



RETIRED EMPLOYEES 2013 HEALTH BENEFITS

Health Service System
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

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Open Enrollment Overview

Open Enrollment takes place October 1–31, 2012. 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.

Any changes you make during October 2012 Open Enrollment will be in effect from January 1, 2013 through December 31, 2013. Dependents who are dropped from coverage during Open Enrollment are not eligible for COBRA continuation coverage.

Open Enrollment Deadline: October 31, 2012

Completed Open Enrollment applications for the January to December 2013 plan year must be received at HSS by 5:30PM, October 31, 2012. 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.

Changing Benefit Elections During Open Enrollment

If you change your medical plan, the plan will issue a new medical ID card before January 1, 2013. If you do not receive your card by January 1, contact your plan. Newly enrolled Kaiser members should contact Kaiser to confirm Primary Care Physician selection. Newly enrolled Blue Shield members should contact Blue Shield to confirm Primary Care Physician and medical group selections.

If You Do Not Make Any Changes During Open Enrollment

If you do not make changes during this Open Enrollment, your current health plan elections and the eligible dependents you have covered will remain the same. Be aware your premium contributions will change, effective January 1, 2013. See pages 43–47 for premium contribution rates.

What's New for January–December 2013

- Premium contribution rates will change, effective January 1, 2013. (See pages 43–47.)
- City Health Plan deductible and out-of-pocket maximum costs incurred from October through December 2012 will be carried over to the 2013 plan year.
- For retirees with Medicare enrolled in City Health Plan, HSS is implementing EGWP (Employer Group Waiver Plan), a federal program for prescription reimbursement that will save an estimated \$2.3 million annually. This change will have no impact on how almost all City Health Plan members access prescription benefits. For details, see page 23.
- As part of the federal Affordable Care Act, effective 2013 coverage for women's health services with no cost sharing is expanded. These services include well woman office visits, contraception, domestic violence screening and more. For a complete list see: www.hrsa.gov/womensguidelines.

Open Enrollment Events

Monday	Tuesday	Wednesday	Thursday	Friday
October 2012				
1	2	3	4	5
Start of Open Enrollment HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM HSS at 850 Bryant Room 551 8:30 AM–4:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM HSS at City Hall Room 421 8:30 AM–4:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM HSS at SFGH Main Cafeteria 8:30 AM–4:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM
8	9	10	11	12
Columbus Day	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM HSS at Laguna Honda New Hospital Conf Room P1191 8:30 AM–4:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM HSS at SFUSD 555 Franklin Street 8:30 AM–4:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM
15	16	17	18	19
HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM HSS at SFO ITB/A Training Room near SFO medical clinic 8:30 AM–4:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM
22	23	24	25	26
HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS
29	30	31		
HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS	End of Open Enrollment HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS All applications due by 5:30 PM		

Open Enrollment FAQ

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 are not adding or dropping dependents, you do not need to take any action during October 2012 Open Enrollment. Premium contributions change January 1, 2013 (pages 43-47).
How do I choose different medical or dental coverage?	Review the plan options carefully, then submit a completed Open Enrollment application form and required eligibility documentation to HSS no later than 5:30PM, October 31, 2012. See page 35.
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 5:30PM, October 31, 2012. For a list of required eligibility documentation, see page 35.
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 5:30PM, October 31, 2012. No additional documentation is required when you are dropping a dependent from coverage during Open Enrollment.
If I drop a dependent during Open Enrollment is he or she eligible for COBRA?	No. In accordance with federal law, dependents dropped during Open Enrollment are not eligible for COBRA.
May I fax my enrollment application and eligibility documentation to HSS?	Yes, you may fax your Open Enrollment application and required eligibility documentation. For a list of required eligibility documentation, see page 35 of this guide. The secure HSS fax number is (415) 554-1721. Faxed applications must be received by HSS no later than 5:30PM, October 31, 2012. Please do not fax the same application multiple times.
Will I receive a confirmation from HSS after I submit my enrollment application?	Yes, HSS will mail a letter to the mailing address that is on file, confirming your benefit elections. These letters will be sent in December 2012. Note: no changes to Open Enrollment elections can be made after October 31, 2012. HSS can only correct administrative errors based on the Open Enrollment application you submitted in October 2012.
How are retiree health premium contributions paid?	Retiree premium contributions are usually deducted from monthly pension checks. See pages 43–47 of this guide for premium contribution rates. Review your pension check to be sure the correct deduction is taken. You are responsible for making sure required healthcare contributions are paid.
What if my pension check does not cover the cost of my premium contributions?	If required monthly premium contributions are greater than the total amount of your pension check, you must contact HSS at (415) 554-1750 to make payment arrangements. One option is HSS Auto-Pay, which allows you to have healthcare contributions deducted automatically from a MasterCard or VISA.
Can an HSS member or dependent be enrolled in two HSS health plans at the same time?	Dual coverage is not allowed. HSS will automatically eliminate any dual coverage. For a member who is covered both as a member and as a dependent of another member, coverage as a dependent will be terminated. For any dependent covered by two members, the dependent will be covered by the member who covered the dependent first, based on the enrollment application date.

Medical Plan Options

These medical plan options are available to retired HSS members and eligible dependents. Required retiree premium contributions, if any, will be deducted from the member's monthly pension check.

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

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

Kaiser Permanente HMO

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

Preferred Provider Organization (PPO)

A PPO offers benefits through in-network, out-of-network and out-of-area providers. You are not assigned to a primary care physician, so you have more responsibility for coordinating your care. You must pay an annual 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.

If you live in an area served by the City Health Plan network, choosing an out-of-network provider will cost more than choosing an in-network provider. If you live outside of the areas served by the City Health Plan network, you will receive service through the out-of-area plan and your covered percentages will be the same as in-network. City Health Plan PPO is a self-insured plan. This means individual premiums are determined by the total cost of services used by the plan's group of participants.

