Retired Employees Benefits Guide 2009 2010

Health Service System

CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

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Open Enrollment Alerts 2009 2010

PacifiCare & Secure Horizons Plan No Longer Being Offered

To help keep costs down for both you and your employer, the PacifiCare & Secure Horizons HMO plan is no longer being offered in Plan Year 2009-2010. Members enrolled in PacifiCare or Secure Horizons must elect a different medical plan by submitting an Open Enrollment Application to HSS no later than 5 PM, April 30, 2009. PacifiCare & Secure Horizons participants who do not submit an application to elect a new medical plan during April 2009 Open Enrollment will be automatically enrolled in the City Plan.

Blue Shield Office Visit Co-Pays Increase To $15

The amount you will pay for an office visit increases to $15 for the Blue Shield HMO as of July 1, 2009.

Blue Shield & City Plan Brand Name & Non-Formulary Prescription Co-Pays Increase

Blue Shield and City Plan enrollees will pay more for brand-name and non-formulary prescriptions. Changes will take effect on July 1, 2009. The cost of prescriptions for generic drugs will not change. See pages 14-21 for details.

Pharmacy Prescriptions - Brand Name	$20 co-pay 30 day supply
Pharmacy Prescriptions - Non Formulary	$35 co-pay 30 day supply
Mail Order Prescriptions - Brand Name	$40 co-pay 90 day supply
Mail Order Prescriptions - Non Formulary	$70 co-pay 90 day supply

No Changes To Kaiser Benefits

There are no changes to Kaiser medical benefits or co-pay costs in Plan Year 2009-2010.

Retiree Contributions Will Increase For All Medical Plans

Retiree contributions for Blue Shield, Kaiser and City Plan will be increasing in Plan Year 2009-2010. The amount of the increase is dependent upon the medical plan. Be sure to check the Rates charts on pages 39-43 so that you are aware what your contribution costs will be for 2009-2010 before deciding what action to take during Open Enrollment.

Plan Year 2009-2010 changes take effect July 1, 2009. This list includes highlighted changes only and may not cover every Plan change for 2009-2010. Please read the Evidence of Coverage (EOC) document for details about your plan's benefits. EOCs are available on myhss.org.

Open Enrollment Alerts

The Last Day To Submit Open Enrollment Changes Is April 30, 2009

Completed Open Enrollment Applications for Plan Year 2009-2010 must be received by HSS by 5PM, April 30, 2009. Open Enrollment Applications can be delivered to HSS in person, sent through the mail or transmitted by fax. Applications must be delivered with required eligibility documentation or they cannot be processed. See page 29 for a checklist of required eligibility documentation.

HSS Address:
Health Service System
1145 Market Street, 2nd Floor
San Francisco, CA 94103

HSS Fax:
(415) 554-1752

Things You Can Do During Open Enrollment

During Open Enrollment you can:

- Elect a different medical or dental plan.
- Add or drop eligible dependents from medical or dental coverage.

HSS Open Enrollment Open House April 1-30, 2009

Members are invited to visit HSS at 1145 Market Street, 2nd Floor, April 1-30, from 8AM to 4:30PM for in-person assistance with Open Enrollment. HSS medical and dental vendors will be on-site from April 13-30.

Visit myhss.org To Download Open Enrollment Applications, Benefit Guides & More

PDF versions of Open Enrollment Applications and Benefit Guides are available online at the HSS website myhss.org. You will also find additional resources to support your decision making process, such as Evidence of Coverage documents, Summaries of Benefits and other plan information.

Social Security Numbers Are Required For All Members & Dependents

HSS requires a valid Social Security number for all individuals enrolled in an HSS administered health plan. Members and dependents who do not have a Social Security number on file at HSS risk having their benefits terminated.

Change Of Address?

After you retire you must notify HSS promptly of any change in your home address. Contact HSS Member Services at (415) 554-1750 if you need to update your address. (Your pension administrator does not update your HSS address record.) This will help us keep you informed about changes that can impact your health benefits and contribution costs.

Open Enrollment

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

Things You Can Do During Open Enrollment

During Open Enrollment you can:

- Elect a different medical and/or dental plan.
- Add or drop eligible dependents from medical and/or dental coverage.

To make changes you must submit a completed Open Enrollment Application in person, by mail or by fax to HSS no later than 5 PM on April 30, 2009.

If you are enrolling new dependents HSS requires that you provide documentation proving that your dependents meet eligibility requirements for the upcoming year. Social Security numbers are also required for all enrolled individuals.

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

Any changes you elect to make during the April 2009 Open Enrollment period will take effect July 1, 2009, and remain in effect through June 30, 2010.

Dependents who are deleted from coverage during the Open Enrollment period are not eligible for COBRA continuation coverage.

If you elect to change your medical plan, the plan will issue you a new medical ID card. You will receive your new ID card before July 1, 2009. If you do not receive your card by July 1, contact your plan.

Benefit Election Changes Outside of Open Enrollment

Outside the annual Open Enrollment period, you must have a qualifying event in order to make any changes to your healthcare elections. See pages 30-31 of this guide for Qualifying Event guidelines.

Pension Deduction Amounts

The amount deducted from your monthly pension check will change in accordance with any approved changes to the rates for Plan Year 2009-2010. (See pages 39-43 of this guide for 2009-2010 rates.) Review your check to be sure the correct deduction is being taken. You are responsible for making sure required healthcare contributions are paid.

