contents

2007-2008 RETIRED EMPLOYEES

Do you need to to submit an Open Enrollment Application to the Health Service System by the April 27 deadline?

YES **if any ONE of the following applies to you:**

- You are currently enrolled in the Health Net HMO.
- You want to delete a dependent from your healthcare coverage.
- You want to add a dependent to your healthcare coverage.
- You want to elect a different medical/dental plan.

NO **if the following applies to you.**

You are not a Health Net member and you don't want to make any changes to your current benefits elections.

KEY CONTACT INFORMATION

Key Contact Information

Health Service System

Health Service System Member Services
1145 Market Street, Suite 200
San Francisco, CA 94103
(Between 7th and 8th Streets — Civic Center Muni/BART Station)
(415) 554-1750; (800) 541-2266 (outside 415 area code)
Fax: (415) 554-1752
www.myhss.org

Medical Plans

City Health Plan *(administered by United HealthCare)*
Tel: (866) 282-0125
Group No. 705287
www.myuhc.com

Blue Shield of California
Tel: (800) 424-6521
Group No. H11054
www.mylifepath.com

Kaiser Foundation Health Plan, Inc.
Tel: (800) 464-4000
Group No. 888
www.members.kp.org

PacifiCare
Tel: (800) 624-8822
Group No. 240806
www.pacificare.com

SecureHorizons
Tel: (866) 622-8055
Group No. 240810
www.securehorizons.com

Dental Plans

Delta Dental
Tel: (888) 335-8227
(800) 4-AREA-DR (referrals to Delta dentists)
Group No. 1673-0001
www.deltadentalca.org

DeltaCare USA Dental Plan *(Formerly PMI)*
Tel: (800) 422-4234
Group No. 01797-0003
www.deltadentalca.org

Pacific Union Dental
Tel: (800) 999-3367
(925) 363-6000
Group No. 881
www.pacificunion.com

Vision Plan

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

WELCOME

Dear Member:

Welcome to open enrollment for the 2007-2008 plan year. This year, our theme at Health Service System has been "new," because your Health Service Board and staff of the Health Service System have been hard at work on a series of improvements to make your health coverage choices better and more affordable.

Karen Breslin
President
Health Service Board

New Member Guides

We hope you like your new member guide, which has been completely redesigned for this year. We wanted to make the guides easier to use (and more appealing to look at). Please take the time to read over your guide, as important notices will appear throughout to help you make better informed, more confident decisions about your medical, dental and other benefit choices.

New Mix of Medical Plans

This year, the Health Service Board conducted a rigorous RFP (or request for proposal) process to make sure members were offered medical plans delivering the best coverage for the lowest cost. As a result, PacifiCare and Blue Shield were able to offer a better value, and Health Net was discontinued. The good news is that Health Net members (and all members) now have the option of choosing a plan that will likely offer them access to the same providers for a lower cost.

Improved Information and Communications

As mentioned earlier, one of our goals for this year's open enrollment was to help you better prepare to make confident benefit choices. Some of the ways were have done this include:

- Posters in your work area and flyers in your pay check (or payroll advice)
- A special open enrollment section on our web site, myhss.org.
- E-mail updates for members who visit myhss.org and sign up for "E-Updates"

And, for the second week (April 9-13) of on-site open enrollment in the HSS Market Street office, representatives from our medical, dental, and vision plans will be present to answer your questions.

As always, our objective at open enrollment is to help you make the best decisions for you and your dependents—ones that you'll be satisfied with for the duration of the plan year. We hope the improvements your Health Service Board and staff of the Health Service System have worked on so hard this year help everyone achieve that goal.

Best Regards,
Karen Breslin

Health Service Board

Karen Breslin, President
James Deignan, Vice President
Scott Heldfond, Commissioner
Sharon Johnson, Commissioner
Mitch Katz, M.D., Commissioner
Claire Zvanski, Commissioner
Sean Elsbernd, Supervisor

Health Service System

Bart Duncan, Director
Jeffrey Hildebrant, Assistant Director
Tess Navarro, Chief Financial Officer

NOTICE OF THE CITY AND COUNTY OF SAN FRANCISCO HEALTH SERVICE SYSTEM PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION

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

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSE FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

TO MAKE OR OBTAIN PAYMENT

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

TO CONDUCT HEALTH CARE OPERATIONS

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

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

For example, the Health Service System may use your health information to conduct case management, quality improvement and utilization review

and provider credentialing activities or to engage in customer service and grievance resolution activities.

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

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

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

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

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

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

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

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

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

For Worker's Compensation. The Health Service System may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

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

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

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

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Health Service System's disclosure of your health information to someone involved in the payment of your care. However, the Health Service System is not required to agree to your request. If you wish to make a request for restrictions, please send your written request to:

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

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

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

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A written request to inspect and copy records containing your health information must be sent to:

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

If you request a copy of your health information, the Health Service System may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Health Service System amend the records. The request may be made as long as the information is maintained by the Health Service System. A request for an amendment of records must be made in writing to:

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

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

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Health Service System for any reason other than for treatment, payment or health operations. The request must be made in writing to:

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

The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Health Service System will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Health Service System will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please send your written request to:

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

You also may obtain a copy of the current version of this notice from the Health Service System Web site at www.myhss.org.

