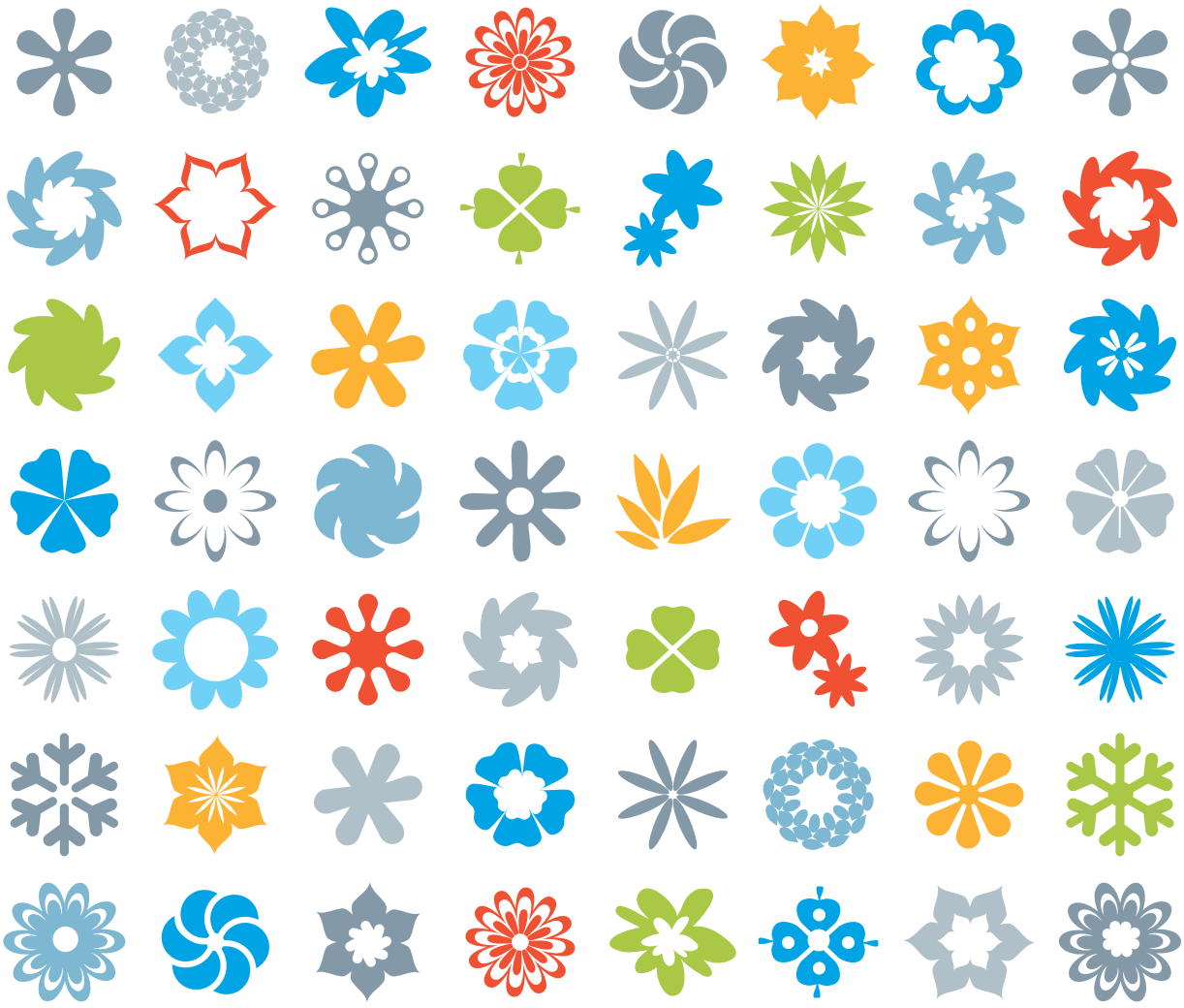
2008-2009 Retired Employees Benefits Guide



Each individual is unique. Take the time to learn about your healthcare benefit options so you can make the best choices for you and your family.

Health Service System
CITY & COUNTY OF SAN FRANCISCO

The City of San Francisco Health Service System is dedicated to providing our active and retired members with affordable, quality healthcare and the information they need to make informed decisions about their healthcare options.

Welcome

Members of the Health Service System can take part in a variety of benefit programs and events. HSS invites your participation and values your feedback.

