	Natural children, stepchildren and adopted children are eligible for coverage up to age 26, effective July 1, 2011. See page 28 for details.
All medical plans	Some preventive care exams, immunizations and tests will be covered at no co-pay cost. Restrictions, such as using in-network providers, may apply. See your plan's Evidence of Coverage, available on www.myhss.org.
Kaiser HMO	Other than those listed above, no additional benefit or co-pay changes.
Blue Shield Access+ HMO	$150 co-pay per hospital admittance $45 co-pay 30-day supply non-formulary drugs (pharmacy) $90 co-pay 90-day supply non-formulary drugs (mail order) 20% up to $100 co-pay (specialty drugs) Residential treatment coverage for chemical dependency No lifetime limit on smoking cessation prescriptions
City Health Plan PPO (United Healthcare)	No lifetime coverage maximum $45 co-pay 30-day supply non-formulary drugs (pharmacy) $90 co-pay 90-day supply non-formulary drugs (mail order)
VSP (Vision Service Plan)	$60 maximum co-pay for contact lens fitting Out-of-network eye exam covered up to $50 Out-of-network eye glass frame allowance up to $70
Delta Dental	Non-cosmetic implants covered at 50% up to $2,500 plan maximum Third cleaning per plan year covered for pregnant women Bi-weekly premiums (for most municipal executives): $2.31 employee only; $4.62 employee+1; $6.92 employee+2. See page 43.

These alerts include highlights only and may not cover every plan change. Please read the Evidence of Coverage (EOC) for details about your plan's benefits. EOCs are available on www.myhss.org.

What's New for 2011–2012

A summary of how federal healthcare reform impacts your health benefits.

Eligibility Rules for Children

Effective July 1, 2011, as a result of the Patient Protection and Affordable Care Act passed by Congress in March 2010, some children up to age 26 are eligible for HSS medical, dental and vision coverage.

Eligible children include:

- Your natural child
- Your adopted child (or child placed for adoption)
- Your stepchild
- Your domestic partner's child

Your children, stepchildren and domestic partner's children have no other eligibility restrictions. They may be married, living independently, or eligible for their own employer coverage and need not be your tax dependent or supported by you.

Dependent eligibility based on tax-deduction status, proven by the submission of a member's tax returns, is no longer permitted.

If your child turned age 25 in 2010 and was or will be dropped from your plan, you may re-enroll the child during Open Enrollment, with coverage for the child to begin July 1, 2011, and continue up to age 26.

Children enrolled due to legal guardianship or court order are eligible up to age 19.

See pages 28-29 of this guide for more information about eligibility rules, deadlines and required documentation.

Prohibition on Lifetime and Annual Limits

Healthcare reform law contains a provision stating that group health plans cannot establish a lifetime or annual limit on the dollar value of essential health benefits.

Preventative Care Services

To help people stay healthy, avoid or delay the onset of disease, lead productive lives, and reduce health insurance costs, federal healthcare reform includes a provision focusing on disease prevention. Depending on your age and health plan type, you can access some preventative services, screenings and immunizations at no cost or reduced out-of-pocket cost. For details check your plan's website and read your plan's Evidence of Coverage, available on www.myhss.org.

Healthcare Flexible Spending Accounts (FSAs)

Effective January 1, 2011, over-the-counter medications are only eligible for FSA reimbursement with a doctor's prescription.

This is just a brief summary of federal healthcare reform highlights. For more information on healthcare reform, please visit www.healthcare.gov.

Open Enrollment FAQ

	Flex Credits	Medical and Dental	Flexible Spending Accounts
What if I do not want to make any changes to my benefit elections in 2011-2012?	You must allocate your flex credits every year. Call EBS at (800) 229-7683 during Open Enrollment for more information. If you do not take action, flex credits are automatically distributed. (See page 22.)	If you want to keep the same medical and dental elections and are not adding or dropping dependents effective July 1, 2011, you do not need to submit an HSS Open Enrollment application.	FSAs require re-enrollment every year. To continue your FSA for the coming year call EBS at (800) 229-7683 during April 2011. If you do not take action, FSA contributions will cease the last pay day of June 2011.
How do I make changes to my benefit elections in 2011-2012?	Call EBS at (800) 229-7683 during Open Enrollment to make changes to your flex credit allocations for the coming year. Otherwise, credits are automatically distributed. (See page 22.)	You must submit a completed HSS Open Enrollment application and any required eligibility documentation to HSS no later than 5:30PM, April 29, 2011.	Call EBS at (800) 229-7683 during Open Enrollment to make changes to your FSA contributions for the coming year. If you don't take action, FSA contributions cease the last pay day of June 2011.
How do I add or drop a dependent from my medical and/or dental plan during Open Enrollment?	If you are adding or dropping dependents during Open Enrollment, this may modify the allocation of your flex credits. Be sure to discuss these changes with EBS.	Submit a completed Open Enrollment application and required eligibility documentation to HSS no later than 5:30PM, April 29, 2011. No documentation is required when dropping dependents during Open Enrollment.	
May I fax my enrollment information?	Call EBS at (800) 229-7683 to update your flex credit allocations, then return your signed confirmation to EBS by fax. If you do not take action, flex credits will be automatically distributed. (See page 22.)	You may fax your HSS Open Enrollment application and eligibility documentation to our secure fax line: (415) 554-1721. Do not fax the same application to HSS multiple times.	Call EBS at (800) 229-7683 to enroll in a healthcare and/or dependent care FSA, then return your signed confirmation to EBS by fax. If you do not take action, your FSA contributions will end the last pay period of June 2011.
Whom do I contact if I have questions?	If you have questions about flex credit allocations, contact EBS by calling (800) 229-7683.	If you have questions about medical and dental enrollment, contact HSS member services at (415) 554-1750.	If you have questions about Flexible Spending Accounts, (FSAs) contact EBS at (800) 229-7683.

Choosing a Medical Plan

1 PPO vs. HMO

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

2 Plan Service Areas

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

3 Medical Groups, Doctors and Hospitals

Identify which doctors, hospitals and other medical services that you and your family prefer. If you are enrolled in the Blue Shield HMO, your Primary Care Physician and medical group affiliation will affect which doctors and hospitals you can access.

4 Health Plan Report Cards and Quality Ratings

Visit online resources to aid your decision-making process.

HSS Vendor Report Cards
www.myhss.org

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

Integrated Healthcare Association
www.iha.org

National Committee for Quality Assurance
www.ncqa.org

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

CalHospitalCompare
www.CalHospitalCompare.org

5 Medical Needs and Services Covered

Learn how the plan works by reviewing the benefits summary and Evidence of Coverage (EOC). Do not wait until you need emergency services to educate yourself about benefit, exclusion and care access details.

6 Plan Costs

Compare the costs of each available medical plan. See page 43 of this guide for 2011-2012 employee premium contributions. Also review co-pay and deductible costs on the Medical Plan Benefits-at-a-Glance summary charts on pages 10-13.