DUTIES OF HEALTH PLAN

The Health Service System is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Health Service System reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Health Service System changes its policies and procedures, a revised copy of this Notice will be provided to you within 60 days of the change. You have the right to express complaints to the Health Service System and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Health Service System should be made in writing to:

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

The Health Service System encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

EFFECTIVE DATE

Original effective date: April 14, 2003

Revised: January 1, 2007

Important Information about Medicare Enrollment

Health Service Board Rules and Regulations require that all eligible retired members enroll in both Part A and Part B of Medicare. All eligible retired members who haven't enrolled in both parts of Medicare will only be eligible to enroll in the City Health Plan. No other medical plan option will be available because the member has not complied with the above Rule.

Following is important information that will assist you in understanding more about how enrolling in Medicare will affect your medical coverage:

What is Medicare ?

Medicare is a federal government health insurance program for people sixty-five (65) years or older who are eligible to receive Social Security benefits and people under age 65 with certain disabilities or kidney disease, as described below.

Medicare has three parts. Part A is for hospital insurance. In most cases, you don't have to pay for Medicare Part A coverage. Part B covers the cost of physician and other medical provider services. You must pay a monthly premium to the Social Security Administration for Medicare Part B. The new Medicare Part D, which provides prescription drug coverage, is discussed below.

How do I know if I qualify for Medicare?

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

- If you're not currently receiving Social Security benefits, it's your responsibility to contact the Social Security Administration prior to your sixty-fifth (65th) birthday to apply for Medicare. Failure to do so could result in penalties being assessed by the Social Security Administration and the Health Service System.

- If you have a permanent disability or you have kidney disease requiring hemodialysis or transplant, you should contact the Social Security Administration immediately to apply for Medicare.

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

What are the Health Service System rules for Medicare Participation?

All retired members who have reached the age of 65 and their family members who qualify for early Social Security, and thereby become eligible for Medicare Part A and Part B, are required to apply for Medicare. It is your responsibility to notify the Health Service System of you Medicare eligibility and enrollment status.

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

You must submit a statement from the Social Security Administration indicating that you're not eligible for non-contributory (free) Medicare Part A (Hospital) coverage . We will update our records accordingly.

HSS requires you to enroll in Medicare Part B, regardless of your eligibility status for non-contributory (free) Medicare Part A.

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

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

What if I'm currently enrolled in the Kaiser HMO or PacifiCare HMO Plan?

If you're 65 years old and are eligible for both Medicare Part A and Part B but don't enroll in both parts or if you already have both parts and do not enroll into the Kaiser Senior Advantage Plan or PacifiCare SecureHorizons Plan, if applicable, your healthcare coverage will be terminated by Kaiser or PacifiCare and the Health Service System will automatically enroll you in the City Health Plan.

Because the City Health Plan is an indemnity plan, claims incurred by a Medicare eligible member who hasn't enrolled in Medicare will be paid at 20% of what is usual, customary and reasonable. In addition, current out of pocket limits will be increased by $7,200.

Contact Kaiser at 1-800-443-0815 or PacifiCare at 1-866-622-8055 for more information.

What if I am currently enrolled in the City Health Plan or Blue Shield HMO?

Except for enrolling in both Parts of Medicare, there are no additional applications for you to complete.

What if I'm currently enrolled in the Blue Shield HMO Plan?

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

If you're 65 years old and are eligible for both Medicare Part A and Part B but don't enroll in both parts, your healthcare coverage will be terminated by Blue Shield and the Health Service System will automatically enroll you in the City Health Plan.

Because the City Health Plan is an indemnity plan, claims incurred by a Medicare eligible member who hasn't enrolled in Medicare will be paid at 20% of what is usual, customary and reasonable. In addition, current out of pocket limits will be increased by $7,200.

Should I enroll in Medicare Part D?

Do not enroll in an individual Medicare Part D plan. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added a new prescription drug program to Medicare. Prescription drug coverage under Medicare Part D will be available starting January 1, 2006. You may receive Medicare Part D enrollment information from the Centers for Medicare and Medicaid Services (CMS).

The good news for you is that the healthcare plan you and your dependents are enrolled in through the Health Service System, has prescription drug coverage that is better than the available Medicare

MEDICARE ENROLLMENT

Part D coverage. In order to be able to continue to offer you such coverage, it is important that you and your dependents don't enroll in an individual Medicare Part D plan.

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

If you're enrolled in Blue Shield, Kaiser or PacifiCare, your plan may communicate with you with specific instructions about how to make sure you continue your prescription coverage through your HSS plan by enrolling in a Medicare Part D plan on a group basis at no cost to you. Please be sure to follow those instructions carefully.

On the next page you'll find a Creditable Coverage Disclosure Notice. Should you decide to enroll in Medicare Part D at some future date, this notice will allow you to enroll without incurring any penalties. Please keep this document with your other valuable papers for safekeeping.

If you have questions about your prescription drug coverage, please contact your Health Service System Operations Analyst at 415-554-1750 or 1-800-541-2266 for assistance.

CREDITABLE COVERAGE DISCLOSURE NOTICE

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it with your important documents.

Original Issue Date: October 6, 2005
Revised Date: January 1, 2007

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

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

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

Eligibility

Member Eligibility

The following members may be eligible for retiree health care coverage administered by the Health Service System:

- Retirees, surviving spouses/domestic partners

Dependent Eligibility

The following dependents of an enrolled member may be eligible for health care coverage administered by the Health Service System:

- Your legal spouse or domestic partner. Please note that a spouse from whom you have been granted a final dissolution of marriage or from whom you are legally separated, or a domestic partner from whom you dissolve your domestic partnership, are not eligible.

  You'll be required to provide proof of marriage or domestic partnership when enrolling a spouse or domestic partner.