Table of Contents

Overview

The Health Service System is committed to ongoing innovation in member services, operations and communications.

Plan Updates 2008-2009

For the Plan Year 2008-2009 there are no changes to the healthcare plans offered or the benefit levels provided to HSS members.

Register Online for E-Updates

Each month HSS sends out an email update to members who have registered on myhss.org. The updates include information about upcoming events, benefits highlights and tips designed to help you navigate the HSS healthcare eligibility and application process. In addition, members who are registered on myhss.org are invited to participate in surveys, polls, vendor report card reviews and other feedback opportunities.

HSS Health Fair October 21 & 22, 2008

Save the date! The third annual HSS member Health Fair is scheduled to take place this fall on October 21 and 22, 2008. In the past the HSS fair has offered free flu shots, wellness screenings, chair massages, movement seminars and more. Watch for announcements on myhss.org.

HSS Member Seminars

This spring HSS is introducing its first series of member seminars, to take place on site at our 1145 Market Street office. Seminar topics include Pre-Open Enrollment planning, fitness demonstrations and other subjects relating to health and well-being. Watch for announcements on myhss.org for information about the seminars and how you can register to attend.

HSS Board Meetings

The Health Service Board meets the second Thursday of every month in Room 416 of City Hall. HSS members are encouraged to attend these public meetings. Visit myhss.org for meeting details.

Open Enrollment

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

Things You Can Do During Open Enrollment

During Open Enrollment retirees can:

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

To make changes you must submit a completed Open Enrollment Application in person, by mail or by fax to HSS no later than 5pm on April 30, 2008.

If you are enrolling new dependents HSS requires that you provide documentation proving that your dependents meet eligibility requirements for the upcoming year.

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

Any changes you elect to make during the April 2008 Open Enrollment period will take effect July 1, 2008, and remain in effect through June 30, 2009.

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

If you elect to change your medical plan, the plan will issue you a new medical ID card. You will receive your new ID card before July 1.

If You Don't Make Any Changes During Open Enrollment

If you don't make any changes during the April 2008 Open Enrollment period, your current medical and dental plan elections as well as the eligible dependents you have covered on your plans will remain the same.

Benefit Election Changes Outside of Open Enrollment

Outside the annual Open Enrollment period, you must have a qualifying event in order to make any changes to your healthcare elections. See pages 28-29 of this guide for Qualifying Event guidelines.

Pension Deduction Amounts

The amount deducted from your monthly pension check may change in accordance with any approved changes to the rates for Plan Year 2008-2009. See pages 39-43 of this guide for 2008-2009 rates.

No Dual HSS Plan Coverage

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

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

Need Assistance With Your Open Enrollment Application?

Visit HSS during Open Enrollment. A Benefit Analyst can help you make sure your application is accurate and complete.

Medicare Enrollment FAQ

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.

The 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 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 on page 6 of this guide.

How do I know if I qualify for Medicare?

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

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

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 website at www.ssa.gov; 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.

Medicare Enrollment FAQ

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'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.

If You Are Eligible to Enroll In Medicare Part A and/or Part B, You Must Do So

Members who fail to enroll in Medicare will automatically be enrolled in the City Health Plan and all healthcare claims will be paid at a significantly reduced rate. Dependents who fail to enroll in Medicare will have their healthcare coverage terminated.

Medicare Part D

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

Individual Medicare Part D Plans and Your HSS Prescription Coverage

Do not enroll in an individual Medicare Part D plan. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added a new prescription drug program to Medicare. 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 is that the medical plan you and your dependents are enrolled in through the Health Service System has prescription drug coverage that is better than the available Medicare Part D coverage. In order to be able to continue to offer you such coverage, it is important that you and your dependents 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.

Group Medicare Part D Plans and Your HSS Prescription Coverage

If you're enrolled in the Blue Shield HMO and are Medicare eligible, you may receive information from Blue Shield with specific instructions about how to make sure you continue the prescription drug coverage available through your medical plan. This information will allow you to enroll in a Medicare Part D plan on a group basis at no cost to you. Please be sure to follow the instructions carefully and return all completed forms to Blue Shield to ensure your continued prescription drug coverage.

Questions About Your Prescription Drug Coverage?

Contact an HSS Benefits Analyst at 415-554-1750 or 1-800-541-2266 for assistance with specific questions about your HSS prescription coverage.