City Health Plan PPO

UnitedHealthcare Choice Plus	Available to all retiree members and eligible dependents
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HSS health plans do not guarantee the continued participation of any provider, such as a doctor, hospital or medical group. You cannot change your plan because a doctor, hospital or medical group chooses not to participate in your plan. You will be assigned or required to select another provider.

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions in effect for the plan from January to December 2013. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. EOCs are available on www.myhss.org.

PPO vs. HMO

	Blue Shield HMO	Kaiser Permanente 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 preventive 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 a Blue Shield or Kaiser Permanente HMO, you must reside in a zip code serviced by the plan. City Health Plan PPO does not have any service area enrollment requirements.

■ = Available in this County. ○ = Available in some zip codes.

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

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

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

Retired Employees with Medicare Parts A & B

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

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

Note: Out-of-pocket maximum does not include premium contributions. City Health Plan co-insurance amounts shown reflect what will be covered after Medicare has paid its portion of a claim.

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

Retired Employees with Medicare Parts A & B

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

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

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

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

Retired Employees Not Eligible for Medicare

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

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

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

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

Retired Employees Not Eligible for Medicare

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

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

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

Medicare and Your HSS Benefits

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

Medicare Basics

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

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

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

If you are receiving Social Security benefits, the Social Security Administration will notify you prior to your 65th birthday or when you become disabled regarding your eligibility for Medicare. If you are not currently receiving Social Security benefits, it is your responsibility to contact the Social Security Administration to apply for Medicare prior to your 65th birthday or when you become disabled. Failure to do so could result in penalties being assessed by the Social Security Administration and the Health Service System. If you have a Social Security-qualified disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant), you should contact the Social Security Administration immediately to apply for Medicare.

Medicare Part A: Hospital Insurance

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

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

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

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

Medicare Part B: Medical Insurance

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

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

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

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

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

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

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

Medicare and Your HSS Benefits

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

Medicare Part D: Prescription Drug Insurance

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

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

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

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

Is there a premium for Medicare Part D?

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

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

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

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

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

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

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

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

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

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

Medicare Contact Information

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

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

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

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

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

Medicare and Your Health Plan

Members and Dependents Must Enroll in Medicare When Eligible

All HSS members and dependents must enroll in Medicare Part A and Medicare Part B as soon as they are eligible. In general, individuals are eligible for Medicare:

- at age 65
- under age 65 with a Social Security-qualified disability
- under age 65 with end-stage renal disease (ESRD)

If an HSS member or dependent was enrolled in HSS retiree medical benefits before age 65, that individual must contact the Social Security Administration 90 days before his or her 65th birthday to begin the Medicare enrollment process. HSS requires that all HSS retiree medical plan enrollees complete Medicare enrollment by the first day of the month before the month of their 65th birthday. (Retirees and dependents under age 65 who become eligible for Medicare due to disability or end-stage renal disease must enroll as soon as they are eligible.)

Once enrolled in Medicare, a copy of the member or dependent's Medicare card must be submitted to HSS. If a retired member or dependent does not enroll in Medicare when eligible, does not provide HSS with proof of Medicare enrollment, or fails to pay required Medicare premiums to Social Security, coverage will be terminated. See page 17 for information about penalties.

Medicare Premiums Must Be Paid

The federal government requires that most people pay a premium for Medicare Part B. Some individuals, based on income, must also pay a premium for Medicare Part D. (Group Medicare Part D is included with all HSS-administered retiree plans.) HSS members and dependents who are Medicare-eligible must maintain continuous Medicare enrollment by paying all Medicare Part B and Part D premiums due to the federal government.

Updating Medicare Assignment When Enrolling in a Different Plan

When an HSS member elects a different plan, Medicare assignments for Medicare-eligible enrollees must be transferred to the new plan. In many cases this happens automatically, and the enrollee will not need to take any action. In some cases, the plan requires completion of a Medicare disenrollment form before an individual's Medicare can be re-assigned to a new plan. Be sure to complete this form if your plan requests that you do so. It is important that Medicare is properly assigned, because Medicare is the primary payer. **Medicare does not allow retroactive terminations.** If you have questions about Medicare reassignment when changing plans, contact your plan or HSS.

Moving Out of Your Plan's Service Area

A member is required to change plans if he or she moves out of a plan's service area. To ensure continuous coverage, the member must contact HSS 30 days before moving and enroll in an HSS medical plan that provides service based on the new address. If you are enrolled in a Medicare Advantage plan, your plan may also require you to complete a form that will release your Medicare so it can be re-assigned to the new plan.

When Some Family Members are Medicare-Eligible, and Others Are Not

An HSS member and his or her covered dependents may not all be eligible for Medicare. (This is sometimes referred to as a "split family.") In that case, the individual with Medicare will be covered under the insurer's plan for Medicare enrollees, and any individuals without Medicare will be covered by the same insurer's non-Medicare plan. If you have questions about split family enrollment or coverage, contact HSS.

Medicare and Your Health Plan

Kaiser HMO Enrollees and Medicare

Upon Medicare enrollment, Kaiser members are enrolled in Kaiser Senior Advantage, which is a Medicare Advantage plan. With this plan, the enrollee assigns Medicare benefits to Kaiser. Medicare is the primary payer for medical services and Kaiser coordinates payments. Kaiser Senior Advantage includes enhanced group Medicare Part D prescription drug coverage.

Kaiser and Medicare: At-A-Glance

MEDICARE ELIGIBILITY	PLAN ENROLLMENT	MEDICARE PART A	MEDICARE PART B	MEDICARE PART D
Kaiser enrollee eligible for Medicare due to age 65+, Social Security-qualified disability or end-stage renal disease	Medicare-eligible Kaiser enrollees can only be covered by the Kaiser Senior Advantage HMO.	Must enroll if eligible for premium-free Medicare Part A.	Must enroll in Medicare Part B and pay federal premiums to maintain continuous enrollment.	Kaiser Senior Advantage includes enhanced group Medicare Part D. Do not enroll in any individual Part D plan. Federal Part D premiums must be paid, if required, based on your income.