- Unmarried children from birth to age twenty-five (25) who 1) aren't married ; 2) don't work full time; 3) continue to reside in the home, except for full-time students and children living with a divorced spouse; and 4) are declared as an exemption on your federal income tax return.

Children include your natural child, step-child (as long as you're married to the natural parent), a legally adopted child, a child under legal guardianship and a natural or legally adopted child of an eligible domestic partner. Legal documentation is required for adoptions and guardianships.

- A child 1) living with you in a parent-child relationship who is economically dependent upon you for support; 2) is 18 years of age or younger; 3) isn't married; and 4) is declared as an exemption on your federal income tax return. A copy of your federal income tax return may be required each year.

- A child who is covered by a National Medical Support Notice (Court Order) will be covered to age 19.

- A child who 1) is over the age of 19; 2) is unmarried; 3) is incapable of self-sustaining employment due to physical handicap or mental retardation that existed prior to the child's attainment of age 25; 4) permanently resides with the employee/retired member; dependent on the member for substantially all of his/her economic support; 5) has been a dependent in a medical plan administered by the Health Service System on a continuous basis; and 6) was enrolled prior to child's nineteenth (19) birthday.

Eligibility may continue by the filing of acceptable medical evidence with the Health Service System at least sixty (60) days prior to the attainment of age twenty-five (25) and annually thereafter.

Enrollment

ANNUAL OPEN ENROLLMENT

During the annual Open Enrollment period, all eligible retirees, surviving spouses/domestic partners will receive important information regarding their rights and responsibilities for electing health care coverage or making changes to current coverage elections. You must submit a completed enrollment application and all required documentation prior to the Open Enrollment deadline. Enrollment/change requests received after the Open Enrollment deadline will not be processed.

During the annual Open Enrollment you may:
- Continue your current benefit elections for the next Plan Year
- Choose a different medical and/or dental plan
- Add or drop eligible dependents to/from coverage

The coverage you elect during the annual Open Enrollment period will be in effect on July 1st of each year and continue through June 30th of the following year, provided you and your dependents remain eligible. Until you receive your identification card, you should use the group identification numbers listed in the Key Contact Information section of this guide.

NEW RETIREES

Newly eligible retirees must enroll in an available medical and/or dental plan within thirty (30) days of their retirement effective date.

Coverage will be effective on the first day of the month following your retirement effective date provided the Health Service System receives your completed enrollment application and any required documentation.

If you don't enroll within your initial 30-day enrollment period, you must wait until 1) the next annual Open Enrollment period; or 2) you have a qualifying change in family status.*

**See Qualifying Change in Family Status information later in this section for details.*

DEPENDENTS

Eligible dependents, as defined in the Eligibility section of this guide must be enrolled 1) during your initial enrollment period as described above; 2) during the annual Open Enrollment period; or 3) within 30 days of a qualifying change in family status.

IMPORTANT NOTICE

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

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

Coverage for eligible dependents added during initial enrollment will become effective the same day as the retiree, surviving spouse/domestic partner unless the dependent is confined in a hospital in which case coverage will be in effect on the date the dependent is released from the hospital.

Important: Coverage for enrolled dependents may be terminated within thirty (30) days of a qualifying change in family status or during the annual Open Enrollment period for a coverage termination date of the following July 1.

QUALIFYING CHANGE IN FAMILY STATUS

A qualifying change in family status is a change in your family situation, as defined by IRS guidelines, which allows you to make certain changes to your benefit elections. A qualifying change in family status may include, but is not limited to:

- **Marriage.** You may enroll your spouse, and his/her eligible child(ren), by submitting a completed enrollment application form and a copy of your marriage license/birth certificate to the Health Service System within thirty (30) days of your marriage. Coverage for your spouse and any eligible child(ren) will be effective on the date of marriage, provided you meet the enrollment deadline and documentation requirements stated above.

- **Domestic Partnership.** You may enroll your domestic partner, and your domestic partner's child(ren), within thirty (30) days of the declaration of domestic partnership, by submitting a 1) completed enrollment application; 2) Certificate of Domestic Partnership showing that a domestic partnership has been processed and that the declaration was either filed with the San Francisco County Clerk's Office or other satisfactory legal evidence of domestic partnership that is valid and binding in another jurisdiction; and 3) copy of the birth certificate for any enrolled child. Coverage for your domestic partner and your domestic partner's child(ren) will be effective on the date of declaration of the domestic partnership, provided you meet the enrollment deadline and documentation requirements stated above.

Important: When you elect coverage for your domestic partner (and any dependent(s) of your domestic partner), you will be taxed on the value of the City and County of San Francisco's contribution toward the cost of a healthcare coverage for these dependents, pursuant to Internal Revenue Service guidelines. This is referred to as imputed income.

- **Birth or Adoption of a Child.** You may enroll your newborn child within thirty (30) days of the date of birth by submitting a completed enrollment application and certificate of birth to the Health Service System. Coverage will be in effect on the child's date of birth provided you meet the submission deadline and documentation requirements listed. An adopted child may be enrolled within thirty (30) days of commencement of physical custody of the child. An adopted child's coverage will be in effect on the date of commencement of physical custody, provided you meet the deadline and documentation requirements listed.

- **Loss of Other Coverage.** You may enroll a qualified dependent that loses health care coverage elsewhere by submitting a completed enrollment application and proof of the loss of coverage within thirty (30) days of the date of loss. The effective date of coverage will be the first day of the month following the date HSS receives a completed enrollment application and any required documentation.