Creditable Coverage Disclosure Notice

This is an important Notice about Your Prescription Drug Coverage and Medicare. Please read this notice carefully and keep it with your important documents.

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

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

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

Original Issue Date: October 6, 2005
Revised Date: January 1, 2008

Eligibility

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

Retired Member Eligibility

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

- Retirees
- A Retiree's Spouse
- A Retiree's Domestic Partner
- A Retiree's Qualified Dependent Children
- A Retiree's Surviving Spouse
- A Retiree's Surviving Domestic Partner

Retiree Eligibility

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

Your retirement effective date will determine when your retiree healthcare coverage will be in effect. If your retirement effective date is the first day of the month, your coverage will be in effect on that date, otherwise your coverage will be in effect on the first day of the month following your retirement effective date, provided the Health Service System receives your completed enrollment application and all required documentation within the initial 30 day enrollment period.

San Francisco City Charter requires that to be eligible for retiree healthcare coverage the retiree must have been a member of the Health Service System at some time during their active employment. Other restrictions may apply.

Spouse/Domestic Partner

- A retired member's legal spouse or domestic partner may be eligible for healthcare coverage administered by the Health Service System. Proof of marriage or registered domestic partnership is required when enrolling a spouse or domestic partner.
- An individual who has been granted a final dissolution of marriage or is legally separated from an HSS member is not eligible. If a domestic partnership has been dissolved, the former partner of the HSS retiree member is not eligible.

A new spouse or domestic partner of a surviving spouse or surviving domestic partner is eligible for coverage as a dependent at unsubsidized rates.

Natural Children, Step-Children, Adopted Children, Legal Guardianships

Children who may be covered under an HSS plan include a retired member's natural child, step-child (as long as the HSS member is married to the natural parent), a legally adopted child, a child under legal guardianship and a natural or legally adopted child of an eligible spouse or domestic partner. Legal documentation is required to enroll an adopted child or a child under guardianship.

To qualify, a child must meet all of the following five criteria:

1. Child must be under 25 years of age.
2. Child must be unmarried.
3. Child cannot be working full time.
4. Child must reside in the member's home (except for full-time college students and children living with a divorced spouse).
5. Child must be declared as an exemption on the member's federal income tax return.

Eligibility

Other Children Residing in a Retiree Member's Home

Children who are not a member's natural child, step-child, legally adopted child, child under legal guardianship or the natural or legally adopted child of an eligible spouse or domestic partner may also be eligible for coverage under an HSS plan. To qualify, a child must meet all of the following five criteria:

1. Child must be under 19 years of age.
2. Child must be unmarried.
3. Child cannot be working full time.
4. Child must reside in the member's home and be economically dependent on the member.
5. Child must be declared as an exemption on the member's federal income tax return. A copy of the member's federal income tax return must be submitted to HSS annually.

Court Ordered Children

Children covered by a National Medical Support Notice (Court Order) can be covered to age 19.

Disabled Children

Children who are disabled may be covered under an HSS plan beyond the age limits stated previously provided all of the following six criteria are met:

1. Child must be unmarried.
2. Child is incapable of self-sustaining employment due to physical handicap or mental retardation that existed prior to the child's attainment of age 25.
3. Child must permanently reside in the member's home and be economically dependent on the member for substantially all of his or her economic support.
4. Child must be declared as an exemption on the member's federal income tax return. A copy of the member's federal income tax return must be submitted to HSS annually if requested.
5. Child must have been enrolled in an HSS healthplan on a continuous basis prior to the child's 19th birthday.
6. Member submits acceptable medical documentation of the disability as may be periodically requested by HSS.

REQUIRED ELIGIBILITY DOCUMENTATION

	EVIDENCE OF RETIREMENT	MARRIAGE CERTIFICATE	DOMESTIC PARTNER REG.	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	COURT ORDER	INCOME TAX RETURN	MEDICAL EVIDENCE
Retiree	■							
Spouse		■						
Domestic Partner			■					
Child: Natural				■				
Child: Step-child		■		■				
Child: Domestic Partner			■	■				
Child: Adopted					■			
Child: Legal Guardianship						■		
Child: IRS Exemption							■	
Child: Court Ordered						■		
Child: Disabled								■

Choosing a Medical Plan

When choosing a medical plan there is more to consider than just the pension deduction amount. A variety of factors determine the true value of a plan and which option is best for you.