Medical Plan Options

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

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). 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 the following HMO plans:

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

Preferred Provider Organization (PPO)

A PPO is a medical plan that offers benefits through in-network and out-of-network healthcare providers. (Going to an out-of-network provider will cost you more.) You are not assigned to a Primary Care Physician, so you have more responsibility for coordinating your care. You must pay a plan year deductible. You also pay a coinsurance percentage each time you access service. Compared to an HMO, enrolling in a PPO usually results in higher out-of-pocket costs. City Health Plan PPO is a self-insured plan. Individual premiums are determined by the total cost of services used by the plan's group of participants. HSS offers the following PPO plan:

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

The healthcare plans administered by HSS do not guarantee the continued participation of any particular doctor, hospital or medical group during the plan year. After Open Enrollment, you won't be allowed to change your health benefit elections if a doctor, hospital or medical group chooses not to participate in your plan. You will be assigned or required to select another provider.

This benefits guide does not explain all the details of your plan contract. The EOC (Evidence of Coverage) contains a complete list of benefits and exclusions in effect for each plan from July 1, 2011 through June 30, 2012. Review your EOC for plan details. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Download plan EOCs at www.myhss.org.

Change of Address?

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

PPO vs. HMO

QUICK COMPARISON CHART

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

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

Medical Plan Service Areas

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

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

■ = Available in this county.

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

If you do not see your county listed above, contact the medical plan to see if service is available to you:

Blue Shield of California: (800) 642-6155

Kaiser Permanente: (800) 464-4000

Medical Plan Benefits-at-a-Glance

	blue of california	KAISER PERMANENTE®
DEDUCTIBLES		
Plan-year deductible	None	None
PREVENTIVE & ROUTINE CARE		
Routine physical	No charge	No charge
Immunizations and inoculations	No charge	No charge
Routine gynecologic wellness exam	No charge	No charge
Well baby care	No charge	No charge
PHYSICIAN & OTHER PROVIDER CARE		
Office and home visits	$20 co-pay	$15 co-pay
Hospital visits	No charge	No charge
PRESCRIPTION DRUGS		
Pharmacy: generic drugs	$5 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: brand-name drugs	$20 co-pay 30-day supply	$15 co-pay 30-day supply
Pharmacy: non-formulary drugs	$45 co-pay 30-day supply	Physician authorized only
Mail order: generic drugs	$10 co-pay 90-day supply	$10 co-pay 100-day supply
Mail order: brand-name drugs	$40 co-pay 90-day supply	$30 co-pay 100-day supply
Mail order: non-formulary drugs	$90 co-pay 90-day supply	Physician authorized only
Speciality drugs	20% up to $100 co-pay 30-day supply	Same as all above
OUTPATIENT SERVICES		
Diagnostic x-ray and laboratory	No charge	No charge
EMERGENCY		
Hospital emergency room	$100 co-pay waived if hospitalized	$100 co-pay waived if hospitalized
Urgent care facility	$20 co-pay within CA network	$15 co-pay
HOSPITAL/SURGERY		
Inpatient	$150 co-pay per admittance	$100 co-pay per admittance
Outpatient	$50 co-pay	$15 co-pay

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 www.myhss.org.

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
$250 employee only $500 employee + 1 $750 employee + 2 or more Annual out-of-pocket maximum $3,750/person	$250 employee only $500 employee + 1 $750 employee + 2 or more Annual out-of-pocket maximum $7,500/person	$250 employee only $500 employee + 1 $750 employee + 2 or more Annual out-of-pocket maximum $3,750/person
100% covered no deductible	Not covered	100% covered no deductible
100% covered no deductible	50% covered no deductible	100% covered no deductible
100% covered no deductible	50% covered after deductible	100% covered no deductible
100% covered no deductible	50% covered after deductible	100% covered no deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
$5 co-pay 30-day supply	50% covered after $5 co-pay; 30-day supply	$5 co-pay 30-day supply
$20 co-pay 30-day supply	50% covered after $20 co-pay; 30-day supply	$20 co-pay 30-day supply
$45 co-pay 30-day supply	50% covered after $45 co-pay; 30-day supply	$45 co-pay 30-day supply
$10 co-pay 90-day supply	Not covered	$10 co-pay 90-day supply
$40 co-pay 90-day supply	Not covered	$40 co-pay 90-day supply
$90 co-pay 90-day supply	Not covered	$90 co-pay 90-day supply
Same as all above	Same as all above	Same as all above
85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	85% covered after deductible; may require prior notification
85% covered after deductible; if non-emergency 50% after deductible	85% covered after deductible; if non-emergency 50% after deductible	85% covered after deductible; if non-emergency 50% after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	85% covered after deductible; may require prior notification
85% covered after deductible	50% covered after deductible	85% covered after deductible

Note: City Health Plan out-of-pocket maximum does not include premium contributions or annual deductible.
*In some cases, billed amounts may exceed reasonable and customary fees, resulting in higher out-of-pocket costs.

Medical Plan Benefits-at-a-Glance

	blue of california	KAISER PERMANENTE®
REHABILITATIVE		
Physical/Occupational therapy	$20 co-pay	$15 co-pay authorization required
Acupuncture	$15 co-pay 30 visits/yr; ASH network only	Not covered
Chiropractic	$15 co-pay 30 visits/yr; ASH network only	$15 co-pay 30 visits/yr; ASH network only
PREGNANCY & MATERNITY		
Routine pre- and post-partum physician care; for hospital stay, see Hospital	No charge newborn must be enrolled within 30 days of birth; visits limited; see EOC	No charge newborn must be enrolled within 30 days of birth; visits limited; see EOC
INFERTILITY		
IVF, GIFT, ZIFT and artificial insemination	50% covered limitations apply	50% covered limitations apply
TRANSGENDER		
Office visits and outpatient surgery	Co-pays apply authorization req. $75,000 lifetime max	Co-pays apply authorization req. $75,000 lifetime max
DURABLE MEDICAL EQUIPMENT		
Home medical equipment	No charge	No charge as authorized by PCP according to formulary
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary
Hearing aids	No charge 1 per ear every 36 months; $2,500 max	No charge 1 per ear every 36 months; $2,500 max
MENTAL HEALTH		
Inpatient hospitalization	$150 co-pay per admittance	$100 co-pay per admittance
Outpatient treatment	$20 co-pay non-severe and severe	$7 co-pay group $15 co-pay individual
CHEMICAL DEPENDENCY		
Inpatient detox	$150 co-pay per admittance	$100 co-pay per admittance
Residential rehabilitation	$150 co-pay per admittance	$100 co-pay per admittance; physician approval required
EXTENDED & END-OF-LIFE CARE		
Skilled nursing facility	No charge up to 100 days per year	No charge up to 100 days per year
Hospice	No charge authorization required	No charge when medically necessary

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

CITY HEALTH PLAN (administered by United Healthcare)