- **Obtaining Other Coverage.** If you or a covered dependent obtain health care coverage elsewhere, you may cancel your coverage or that of your dependent by submitting a completed enrollment application and proof of the other coverage within thirty (30) days of the effective date of the

other coverage. Coverage(s) will cease on the last day of the month in which HSS receives a completed change application and required documentation.

- **Divorce, Legal Separation, Dissolution of Domestic Partnership or Death.** You may cancel coverage(s) for your spouse/domestic partner and his/her child(ren) within thirty (30) days of your divorce, legal separation or dissolution of domestic partnership by submitting an enrollment application form and a copy of your final divorce decree, legal separation papers which have been filed with the County Clerk, the dissolution document issued by the County Clerk or death certificate.

  Except for death, coverage will cease on the last day of the month in which the applicable event occurred provided you meet the notification and documentation requirements stated above.

- **Ineligibility.** Dependent(s) should be cancelled from your coverage once they become ineligible. Please refer to Dependent Eligibility on page 11. If a dependent doesn't meet any one of the criteria for eligibility, you must cancel his/her coverage immediately.

Important: All change requests must be on account of and consistent with the change in your family status. Contact HSS Member Services for more information.

Medical Plan Options

ELIGIBLE FOR MEDICARE PART A OR B?

Important Notice!

If you're eligible to enroll in Medicare Part A and/or Part B, you must do so. Failure to enroll in Medicare will result in automatic enrollment in the City Health Plan and your health care claims will be paid at a significantly reduced rate.

The medical plan options described below are available to eligible retirees, surviving spouses/domestic partners and their eligible dependents.

City Health Plan PPO

City Health Plan is a Preferred Provider Organization (PPO). A PPO is a medical plan that gives you freedom of choice between PPO providers who offer their services at discounted rates, and non-PPO providers.

When you obtain care from a PPO provider, the plan pays higher benefits, up to 85% after the required deductible, and your out-of-pocket expenses are less. When you use a PPO provider, he/she will submit claims on your behalf.

If you obtain care from a non-PPO provider, the plan pays lower benefits and you may be required to pay for services directly to the provider and submit your own claims to the plan.

You must pay the applicable deductible each Plan Year for most services before this plan will pay benefits. After your deductible requirement has been met, you'll pay a percentage of the cost of services provided.

Refer to the Plan Document for a detailed list of covered expenses, exclusions and limitations under this plan.

Blue Shield of California HMO

Blue Shield of California is a Health Maintenance Organization (HMO). An HMO is a medical plan that requires you to receive all of your care from contracted health care providers. Services are provided by a primary care physician who treats you or, when necessary, refers you to other doctors within the HMO network. Most services are covered at 100% after you pay the applicable copayment.

Refer to the applicable Blue Shield Evidence of Coverage for a detailed list of covered services, exclusions and limitations.

Kaiser Permanente HMO

Under the Kaiser Permanente HMO plan, you're required to receive all of your care through an integrated system of participating physicians, hospitals and other health care providers. You have access to full-service medical care. You must use plan providers at Kaiser Permanente facilities to be covered. Most services are covered at 100% after you pay the applicable copayment.

Refer to the applicable Kaiser Permanente Evidence of Coverage for a detailed list of covered services, exclusions and limitations.

Kaiser Senior Advantage

If you're Medicare Part A and B eligible this is the only Kaiser option available to you. Refer to the

applicable Kaiser Permanente Evidence of Coverage for a detailed list of covered services, exclusions and limitations.

PacifiCare HMO

PacifiCare is a Health Maintenance Organization (HMO). You're required to select a primary care physician who is contracted with PacifiCare and who is primarily responsible for the coordination of your healthcare services. Your primary care physician will seek authorization for any referrals to a PacifiCare contracted specialist, as well as initiate any necessary hospital services. Most services are covered at 100% after you pay the applicable copayment.

Refer to the applicable PacifiCare Evidence of Coverage for a detailed list of covered services, exclusions and limitations.

SecureHorizons

If you're Medicare Part A and B eligible this is the only PacifiCare option available to you. Refer to the applicable PacifiCare Evidence of Coverage for a detailed list of covered services, exclusions and limitations.

Important: To participate in an available HMO plan, you must live in a one of the zip code service areas served by that HMO. Please refer to the Medical Plan Service Areas chart on the next page of this guide for details

Medical Plan Service Areas

■ = Available in this county

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

County	City Health Plan	Blue Shield	Kaiser	PacifiCare	SecureHorizons
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	■	❍		❍	❍
Orange	■	■	■	■	■

Medical Plan Services Areas Continued

■ = Available in this county

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

County	City Health Plan	Blue Shield	Kaiser	PacifiCare	SecureHorizons
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 of Area	■	Emergency/ Urgent Care	Emergency/ Urgent Care	Emergency/ Urgent Care	Emergency/ Urgent Care

Dental Plan Options

The dental plan options described below are available to eligible retirees, surviving spouses/domestic partners and their eligible dependents. See the Dental Plan Comparison chart on the next page for details of each of the dental plan options.

DELTA DENTAL PLAN

Delta Dental Plan provides three options for selecting a dental provider. Each option provides coverage for the same types of services, but at different benefit levels.

- **Delta Dental PPO Plan**. For the lowest out-of-pocket expense, you can visit a PPO network provider. PPO level benefits are available from more than 13,000 PPO offices in California. Significant cost savings are available when visiting a dentist in the PPO network through negotiated lower fees on services.