Blue Shield of California HMO Enrollees and Medicare

Upon Medicare enrollment, Blue Shield members who reside in a Blue Shield 65 Plus plan zip code are enrolled in Blue Shield 65 Plus (Medicare Advantage). With this plan, the enrollee assigns Medicare benefits to Blue Shield. Medicare is the primary payer for medical services and Blue Shield coordinates payments. Be aware that the doctors and hospital in the Blue Shield 65 Plus plan network may be different than the Blue Shield plan which covers members without Medicare. Blue Shield 65 Plus HMO includes enhanced group Medicare Part D prescription drug coverage.

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

Blue Shield Plans and Medicare: At-A-Glance

MEDICARE ELIGIBILITY	PLAN ENROLLMENT	MEDICARE PART A	MEDICARE PART B	MEDICARE PART D
Blue Shield enrollee eligible for Medicare due to age 65+, Social Security-qualified disability or end-stage renal disease	Medicare-eligible Blue Shield enrollees who live in the 65 Plus service area can only be covered by the 65 Plus Medicare Advantage HMO.	Must enroll if eligible for premium-free Medicare Part A.	Must enroll in Medicare Part B and pay federal premiums to maintain continuous enrollment.	Enhanced group Medicare Part D is part of Blue Shield 65 Plus. Do not enroll in individual Part D. Federal Part D premiums must be paid, if required, based on your income.
	Medicare-eligible Blue Shield enrollees living outside the 65 Plus service area can only be covered by the Blue Shield Access+ (Medicare Coordinated) HMO.	Must enroll if eligible for premium-free Medicare Part A.	Must enroll in Medicare Part B and pay federal premiums to maintain continuous enrollment.	Access+ enrollees are also enrolled in Blue Shield Medicare Rx, enhanced group Medicare Part D. Do not enroll in any individual Part D plan. Federal Part D premiums must be paid, if required, based on your income.

Medicare and Your Health Plan

City Health Plan PPO Enrollees and Medicare

For City Health Plan members enrolled in Medicare, Medicare is the primary payer. With City Health Plan, you do not assign Medicare benefits to UnitedHealthcare. Present both your Medicare card and UnitedHealthcare ID card to your service provider. You will be responsible for costs that are not covered by either Medicare or the plan, including deductibles, copays, your percentage of costs, and billed amounts that exceed reasonable and customary fees. (This is called Medicare COB, or Coordination of Benefits.) The UnitedHealthcare PPO plan for Medicare-eligible retirees includes enhanced group Medicare Part D prescription drug coverage.

City Health Plan and Medicare: At-A-Glance

MEDICARE ELIGIBILITY	PLAN ENROLLMENT	MEDICARE PART A	MEDICARE PART B	MEDICARE PART D
City Health Plan enrollee eligible for Medicare due to age 65+, Social Security-qualified disability or end-stage renal disease	Medicare-eligible City Health Plan enrollees can only be covered by the UnitedHealthcare Medicare COB (Coordination of Benefits) plan.	Must enroll if eligible for premium-free Medicare Part A.	Must enroll in Medicare Part B and pay federal premiums to maintain continuous enrollment.	The City Health Plan for Medicare enrollees includes enhanced group Medicare Part D. Do not enroll in any individual Part D plan. Federal Part D premiums must be paid, if required, based on your income.

City Health Plan PPO In-Network, Out-of-Network and Out-of-Area Providers

With City Health Plan PPO, the type of providers you choose affect your out-of-pocket costs.

In-Network Providers

In most instances, your out-of-pocket expenses will be less when you receive service from a physician or other provider who is part of the UnitedHealthcare nationwide network, or when you obtain care at an in-network hospital. If you live in a zip code where an in-network provider is available, but you choose an out-of-network doctor, you will pay the higher, out-of-network costs. The most up-to-date directory of in-network providers across the country is available at www.myuhc.com.

Out-of-Network Providers

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

Out-of-Area Providers

If you live in a zip code where UnitedHealthcare in-network providers are not available, the percentage of costs you are responsible for when obtaining care is equivalent to what is paid for an in-network provider. To find out if you live in an out-of-area zip code, contact UnitedHealthcare at (866) 282-0125. Be aware that your out-of-area status can change as doctors are added to (or leave) the network in your area.

Medicare and Your Health Plan

City Health Plan Pharmacy Benefits for Medicare Enrollees

The federal Affordable Care Act offered the City Health Plan an opportunity to reduce costs for enhanced group Medicare Part D pharmacy benefits. As a result, effective January 2013 the Health Service System is implementing the Employer Group Waiver Plan (EGWP) for City Health Plan, to take advantage of an estimated savings of \$2,325,000 annually on costs for this plan.

Almost all HSS members who are Medicare-eligible and enrolled in City Health Plan will not experience any impact from the change to EGWP. Under EGWP, Medicare will pay City Health Plan a higher portion of pharmacy benefits. These savings do not affect how any individual enrollee will utilize his or her pharmacy benefits. The savings are used to stabilize premium contributions for all participants in the plan.

- Pharmaceutical companies will pay the plan 50% of the cost of brand-name medications (after patient co-pays) occurring in the Part D coverage gap between the initial coverage limit and the catastrophic coverage threshold. (This is sometimes called the Part D donut hole). Previously the City Health Plan paid to cover this gap for HSS members.
- For pharmacy costs that reach the Medicare Part D catastrophic coverage threshold, Medicare will pay the plan 80%, after member co-pays of \$5 (generic) and \$20 (brand name).
- Administration and billing for pharmacy benefits are simplified for HSS.