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

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

Adult Preventative Care Summary

	adult women age 20-49	adult men age 20-49	adult women age 50 and up	adult men age 50 and up
Annual wellness exam check height, weight, blood pressure; assess tobacco and alcohol use, depression risk and other concerns	Yes	Yes	Yes	Yes
Diabetes type 2 screening blood glucose	Yes	Yes	Yes	Yes
Lipid screening blood cholesterol	Yes, over age 45 frequency based on risk	Yes, over age 35 frequency based on risk	Yes frequency based on risk	Yes frequency based on risk
STD screenings sexually transmitted diseases	Yes if at risk	Yes if at risk	Yes if at risk	Yes if at risk
Pap smear cervical cancer screening	Yes every 2 years; after 3 normal screenings as doctor recommends		Yes every 3 years; discontinue at age 65 if low risk	
Mammogram breast cancer screening	Yes, over age 40 every 1-2 years		Yes every 1-2 years; up to age 75	
Osteoporosis screening bone density			Yes over age 65; sooner if high risk	
Colorectal cancer screening			Yes ages 50-75	Yes ages 50-75
AAA screening abdominal aortic aneurysm				Yes if man ever smoked; ages 65-75; one time
Annual flu immunization seasonal flu	Yes if at risk	Yes if at risk	Yes	Yes
Hepatitis A immunization	Yes if at risk	Yes if at risk	Yes if at risk	Yes if at risk
Hepatitis B immunization	Yes if at risk	Yes if at risk	Yes if at risk	Yes if at risk
HPV immunization human papillomavirus	Yes up to 26 years old			
MMR immunization measles, mumps, rubella	Yes if no proof of immunity	Yes if no proof of immunity	Yes if at risk	Yes if at risk
Tdap/Td immunization tetanus, diphtheria, whooping cough	Yes every 10 years	Yes every 10 years	Yes every 10 years	Yes every 10 years
Varicella immunization chicken pox	Yes if no proof of immunity	Yes if no proof of immunity	Yes if no proof of immunity	Yes if no proof of immunity
Zoster immunization shingles		Yes ages 60 and up; once		Yes ages 60 and up; once
Pneumococcal immunization pneumonia			Yes age 65 and up; sooner if high risk	Yes age 65 and up; sooner if high risk

Consult with your doctor about the types of screenings and immunizations that are right for you. This is a brief summary based on U.S. Preventative Services Task Force guidelines for adults. For more details, including recommendations for children, see www.healthcare.gov/center/regulations/prevention/recommendations.html.

Additional Wellness Benefits

Health Plan Wellness Tools

Blue Shield of California

Healthy Lifestyle Rewards, Health Risk Assessment, 24/7 registered nurse hotline, condition management programs and more:

www.blueshieldca.com/hw/

Wellness discounts and savings:
www.blueshieldca.com/bsc/hw/hw_375.jhtml

Kaiser Permanente

Hundreds of classes, Health Risk Assessment, audio podcasts and more:

www.kp.org/healthyliving

ChooseHealthy discounts and savings:
www.kp.org/healthyroads

UnitedHealthcare

Live nurse chat, conditions A-Z, online symptom checker, Health Risk Assessment and more:

www.myuhc.com

Delta Dental

Oral health A-Z, dental health education videos, kids' games and more:

www.wekeepyousmiling.org/group_oral_health
www.mysmilekids.com

Vision Service Plan (VSP)

Eye care recommendations by age, diabetes and vision information, and educational games:

www.vsp.com/cms/edc/discovery.html
www.vsp.com/cms/edc/diabetes-discovery.html

HSS Employee Assistance Program (EAP)

City employees and their family members can access this voluntary, confidential, no-cost program. EAP staff are licensed counselors who provide assessment, short-term therapy (up to six sessions), referrals and follow-up for individuals, couples, families and groups regarding personal or work-related issues such as stress, marital, family and relationship problems, anger management, substance abuse, work performance issues, or other emotional difficulties. The EAP staff is also available for mediation/conflict resolution sessions, workplace violence prevention and critical incident debriefing following a traumatic event. Call the EAP at (800) 795-2351 to make an appointment. EAP is located at 1145 Market Street, Suite 200, San Francisco. Office hours are Monday through Friday, 8:00 AM to 5:00 PM.

HSS Fitness Classes and Wellness Seminars

HSS offers employees a variety of free and low-cost movement classes and wellness seminars throughout the year. Monthly class calendar: www.myhss.org.

Maximize Your Benefits Health Fair

HSS presents an annual no-cost health fair with free flu shots, health screenings, fitness and nutrition demonstrations and more: www.myhss.org.

HSS eUpdates

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

24 Hour Fitness Discount

Employees can take advantage of a special offer from 24 Hour Fitness gyms. There is no initiation fee and no processing fee. Membership is paid monthly, with no long-term contract. Proof of employment may be required at time of enrollment; other limitations may apply. Enroll online (enter code 100961) or call (800) 224-0240.
www.24hourfitness.com/corp/sanfranemps

Dental Plan Options

Dental benefits are an important part of your healthcare coverage and are key to your overall health. HSS offers a choice of plans, providers and coverage options.

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 dentist.

HSS offers the following PPO-style dental plan:

- **Delta Dental**

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

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

You can go to any dentist in either network, or choose any dentist outside of these networks. When you go to a licensed dentist not in one of the networks described above, the plan pays the same percentage of cost that it pays a Delta Dental network dentist. However, payment is based on reasonable and customary costs for the geographical area. Your share of the expenses will be higher if your out-of-network dentist charges more than reasonable and customary fees. Please ask a dentist about costs before receiving services. Delta Dental can also help you estimate costs before you receive treatment. Call Delta Dental at (888) 335-8227.

HMO-style Dental Plans

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

You will be required to select a primary care dental office, and you must go to this office for all of your dental care. 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 elect to enroll in an HSS dental plan even if you elect not to enroll in an HSS medical plan.

Dental Plan Service Areas

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

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

■ = Available in this county

If you do not see your county listed above, contact the dental plan to see if service is available to you:

Delta Dental: (888) 335-8227

DeltaCare USA: (800) 422-4234

Pacific Union Dental: (800) 999-3367

Dental Plan Benefits-at-a-Glance

	DELTA DENTAL PPO		DELTACARE USA DMO	PACIFIC UNION DENTAL DMO
	Preferred In-Network Providers	Premier & Out-of-Network Providers		
Types of Service				
Cleanings and exams	100% covered Per plan year 2x; pregnant women 3x	100% covered Per plan year 2x; pregnant women 3x	100% covered Limit 1 every 6 months	100% covered Limit 1 every 6 months
X-rays	100% covered	100% covered	100% covered	100% covered
Extractions	90% covered	80% covered	100% covered	100% covered
Fillings	90% covered	80% covered	100% covered Limitations apply to resin materials.	100% covered
Crowns	90% covered	80% covered	100% covered Limitations apply to resin materials.	100% covered
Dentures, pontics and bridges	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	100% covered Full and partial dentures 1x every 5 yrs; fixed bridgework; certain limitations apply.	100% covered Full and partial dentures 1x every 5 yrs; fixed bridgework; certain limitations apply.
Endodontic/ Root Canals	90% covered	80% covered	100% covered Excluding the final restoration.	100% covered
Oral surgery	90% covered	80% covered	100% covered	100% covered
Implants	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	Not covered	Not covered
Orthodontia	50% covered Adults and children; up to $2,500 lifetime max; 6-month wait for new enrollees	50% covered Adults and children; up to $2,500 lifetime max; 6-month wait for new enrollees	Employee pays: $1,600/child $1,800/adult $350 startup fee; limitations apply.	Employee pays: $1,600/child $1,800/adult $350 startup fee; limitations apply.
Annual Maximum				
Total dental benefits	$2,500 per year Excluding orthodontia benefits.	$2,500 per year Excluding orthodontia benefits.	None	None
Annual Deductible				
Before accessing benefits	None	None	None	None

This 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 www.myhss.org.

Dental Plan Comparison

DENTAL PLAN QUICK COMPARISON

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

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 www.vsp.com or contacting VSP Member Services at (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 www.vsp.com.

Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every 24 months, based on last date of service. If retractor examination reveals an Rx change of .50 diopter or more after 12 months, replacement is 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 www.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*
Progressive lenses	Average 20-25% off Of provider's usual and customary charges; every 24 months*	Up to $65 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

*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 www.myhss.org.

Flex Credit Overview

Dollar Value of Credits

In lieu of dependent coverage subsidized by the City, MEA and unrepresented managers are allocated a dollar value in flex credits that they can apply to a variety of pre- and post-tax options. In 2011-2012, eligible **City and County of San Francisco enrollees** will receive **$319.39** in credits **bi-weekly**. Eligible **Superior Court enrollees** will receive **$636.00** in credits **bi-weekly**. Flex credit options are listed on page 23.

Initial Enrollment

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

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

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

Denied Coverage

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

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

OR

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

Members who elect to reallocate flex credits to the Miscellaneous Reimbursement option will not receive the retroactive value of the applicable flex credits but will have the applicable amount applied to Miscellaneous Reimbursement moving forward.

Miscellaneous Reimbursement

For credits allocated to Miscellaneous Reimbursement, you must provide proof of qualifying expenses incurred between July 1, 2011 and June 30, 2012 to EBS no later than September 30, 2012. Paper claim forms and proof of expenditures must be filed directly with EBS for reimbursement. Download claim forms at www.myhss.org.

Miscellaneous Reimbursement Forfeiture

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

Family Status Changes

Members may only elect to reallocate flex credits if the reallocation relates directly to a qualified change in family status. (See pages 30-32.)

Open Enrollment

Members must allocate flex credits annually during Open Enrollment. Call EBS at (800) 229-7683.

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

- If the member has medical and/or dental plan coverage, flex credits for the 2011-2012 plan year will be automatically applied to the employee premium contribution cost at the level of coverage currently in place. Any additional amount required to cover the cost of employee premium contributions will be covered by payroll deductions. Remaining flex credits, if any, will be allocated to the Miscellaneous Reimbursement Account and will be subject to taxable, imputed income.
- If the member currently has no medical or dental plan coverage, all credits will be allocated to the Miscellaneous Reimbursement Account and will be subject to taxable, imputed income.

Flex Credit Options

More detailed benefit summaries for these flex credit options are available online at myhss.org. You must contact EBS at (800) 229-7683 during Open Enrollment to allocate flex credits.

SECTION 125 PRE-TAX BENEFIT OPTIONS

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

OTHER TAXABLE BENEFIT OPTIONS

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

Flexible Spending Accounts

An FSA is an IRS-approved tax-favored account to pay for eligible medical and dependent care expenses. Funds are deducted from your salary pre-tax.

How an FSA Works

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

It is possible to realize tax savings with an FSA, but any unused FSA dollars will be forfeited at the end of the plan year per IRS rules. Plan ahead to make the most of an FSA. To calculate potential FSA tax savings, visit www.myfbmc.com/ccsf and click on tax calculator. You should also consult a tax advisor or the IRS for information about your specific situation.

The following information provides an overview of your FSA benefits. To get details about this benefit, visit www.myfbmc.com/ccsf. You can also request an FSA resource guide from HSS Member Services. The Flexible Spending Account benefit is administered by Fringe Benefits Management Company, a Division of WageWorks.

Healthcare FSA

- Set aside between $120 and $5,000 pre-tax per household in a plan year. Depending on the annual amount you elect, deductions between $4.62 and $192.30 will be taken bi-weekly from your paycheck in 2011-2012.
- Submit reimbursement forms to Fringe Benefits Management Company, a Division of WageWorks, for eligible out-of-pocket expenses, including medical, dental and vision deductibles, co-pays and prescription costs.
- When you elect a Healthcare FSA, the total annual amount you designate becomes available for eligible healthcare expenses at the start of the plan year. You do not have to wait for your contributions to accumulate in your account.

Dependent Care FSA

- Set aside between $120 and $5,000 pre-tax per household in a calendar year. Depending on the annual amount that you specify, deductions between $4.62 and $192.30 will be taken bi-weekly from your paycheck in 2011-2012.
- If you have a stay-at-home spouse, you may not enroll in the Dependent Care FSA.
- Submit reimbursement forms to Fringe Benefits Management Company, a Division of WageWorks, for eligible out-of-pocket expenses, such as certified day care, pre-school and elder care for your qualifying dependents. (Children in day care must be under age 13.)
- Funds for a Dependent Care FSA are available after being deducted from your paycheck and received by the plan administrator. Unlike a Healthcare FSA, the entire annual amount for a Dependent Care FSA is not available at the start of the plan year.

Estimating FSA Expenses

Before enrolling in your FSA, you should work out a detailed estimate of the eligible expenses you are likely to incur for the plan year ahead. Budget conservatively. Any unreimbursed funds are forfeited at the end of the plan year and cannot be returned to you. You can find FSA calculation tools on www.myfbmc.com. For a list of eligible expenses, the definition of qualifying family members and how to submit reimbursements, visit www.myfbmc.com/ccsf. FSA expenses must meet Internal Revenue Service (IRS) eligibility criteria. Please refer to IRS publications 502 and 503: www.irs.gov/pub/irs-pdf/p502.pdf and www.irs.gov/pub/irs-pdf/p503.pdf.

FSA Rules

- Expenses for services incurred before July 1, 2011 or after June 30, 2012 are not eligible for reimbursement during the 2011-2012 plan year.
- You must re-enroll in Flexible Spending Account(s) every Open Enrollment period.
- You cannot transfer money between Healthcare and Dependent Care Flexible Spending Accounts.
- You cannot change the amount(s) you contribute to your Flexible Spending Account(s) during the plan year unless you experience a qualifying change in family status. See pages 30-32.
- If your employment ends during the plan year, you can only file claims for eligible FSA expenses that were incurred while you were actively employed.
- Allowed FSA contribution amounts, eligible expenses and other information listed here may change as a result of federal health care legislation.

FSA Account Information

Visit www.myfbmc.com/ccsf or call (800) 342-8017, Monday-Friday, 4:00AM-7:00PM Pacific Time to get information about your FSA. To apply for no fee direct deposit reimbursement, complete the Direct Deposit Enrollment Form on www.myfbmc.com/ccsf or call (800) 342-8017.

FSAs and Unpaid Leaves of Absence

Healthcare FSA

During an unpaid leave of absence, no payroll deductions can be taken. You may suspend your Healthcare FSA if you notify HSS at the beginning of your leave. Accounts that remain unpaid for three consecutive pay periods will be suspended retroactively to the first missed pay period. To reinstate your Healthcare FSA you must notify HSS within 30 days of your return to work. A retroactive reinstatement back to the FSA suspension date allows claims incurred during your leave to be reimbursable. In this case, you must increase your bi-weekly FSA deductions (up to a maximum of $192.30) for the remainder of the plan year so your annual FSA contribution is equal to the total designated during Open Enrollment. You also have the option of reinstating a Healthcare FSA on a go-forward basis, at the original bi-weekly deduction amount. This will reduce your total FSA contribution for the plan year.