If required monthly contributions are greater than the total amount of your pension check you must contact HSS to make payment arrangements. One option is HSS Auto-Pay, which allows you to have healthcare contributions deducted automatically from a MasterCard or VISA so that you can avoid termination of benefits due to a missed payment.

No Dual HSS Plan Coverage

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

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

Open Enrollment

FREQUENTLY ASKED QUESTIONS

Medical & Dental Coverage	
What if I don't want to make any changes to my medical or dental coverage?	If you do not want to choose a different medical or dental plan and you are not adding or dropping dependents you do not need to take any action. PacifiCare and Secure Horizons will be discontinued in 2009-2010. All PacifiCare and Secure Horizons participants must enroll in an alternate medical plan.
How do I change my choice of medical and/or dental plan?	Review the plan options carefully, then submit a completed Open Enrollment Application form and any required eligibility documentation to HSS no later than 5 PM, April 30, 2009. For a list of required eligibility documentation see page 29.
How do I add a dependent to my medical and/or dental plan?	You must submit a completed Open Enrollment Application form and any required eligibility documentation to HSS no later than 5 PM, April 30, 2009. For a list of required eligibility documentation see page 29.
How do I drop a dependent from my medical and/or dental plan?	You must submit a completed Open Enrollment Application form to HSS no later than 5 PM, April 30, 2009. No additional documentation is required when you are dropping a dependent from coverage.

Your Open Enrollment Application	
May I fax my Open Enrollment Application to HSS?	You can mail, fax or drop-off your Open Enrollment Application and any required eligibility documentation to HSS at 1145 Market Street, 2nd Floor. The HSS fax number is (415) 554-1752. If you fax your application, please keep a copy of your fax confirmation as proof of your submission.
What else is required in addition to my Application form?	Your application must be accompanied by any required eligibility documentation. For a list of required eligibility documentation see page 29.
May I get Open Enrollment materials online?	Yes, you can download the Open Enrollment Application form and 2009-2010 Benefits Guide for retirees from our website myhss.org.
After I submit my Enrollment Application will I receive a confirmation from HSS?	Yes, HSS will mail a letter to the home address that is on file with HSS, confirming your benefit elections. These letters are sent in June 2009.

Medicare & Your HSS Medical Benefits

Health Service Board Rules and Regulations require enrollment in both Part A and Part B of Medicare by (1) all eligible retired members and (2) any eligible dependents of a retired member who are enrolled in the member's medical plan. Failure by you or your enrolled dependents to comply with this rule by the required deadline will mean a change in or loss of medical plan coverage.

What is Medicare?

Medicare is a federal government health insurance program for people age 65 years or older and for people under age 65 with certain disabilities or kidney disease. Medicare has three parts that are important for you to understand. Part A is for hospital insurance. In most cases, you don't have to pay for Medicare Part A coverage. Part B covers the cost of physician and other medical provider services. You must pay a monthly premium to the Social Security Administration for Medicare Part B. The relatively new Medicare Part D provides prescription drug coverage.

How do I know if I qualify for Medicare?

If you're receiving Social Security benefits, the Social Security Administration will notify you prior to your 65th birthday regarding your eligibility for Medicare.

- If you're not currently receiving Social Security benefits, it's your responsibility to contact the Social Security Administration prior to your 65th birthday to apply for Medicare. Failure to do so could result in penalties being assessed by the Social Security Administration and the Health Service System.
- If you have a permanent disability or you have kidney disease requiring hemodialysis or transplant, you should contact the Social Security Administration immediately to apply for Medicare.

For information about Medicare eligibility and enrollment, call the Social Security Administration, the federal agency responsible for handling Medicare. You can reach them at 1-800-772-1213 (TTY: 1-800-325-0778) or visit them at the office most convenient for you. The location of these offices can be found in the blue, government pages of your local phone book. You can also obtain information from the Social Security Administration's official website at www.ssa.gov; click on Medicare Information.

What are the Health Service System rules for Medicare Participation?

Medicare Part A and B enrollment for eligible retirees and their enrolled eligible dependents is mandatory. It is your responsibility to notify HSS of your Medicare eligibility and enrollment status.

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

You must submit a statement from the Social Security Administration indicating that you're not eligible for non-contributory (free) Medicare Part A (Hospital) coverage. We will update our records accordingly. HSS requires you to enroll in Medicare Part B, regardless of your eligibility status for non-contributory (free) Medicare Part A.

What if I didn't enroll in the Part B (Medical) portion of Medicare when I was originally eligible?

If you did not enroll in both parts of Medicare when you attained the age of 65, or upon retirement after age 65, you may be assessed a penalty by the Social Security Administration for each year in which you failed to enroll when eligible. Nevertheless, you're still required to enroll in Medicare in accordance with the Health Service Board rules and regulations.

What if I don't enroll despite HSS rules?

If you're retired, 65 years old and eligible for both Medicare Part A and/or Part B but don't enroll, you and your enrolled dependents will lose your current medical plan coverage. If you were in an HMO, your HMO coverage will terminate

and you will automatically be enrolled in the City Health Plan 20. If you were already in the City Health Plan, you will automatically be enrolled in the City Health Plan 20. Under the City Health Plan 20, the plan will first estimate and subtract what Medicare would have paid if you and/or a dependent were enrolled. The remaining claim will be paid at 20% of what is usual and customary. You will be responsible for paying the amount that Medicare would have paid and 80% of the remaining claims costs, plus any amounts above usual and customary fees. In addition, your yearly out-of-pocket limits will increase to $10,950.