Under EGWP, the Centers for Medicare & Medicaid Services (CMS) enforces a few restrictions that may result in a formulary change for the small number of HSS members who utilize pharmacy compounded medications. HSS will work with UnitedHealthcare to notify these members and advise them of their options.

Creditable Coverage Disclosure Notice

An important notice about prescription drug coverage and Medicare.
Please read carefully and keep with your important documents.

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

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

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

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

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

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

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

Issue Date: January 1, 2012

Adult Preventive Care

	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 height, weight, blood pressure; tobacco and alcohol use, depression	Yes	Yes	Yes	Yes
Annual well woman exam age appropriate preventive care	Yes		Yes	
AAA screening abdominal aortic aneurysm				Yes if man ever smoked; ages 65–75; one time
Colorectal cancer screening			Yes ages 50–75	Yes ages 50–75
Contraception birth control, sterilization, counseling	Yes		Yes until fertility ends	
Diabetes type 2 screening blood glucose	Yes	Yes	Yes	Yes
Domestic violence prevention screening and counseling	Yes		Yes	
Flu immunization seasonal flu	Yes annually, if at risk	Yes annually, if at risk	Yes	Yes
Hepatitis A and B immunization	Yes if at risk	Yes if at risk	Yes if at risk	Yes if at risk
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
Mammogram breast cancer screening	Yes, over age 40 every 1–2 years		Yes every 1–2 years to age 75	
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
Osteoporosis screening bone density			Yes over age 65; or high risk	
Pap smear cervical cancer screening	Yes every 2 years, after 3 normal screenings		Yes every 2 years, after 3 normal screenings	
Papillomavirus screening	Yes DNA test if high risk		Yes DNA test if high risk	
Pneumococcal immunization pneumonia			Yes age 65 and up; sooner if high risk	Yes age 65 and up; sooner if high risk
STD screenings and counseling sexually transmitted diseases	Yes if at risk	Yes if at risk	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

The Affordable Care Act mandates that many preventive services be provided at no cost to insured patients. Consult with your doctor about the types of screenings and immunizations that are right for you. For more details, including recommendations for children, see www.healthcare.gov/center/regulations/prevention/recommendations.html and www.healthcare.gov/law/resources/regulations/womensprevention.html.

Wellness Benefits

Health Plan Wellness Tools

Blue Shield of California

Healthy Lifestyle Rewards offers a Health Risk Assessment and condition management programs:

www.blueshieldca.com/hlr

Wellness discounts and savings:

www.blueshieldca.com/hw

Quit For Life smoking cessation:

(866) 784-8454

www.quitnow.net

Kaiser Permanente

Senior Health Series free interactive lectures and workshops. Call (415) 833-3450.

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

www.kp.org/healthyliving

ChooseHealthy discounts and savings:

www.kp.org/healthyroads

UnitedHealthcare

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.wekeepyoumiling.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

24/7 Nurse Hotline

Need answers fast? Have an after-hours, non-emergency question about care? Talk with a registered nurse anytime—day or night—seven days a week. Experienced nurses are available to answer questions and help you make decisions about your health care.

Kaiser San Francisco Nurse Advice Line:

English (415) 833-2200

Chinese (415) 833-2239

Spanish (415) 833-2203

For other Kaiser locations go to www.kp.org and click Locate Our Services.

Blue Shield NurseHelp 24/7:

English or Spanish (877) 304-0504

Brown & Toland Ask-A-Nurse line:

Brown & Toland patients only (855) 423-9974

UnitedHealthcare Nurseline:

(800) 237-4936

Always Active

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

www.alwaysactive.org.

HSS eUpdates

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

Fitness Classes and Gym Discounts

Fitness Classes: Civic Center, 1 South Van Ness, SFGH and the Airport

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

Class schedule for San Francisco General Hospital: www.sfghwellness.org/calendar

Class schedule for Civic Center, 1 South Van Ness and the Airport: www.myhss.org/events/seminars.html

Gym Membership Discounts

	<p>Access to participating locations nationwide, including 24 Hour Fitness, YMCAs and Curves.</p>	<p>When you are enrolled in Blue Shield 65 Plus through the Health Service System, SilverSneakers is included at no additional cost to you.</p>	<p>www.silversneakers.com (800) 776-4466 TDD (800) 794-1099 Over 10,000 participating gyms nationwide</p>
	<p>Group exercise classes, cardio machines, free weights, resistance training. Some clubs have lap pools, basketball, volleyball, and/or racquetball courts.</p>	<p>One Club Sport \$24.99/month All Club Sport \$29.99/month All Club Super \$44.99/month No initiation fee; month-to month, no contract.</p>	<p>24hourfitness.com/corp/sanfranemps enter code 100961 (800) 224-0240 Bay area and nationwide</p>
	<p>Aerobic classes, dance classes, yoga, Pilates, spin cycling, free weights, machine weights.</p>	<p>One-time enrollment fee \$59.00 per person; unlimited California club access \$54.99 per month. Month-to-month, no contract.</p>	<p>www.crunch.com (415) 602-6193 San Francisco, Daly City, San Mateo, Redwood City</p>
	<p>Cardio, strength and weight training equipment; free unlimited fitness training with membership.</p>	<p>\$15/month San Francisco only; \$29 sign-up fee and \$30 annual lock-in rate. \$19.99/month multi-club; no sign-up fee; \$39.99 annual lock-in rate. Month-to-month; no contract.</p>	<p>www.planetfitness.com planetfitness@gmail.com (415) 433-3033 San Francisco, Daly City, Hayward, Fremont and nationwide</p>
	<p>Cardio, strength and weight training equipment; exercise classes; massage, chiropractic and acupuncture treatments.</p>	<p>Basic gym \$47/month; gym and unlimited classes \$67/month; gym, unlimited classes and monthly massage \$85/month. Other packages available. Month-to-month; no contract.</p>	<p>www.livefitgym.com (415) 525-4364 Hayes Valley and Mission district, San Francisco</p>
	<p>Group classes, free and machine weights, heated pools, racquetball courts, onsite child care.</p>	<p>Waive \$150 initiation fee.</p>	<p>www.sonorafitness.com (209) 532-1202 13760 Mono Way Sonora, CA</p>

You must show proof of retirement from the City, SFUSD or SFCCD to participate in these special offers. Discounts are subject to change. See www.myhss.org for the most updated list of fitness club discounts.