PPO vs HMO QUICK COMPARISON CHART

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

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

Choosing a Medical Plan

Vendor report cards, quality ratings, member comments and other resources are available online to assist you in your decision making process.

Step 1 **PPO vs. HMO**

Learn about the differences between a PPO plan and an HMO plan.
(See the chart on page 10 of this guide.)

Step 2 **Plan Service Areas**

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

Step 3 **Doctors and Hospitals**

Determine which medical plan networks include the doctors, hospitals and other medical services that you and your family want to use.

Step 4 **Vendor Report Cards and Quality Ratings**

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

HSS
myhss.org

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

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

NCQA
http://web.ncqa.org/

America's Best Health Plans
http://health.usnews.com/sections/health/health-plans/index.html

AHRQ
www.ahrq.gov/consumer/insuranceqa/

Step 5 **Services Covered**

Make sure you understand how your plan works. Don't wait until you need emergency care to ask questions about plan details.

- What types of services are covered by the plan?
- What steps do you need to take to get the care you and your family members need?
- When do you need prior approval to ensure coverage for care, such as a hospitalization or scheduled surgery?
- How are benefits paid?

Step 6 **Medical Needs**

- Do you or a family member require specialists or specific treatments?
- Does someone in your family need ongoing care or costly medication?
- Will the location of doctors or medical facilities make transportation an issue?
- Do you or your family members require mental health benefits?

Step 7 **Plan Costs**

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

Medical Plan Options

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

This section highlights the different medical plans available to eligible employees and their dependents. For your convenience, we've included a medical plan comparison chart on pages 14-21 that contains key plan features and benefits for each plan. Please refer to the plan's Evidence of Coverage (EOC) for a detailed list of covered services, exclusions and limitations. EOCs are available online at myhss.org.

Health Maintenance Organization (HMO)

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

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

Preferred Provider Organization (PPO)

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

HSS offers you the following PPO plan:

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

Medicare Advantage Plan

A Medicare Advantage plan is a healthcare plan that is administered by a private insurance company that contracts with Medicare to provide your healthcare coverage. Medicare Advantage plans are only available to Medicare eligible HSS members and/or their Medicare eligible dependents who are enrolled in Medicare Part A and Part B.

HSS offers you the following Medicare Advantage plans:

- **Kaiser Senior Advantage HMO**
- **Secure Horizons HMO (Administered by UnitedHealthCare)**

Evidence of Coverage (EOC)

The EOC contains a complete list of benefits and exclusions in effect July 1, 2008 through June 30, 2009 for each plan. This benefits guide cannot cover every detail of your plan contract; you should review the EOC for plan details. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. You can read or download plan EOCs at myhss.org.

Medical Plan Service Areas

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

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

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

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

Retired Employees with Medicare Parts A & B

	blue of california	KAISER PERMANENTE® Senior Advantage	SecureHorizons® by UnitedHealthcare
DEDUCTIBLES			
Plan-year deductible Includes Medicare deductible	None	None	None
Lifetime maximum	None	None	None
PREVENTATIVE & GENERAL CARE			
Routine physical	No charge	$10 co-pay	$10 co-pay
Immunizations & Innoculations	No charge	No charge	No charge
Gynecologic exam	No charge	$10 co-pay	$10 co-pay
Allergy Testing & Treatment	$10 co-pay	$10 co-pay	$10 co-pay
PHYSICIAN CARE			
Office & home visits	$10 co-pay	$10 co-pay	$10 co-pay
Hospital visits	No charge	No charge	No charge
PRESCRIPTION DRUGS			
Pharmacy - generic drugs	$5 co-pay 30 day supply	$5 co-pay 30 day supply	$5 co-pay 30 day supply
Pharmacy - brand-name drugs	$15 co-pay 30 day supply	$15 co-pay 30 day supply	$15 co-pay 30 day supply
Pharmacy - non-formulary drugs	$25 co-pay 30 day supply	Physician authorized only	Physician authorized only
Mail order - generic drugs	$10 co-pay 90 day supply	$10 co-pay 100 day supply	$10 co-pay 90 day supply
Mail order - brand-name drugs	$30 co-pay 90 day supply	$30 co-pay 100 day supply	$30 co-pay 90 day supply
Mail order - non-formulary drugs	$50 co-pay 90 day supply	Physician authorized only	Physician authorized only
OUTPATIENT SERVICES			
Diagnostic X-ray & laboratory	No charge	No charge	No charge
EMERGENCY			
Hospital emergency room	$50 co-pay waived if hospitalized; $10 co-pay urgent care	$50 co-pay waived if hospitalized; $10 co-pay urgent care	$50 co-pay waived if hospitalized
HOSPITALIZATION			
Inpatient	$100 co-pay per admittance	$100 co-pay per admittance	$100 co-pay per admittance
Outpatient	$50 co-pay	$10 co-pay	$10 co-pay
SURGERY			
In Hospital	$100 co-pay per admittance	$100 co-pay per admittance	$100 co-pay per admittance
In Doctor's Office	$10 co-pay	$10 co-pay	$10 co-pay