What if my enrolled eligible dependent does not enroll despite HSS rules?

If your enrolled eligible dependent does not enroll in both Medicare Part A and Part B, medical plan coverage will be terminated.

What if I'm a Kaiser member?

Kaiser offers the Senior Advantage Plan. You assign your Medicare benefits to Kaiser and must use their network. If you're 65 years old and are eligible for both Medicare Part A and Part B you must enroll in both Medicare A and B. In addition, you must enroll in the Kaiser Senior Advantage Plan.

If you fail to do so, your healthcare coverage will be terminated by Kaiser. HSS will then automatically enroll you in the City Health Plan 20. Under the City Health Plan 20, the plan will first estimate and subtract what Medicare would have paid if you and/or a dependent were enrolled. The remaining claim will be paid at 20% of what is usual and customary. You will be responsible for paying the amount that Medicare would have paid and 80% of the remaining claims costs, plus any amounts above usual and customary fees. In addition, your yearly out-of-pocket limits will increase to $10,950. Contact Kaiser for more information about enrolling in Senior Advantage: (800) 443-0815.

What if I'm a Blue Shield member?

Under the Blue Shield HMO plan, members don't assign their Medicare benefits to the HMO. Members have the freedom to use Medicare providers outside of the HMO network. In such a case, benefits will be partially paid by Medicare, if applicable, and the HMO will not be liable for any charges not paid by Medicare.

If you're 65 years old and are eligible for both Medicare Part A and Part B but don't enroll in both parts, your healthcare coverage will be terminated by Blue Shield and the Health Service System will automatically enroll you in the City Health Plan 20. Under the City Health Plan 20, the plan will first estimate and subtract what Medicare would have paid if you and/or a dependent were enrolled. The remaining claim will be paid at 20% of what is usual and customary. You will be responsible for paying the amount that Medicare would have paid and 80% of the remaining claims costs, plus any amounts above usual and customary fees. In addition, your yearly out-of-pocket limits will increase to $10,950.

In 2009 Blue Shield is offering a Medicare Advantage Plan (Blue Shield 65 Plus). If you are over 65 and live in an area serviced by this plan, Blue Shield will be working with HSS to send you an invitation to consider this plan in early June. The choice of whether to move into this plan is up to you. If you have questions call Blue Shield at (800) 776-4466.

What about Medicare Part D?

Do not enroll in Medicare Part D. See page 8 for more information.

Eligible Retiress Must Enroll in Medicare Parts A & B

Health Service Board Rules require that all eligible retired members enroll in both Part A and Part B of Medicare.

Medicare Part D

Do not enroll in an individual Medicare Part D plan. Prescription drug coverage provided by your HSS medical plan is better than available Medicare Part D coverage.

Individual Medicare Part D Plans and Your HSS Prescription Coverage

Do not enroll in an individual Medicare Part D plan. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added a new prescription drug program to Medicare. You may receive Medicare Part D enrollment information from the Centers for Medicare and Medicaid Services (CMS).

The good news is that the medical plan you and your dependents are enrolled in through the Health Service System has prescription drug coverage that is better than the available Medicare Part D coverage. In order to be able to continue to offer you such coverage, it is important that you and your dependents do not enroll in an individual Medicare Part D plan.

If you do enroll, the Health Service System will not benefit from CMS subsidies that are helping us to offer you better coverage at a reasonable cost. This could jeopardize your future prescription coverage through HSS.

Creditable Coverage Disclosure Notice

This is an important notice about your prescription drug coverage and Medicare. Please read this notice carefully and keep it with your important documents.

We have determined that the prescription drug coverage that you have in your medical plan is "creditable coverage" under Medicare Part D. From a technical standpoint, "creditable coverage" means that the amount that the plan expects to pay on average for prescription drugs for individuals covered by the plan is the same or more than what standard Medicare prescription drug coverage would be expected to pay on average. In lay terms, this means that your current prescription drug coverage is better than the Medicare Part D coverage that became available January 1, 2006.

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

You only need to worry about this rule if, in the future, you terminate or lose the healthcare coverage administered through the Health Service System. At that point, your evidence of creditable coverage will prevent you from incurring any late enrollment penalties, as long as you enroll in Medicare Part D no more than 62 days after your coverage terminates. Anyone who fails to act within that time period, will incur the late enrollment penalty of at least 1% per month for every month after May 15, 2006 that he or she did not have creditable coverage (as you do now) or enrollment in Part D. For example, if 19 months passed between the time a person terminated creditable coverage with the Health Service System and that person's enrollment in Medicare Part D, that person's premium would always be at least 19% higher than what most other people pay. That person might also me required to wait until the next November Open Enrollment period for Medicare in order to sign up for Medicare Part D coverage.

Original Issue Date: October 6, 2005
Revised Date: January 1, 2009

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 11.)

2 Plan Service Areas

Find out which plans offer service to you based on the home zip code of the primary HSS member. (See the chart on page 13 of this guide.)

3 Doctors and Hospitals

Determine which doctors, hospitals and other medical services that you and your family prefer.