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.

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 dental plan:

- **Delta Dental**

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

Do you know if your Delta Dental dentist is PPO or Premier? The Delta Dental plan has two different networks. Ask your dentist if he or she is PPO or Premier. Both networks are held to the same quality standards. But choosing a PPO dentist will save you money on out-of-pocket costs.

- With Delta Dental PPO dentists you pay less out-of-pocket costs. Most preventive services are covered at 100%; many other services are covered at 80% or 50%.
- Delta Dental Premier dentists charge higher out-of-pocket fees. Covered charges are based on pre-arranged fees with contracted dentists. Most preventive services are covered at 80%; many other services are covered at 50%.

You can also choose any dentist outside of the PPO and Premier networks. When you go to a licensed dentist outside of Delta's networks, the plan pays the same percentage of cost that it pays a Delta Dental network dentist. 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.

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

Dental Plan Service Areas

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

■ = Available in this county

County	Delta Dental	DeltaCare USA	Pacific U
Alameda	■	■	■
Alpine			
Amador	■	■	
Butte	■	■	■
Calaveras	■		
Colusa	■		
Contra Costa	■	■	■
Del Norte	■		
El Dorado	■	■	■
Fresno	■	■	■
Glenn	■		
Humboldt	■	■	
Imperial	■	■	■
Inyo	■		
Kern	■	■	■
Kings	■	■	■
Lake	■	■	
Lassen	■		
Los Angeles	■	■	■
Madera	■	■	■
Marin	■	■	■
Mariposa	■		
Mendocino	■		
Merced	■	■	■
Modoc	■		
Mono	■		
Monterey	■	■	■
Napa	■	■	■
Nevada	■		

County	Delta Dental	DeltaCare USA	PacificU
Orange	■	■	■
Placer	■	■	■
Plumas	■		
Riverside	■	■	■
Sacramento	■	■	■
San Benito	■	■	■
San Bernardino	■	■	■
San Diego	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Luis Obispo	■	■	
San Mateo	■	■	■
Santa Barbara	■	■	■
Santa Clara	■	■	■
Santa Cruz	■	■	■
Shasta	■	■	
Sierra	■		
Siskiyou	■		
Solano	■	■	■
Sonoma	■	■	■
Stanislaus	■	■	■
Sutter	■	■	
Tehama	■		
Trinity	■		
Tulare	■	■	■
Tuolumne	■		
Ventura	■	■	■
Yolo	■	■	■
Yuba	■		
Outside California	■		

Refer to the chart above to determine whether or not you live in the plan's service area. If you do not see your county listed above, contact the dental plan to see if service is available to you:

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

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

Dental Plan Comparison

DENTAL PLAN QUICK COMPARISON

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

Vision Plan Benefits

All HSS members and 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 dependents 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, per 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*
Scratch-resistant coating	Fully covered Every 24 months*	Not covered
Frames	Up to \$150 After \$25 co-pay; 20% off total over \$150; every 24 months*	Up to \$70 After \$25 co-pay; every 24 months*
Contact lenses, fitting and evaluation	Up to \$150 Every 24 months*; fitting and evaluation exam fully covered after a maximum \$60 co-pay	Up to \$105 Every 24 months*
Urgent eye care	\$5 co-pay Limited coverage for urgent and acute eye conditions	Not covered
Savings and Discounts		
Non-covered lens options; (ie, progressives, anti-reflective coat- ing, photochromic, polycarbonate)	Average 20–25% off Of provider's usual and customary charges; every 24 months*	Not applicable
Laser Vision Correction	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities	Not applicable

*Based on your last date of service.

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

Eligibility

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

Retiree Member Eligibility

The San Francisco City Charter requires that the retiree must have been a member of HSS at some time during active employment to be eligible for retiree healthcare coverage. (This means you must have been enrolled in HSS health benefits at some time during active employment.) If you choose to take a lump sum pension distribution, your retiree healthcare premium contributions will be unsubsidized, and you will pay full cost. Other eligibility restrictions may apply.

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

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

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

For more information, visit:

www.myhss.org/member_services/new_retirees.html

Dependent Eligibility

Spouse or Domestic Partner

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

Natural Children, Stepchildren, Adopted Children

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

Legal Guardianships and Court-Ordered Children

Children under 19 years 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. Coverage terminates at the end of the coverage period in which the child turns 19. The member must provide HSS with proof of guardianship, court order or decree by required deadlines.

Eligibility

Adult Disabled Children

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

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 retiree 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 ineligible dependent health premiums and any medical service provided.

REQUIRED ELIGIBILITY DOCUMENTATION

	EVIDENCE OF RETIREMENT	MARRIAGE CERTIFICATE	DOMESTIC PARTNER CERT.	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	PROOF OF PLACEMENT	COURT DECREE OR ORDER	MEDICAL EVIDENCE	SOCIAL SECURITY #	MEDICARE CARD
Retiree	■								■	■
Spouse		■							■	■
Domestic Partner			■						■	■
Child: Natural				■					■	
Child: Adopted					■				■	
Child: Placed for Adoption						■			■	
Stepchild: Spouse		■		■					■	
Stepchild: Domestic Partner			■	■					■	
Child: Legal Guardianship							■		■	
Child: Court Ordered							■		■	
Adult Child: Disabled								■	■	■

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

Changing Elections Outside of Open Enrollment

A member may make a benefits election change due to a qualifying event a maximum of two times during the 2013 plan year. For changes to benefit elections due to a qualifying event the member must notify the Health Service System and complete the enrollment process **no later than 30 calendar days** after the qualifying event. This includes the submission of all required documentation. A Social Security number is required for all newly enrolled individuals.