This chart is intended to provide a quick comparison of benefits; it is not a contract. For a more detailed description of benefits and exclusions for each plan, please review the individual plan documents (Evidence of Coverage), available on myhss.org.

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
$250 employee only $500 employee + 1 $750 employee + 2 or more	$250 employee only $500 employee + 1 $750 employee + 2 or more	$250 employee only $500 employee + 1 $750 employee + 2 or more
$2,000,000 per covered person for any combination of In Network, Out-of-Network and Out-of-Area options utilized		
85% covered after deductible	Not covered	85% covered after deductible
100% covered no deductible	50% covered no deductible	100% covered no deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	85% covered after deductible	85% covered after deductible
$5 co-pay 30 day supply	50% covered after $5 co-pay; 30 day supply	$5 co-pay 30 day supply
$15 co-pay 30 day supply	50% covered after $15 co-pay; 30 day supply	$15 co-pay 30 day supply
$25 co-pay 30 day supply	50% covered after $25 co-pay; 30 day supply	$25 co-pay 30 day supply
$10 co-pay 90 day supply	Not covered	$10 co-pay 90 day supply
$30 co-pay 90 day supply	Not covered	$30 co-pay 90 day supply
$50 co-pay 90 day supply	Not covered	$50 co-pay 90 day supply
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible; 50% after deductible if non-emergency	85% covered after deductible; 50% after deductible if non-emergency	85% covered after deductible; 50% after deductible if non-emergency
85% covered after deductible;	50% covered after deductible;	85% covered after deductible;
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible

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

Retired Employees with Medicare Parts A & B

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

This chart is intended to provide a quick comparison of benefits; it is not a contract. For a more detailed description of benefits and exclusions for each plan, please review the individual plan documents (Evidence of Coverage), available on myhss.org.

CITY HEALTH PLAN (adminstered by United Healthcare)

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

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

Retired Employees Not Eligible for Medicare

	blue of california	KAISER PERMANENTE®	PacifiCare®
DEDUCTIBLES			
Plan-year deductible	None	None	None
Lifetime maximum	None	None	None
PREVENTIVE & GENERAL CARE			
Routine physical	No charge	$10 co-pay	$10 co-pay
Immunizations & Innoculations	No charge	No charge	No charge
Gynecologic exam	No charge	$10 co-pay	No charge
Well baby care	No charge	$10 co-pay	No charge
PHYSICIAN CARE			
Office & home visits	$10 co-pay	$10 co-pay	$10 co-pay
Hospital visits	No charge	No charge	No charge
PRESCRIPTION DRUGS			
Pharmacy - generic drugs	$5 co-pay 30 day supply	$5 co-pay 30 day supply	$5 co-pay 30 day supply
Pharmacy - brand-name drugs	$15 co-pay 30 day supply	$15 co-pay 30 day supply	$15 co-pay 30 day supply
Pharmacy - non-formulary drugs	$25 co-pay 30 day supply	Physician authorized only	$25 co-pay 30 day supply
Mail order - generic drugs	$10 co-pay 90 day supply	$10 co-pay 100 day supply	$10 co-pay 90 day supply
Mail order - brand-name drugs	$30 co-pay 90 day supply	$30 co-pay 100 day supply	$30 co-pay 90 day supply
Mail order - non-formulary drugs	$50 co-pay 90 day supply	Physician authorized only	$50 co-pay 90 day supply
OUTPATIENT SERVICES			
Diagnostic X-ray & laboratory	No charge	No charge	No charge
EMERGENCY			
Hospital emergency room	$50 co-pay waived if hospitalized; $10 co-pay urgent care	$50 co-pay waived if hospitalized; $10 co-pay urgent care	$50 co-pay waived if hospitalized; $30 co-pay urgent care
HOSPITALIZATION			
Inpatient	$100 co-pay per admittance	$100 co-pay per admittance	$100 co-pay per admittance
Oupatient	$50 co-pay	$10 co-pay	$10 co-pay
SURGERY			
In Hospital	$100 co-pay per admittance	$100 co-pay per admittance	$100 co-pay per admittance