4 Vendor Report Cards & Quality Ratings

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

HSS
www.myhss.org

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

Integrated Healthcare Association
www.iha.org/p4ptoprf.htm

National Committee for Quality Assurance
http://web.ncqa.org/

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

5 Medical Needs & Services Covered

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

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

6 Plan Costs

Compare the costs of each available medical plan. See pages 39-43 of this guide for cost comparison charts.

PPO vs. HMO

QUICK COMPARISON CHART

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

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

Medical Plan Options

These medical plan options are available to eligible retirees and their eligible dependents. Required contributions, if any, will be deducted from a member's monthly retirement check.

Health Maintenance Organization (HMO)

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

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

Preferred Provider Organization (PPO)

A PPO is a medical plan that gives you freedom of choice by allowing you to go to any in-network or out-of-network healthcare providers. When you go to in-network providers the plan pays higher benefits and you pay less. A PPO typically does not assign you a primary care physician, so you have more responsibility for coordinating your care.

HSS offers the following PPO plan:

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

For your convenience, we've included a medical plan comparison chart on pages 14-21 that contains key plan features and benefits for each plan. However, this benefits guide cannot cover every detail of your plan contract. Please refer to the plan's Evidence of Coverage (EOC) for a detailed list of covered services, exclusions and limitations. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. You can download plan EOCs at myhss.org.

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

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

If you are 65 years old or older and retired, you must be enrolled in Medicare Parts A and B. See pages 6-8 for information about Medicare and your HSS medical benefits.

Medical Plan Service Areas

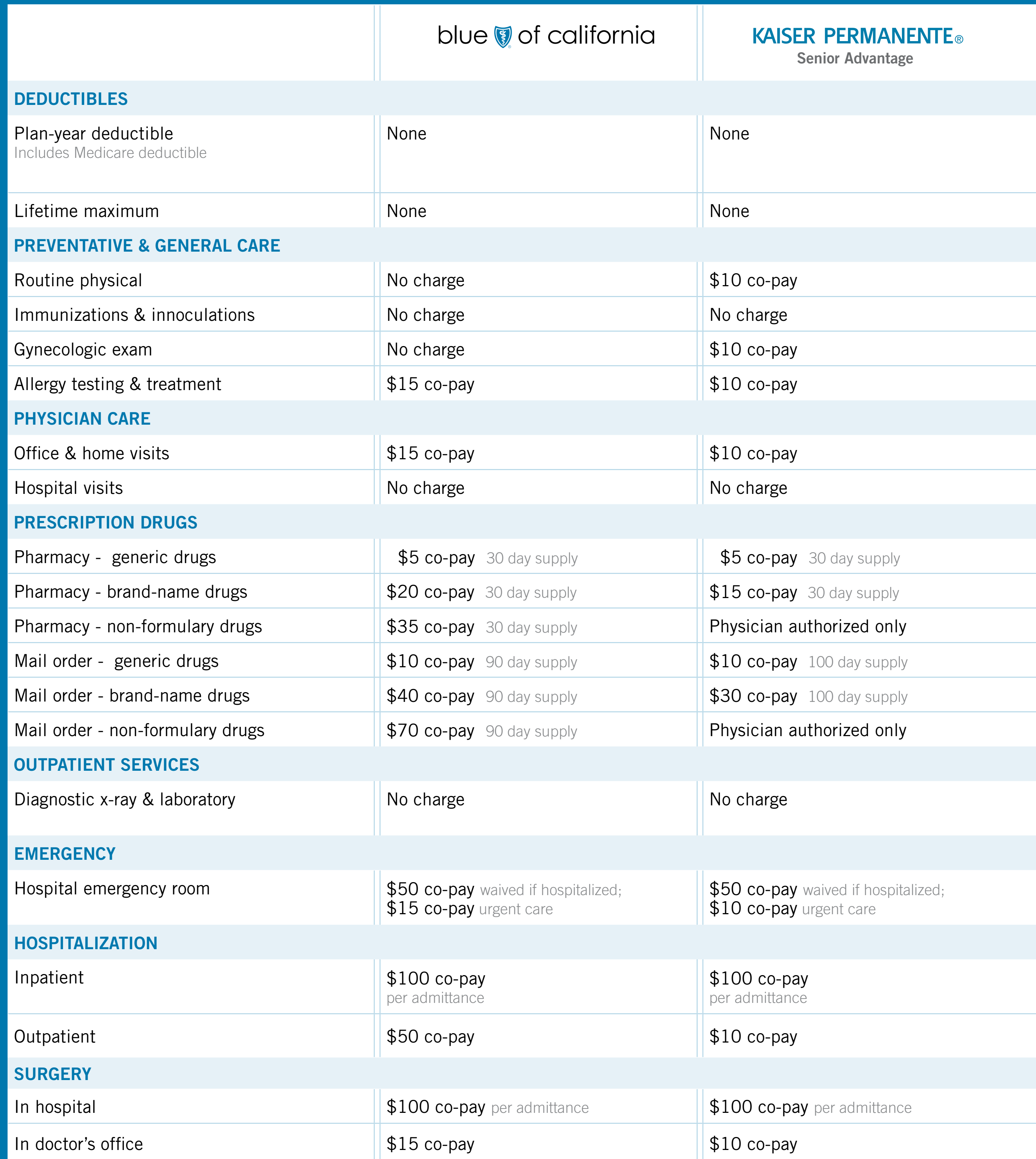
To enroll in Blue Shield or Kaiser you must reside in a zip code serviced by the plan. Refer to the chart below or contact the plan to determine whether or not you live in the plan's service area.