FAMILY STATUS	Enrollment Change	Documentation	Coverage
Marriage Legal Domestic Partnership	Add new spouse or partner to medical and/or dental coverage	<ul style="list-style-type: none"> • HSS enrollment application • Marriage certificate or certificate of partnership • Proof of Medicare enrollment for Medicare-eligible same-sex spouse or domestic partner of either gender 	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.
	Add new stepchild to medical and/or dental coverage	<ul style="list-style-type: none"> • HSS enrollment application • Marriage certificate or certificate of partnership • Child's birth certificate 	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.
	Waive member's medical and/or dental coverage	<ul style="list-style-type: none"> • HSS enrollment application • Marriage certificate or certificate of partnership • Proof of member enrollment in other coverage 	Coverage terminates the first day of the coverage period following submission of required documentation by 30-day deadline.
Divorce Legal Separation Dissolution of Partnership Annulment	Drop former spouse, partner and associated stepchildren from coverage	<ul style="list-style-type: none"> • HSS enrollment application • Divorce decree or legal documents proving separation, dissolution of partnership or annulment 	These individuals are no longer eligible for HSS coverage; failure to drop may result in penalties. Coverage terminates the first day of the coverage period following submission of required documentation.
Birth of a Child Adoption of a Child Child Placed for Adoption	Add child to medical and/or dental coverage	<ul style="list-style-type: none"> • HSS enrollment application • If newborn, birth verification letter from hospital; birth certificate when issued • If adopted, adoption certificate or proof of adoption 	Coverage is effective the day of the child's birth, if documentation is submitted by 30-day deadline.
Legal Guardianship of a Child	Add child to medical and/or dental coverage	<ul style="list-style-type: none"> • HSS enrollment application • Court decree 	Coverage effective the date guardianship takes effect, if documentation submitted by 30-day deadline.
Court-Ordered Coverage for a Child	Add child to medical and/or dental coverage	<ul style="list-style-type: none"> • HSS enrollment application • Court order to add child 	Coverage effective the date of court order, if documentation submitted by 30-day deadline.
	Drop child from medical and/or dental coverage	<ul style="list-style-type: none"> • HSS enrollment application • Court order for other coverage • Proof child has other coverage 	Coverage terminates the first day of the coverage period following submission of required documentation by 30-day deadline.

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

LOSS OF COVERAGE	Enrollment Change	Documentation	Coverage
Member Loses Other Coverage	Enroll member (and dependents who also lost coverage) in medical and/or dental coverage	<ul style="list-style-type: none"> • HSS enrollment application • Proof of loss of coverage 	Coverage is effective the first day of the coverage period following submission of required documentation by 30-day deadline.
Spouse or Partner Loses Other Coverage	Enroll spouse or partner in medical and/or dental coverage	<ul style="list-style-type: none"> • HSS enrollment application • Proof of loss of coverage • Marriage certificate or certification of legal partnership 	Coverage is effective the first day of the coverage period following submission of required documentation by 30-day deadline.
Dependent Child or Stepchild Loses Other Coverage	Enroll child or stepchild in medical and/or dental coverage	<ul style="list-style-type: none"> • HSS enrollment application • Proof of loss of coverage • Child's birth certificate • Marriage certificate or certification of legal partnership (if stepchild) 	Coverage is effective the first day of the coverage period following submission of required documentation by 30-day deadline.

A member or dependent who gains other coverage due to commencement of employment, a change from part-time to full-time employment, adding other coverage during another employer's Open Enrollment, eligibility for Medicare or Medicaid, or return to work from an unpaid leave of absence may drop HSS coverage **within 30 calendar days** of these qualifying events. A member may only waive coverage for him or her self and/or dependents outside of Open Enrollment with proof of obtaining other coverage. If a member waives coverage, dependent coverage must also be waived.

GAIN OF COVERAGE	Enrollment Change	Documentation	Coverage
Member Gains Other Coverage	Waive member medical and/or dental coverage	<ul style="list-style-type: none"> • HSS enrollment application • Proof of other coverage 	Coverage terminates the first day of the coverage period following submission of required documentation by 30-day deadline.
Spouse or Partner Gains Other Coverage	Drop spouse or partner from medical and/or dental coverage	<ul style="list-style-type: none"> • HSS enrollment application • Proof of other coverage 	Coverage terminates the first day of the coverage period following submission of required documentation by 30-day deadline.
Dependent Child or Stepchild Gains Other Coverage	Drop child or stepchild from medical and/or dental coverage	<ul style="list-style-type: none"> • HSS enrollment application • Proof of other coverage 	Coverage terminates the first day of the coverage period following submission of required documentation by 30-day deadline.

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Changing Elections Outside of Open Enrollment

Death of a Dependent

If an enrolled dependent dies, you should notify HSS as soon as possible and submit a copy of the death certificate **within 30 days** 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 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 (if not already on file with HSS)
- Copy of survivor's Medicare card (if survivor is Medicare-eligible)

A surviving spouse or partner who is not enrolled on the deceased member's health plan at the time of the member's death may be eligible for coverage, but must wait until Open Enrollment to enroll. Surviving dependent children of a member must meet eligibility requirements for dependent children. (See pages 34–35.) Eligible surviving dependent children may be enrolled, but do not qualify for employer-subsidized benefits.

Moving Out of a Plan's Service Area

If you move your primary residence to a location outside your health plan's service areas, you 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 the next Open Enrollment.