- **DeltaPremier.** Considerable savings are also available when using a DeltaPremier provider. Your out-of-pocket expense may be greater than when using a PPO provider.

- **Non-Delta Dental Providers.** You may elect to receive services from any licensed dental provider. Providers who don't participate in the Delta Dental network generally charge fees that are higher than those charged by providers who participate in the network, resulting in higher out-of-pocket costs to you.

DELTACARE USA DENTAL PLAN (Formerly PMI Dental Plan)

DeltaCare USA Dental Plan is a managed dental care plan. If you enroll in this plan, you must receive all services from dentists affiliated with DeltaCare USA . Dental services are provided by a primary care dentist who treats you or, when necessary, refers you to other dentists within the plan's network. Generally, you pay only a copayment for services. Preauthorization from the plan is required for major services.

PACIFIC UNION DENTAL PLAN

Pacific Union Dental Plan is a managed dental care plan. If you enroll in this plan, you must receive all care from dentists affiliated with Pacific Union Dental. Dental services are provided by a primary care dentist who treats you or, when necessary, refers you to other dentists within the plan's network. Generally, you pay only a copayment for services. Preauthorization from the plan is required for major services.

Important: To elect coverage in the DeltaCare USA or Pacific Union Dental Plans, you must live in a service area served by the dental plan. Please refer to the Dental Plan Service Areas chart on page 21 for details.

Dental Plan Comparison

The chart below is a brief summary of available dental plan options. If any discrepancy exists between the information in this chart and the official Plan Documents, the official Plan Documents will govern.

TYPE OF SERVICE	DELTA DENTAL		DELTACARE USA	PACIFIC UNION
	Delta PPO Option	**DeltaPremier & Non-Delta Providers***		
Cleanings and Exam	100% Limit 2x per Plan Year	80% Limit 2x per Plan Year	100% Limit once every 6 months	100% Limit once every 6 months
X-rays	100%	80%	100%	100%
Extractions	80%	80%	100%	$5 co-pay
Fillings	80%	80%	100%	$5 co-pay
Crowns	50%	50%	100%	$85 co-pay
Dentures, Pontics and Bridges	50%	50%	No charge Full and partial dentures once every 5 years; Fixed bridgework; certain limitations apply	$85 to $150 co-pay
Root Canals	50%	50%	100%	$50 co-pay
Orthodontia	Not Covered	Not Covered	$1660 per case to age 19; $1880 charge per case age 19 or older; $350 start-up fee Other limitations apply	$1600 per case to age 19; $1800 charge per case age 19 or older; $350 start-up fee Other limitations apply
Annual Maximum	$1,000 per person per Plan Year	$1,000 per person per Plan Year	None	None
Annual Deductible	None	$50.00 per person per Plan Year for all services except diagnostic and preventative services	None	None
Waiting Period	None	None	None	None

* Benefits are based on Reasonable and Customary charges for non-Delta Providers

Dental Plan Service Areas

■ = Available in this county

County	Delta Dental	DeltaCare USA	Pacific Union
Alameda	■	■	■
Alpine	■		
Amador	■		
Butte	■	■	■
Calaveras	■		
Colusa	■	■	■
Contra Costa	■	■	■
El Dorado	■	■	■
Glenn	■		
Lake	■	■	
Madera	■	■	■
Marin	■	■	■
Mariposa	■		
Mendocino	■	■	■
Merced	■	■	■
Mono	■		
Monterey	■	■	■
Napa	■	■	■
Nevada	■		

If you don't see your County listed, contact the dental plan for enrollment eligibility information

Dental Plan Services Areas Continued

■ = Available in this county

County	Delta Dental	DeltaCare USA	Pacific Union
Placer	■	■	■
Plumas	■		
Sacramento	■	■	■
San Benito	■		■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Clara	■	■	■
Santa Cruz	■	■	■
Sierra	■		
Siskiyou	■	■	■
Solano	■	■	■
Sonoma	■	■	■
Stanislaus	■	■	■
Sutter	■	■	
Tuolumne	■		
Yolo	■	■	
Yuba	■	■	
Outside of Area	■		

If you don't see your County listed, contact the dental plan for enrollment eligibility information

VISION PLAN

Vision Plan

The City & County of San Francisco offers all retirees and their eligible dependent(s) that enroll in an available medical plan option a vision plan that is administered by Vision Service Plan (VSP).

If you don't enroll in an available medical plan option, you won't have vision plan coverage.

The vision plan provides you and your eligible dependents with one eye exam every 12 months when using a VSP network doctor. The vision plan also helps you and your eligible dependents cover the cost of eyewear, such as glasses or contacts.

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

You can find a VSP network doctor in your area by visiting www.vsp.com or contacting VSP Member Services at (800) 877-7195. When you wish to receive services from a VSP network doctor, simply contact the doctor and make your appointment. VSP will then provide benefit authorization to the doctor. There are no ID cards issued for the vision plan.

TYPE OF SERVICE	VSP NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
Vision Exam	Covered in full every 12 months[1] after the $10 co-pay	Up to $40 every 12 months[1] after the $10 co-pay
Single Vision Lenses	Covered in full once every 24 months[1] after the $25 co-pay	Up to $45 every 24 months[1] after the $25 co-pay
Lined Bifocal Lenses	Covered in full once every 24 months[1] after the $25 co-pay	Up to $65 once every 24 months[1] after the $25 co-pay
Lined Trifocal Lenses	Covered in full once every 24 months[1] after the $25 co-pay	Up to $85 once every 24 months[1] after the $25 co-pay
Frames ***Note:*** *Single co-pay of $25 applies to both frames and lenses*	Covered up to $130 once every 24 months[1] after the $25 co-pay	Up to $55 once every 24 months[1] after the $25 co-pay
Contact Lenses	Covered up to $150[2] once every 24 months[1] in lieu of frames/lenses; no co-pay	Covered up to $105[2] once every 24 months[1] in lieu of frames/lenses; no co-pay

[1]Based on your last date of service
[2]The allowance will apply toward the contact lens fitting and evaluation exam, and contacts.