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

COUNTY	CITY PLAN	BLUE SHIELD	KAISER
Alameda	■	■	■
Alpine	■		
Amador	■		❍
Butte	■	■	
Calaveras	■		
Colusa	■		
Contra Costa	■	■	■
El Dorado	■	❍	❍
Fresno	■	■	❍
Glenn	■		
Lake	■		
Lassen	■		
Madera	■	■	❍
Marin	■	■	■
Mariposa	■		❍
Mendocino	■		
Merced	■	■	
Mono	■		
Monterey	■		
Napa	■		❍
Nevada	■	❍	
Placer	■	❍	❍
Plumas	■		
Sacramento	■	■	■
San Benito	■		
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Barbara	■	■	
Santa Clara	■	■	❍
Santa Cruz	■	■	
Sierra	■		
Solano	■	■	■
Sonoma	■	■	❍
Stanislaus	■	■	■
Sutter	■		❍
Yolo	■	■	❍
Outside California	■	Urgent/ER Only	Urgent/ER Only

If you do not see your County listed please contact the medical plan to confirm availability in your zip code.

Retired Employees with Medicare Parts A & B



	blue of california	KAISER PERMANENTE® Senior Advantage
DEDUCTIBLES		
Plan-year deductible Includes Medicare deductible	None	None
Lifetime maximum	None	None
PREVENTATIVE & GENERAL CARE		
Routine physical	No charge	$10 co-pay
Immunizations & innoculations	No charge	No charge
Gynecologic exam	No charge	$10 co-pay
Allergy testing & treatment	$15 co-pay	$10 co-pay
PHYSICIAN CARE		
Office & home visits	$15 co-pay	$10 co-pay
Hospital visits	No charge	No charge
PRESCRIPTION DRUGS		
Pharmacy - generic drugs	$5 co-pay 30 day supply	$5 co-pay 30 day supply
Pharmacy - brand-name drugs	$20 co-pay 30 day supply	$15 co-pay 30 day supply
Pharmacy - non-formulary drugs	$35 co-pay 30 day supply	Physician authorized only
Mail order - generic drugs	$10 co-pay 90 day supply	$10 co-pay 100 day supply
Mail order - brand-name drugs	$40 co-pay 90 day supply	$30 co-pay 100 day supply
Mail order - non-formulary drugs	$70 co-pay 90 day supply	Physician authorized only
OUTPATIENT SERVICES		
Diagnostic x-ray & laboratory	No charge	No charge
EMERGENCY		
Hospital emergency room	$50 co-pay waived if hospitalized; $15 co-pay urgent care	$50 co-pay waived if hospitalized; $10 co-pay urgent care
HOSPITALIZATION		
Inpatient	$100 co-pay per admittance	$100 co-pay per admittance
Outpatient	$50 co-pay	$10 co-pay
SURGERY		
In hospital	$100 co-pay per admittance	$100 co-pay per admittance
In doctor’s office	$15 co-pay	$10 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 myhss.org.

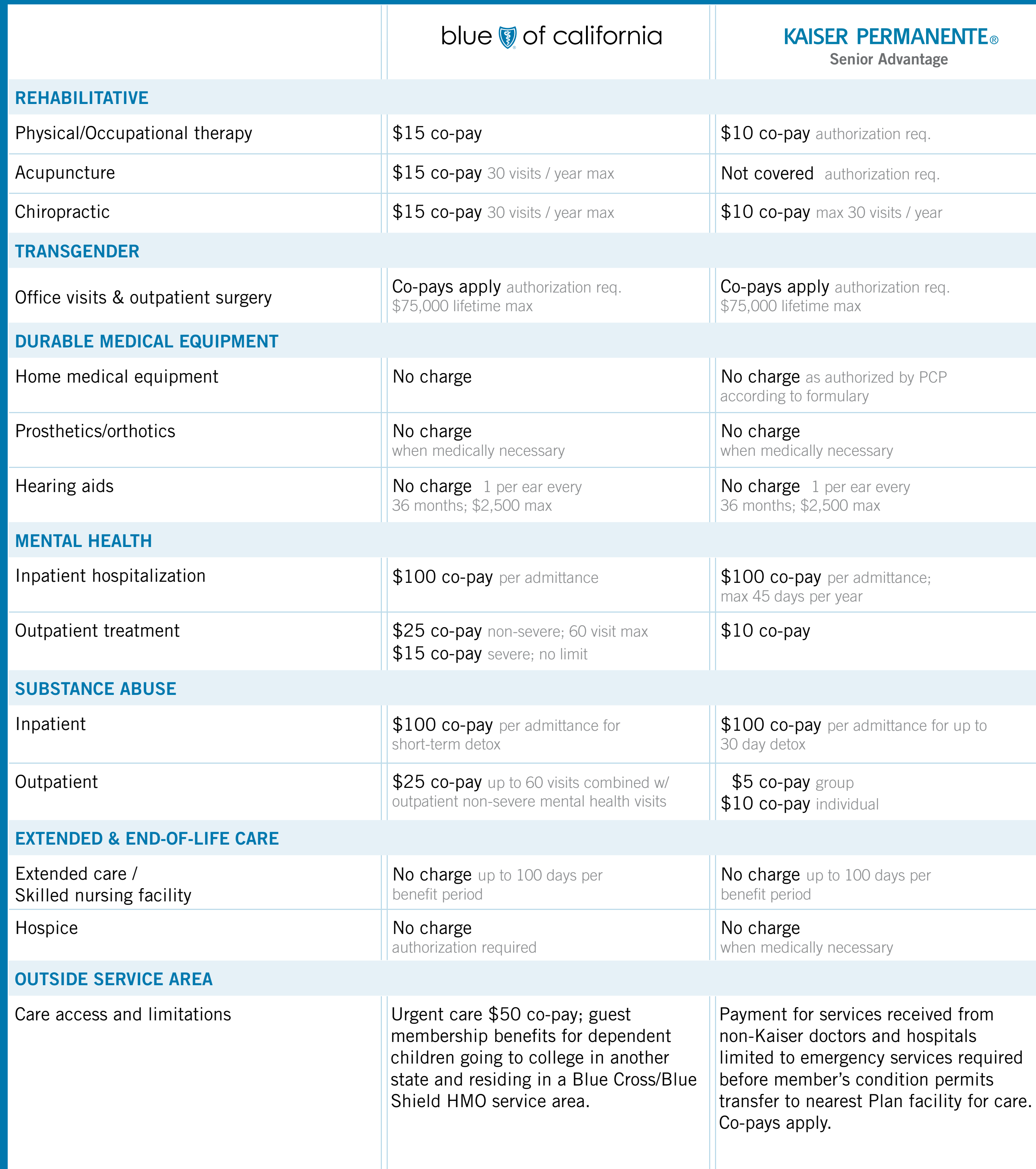
CITY HEALTH PLAN (administered by United Healthcare)