Financial Penalties for Failing to Disenroll Ineligible Dependents

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

COBRA

COBRA Continuation Coverage

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

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

Time Limits for COBRA Elections

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

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

Duration of COBRA Continuation Coverage

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

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

Termination of COBRA Continuation Coverage

COBRA coverage will end if:

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

Paying for COBRA

Once COBRA continuation coverage is elected, it is the responsibility of the covered individuals to remit the required healthcare premium payments directly to the COBRA Administrator. For COBRA rate information, visit www.myhss.org or contact HSS.

COBRA Continuation Coverage Alternatives

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

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

For up-to-date information about COBRA benefits, contact 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 manufacturers.

COBRA

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

Co-Insurance

Co-insurance refers to the amount of money that a member is required to pay for healthcare services, after any required deductible has been paid. Co-insurance is often specified by a percentage. For example, the retiree 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

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

Dependent

A family member 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.

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 the benefits and exclusions of a health plan 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.

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 (EOC).

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 or retiree's domestic partner, be reported as taxable income on a federal income tax return.

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

Glossary of Healthcare Terms

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.

Medicare Advantage Plan

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

Medicare Coordinated Plan

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

Medicare Part A

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

Medicare Part B

Outpatient medical insurance provided by the federal government to individuals who are eligible based on age or certain qualifying disabilities.

Medicare Part D

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

Member

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

Non-Formulary Drug

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

Open Enrollment

The period of time when you can change 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 that are not in your health plan's provider network. Some plans do not cover Out-of-Network service costs. Others charge a higher co-payment 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 his or her own pocket, before an insurance company will pay 100% for that individual's healthcare expenses.

PDP

A prescription drug plan.

Preferred Provider Organization (PPO)

An entity that contracts to provide healthcare services to subscribers at negotiated, often discounted, rates.

Premium

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

Primary Care Physician (PCP)

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

Privacy

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

Qualifying Event

A change in your life situation that allows you to make a change in your benefit elections outside Open Enrollment. 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.

Retiree Premium Contribution

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

Medical Plan Costs

In the next year, the Health Service System will spend over \$700 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 preventive 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, for the same benefits. Choose the plan that's best for you.
- **24/7 nurse hotlines.** Make use of your plan's free, 24/7 hotline to consult with a nurse about care options. For hotline phone numbers see page 26.
- **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.** Don't skip appointments. If you must cancel, notify your doctor's office in advance.
- **Outpatient surgery.** When appropriate, request that your doctor schedule 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.

The Health Service System respects your privacy, to view our privacy policy visit:
www.myhss.org/health_service_board/privacy_policy.html

Rates: Retiree Not Eligible for Medicare

MONTHLY CONTRIBUTIONS EFFECTIVE JANUARY 1, 2013–DECEMBER 31, 2013

MEDICAL	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	1,409.74	26.24	1,076.98	\$1.12	1,104.40	362.09
Retiree + 1 Dependent with no Medicare	1,745.75	335.39	1,344.48	268.61	1,815.47	1,073.17
Retiree + 2 or More Dependents with no Medicare	1,756.90	859.70	1,344.48	712.65	1,815.47	2,089.31
Retiree + 1 Dependent with Medicare Part A Only	1,745.75	335.39	1,344.48	268.61	1,654.27	911.96
Retiree + 1 Dependent with Medicare Part B Only	1,745.75	335.39	1,344.48	268.61	1,382.31	639.99
Retiree + 1 Dependent with Medicare Part A and Part B	1,603.80	193.45	1,243.68	167.82	1,274.17	531.85
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,756.90	859.70	1,344.48	712.65	1,654.27	1,928.10
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,756.90	859.70	1,344.48	712.65	1,382.31	1,656.13
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,614.95	717.76	1,243.68	611.86	1,274.17	1,547.99

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	39.87	0	16.47	0	31.70
Retiree + 1 Dependent	0	79.80	0	27.20	0	52.31
Retiree + 2 or more Dependents	0	120.54	0	40.22	0	77.37

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

Rates: Retiree Eligible for Medicare Part A and Part B

MONTHLY CONTRIBUTIONS EFFECTIVE JANUARY 1, 2013–DECEMBER 31, 2013

MEDICAL	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	363.30	0	335.43	0	374.49	0
Retiree + 1 Dependent with no Medicare	685.88	322.58	602.93	267.49	1,085.56	711.08
Retiree + 2 or More Dependents with no Medicare	685.88	858.04	602.93	711.53	1,085.56	1,727.22
Retiree + 1 Dependent with Medicare Part A Only	685.88	322.58	602.93	267.49	924.36	549.87
Retiree + 1 Dependent with Medicare Part B Only	685.88	322.58	602.93	267.49	652.40	277.90
Retiree + 1 Dependent with Medicare Part A and Part B	543.93	180.64	502.13	166.70	544.26	169.76
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	685.88	858.04	602.93	711.53	924.36	1,566.01
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	685.88	858.04	602.93	711.53	652.40	1,294.04
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	543.93	716.10	502.13	610.74	544.26	1,185.90

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	39.87	0	16.47	0	31.70
Retiree + 1 Dependent	0	79.80	0	27.20	0	52.31
Retiree + 2 or more Dependents	0	120.54	0	40.22	0	77.37

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Rates: Retiree Eligible for Medicare Part A Only

MONTHLY CONTRIBUTIONS EFFECTIVE JANUARY 1, 2013–DECEMBER 31, 2013

MEDICAL	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	1,379.79	56.19	1,076.98	1.12	896.88	247.21
Retiree + 1 Dependent with no Medicare	1,702.37	378.77	1,344.48	268.61	1,607.95	958.29
Retiree + 2 or More Dependents with no Medicare	1,702.37	914.23	1,344.48	712.65	1,607.95	1,974.43
Retiree + 1 Dependent with Medicare Part A Only	1,702.37	378.77	1,344.48	268.61	1,446.75	797.08
Retiree + 1 Dependent with Medicare Part B Only	1,702.37	378.77	1,344.48	268.61	1,174.79	525.11
Retiree + 1 Dependent with Medicare Part A and Part B	1,560.42	236.83	1,243.68	167.82	1,066.65	416.97
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,702.37	914.23	1,344.48	712.65	1,446.75	1,813.22
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,702.37	914.23	1,344.48	712.65	1,174.79	1,541.25
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,560.42	772.29	1,243.68	611.86	1,066.65	1,433.11