Dependent Care FSA

A Dependent Care FSA must be suspended while you are on leave. Claims incurred during leave are not reimbursable. To reinstate your FSA you must notify HSS within 30 days of your return to work. Reinstatement of a Dependent Care FSA is only allowed on a go-forward basis. You may reinstate at the original bi-weekly FSA deduction amount or you can increase bi-weekly FSA deductions (up to a maximum of $192.30) for the remainder of the plan year. If you increase deductions, total plan year contributions must equal, and cannot exceed, the amount you designated during Open Enrollment.

FSA Reinstatement Rules

If you do not notify HSS within 30 days of your return to work and request reinstatement of your FSA payroll deduction, Healthcare and/or Dependent Care FSA(s) will be cancelled for that plan year–no exceptions. If you return to work after the end of the plan year, a suspended Healthcare or Dependent Care FSA initiated during the previous plan year cannot be reinstated–no exceptions.

Avoid Forfeiting FSA Contributions

FSA expenses for plan year 2011-2012 must be incurred between July 1, 2011 and June 30, 2012. Reimbursement claims must be received by the plan administrator no later than September 30, 2012. Per IRS rules, you forfeit money remaining in an FSA at the end of the claim filing period–no exceptions.

New or Returning Employees

Municipal Executive Benefits

Eligible Municipal Executives Association members and unrepresented City managers can enroll in medical, dental, vision and Flexible Spending Account benefits. Instead of subsidized premium contributions for dependents, these managers are allocated flex credits that can be applied to a variety of pre- and post-tax benefits, including health premium contributions. For this year's flex credit value and credit allocation options, see pages 22-23 of this guide. To allocate flex credits, new hires must meet in person with a representative from EBS at the HSS office within 30 days of the date of hire or promotion. Appointments are available on Wednesdays. Call HSS at (415) 554-1750 to schedule your EBS appointment.

New or Rehired Employees Must Enroll within 30 Days

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

To enroll in an HSS healthcare plan, new or returning employees must submit a completed Enrollment application and any required eligibility documentation to HSS. For a checklist of required eligibility documentation, see page 29. Please submit copies of eligibility documentation–not your original documents. If you choose not to hand in an application during your new employee orientation, applications and supporting documentation can be mailed, faxed or dropped off at the HSS office **within 30 calendar days** of your official start work date. See page 44 for HSS phone, fax and address details.

When Coverage Begins

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

Employee Responsibility for Healthcare Premium Contributions

Employee premium contributions are deducted from paychecks bi-weekly. Carefully check your paycheck to verify that the correct employee premium contribution is being deducted. If the deduction is incorrect or does not appear on your paycheck, contact HSS Member Services at (415) 554-1750. You are responsible for all required employee premium contributions, whether they are deducted from your paycheck or not. (See chart on page 27 for contribution due dates.) If you fail to make a required employee premium contribution by the date it is due, your coverage will be terminated and you will not be permitted to re-enroll in coverage until Open Enrollment in spring 2012, with coverage to begin July 1, 2012.

Healthcare Coverage Periods Calendar

Payroll Deductions Taken Bi-Weekly

Effective July 2011, employee premium contributions will be deducted from paychecks bi-weekly–a total of 26 payroll deductions per year. All required employee premium contributions for any benefits coverage period must be paid in advance of the coverage period for a member and dependents to be covered during that period.

WORK DATES	PAY DATE	BENEFITS COVERAGE PERIOD
June 11, 2011 – June 24, 2011	July 5, 2011	July 1, 2011 – July 8, 2011
June 25, 2011 – July 8, 2011	July 19, 2011	July 9, 2011 – July 22, 2011
July 9, 2011 – July 22, 2011	August 2, 2011	July 23, 2011 – August 5, 2011
July 23, 2011 – August 5, 2011	August 16, 2011	August 6, 2011 – August 19, 2011
August 6, 2011 – August 19, 2011	August 30, 2011	August 20, 2011 – September 2, 2011
August 20, 2011 – September 2, 2011	September 13, 2011	September 3, 2011 – September 16, 2011
September 3, 2011 – September 16, 2011	September 27, 2011	September 17, 2011 – September 30, 2011
September 17, 2011 – September 30, 2011	October 11, 2011	October 1, 2011 – October 14, 2011
October 1, 2011 – October 14, 2011	October 25, 2011	October 15, 2011 – October 28, 2011
October 15, 2011 – October 28, 2011	November 8, 2011	October 29, 2011 – November 11, 2011
October 29, 2011 – November 11, 2011	November 22, 2011	November 12, 2011 – November 25, 2011
November 12, 2011 – November 25, 2011	December 6, 2011	November 26, 2011 – December 9, 2011
November 26, 2011 – December 9, 2011	December 20, 2011	December 10, 2011 – December 23, 2011
December 10, 2011 – December 23, 2011	January 3, 2012	December 24, 2011 – January 6, 2012
December 24, 2011 – January 6, 2012	January 17, 2012	January 7, 2012 – January 20, 2012
January 7, 2012 – January 20, 2012	January 31, 2012	January 21, 2012 – February 3, 2012
January 21, 2012 – February 3, 2012	February 14, 2012	February 4, 2012 – February 17, 2012
February 4, 2012 – February 17, 2012	February 28, 2012	February 18, 2012 – March 2, 2012
February 18, 2012 – March 2, 2012	March 13, 2012	March 3, 2012 – March 16, 2012
March 3, 2012 – March 16, 2012	March 27, 2012	March 17, 2012 – March 30, 2012
March 17, 2012 – March 30, 2012	April 10, 2012	March 31, 2012 – April 13, 2012
March 31, 2012 – April 13, 2012	April 24, 2012	April 14, 2012 – April 27, 2012
April 14, 2012 – April 27, 2012	May 8, 2012	April 28, 2012 – May 11, 2012
April 28, 2012 – May 11, 2012	May 22, 2012	May 12, 2012 – May 25, 2012
May 12, 2012 – May 25, 2012	June 5, 2012	May 26, 2012 – June 8, 2012
May 26, 2012 – June 8, 2012	June 19, 2012	June 9, 2012 – June 22, 2012

If you take an approved leave of absence, in most cases you must pay HSS directly for the employee premium contributions that were being deducted from your paycheck. Your employee premium contributions are due no later than the first day of the benefits coverage periods listed above. See page 34 for more information about medical, dental and vision coverage during a leave of absence. See page 25 for details about Flexible Spending Accounts and leaves of absence.

Eligibility

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

Member Eligibility

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

- City and County Employees
  - All permanent employees of the City and County of San Francisco whose normal work week is not less than 20 hours;
  - All regularly scheduled provisional employees of the City and County of San Francisco whose normal work week is not less than 20 hours;
  - All other employees of the City and County of San Francisco, including temporary exempt or "as needed" employees, who have worked more than 1,040 hours in any consecutive 12-month period and whose normal work week is not less than 20 hours.
- Elected Officials of the City and County of San Francisco
- All members of designated boards and commissions during their time in service to the City and County of San Francisco as defined in San Francisco Administrative Code Section 16.700(c).
- All officers and employees as determined eligible by the governing bodies of the San Francisco Transportation Authority, San Francisco Parking Authority, San Francisco Redevelopment Agency, Treasure Island Development Authority, San Francisco Superior Court and any other employees as determined eligible by ordinance.