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

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

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

Retired Employees with Medicare Parts A & B



	blue of california	KAISER PERMANENTE® Senior Advantage
REHABILITATIVE		
Physical/Occupational therapy	$15 co-pay	$10 co-pay authorization req.
Acupuncture	$15 co-pay 30 visits / year max	Not covered authorization req.
Chiropractic	$15 co-pay 30 visits / year max	$10 co-pay max 30 visits / year
TRANSGENDER		
Office visits & outpatient surgery	Co-pays apply authorization req. $75,000 lifetime max	Co-pays apply authorization req. $75,000 lifetime max
DURABLE MEDICAL EQUIPMENT		
Home medical equipment	No charge	No charge as authorized by PCP according to formulary
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary
Hearing aids	No charge 1 per ear every 36 months; $2,500 max	No charge 1 per ear every 36 months; $2,500 max
MENTAL HEALTH		
Inpatient hospitalization	$100 co-pay per admittance	$100 co-pay per admittance; max 45 days per year
Outpatient treatment	$25 co-pay non-severe; 60 visit max $15 co-pay severe; no limit	$10 co-pay
SUBSTANCE ABUSE		
Inpatient	$100 co-pay per admittance for short-term detox	$100 co-pay per admittance for up to 30 day detox
Outpatient	$25 co-pay up to 60 visits combined w/ outpatient non-severe mental health visits	$5 co-pay group $10 co-pay individual
EXTENDED & END-OF-LIFE CARE		
Extended care / Skilled nursing facility	No charge up to 100 days per benefit period	No charge up to 100 days per benefit period
Hospice	No charge authorization required	No charge when medically necessary
OUTSIDE SERVICE AREA		
Care access and limitations	Urgent care $50 co-pay; guest membership benefits for dependent children going to college in another state and residing in a Blue Cross/Blue Shield HMO service area.	Payment for services received from non-Kaiser doctors and hospitals limited to emergency services required before member's condition permits transfer to nearest Plan facility for care. Co-pays apply.

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

CITY HEALTH PLAN (adminstered by United Healthcare)