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	39.87	0	16.47	0	31.70
Retiree + 1 Dependent	0	79.80	0	27.20	0	52.31
Retiree + 2 or more Dependents	0	120.54	0	40.22	0	77.37

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Rates: Retiree Eligible for Medicare Part B Only

MONTHLY CONTRIBUTIONS EFFECTIVE JANUARY 1, 2013–DECEMBER 31, 2013

MEDICAL	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	1,435.98	0	1,078.10	0.00	600.16	0
Retiree + 1 Dependent with no Medicare	1,758.56	322.58	1,345.60	267.49	1,311.23	711.08
Retiree + 2 or More Dependents with no Medicare	1,758.56	858.04	1,345.60	711.53	1,311.23	1,727.22
Retiree + 1 Dependent with Medicare Part A Only	1,758.56	322.58	1,345.60	267.49	1,150.03	549.87
Retiree + 1 Dependent with Medicare Part B Only	1,758.56	322.58	1,345.60	267.49	878.07	277.90
Retiree + 1 Dependent with Medicare Part A and Part B	1,616.61	180.64	1,244.80	166.70	769.93	169.76
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,758.56	858.04	1,345.60	711.53	1,150.03	1,566.01
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,758.56	858.04	1,345.60	711.53	878.07	1,294.04
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,616.61	716.10	1,244.80	610.74	769.93	1,185.90

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	39.87	0	16.47	0	31.70
Retiree + 1 Dependent	0	79.80	0	27.20	0	52.31
Retiree + 2 or More Dependents	0	120.54	0	40.22	0	77.37

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Rates: Eligible Surviving Spouse/Domestic Partner

MONTHLY CONTRIBUTIONS EFFECTIVE JANUARY 1, 2013–DECEMBER 31, 2013

MEDICAL	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Survivor Not Eligible for Medicare	1,409.74	26.24	1,076.98	1.12	1,104.40	362.09
Survivor + 1 Dependent with no Medicare	1,423.17	657.97	1,076.98	536.11	1,104.40	1,784.24
Survivor + 1 Dependent with Medicare Part A and Part B	1,423.17	374.08	1,076.98	334.52	1,104.40	701.62
Survivor + 2 or More Dependents with no Medicare	1,434.32	1,182.28	1,076.98	980.15	1,104.40	2,800.38
	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
Survivor with Medicare Part A and B	363.30	0	335.43	0.00	374.49	0
Survivor with Medicare A and B + 1 Dependent no Medicare	363.30	645.16	335.43	534.99	374.49	1,422.15
Survivor with Medicare A and B + 1 Dependent with Medicare A and B	363.30	361.27	335.43	333.40	374.49	339.53
Survivor with Medicare A and B + 2 or more Dependents with no Medicare	363.30	1,180.62	335.43	979.03	374.49	2,438.29

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	39.87	0	16.47	0	31.70
Retiree + 1 Dependent	0	79.80	0	27.20	0	52.31
Retiree + 2 or More Dependents	0	120.54	0	40.22	0	77.37

The rates above apply to eligible survivors who receive a monthly survivor's pension from a participating retirement system.

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

Key Contact Information

HEALTH SERVICE SYSTEM

Member Services

1145 Market Street, 2nd Floor
San Francisco, CA 94103
(Civic Center station between 7th and 8th)
Tel: (415) 554-1750
(800) 541-2266 (outside 415 area code)
Fax: (415) 554-1721
www.myhss.org

MEDICAL PLANS

City Health Plan PPO

(UnitedHealthcare Choice Plus)

Tel: (866) 282-0125
Group No. 752103
www.myuhc.com

Blue Shield of California

Blue Shield 65 Plus (Medicare Advantage) HMO

Tel: (800) 776-4466
TTY/TDD call (800) 794-1099,
seven days a week, 7:00AM to 8:00PM
Group No. MA0002
www.blueshieldca.com/sfhss

Blue Shield of California

Access+ HMO

Tel: (800) 642-6155
Group No. H12188 (with Medicare)
Group No. H12189 (without Medicare)
www.blueshieldca.com/sfhss

Kaiser Permanente HMO

Tel: (800) 464-4000
Group No. 888 (Northern California)
Group No. 231003 (Southern California)
my.kp.org/ca/cityandcountyofsanfrancisco

VISION PLAN

Vision Service Plan (VSP)

Tel: (800) 877-7195
Group No. 12145878
www.vsp.com

DENTAL PLANS

Delta Dental

Tel: (888) 335-8227
Group No. 1673-0001
www.deltadentalins.com/ccsf

DeltaCare USA Dental

Tel: (800) 422-4234
Group No. 1797-0003
www.deltadentalins.com/ccsf

Pacific Union Dental

Tel: (800) 999-3367
Group No. 705287-0048
www.myuhcdental.com

COBRA

Fringe Benefits Management Company a Division of WageWorks

Tel: (800) 342-8017
www.myfbmc.com

CITY AGENCIES

Department of Human Resources

Tel: (415) 557-4800
www.sfgov.org/dhr

San Francisco Employees' Retirement System (SFERS)

Tel: (415) 487-7000
www.sfers.org

FEDERAL AGENCIES

Social Security Administration

Tel: (800) 772-1213
TTY/TDD call (800) 325-0778,
seven days a week, 7:00AM to 8:00PM
www.ssa.gov

Medicare

Tel: (800) 633-4227
TTY/TDD call (877) 486-2048,
seven days a week, 7:00AM to 8:00PM
www.medicare.gov