Dependent Eligibility

Spouse or Domestic Partner
A member's legal spouse or domestic partner may be eligible for HSS healthcare coverage. Proof of Medicare enrollment must also be provided for a same sex spouse or domestic partner (of either gender) who is age 65 or older, or Medicare-eligible due to a disability. Enrollment in HSS benefits must be completed within 30 days of the date of marriage or partnership. In that case, coverage begins on the first day of the coverage period 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. Eligibility documentation (listed on page 29) must be provided upon initial enrollment of the child.

Legal Guardianships and Court-ordered Children
Children under 19 years old 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. The member must provide HSS with proof of guardianship, court order or decree by required deadlines.

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-administered 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

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

REQUIRED ELIGIBILITY DOCUMENTATION

	EVIDENCE OF HIRE	BENEFIT AUTH. FORM	MARRIAGE CERTIFICATE	DOMESTIC PARTNER CERT	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	PROOF OF PLACEMENT	COURT ORDER OR DECREE	MEDICAL EVIDENCE	SOCIAL SECURITY #
Employee: Permanent/Provisional	■									■
Employee: Temporary/Exempt		■								■
Spouse			■							■
Domestic Partner				■						■
Child: Natural					■					■
Stepchild: Spouse			■		■					■
Stepchild: Domestic Partner				■	■					■
Child: Adopted						■				■
Child: Placed for Adoption							■			■
Child: Legal Guardianship								■		■
Child: Court Ordered								■		■
Adult Child: Disabled									■	■

Note: Proof of Medicare enrollment is also required for a Medicare-eligible same sex spouse, domestic partner or disabled child.

Changing Benefit Elections

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

Marriage or Domestic Partnership

To enroll a new spouse or domestic partner and eligible children of a spouse or partner in HSS healthcare coverage, you must submit a completed HSS enrollment application, a copy of your marriage certificate or certificate of domestic partnership, and a birth certificate for each child to HSS **within 30 days** from the date of the marriage or certification of domestic partnership. A Social Security number must be provided for each dependent. Proof of Medicare enrollment is also required for a same sex spouse or domestic partner (of either gender) who is Medicare-eligible due to either age or disability. Coverage for your spouse or domestic partner and his or her eligible children will be effective the first day of the coverage period following the submission of the required application and documentation. If you do not complete the enrollment process **within 30 days** from the date of your marriage or certification of domestic partnership, you must wait until the next Open Enrollment to add your new family members.

Birth or Adoption

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

Loss of Other Health Coverage

Employees and eligible dependents who lose other coverage may be enrolled by submitting a completed HSS enrollment application form and proof of the loss of coverage **within 30 days** from the date other coverage terminates. Documentation of lost coverage must indicate the date other coverage ends and the names of the individuals losing coverage. If HSS receives a completed HSS enrollment application and eligibility documentation **within 30 days** of the loss of coverage, HSS coverage will be effective on the first day of the next coverage period. There may be a break in coverage between the date other coverage terminates and the date HSS coverage begins. If you do not complete the HSS enrollment process **within 30 days** from the date other coverage terminates for either yourself or an eligible family member, you must wait until the next Open Enrollment.

Divorce, Separation and Dissolution of Partnership

Termination of HSS health coverage for your ex-spouse or domestic partner due to divorce, legal separation or dissolution of domestic partnership is required by law. To drop the dependent, you must submit a completed HSS application form and a copy of your divorce decree, legal separation documents or dissolution of domestic partnership documents

Changing Benefit Elections

You must notify HSS immediately if enrolled dependents become ineligible for coverage due to divorce, legal separation, or dissolution of partnership.

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

Obtaining Other Health Coverage

You may waive HSS coverage for yourself and/or any enrolled dependent who enrolls in other healthcare coverage. (If you waive coverage for yourself, coverage for your enrolled dependents must also be waived.) Submit a completed HSS enrollment application form and proof of other healthcare coverage enrollment **within 30 days** from the date of enrollment in the other health plan. Proof of coverage must indicate the effective date of coverage and the names of enrolled individuals. Your HSS healthcare coverage will terminate on the last day of the coverage period in which HSS receives a completed HSS enrollment application, provided you meet the 30-day deadline and documentation requirements. There may be an overlap of healthcare coverage between the date other coverage begins and the date your HSS coverage terminates. You are responsible for paying all required contributions up to the termination date of your HSS healthcare coverage. If you do not complete the coverage termination process **within 30 days** from the date of enrollment in another healthcare plan, you must wait until the next annual Open Enrollment.

Moving Out of Your Plan's Service Area

If you move your primary residence to a location outside your health plan's service areas, you will no longer will 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 next Open Enrollment.

Death of a Dependent

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

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Changing Benefit Elections

HSS to obtain information about eligibility for survivor health benefits. To be eligible for health benefits, the surviving spouse or domestic partner of an employee must have been 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
- 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 28-29.) Eligible surviving dependent children may be enrolled, but do not qualify for employer-subsidized benefits.

Responsibility for Premium Contributions

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

Ineligible Dependent Penalty

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

Domestic Partner/Same Sex Spouse Taxation

Health coverage for your domestic partner, same sex spouse, and any children of that partner or spouse through an HSS plan is typically a taxable benefit.

Tax Treatment of Health Benefits

The federal government does not recognize domestic partnership or same sex marriage for tax purposes. Employer contributions to health premiums for an employee's domestic partner, same sex spouse, and children of a domestic partner or same sex spouse, are taxable (imputed) income. Also, employee premium contributions are taken post-tax. By comparison, if an employee is married to a member of the opposite sex, no taxable imputed income results from employer contributions to the spouse's health premium costs and employee premium contributions for the spouse are paid pre-tax.

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), a same sex spouse, and children of a domestic partner or same sex spouse qualify for favorable tax treatment if:

1. Partner, spouse or child receives more than half of his or her financial support from the employee, and
2. Partner, spouse 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, spouse 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 these requirements the employee may submit an annual declaration to HSS, and there will be no imputed income for the employer contribution to dependent health premiums and employee premium contributions will be paid pre-tax. To take advantage of this favorable tax treatment, you must file the HSS declaration annually with HSS by required deadlines.

Equitable California State Tax Treatment

If your dependent does not meet the IRS code section 152 requirements for favorable tax treatment under federal law, you may still take advantage of equitable California state tax treatment if your dependent qualifies under California state law. (This California law only applies to same sex domestic partners and same sex spouses–not opposite sex domestic partners.) To obtain equitable tax treatment under California state law, you are required to have either a valid California marriage license or a Declaration of Domestic Partnership issued by the Secretary of the State of California. In this case, you will need to deduct the value of the employer-paid health insurance premiums for your same sex domestic partner or same sex spouse, 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, same sex spouses and their children. Please consult with a professional tax advisor before taking any action. You remain subject to all state and federal tax law and will be responsible for any consequences that result from the forms, documents or declarations you submit to the Health Service System.