VISION PLAN

Benefit Authorization

When you make an appointment with a VSP network doctor, the doctor will obtain benefit authorization directly from VSP. Services must be received prior to the benefit authorization expiration date. You pay only the applicable copayment(s), if any, to a VSP network doctor for services covered by the Plan. VSP will pay the doctor directly for the remainder of eligible charges. If you receive services from a VSP network doctor without benefit authorization or obtain services from an out-of-network provider, you are responsible for payment in full to the provider and then submitting an itemized bill directly to VSP for partial reimbursement. A claim form can be obtained by accessing the VSP Web site at www.vsp.com.

Plan Limits and Exclusions

- The vision plan covers one set of contacts or eyeglass lenses every 24 months.
- If you choose contact lenses, you'll be eligible for a frame 24 months after the last date of obtaining the contacts lenses. This rule also applies to your eligible dependents.
- Cosmetic extras such as progressive lenses, tinted lenses or oversize lenses will cost you extra. If you use a VSP network doctor, you'll pay the VSP discounted price for these cosmetic extras. If you're using an out-of-network provider, you'll pay the retail price.
- The plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, the plan will pay the basic cost of the allowed lenses, and you'll be responsible for any additional cost for the options, unless the extra is defined in the Schedule of Benefits.
  - Blended lenses
  - Contact lenses (except as noted in the Schedule of Benefits)
  - Oversize lenses
  - Photochromic and tinted lenses
  - Progressive multi-focal lenses
  - The coating of the lens or lenses, except scratch resistant coatings
  - The laminating of the lens or lenses
  - A frame that costs more than the Plan allowance
  - Certain limitations on low vision care
  - Cosmetic lenses
  - Optional cosmetic processes
  - UV (ultraviolet) protected lenses

Vision Expenses Not Covered

- Orthoptics or vision training and any associated supplemental testing, plano (non-prescription) lenses or two pairs of glasses in lieu of bifocals
- Replacement of lenses or frames furnished under this plan that are lost or broken, except at the normal intervals
- Medical or surgical treatment of the eyes
- Costs for securing materials such as lenses and a frame under the vision plan
- Corrective vision treatment such as, but not limited to, RK and PRK laser surgery. (You may be eligible for discounts when services are provided by a VSP network doctor. To inquire about discounts, call VSP).

FAQS

Frequently Asked Questions

The information in this section is general in nature and isn't intended to be a complete source of information for retired Health Service System members. Please contact HSS Member Services for assistance with your particular situation.

What should I do if the deduction for my health care coverage is incorrect or isn't being deducted from my retirement check?

When you select your initial retiree health care coverage or change your coverage during the annual Open Enrollment or because of a qualifying change in family status, you should carefully check your monthly retirement check deductions to verify that the correct premium deduction is being taken.

If the premium deduction is incorrect or doesn't appear on your retirement check, you should contact HSS Member Services for assistance. You'll be responsible for all required premium payments, whether they are taken out of your retirement check or not.

Who should I contact if I need an identification card or a benefit booklet, or if I have a question about my coverage?

Contact the plan directly. Refer to the Key Contact Information section of this guide for benefit plan telephone numbers and Web site addresses.

What happens if I move outside the service area covered by my medical/dental plan?

The medical, dental and vision plans do not guarantee the continued network participation of any particular doctor, dentist, hospital, medical group or other provider during the Plan Year.

After the annual Open Enrollment deadline, you won't be able to change your medical and/or dental plan elections because your provider and/or your medical group choose not to participate in a particular benefit plan. You'll be assigned or will be required to select another provider.

Is health care coverage available for dependents that no longer meet the eligibility requirements for coverage under my plan?

Yes. Pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), dependents who are no longer eligible may continue group coverage for up to thirty-six (36) months in the event of loss of eligibility under Health Service System's eligibility guidelines.

See the Continuation Coverage for Ineligible Dependents of Retirees (COBRA) section of this guide for details.

In the event of my death, what happens to the coverage of my dependents?

Generally, surviving dependents of an eligible retiree may continue health care coverage after the death of the member. Certain restrictions apply. Upon your death, covered dependents should contact HSS Member Services for information on available health care coverage continuation options.

Continuation Coverage for Ineligible Dependents of Retirees (COBRA)

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), employees and their dependents who are enrolled in a medical, dental or vision insurance plan may be entitled to an extension of health coverage, called "continuation coverage," in certain circumstances (for example, termination of employment, divorce, etc. This is called a "qualifying event").

The Health Service Board has extended this continuation coverage continuation coverage to family members of retired employees who become ineligible.

COBRA is available in certain instances called "qualifying event" where coverage under the plan would otherwise end. The same plans a dependent participated in as a family member of a retiree can be continued (subject to change if group coverage changes). The coverage period for dependents is 36 months. The cost is 102% of the group plan contract premium (2% administrative charge added as provided under the Act).

When a qualifying event occurs, the Health Service System's COBRA administrator will notify you of your right to COBRA coverage. You'll have 60 days from the date of the notice to elect COBRA coverage. The coverage must be continuous from the date of the qualifying event (you cannot have a break in your coverage).