This chart is intended to provide a quick comparison of benefits; it is not a contract. For a more detailed description of benefits and exclusions for each plan, please review the individual plan documents (Evidence of Coverage), available on myhss.org.

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
$250 employee only $500 employee + 1 $750 employee + 2 or more	$250 employee only $500 employee + 1 $750 employee + 2 or more	$250 employee only $500 employee + 1 $750 employee + 2 or more
$2,000,000 per covered person for any combination of In Network, Out-of-Network and Out-of-Area options utilized		
85% covered after deductible	Not covered	85% covered after deductible
100% covered no deductible	50% covered no deductible	100% covered no deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
$5 co-pay 30 day supply	50% covered after $5 co-pay; 30 day supply	$5 co-pay 30 day supply
$15 co-pay 30 day supply	50% covered after $15 co-pay; 30 day supply	$15 co-pay 30 day supply
$25 co-pay 30 day supply	50% covered after $25 co-pay; 30 day supply	$25 co-pay 30 day supply
$10 co-pay 90 day supply	Not covered	$10 co-pay 90 day supply
$30 co-pay 90 day supply	Not covered	$30 co-pay 90 day supply
$50 co-pay 90 day supply	Not covered	$50 co-pay 90 day supply
85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	85% covered after deductible; may require prior notification
85% covered after deductible; if non-emergency 50% after deductible	85% covered after deductible: if non-emergency 50% after deductible	85% covered after deductible: if non-emergency 50% after deductible
85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	85% covered after deductible; may require prior notification
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	85% covered after deductible; may require prior notification

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

Retired Employees Not Eligible for Medicare

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

This chart is intended to provide a quick comparison of benefits; it is not a contract. For a more detailed description of benefits and exclusions for each plan, please review the individual plan documents (Evidence of Coverage), available on myhss.org.

CITY HEALTH PLAN (administered by United Healthcare)

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

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

Dental Plan Options

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

Below is a brief overview of the types of dental plans available. See page 24 for a comparison chart of key dental plan features and benefits.

HMO-Style Dental Plans

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

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

HSS offers you the following DMO plans:

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

PPO-Style Dental Plans

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

HSS offers you the following PPO-style dental plan:

- **Delta Dental**

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

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

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

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) they contract with before making your selection.

■ = Available in this County

COUNTY	DELTA DENTAL	DELTACARE USA DMO	PACIFIC UNION DMO
Alameda	■	■	■
Alpine	■		
Amador	■		
Butte	■	■	■
Calaveras	■		
Colusa	■	■	■
Contra Costa	■	■	■
El Dorado	■	■	■
Fresno	■	■	
Glenn	■		
Lake	■	■	
Lassen	■		
Madera	■	■	■
Marin	■	■	■
Mariposa	■		
Mendocino	■	■	■
Merced	■	■	■
Mono	■		
Monterey	■	■	■
Napa	■	■	■
Nevada	■		
Placer	■	■	■
Plumas	■		
Sacramento	■	■	■
San Benito	■		■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Barbara	■	■	
Santa Clara	■	■	■
Santa Cruz	■	■	■
Sierra	■		
Solano	■	■	■
Sonoma	■	■	■
Stanislaus	■	■	■
Sutter	■	■	
Yolo	■	■	
Yuba	■	■	
Outside of 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 please contact the dental plan to confirm that service is available to you.