Learn more online:
www.myhss.org/member_services

Leaves of Absence and Healthcare Coverage

Type of Leave	Eligibility	Your Responsibilities
Family and Medical Leave (FMLA) Worker's Compensation Leave Family Care Leave Military Leave	If you notify HSS within 30 days of when your leave begins, you may be eligible to continue or discontinue (waive) your healthcare coverage for the duration of your approved leave of absence. You may have additional rights under an approved FMLA leave. Contact your departmental personnel representative for details.	1. Notify your department's personnel officer. They will provide HSS with important information about your leave. 2. Contact HSS within 30 days of when leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits. 3. Contact HSS immediately (within 30 days of return to work) to request that premium contributions return to active status.
Personal Leave Following Family Care Leave	If you have been on an approved Family Care Leave and elect to extend your leave period as a Personal Leave, you may be eligible to continue (or waive) your healthcare coverage for the duration of your approved Personal Leave, if: - The reason for the Personal Leave is the same as the reason for the prior Family Care Leave. - Your required employee premium contribution payments, if any, are current. - You notify HSS before your leave begins.	1. Notify your department's personnel officer. They will provide HSS with important information about your leave. 2. Contact HSS within 30 days of when leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits. 3. Contact HSS immediately (within 30 days of return to work) to request that premium contributions return to active status.
Educational Leave Personal Leave Leave for Employment as an Employee Organization Officer or Representative	If you notify HSS within 30 days of when your leave begins, you may be eligible to continue (or waive) your healthcare coverage for the duration of your approved leave of absence.	1. Notify your department's personnel officer. They will provide HSS with important information about your leave. 2. Contact HSS within 30 days of when leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits. 3. If your leave lasts beyond 12 weeks, you must pay the total cost of medical and dental coverage for yourself and any covered dependents. This includes your employee premium contribution amount plus the City and County of San Francisco's contribution. Contact HSS for details. 4. Contact HSS immediately (within 30 days of return to work) to request that premium contributions return to active status.

See page 25 for information about Flexible Spending Accounts and leaves of absence.

Approaching Retirement

Transition to Retirement

The transition of health benefits from active to retiree status does not happen automatically. You must elect to continue retiree healthcare coverage by submitting the required retiree enrollment form and supporting documents to HSS. Contact HSS Member Services at (415) 554-1750 three months before your retirement date to learn about enrolling in retiree benefits. You are required to notify HSS of your retirement even if you are not planning to elect HSS coverage on your retirement date.

Depending on your retirement date, there can be a gap between when active employee coverage ends and retiree coverage begins. Setting a retirement date at the end of the month will help avoid a gap in HSS coverage. Call HSS at (415) 554-1750 to review your options before deciding on your retirement date.

If you choose to continue medical and/or dental coverage through HSS after you retire, your retiree premium contribution may be higher than your active employee contributions. As a retired member, you will also be required to pay for dental coverage. Costs will depend on your plan choices, number of dependents covered and your Medicare status. **If you choose to take a lump sum pension distribution, your retiree healthcare premium contributions will be unsubsidized, and you will pay the full cost.**

A retiree must have been a member of HSS at some time during his or her active employment in order to be eligible for retiree health benefits. Other restrictions may apply.

Health premium contributions will be taken from your pension check. If required monthly contributions are greater than the total amount of your pension check, you must contact HSS to make payment arrangements. Premium contribution rates may change every plan year.

All retirees and dependents who are Medicare-eligible due to age or disability are required to enroll. Failure of a retired member or dependent to enroll in Medicare when eligible will result in penalties, limitations in retiree member coverage and the termination of retiree dependent coverage.

Medicare Requirements for Active Employees and Dependents over Age 65

Active Employees and Opposite Sex Spouses
If you are working and eligible for HSS health coverage at age 65 or older, the federal government and HSS do not require that you enroll in Medicare. However, even though it is not required, you are eligible for Medicare at age 65 and can enroll if you choose to do so. Many active employees over age 65 choose to enroll in premium-free Medicare Part A while they are still working. If you enroll in Part A, remember you must contact the Social Security Administration and enroll in Medicare Part B when you retire or otherwise leave City employment. If you are over age 65 and not enrolled in both Medicare Part A and Part B upon retirement, you may be charged penalties by the federal government. These same rules apply to an opposite sex spouse covered on your HSS plan.

Same Sex Spouses and Domestic Partners
Unlike an opposite sex spouse, a same sex spouse or domestic partner (of either gender) of an active employee must enroll, and remain enrolled, in both premium-free Medicare Part A and Medicare Part B upon reaching age 65. Proof of Medicare enrollment, such as a copy of the Medicare card, must be provided to HSS. A same sex spouse or domestic partner who is age 65 or older and eligible for Medicare but not enrolled in Part A and Part B cannot be enrolled in HSS coverage. If enrolled in HSS medical coverage without Medicare, spouse or partner benefits can be terminated. Be aware that the federal government charges a premium for Medicare Part B, and these Medicare premium payments must be paid to maintain Medicare enrollment. Also, a same sex spouse or domestic partner who fails to enroll in Medicare Part B as soon as he or she is eligible may be charged penalties by the federal government.

Holdover and COBRA Coverage

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

Employees with Holdover Rights

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

1. Employees must certify, on an annual basis, that they are unable to obtain healthcare coverage from another source.
2. Premium contributions must be paid. (Rates are subject to increase each plan year).

Note: COBRA coverage may be available when holdover benefits have been exhausted.

Employees with No Holdover Rights

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

COBRA Continuation Coverage

COBRA, a federal law enacted in 1986, allows employees and their covered dependents to elect a temporary extension of healthcare coverage in certain instances where coverage would otherwise end. COBRA is administered by Fringe Benefits Management Company, a Division of WageWorks.

COBRA Qualifying Events

Under COBRA, employees may elect to continue healthcare coverage if it is lost due to any of the following qualifying events:

- Voluntary or involuntary termination of employment (except for gross misconduct).
- Hours of employment reduced, making the employee ineligible for employer health coverage.

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

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

Covered dependent children may elect COBRA coverage if healthcare coverage is lost due to any of the following qualifying events:

- Loss of dependent child status under the plan rules.
- Voluntary or involuntary termination of the employee's employment (except for gross misconduct).
- Hours of employment reduced, making the employee ineligible for employer health coverage.
- Parent's divorce, legal separation or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

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

COBRA Notification and Time Limits for COBRA Elections

When a qualifying event occurs, the COBRA Administrator will notify you of the opportunity to elect COBRA coverage. You have 60 days from the notification date to complete enrollment for yourself and any dependents who were covered on your employer-provided plan at the time of your termination. Coverage will be retroactive to the date of the COBRA qualifying event, so there is no break in your healthcare coverage. While covered under COBRA, you have 30 days to add any newly eligible dependent (spouse, domestic partner, newborn or adopted child) to your COBRA coverage based on the date of the qualifying event (marriage, partnership, birth, adoption). If a dependent loses coverage (due to divorce or aging out of a plan) the employee or dependent must notify the COBRA Administrator within 30 days of the qualifying event.

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.

Employees 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.

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 to the COBRA Administrator. For COBRA premium rate information contact HSS at (415) 554-1750 or visit www.myhss.org.

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

Federal Legislation and COBRA

This information may not reflect changes to COBRA resulting from federal legislation. For the most up-to-date information about how federal legislation may impact COBRA benefits, please contact Fringe Benefits Management Company, a Division of WageWorks, at (800) 342-8017.

COBRA Questions?

For questions about COBRA continuation coverage, contact the COBRA Administrator–Fringe Benefits Management Company, a Division of WageWorks– at (800) 342-8017.

Glossary of Healthcare Terms

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

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

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

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

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

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

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

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

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

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

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 the services provided, amounts paid and costs billed by the health plan.