Any newly eligible dependent (spouse, domestic partner, newborn or adopted child) is eligible to be added to COBRA coverage within 30 days from the date of the event (birth, marriage, etc.).
COBRA coverage will end at the earliest of: 1) coverage under another group plan if no pre-existing condition limitation under the new plan applies to the individual; 2) failure to pay the contribution required under the plan within the grace period; or 3) the end of the applicable COBRA period.

As an alternative to COBRA coverage, you may be able to purchase individual coverage directly from your healthcare plan. Contact your plan for details and rates.

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

MONTHLY MEDICAL AND DENTAL PLAN RATES EFFECTIVE 7/1/07 - 6/30/08

Retiree Not Eligible for Medicare

✕ = Not Available. Dependents must be enrolled in both Medicare Part A and Part B to be eligible

△ = New enrollees not allowed

LEVEL OF COVERAGE	City Health Plan			Blue Shield			Kaiser			PacifiCare		
	Total Cost	City Pays	Retiree Pays	Total Cost	City Pays	Retiree Pays	Total Cost	City Pays	Retiree Pays	Total Cost	City Pays	Retiree Pays
Retiree Only	826.86	779.48	47.38	915.64	910.56	5.08	822.61	819.15	3.46	956.16	939.09	17.07
Retiree + 1 Dependent with no Medicare	1,201.74	966.92	234.82	1,315.20	1,116.69	198.51	1,219.87	1,023.66	196.21	1,379.08	1,157.21	221.87
Retiree + 2 or More Dependents with no Medicare	1,516.59	966.92	549.67	1,638.62	1,116.69	521.93	1,541.56	1,023.66	517.90	1,721.44	1,157.21	564.23
Retiree + 1 Dependent with Medicare Part A Only	1,181.64	956.87	224.77	1,315.20	1,116.69	198.51	✕			✕		
Retiree + 1 Dependent with Medicare Part B Only	1,172.23	952.16	220.07	1,315.20	1,116.69	198.51	1,175.83	1,000.77	175.06 △	✕		
Retiree + 1 Dependent with Medicare Part A and B	1,067.32	899.71	167.61	1,256.14	1,085.64	170.50	1,175.83	1,000.77	175.06	1,219.17	1,074.31	144.86
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,496.49	956.87	539.62	1,638.62	1,116.69	521.93	✕			✕		
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,487.08	952.16	534.92	1,638.62	1,116.69	521.93	✕			✕		
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,382.17	899.71	482.46	1,579.56	1,085.64	493.92	1,497.52	1,000.77	496.75	1,561.53	1,074.31	487.22

LEVEL OF COVERAGE	Delta Dental	DeltaCare USA	Pacific Union
Retiree Only	36.90	29.65	16.47
Retiree + 1 Dependent	73.86	48.93	27.20
Retiree + 2 or More Dependents	111.57	72.37	40.22

MONTHLY MEDICAL AND DENTAL PLAN RATES EFFECTIVE 7/1/07 - 6/30/08

Retiree Eligible for Medicare Part A and Part B

× = Not Available. Dependents must be enrolled in both Medicare Part A and Part B to be eligible

LEVEL OF COVERAGE	City Health Plan			Blue Shield			Kaiser Sr Advantage			PacifiCare SecureHorizons		
	Total Cost	City Pays	Retiree Pays	Total Cost	City Pays	Retiree Pays	Total Cost	City Pays	Retiree Pays	Total Cost	City Pays	Retiree Pays
Retiree Only	286.71	286.08	0.63	351.20	351.20	0.00	364.29	364.29	0.00	271.48	271.48	0.00
Retiree + 1 Dependent with no Medicare	661.59	473.52	188.07	750.76	557.33	193.43	761.55	568.80	192.75	694.40	489.60	204.80
Retiree + 2 or More Dependents with no Medicare	976.44	473.52	502.92	1,074.18	557.33	516.85	1,083.24	568.80	514.44	1,036.76	489.60	547.16
Retiree + 1 Dependent with Medicare Part A Only	641.49	463.47	178.02	750.76	557.33	193.43	×			×		
Retiree + 1 Dependent with Medicare Part B Only	632.08	458.76	173.32	750.76	557.33	193.43	×			×		
Retiree + 1 Dependent with Medicare Part A and B	527.17	406.31	120.86	691.70	526.28	165.42	717.51	545.91	171.60	534.49	406.70	127.79
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	956.34	463.47	492.87	1,074.18	557.33	516.85	×			×		
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	946.93	458.76	488.17	1,074.18	557.33	516.85	×			×		
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	842.02	406.31	435.71	1,015.12	526.28	488.84	1,039.20	545.91	493.29	876.85	406.70	470.15

LEVEL OF COVERAGE	Delta Dental	DeltaCare USA	Pacific Union
Retiree Only	36.90	29.65	16.47
Retiree + 1 Dependent	73.86	48.93	27.20
Retiree + 2 or More Dependents	111.57	72.37	40.22

MONTHLY MEDICAL AND DENTAL PLAN RATES EFFECTIVE 7/1/07 - 6/30/08

Retiree Eligible for Medicare Part A Only

× = Not Available. Retiree and dependents must be enrolled in both Medicare Part A and Part B to be eligible