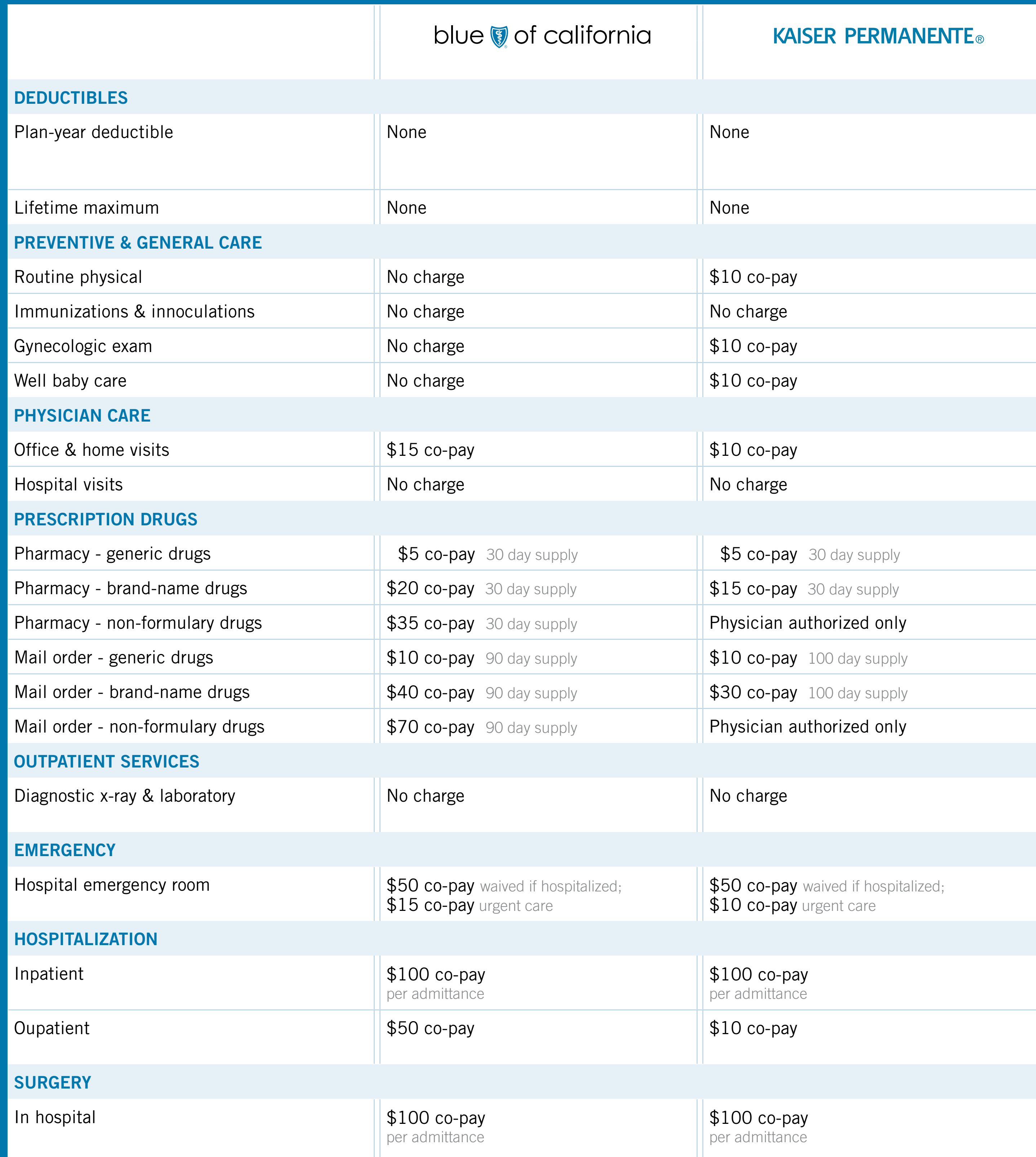
In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
85% covered after deductible; 60 visits / year	**50% covered** after deductible; 60 visits / year	**85% covered** after deductible; 60 visits / year
50% covered after deductible; $1,000 / year	**50% covered** after deductible; $1,000 / 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; prior notification required; $75,000 lifetime max	**50% covered** after deductible; prior notification required; $75,000 lifetime max	**85% covered** after deductible; prior notification required; $75,000 lifetime max
85% covered after deductible; rental not to exceed purchase price	**50% covered** after deductible; rental not to exceed purchase price	**85% covered** after deductible; rental not to exceed purchase price
85% covered after deductible; when medically necessary	**50% covered** after deductible; when medically necessary	**85% covered** after deductible; when medically necessary
100% covered after deductible; 1 per ear every 36 months; $2,500 max	**100% covered** after deductible; 1 per ear every 36 months; $2,500 max	**100% covered** after deductible; 1 per ear every 36 months; $2,500 max
85% covered after deductible; up to 30 hospital days per year max; auth. req.	**50% covered** after deductible; up to 30 hospital days per year max; auth. req.	**85% covered** after deductible; up to 30 hospital days per year max; auth. req.
85% covered after deductible; up to 25 visits per year max	**50% covered** after deductible; up to 25 visits per year max	**85% covered** after deductible; up to 25 visits per year max
85% covered after deductible; 30 day detox; 60 day rehab	**50% covered** after deductible; 30 day detox; 60 day rehab	**85% covered** after deductible; 30 day detox; 60 day rehab
85% covered after deductible; up to 25 visits per year max	**50% covered** after deductible; up to 25 visits per year max	**85% covered** after deductible; up to 25 visits per year max
85% covered after deductible; up to 120 days max; custodial care not covered	**50% covered** after deductible; up to 120 days max; custodial care not covered	**85% covered** after deductible; up to 120 days max; custodial care not covered
85% covered after deductible; $10,000 max; prior notification required	**50% covered** after deductible; $10,000 max; prior notification required	**85% covered** after deductible; $10,000 max; prior notification required
Out-of-Network benefits apply.	Out-of-Network benefits apply.	Out-of-Network benefits apply.