Evidence of Coverage (EOC)
The Evidence of Coverage is a legal document that gives details about plan benefits and exclusions and how to get the care you need. It explains your rights, benefits and responsibilities as a member of your plan and the plan providers' responsibilities to you. EOCs are available on www.myhss.org.

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

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

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 are a therapeutic equivalent to the brand-name drug, contain the same active ingredient as the brand-name drug, and cost less than the brand-name drug equivalent.

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

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

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

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

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

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

Non-formulary Drug
A drug that is not on the insurer's list of approved medications. Non-formulary drugs can usually only be prescribed with a physician's special authorization.

Open Enrollment
The period of time when you can change your 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 which are not in your health plan's provider network. Some plans do not cover Out-of-network service costs. Others charge a higher co-payment for this type of service.

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

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

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

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

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

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

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

Privacy Policy

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

Use and Disclosure of Health Information

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

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

To Make or Obtain Payment

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

To Conduct Healthcare Operations

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

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

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

For Treatment Alternatives

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

For Distribution of Health-Related Benefits and Services

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

For Disclosure to the Plan Actuaries

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

When Legally Required

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

To Conduct Health Oversight Activities

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

In Connection With Judicial and Administrative Proceedings

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

For Law Enforcement Purposes

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

In the Event of a Serious Threat to Health or Safety

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

For Specified Government Functions

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

For Worker's Compensation

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

Authorization To Use Or Disclose Health Information

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

Your Rights With Respect to Your Health Information

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

Right to Request Restrictions

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

Right to Receive Confidential Communications

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

Right to Inspect and Copy Your Health Information

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

Right to Amend Your Health Information

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

Right to an Accounting

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

Right to a Paper Copy of this Notice

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

Duties of the Health Plan

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

Written Authorizations and Requests

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

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

Effective Date

Original Effective Date: April 14, 2003
Revised January 1, 2011

Medical Plan Costs

In 2011-2012, the Health Service System will spend an estimated $694 million on health benefits for over 109,000 members and dependents. Here are things you can do to help contain healthcare costs.

Stay Healthy

- **Quit smoking.** On average, smokers die 12 years sooner than non-smokers. In 2007, the national cost to treat tobacco-related illness was over $50 billion.
- **Manage stress.** Take advantage of stress reduction classes offered by your health plan and HSS.
- **Exercise.** Incorporate 30 minutes of moderate exercise, such as walking, into your daily routine.
- **Eat more fruits, vegetables and whole grains.** Eat less sugar and saturated fat (red meat, dairy). Eliminate trans fats and fried foods.
- **Avoid heavy drinking.** National expenditures for alcohol-related illness amount to $22.5 billion. Heavy drinkers have higher healthcare costs. All HSS health plans cover alcohol abuse treatment.
- **Get an annual check-up and preventative screenings.** Most are covered at no co-pay cost.
- **Keep track of your health concerns.** Write them down; do not forget to discuss with your doctor.
- **Follow doctor's orders.** Listen to your doctor; work together to speed recovery or manage a condition.
- **Complete a Health Risk Assessment (HRA).** Identify medical needs, share results with your doctor and be proactive about your care. All HSS plans offer free, confidential HRAs.
- **Complete an Advance Directive.** You do not need a lawyer. Document your medical care wishes for your loved ones, in case you can't speak for yourself. www.ag.ca.gov/consumers/general/adv_hc_dir.htm

Work With Your Doctor and Your Health Plan

- **Compare health plans.** Service areas, provider networks and out-of-pocket costs vary, but in most cases HSS medical plans provide the same benefits. Research and choose the plan that's best for you.
- **Wellness education.** Your plan and/or medical group may offer free or low cost fitness seminars or classes on wellness-related topics.
- **Generic drugs, by mail order.** Take advantage of your plan's reduced costs for generic and mail order prescriptions.
- **Email your doctor.** Make use of any online tools provided by your doctor's office for communicating concerns or appointment scheduling. Some doctors may also schedule telephone consultations.
- **Pay attention to appointment reminders.** Do not skip appointments. If you must cancel, notify your doctor's office in advance.
- **Outpatient surgery.** When possible, your doctor may schedule you to have surgery on an outpatient (non-hospitalized) basis.
- **Chronic condition management programs.** These services can help you and your family become better educated and coordinate care for diabetes, asthma, heart health, cancer, obesity and other conditions.
- **Vision Service Plan (VSP) coverage for urgent eye conditions.** See a VSP network eye doctor for urgent or acute eye ailments–just a $5 co-pay.

For more information about HSS finances and membership demographics, visit www.myhss.org/finance.

Bi-Weekly Health Plan Rates

MEDICAL PLAN BI-WEEKLY PREMIUM CONTRIBUTION RATES		JULY 1, 2011 - JUNE 30, 2012
CITY HEALTH PLAN PPO	**CCSF**	**Superior Court**
Employee Only	280.12	512.71
Employee + 1 Dependent	772.94	1,005.53
Employee + 2 or More Dependents	1,177.75	1,410.34
BLUE SHIELD OF CALIFORNIA HMO	**CCSF**	**Superior Court**
Employee Only	39.44	272.03
Employee + 1 Dependent	311.02	543.60
Employee + 2 or More Dependents	536.41	769.00
KAISER HMO	**CCSF**	**Superior Court**
Employee Only	.59	233.18
Employee + 1 Dependent	233.30	465.89
Employee + 2 or More Dependents	426.45	659.04

DENTAL PLAN BI-WEEKLY PREMIUM CONTRIBUTION RATES*		JULY 1, 2011 - JUNE 30, 2012
DELTA DENTAL	**CCSF**	**Superior Court**
Employee Only	2.31	0
Employee + 1 Dependent	4.62	0
Employee + 2 or More Dependents	6.92	0
DELTACARE USA	**CCSF**	**Superior Court**
Employee Only	0	0
Employee + 1 Dependent	0	0
Employee + 2 or More Dependents	0	0
PACIFIC UNION DENTAL	**CCSF**	**Superior Court**
Employee Only	0	0
Employee + 1 Dependent	0	0
Employee + 2 or More Dependents	0	0

*Unrepresented Employees and Elected Officials do not pay Delta Dental bi-weekly premium contributions.

The information printed on this page for the Superior Court is subject to change due to upcoming collective bargaining.

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

See pages 22-23 for information about flex credits, which can be allocated toward premium contributions.

Key Contact Information

HEALTH SERVICE SYSTEM

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

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

MEDICAL PLANS

City Health Plan (UnitedHealthcare)
Tel: (866) 282-0125
Group Number 705287
www.myuhc.com

Blue Shield of California
Tel: (800) 642-6155
Group Number H11054
www.blueshieldca.com/sfhss

Kaiser Permanente
Tel: (800) 464-4000
Group No. 888
my.kp.org/ca/cityandcountyofsanfrancisco

DENTAL PLANS

Delta Dental
Tel: (888) 335-8227
Group Number 9502-0003
www.deltadentalins.com/ccsf

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

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

VISION PLAN

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

FLEXIBLE SPENDING ACCOUNTS

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

COBRA

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

CITY AGENCIES

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

Department of the Environment (Commuter Benefits)
Tel: (415) 355-3729
www.sfenvironment.org

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

STATE AGENCIES

CalPERS
Tel: (888) 225-7377
www.calpers.ca.gov