LEVEL OF COVERAGE	City Health Plan			Blue Shield			Kaiser Senior Advantage			PacifiCare SecureHorizons		
	Total Cost	City Pays	Retiree Pays	Total Cost	City Pays	Retiree Pays	Total Cost	City Pays	Retiree Pays	Total Cost	City Pays	Retiree Pays
Retiree Only	776.79	729.41	47.38	915.64	910.56	5.08		×			×	
Retiree + 1 Dependent with no Medicare	1,151.67	916.85	234.82	1,315.20	1,116.69	198.51		×			×	
Retiree + 2 or More Dependents with no Medicare	1,466.52	916.85	549.67	1,638.62	1,116.69	521.93		×			×	
Retiree + 1 Dependent with Medicare Part A Only	1,131.57	906.80	224.77	1,315.20	1,116.69	198.51		×			×	
Retiree + 1 Dependent with Medicare Part B Only	1,122.16	902.09	220.07	1,315.20	1,116.69	198.51		×			×	
Retiree + 1 Dependent with Medicare Part A and B	1,017.25	849.64	167.61	1,256.14	1,085.64	170.50		×			×	
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,446.42	906.80	539.62	1,638.62	1,116.69	521.93		×			×	
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,437.01	902.09	534.92	1,638.62	1,116.69	521.93		×			×	
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,332.10	849.64	482.46	1,579.56	1,085.64	493.92		×			×	

LEVEL OF COVERAGE	Delta Dental	DeltaCare USA	Pacific Union
Retiree Only	36.90	29.65	16.47
Retiree + 1 Dependent	73.86	48.93	27.20
Retiree + 2 or More Dependents	111.57	72.37	40.22

MONTHLY MEDICAL AND DENTAL PLAN RATES EFFECTIVE 7/1/07 - 6/30/08

Retiree Eligible for Medicare Part B Only

× = Not Available. Retiree and dependents must be enrolled in both Medicare Part A and Part B to be eligibl
△ = New enrollees not allowec

LEVEL OF COVERAGE	City Health Plan			Blue Shield			Kaiser Sr Advantage			PacifiCare SecureHorizons		
	Total Cost	City Pays	Retiree Pays	Total Cost	City Pays	Retiree Pays	Total Cost	City Pays	Retiree Pays	Total Cost	City Pays	Retiree Pays
Retiree Only	485.04	484.41	0.63	915.64	915.64	0.00	364.29	364.29	0.00 △	×		
Retiree + 1 Dependent with no Medicare	859.92	671.85	188.07	1,315.20	1,121.77	193.43	761.55	568.80	192.75	×		
Retiree + 2 or More Dependents with no Medicare	1,174.77	671.85	502.92	1,638.62	1,121.77	516.85	1,083.24	568.80	514.44	×		
Retiree + 1 Dependent with Medicare Part A Only	839.82	661.80	178.02	1,315.20	1,121.77	193.43	×			×		
Retiree + 1 Dependent with Medicare Part B Only	830.41	657.09	173.32	1,315.20	1,121.77	193.43	717.51	545.91	171.60 △	×		
Retiree + 1 Dependent with Medicare Part A and B	725.50	604.64	120.86	1,256.14	1,090.72	165.42	717.51	545.91	171.60	×		
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,154.67	661.80	492.87	1,638.62	1,121.77	516.85	×			×		
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,145.26	657.09	488.17	1,638.62	1,121.77	516.85	1,039.20	545.91	493.29 △	×		
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,040.35	604.64	435.71	1,579.56	1,090.72	488.84	1,039.20	545.91	493.29	×		

LEVEL OF COVERAGE	Delta Dental	DeltaCare USA	Pacific Union
Retiree Only	36.90	29.65	16.47
Retiree + 1 Dependent	73.86	48.93	27.20
Retiree + 2 or More Dependents	111.57	72.37	40.22

MONTHLY MEDICAL AND DENTAL PLAN RATES EFFECTIVE 7/1/07 - 6/30/08

Eligible Surviving Spouse/Domestic Partner

LEVEL OF COVERAGE	City Health Plan			Blue Shield			Kaiser			PacifiCare		
	Total Cost	City Pays	Survivor Pays	Total Cost	City Pays	Survivor Pays	Total Cost	City Pays	Survivor Pays	Total Cost	City Pays	Survivor Pays
Survivor not eligible for Medicare	826.86	779.48	47.38	915.64	910.56	5.08	822.61	819.15	3.46	956.16	939.09	17.07
Survivor + 1 Dependent with no Medicare	1,201.74	779.48	422.26	1,315.20	910.56	404.64	1,219.87	819.15	400.72	1,379.08	939.09	439.99
Survivor + 2 or More Dependents with no Medicare	1,516.59	779.48	737.11	1,638.62	910.56	728.06	1,541.56	819.15	722.41	1,721.44	939.09	782.35
Survivor with Medicare Part A and Part B	286.71	286.08	0.63	351.20	351.20	0.00	364.29	364.29	0.00	271.48	271.48	0.00
Survivor + 1 Dependent with no Medicare	661.59	286.08	375.51	750.76	351.20	399.56	761.55	364.29	397.26	694.40	271.48	422.92
Survivor + 2 or More Dependents with no Medicare	976.44	286.06	690.36	1,074.18	351.20	722.98	1,083.24	364.29	718.95	1,036.76	271.48	765.28

LEVEL OF COVERAGE	Delta Dental	DeltaCare USA	Pacific Union
Survivor Only	36.90	29.65	16.47
Survivor + 1 Dependent	73.86	48.93	27.20
Survivor + 2 or More Dependents	111.57	72.37	40.22

CITY AND COUNTY OF SAN FRANCISCO

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