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

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

2009-2010 Medical Plan Benefits-at-a-Glance

Retired Employees Not Eligible for Medicare



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

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

CITY HEALTH PLAN (administered by United Healthcare)

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

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

Retired Employees Not Eligible for Medicare

	blue of california	KAISER PERMANENTE®
REHABILITATIVE		
Physical/Occupational therapy	$15 co-pay	$10 co-pay authorization req.
Acupuncture	$15 co-pay 30 visits / year max	Not covered authorization req.
Chiropractic	$15 co-pay 30 visits / year max	$10 co-pay 30 visits / year max
PREGNANCY & MATERNITY		
Pre/post-natal physician care For hospital stay, see Hospitalization.	No charge newborn must be enrolled within 30 days	$10 co-pay newborn must be enrolled within 30 days
INFERTILITY		
IVF, GIFT, ZIFT & Artificial Insemination	50% covered of the allowable amount; limitations apply	50% covered limitations apply
TRANSGENDER		
Office visits & outpatient surgery	Co-pays apply authorization req. $75,000 lifetime max	Co-pays apply authorization req. $75,000 lifetime max
DURABLE MEDICAL EQUIPMENT		
Home medical equipment	No charge	No charge as authorized by PCP according to formulary
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary
Hearing aids	No charge 1 per ear every 36 months; $2,500 max	No charge 1 per ear every 36 months; $2,500 max
MENTAL HEALTH		
Inpatient hospitalization	$100 co-pay per admittance	$100 co-pay per admittance; max 45 days / year
Outpatient treatment	$25 co-pay non-severe; 60 visit max $15 co-pay severe; no limit	$5 co-pay group $10 co-pay individual; up to 20/year
SUBSTANCE ABUSE		
Inpatient	$100 co-pay per admittance for short-term detox	$100 co-pay per admittance for up to 30 day detox
Outpatient	$25 co-pay up to 60 visits combined w/ outpatient non-severe mental health visits	$5 co-pay group $10 co-pay individual
EXTENDED & END-OF-LIFE CARE		
Skilled nursing facility	No charge up to 100 days per year	No charge up to 100 days per year
Hospice	No charge authorization required	No charge when medically necessary

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

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
85% covered after deductible; 60 visits / year	**50% covered** after deductible; 60 visits / year	**85% covered** after deductible; 60 visits / year
50% covered after deductible; $1,000 / year	**50% covered** after deductible; $1,000 / year	**50% covered** after deductible; $1,000 / year
50% covered after deductible; $1,000 / year	**50% covered** after deductible; $1,000 / year	**50% covered** after deductible; $1,000 / year
85% covered after deductible; newborn must be enrolled within 30 days	**50% covered** after deductible; newborn must be enrolled within 30 days	**85% covered** after deductible; newborn must be enrolled within 30 days
50% covered after deductible; limitations apply; prior notification required	**50% covered** after deductible; limitations apply; prior notification required	**50% covered** after deductible; limitations apply; prior notification required
85% covered after deductible; prior notification required; $75,000 lifetime max	**50% covered** after deductible; prior notification required; $75,000 lifetime max	**85% covered** after deductible; prior notification required; $75,000 lifetime max
85% covered after deductible; rental not to exceed purchase price	**50% covered** after deductible; rental not to exceed purchase price	**85% covered** after deductible; rental not to exceed purchase price
85% covered after deductible; when medically necessary	**50% covered** after deductible; when medically necessary	**85% covered** after deductible; when medically necessary
100% covered after deductible; 1 per ear every 36 months; $2,500 max	**100% covered** after deductible; 1 per ear every 36 months; $2,500 max	**100% covered** after deductible; 1 per ear every 36 months; $2,500 max
85% covered after deductible; up to 30 hospital days per year max; auth. required	**50% covered** after deductible; up to 30 hospital days per year max; auth. required	**85% covered** after deductible; up to 30 hospital days per year max; auth. required
85% covered after deductible; up to 25 visits per year max; authorization required	**50% covered** after deductible; up to 25 visits per year max; authorization required	**85% covered** after deductible; up to 25 visits per year max; authorization required
85% covered after deductible; 30 day detox / 60 day rehab; authorization required	**50% covered** after deductible; 30 day detox / 60 day rehab; authorization required	**85% covered** after deductible; 30 day detox / 60 day rehab; authorization required
85% covered after deductible; up to 25 visits per year max; authorization required	**50% covered** after deductible; up to 25 visits per year max; authorization required	**85% covered** after deductible; up to 25 visits per year max; authorization required
85% covered after deductible; 120 days per year; prior authorization required; custodial care not covered	**50% covered** after deductible; 120 days per year; prior authorization required; custodial care not covered	**85% covered** after deductible; 120 days per year; prior authorization required; custodial care not covered
85% covered after deductible; $10,000 max; prior notification required	**50% covered** after deductible; $10,000 max; prior notification required	**85% covered** after deductible; $10,000 max; prior notification required

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

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 for retired HSS members.

HMO-Style Dental Plans

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

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

HSS offers you 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.

PPO-Style Dental Plans

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

HSS offers you the following PPO-style dental plan:

- **Delta Dental**

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

- The Delta Preferred Option network offers the highest benefit. Most preventive services are covered at 100%; many other services are covered at 80%.
- The Delta Premier network pays benefits based on a pre-arranged fee agreed to by the network's dentists. Most preventive services are covered at 80%; many other services are covered at 50%.

You may go to any dentist from either network, or you may also go to a dentist that is in neither network. When you go to any licensed dentist not in one of the newtworks described above, the plan pays the same percentage of cost that it pays a Delta Participating Dentist. However, payment is based on what is considered reasonable and customary (R&C) for the geographical area. This means that your share of the expenses will be higher if your out-of-network dentist charges more than R&C. Don't be shy about asking a dentist financial questions before receiving services. Delta can also help you understand what your costs will be. Call Delta with any questions.