Dental Plan Benefits-at-a-Glance

	DELTA DENTAL		DELTACARE	PACIFIC UNION
	In-Network Providers	Out-of-Network Providers*		
Types of Service				
Cleanings & Exams	100% covered Limit 2x per plan year	80% covered Limit 2x per plan year	100% covered Limit 1 every 6 months	100% covered Limit 1 every 6 months
X-rays	100% covered	80% covered	100% covered	100% covered
Extractions	80% covered	80% covered	100% covered	$5 co-pay
Fillings	80% covered	80% covered	100% covered	$5 co-pay
Crowns	50% covered	50% covered	100% covered Limitations apply to resin materials.	$85 co-pay
Dentures, Pontics & Bridges	50% covered	50% covered	No charge Full and partial dentures 1x every 5 yrs; fixed bridgework; certain limitations apply.	$85 - $100 co-pay
Root Canals	50% covered	50% covered	100% covered Excluding the final restoration	$50 co-pay
Orthodontia	Not Covered	Not Covered	Member pays: $1,600/child $1,880/adult $350 startup fee; limitations apply.	Member pays: $1,600/child $1,800/adult $350 startup fee; limitations apply.
Annual Maximum				
Total Dental Benefits	$1,000 per person per plan year	$1,000 per person per plan year	None	None
Annual Deductible				
Before Accessing Benefits	None	$50 per person per plan year for all services except diagnostic and preventative care.	None	None

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

Dental Plan Benefits At-a-Glance

When reviewing dental plan options make sure you understand the plan details before deciding which plan will best serve your needs.

DENTAL PLAN QUICK COMPARISON CHART			
	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. You must live in this DMO's service area to enroll.	Yes. You must live in this DMO's service area to enroll.

Vision Plan Benefits

All HSS members and eligible dependents who are enrolled in a medical plan receive vision benefits, including an annual eye exam.

VSP Vision

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

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.

Choice of Providers

Under the vision plan, you have the choice of using a VSP network doctor or a non-VSP provider. It is usually to your advantage financially 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.

Accessing Your Vision Benefits

There are no ID cards issued for the vision plan. If 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. Services must be received prior to the benefit authorization expiration date.

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. You then submit an itemized bill directly to VSP for partial reimbursement. You can download a claim form from the VSP website at www.vsp.com.

VISION PLAN BENEFITS AT-A-GLANCE

	VSP NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
Vision Exam	Covered in full once every 12 months* after the $10 co-pay	up to $40 every 12 months* after the $10 co-pay
Single Vision Lenses	Covered in full once every 24 months* after the $25 co-pay	up to $45 every 24 months* after the $25 co-pay
Lined Bifocal Lenses	Covered in full once every 24 months* after the $25 co-pay	up to $65 once every 24 months* after the $25 co-pay
Lined Trifocal Lenses	Covered in full once every 24 months* after the $25 co-pay	up to $85 once every 24 months* after the $25 co-pay
Frames	Covered up to $150 every 24 months* after the $25 co-pay	up to $55 once every 24 months* after the $25 co-pay
Contact Lenses	Covered up to $150 every 24 months* no co-pay; in lieu of frames/lenses; allowance applies toward contact lens fitting, evaluation exam and contacts	Covered up to $105 every 24 months* no co-pay; in lieu of frames/lenses; allowance applies toward contact lens fitting, evaluation exam and contacts

*Based on your last date of service

Vision Plan Limits & Exclusions

The vision plan is designed to cover your visual correction needs. If you select cosmetic options, you'll be responsible for paying those additional costs.

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 lenses and an eyeglass frame benefit 24 months after the last date of obtaining the contact 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 vision 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
    - Coatings of the lens or lenses, except scratch resistant coatings
    - 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 treatments such as, but not limited to, LASIK 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.)

Coordinating Vision Benefits with Medical Plan Benefits

The VSP vision plan is designed to cover visual correction needs, such as eyeglasses and contact lenses. Some HMOs also offer optometry services where you can get eye exams and purchase glasses and lenses. HSS recommends that you compare the out-of-pocket cost you will incur using your HMO's vision services to your out-of-pocket costs when using a VSP network doctor. In addition, be aware that your medical plan may offer coverage for medical conditions and diseases relating to the eyes.

No Medical Plan, No Vision Benefits

If you don't enroll in an HSS medical plan, you won't have the vision benefits available through VSP.

Qualifying Events in Family Status

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

Marriage or Domestic Partnership

To enroll your new spouse or domestic partner and their eligible child(ren) in your HSS healthcare coverage you must submit a completed HSS Enrollment Application and a copy of your marriage license or certificate of domestic partnership and birth certificates for their child(ren) to the Health Service System **within 30 days** from the date of your marriage or certification of domestic partnership. Coverage for your spouse or domestic partner and their eligible children will be effective on the date of marriage or certification of domestic partnership, provided you meet the enrollment deadline and documentation requirements stated above. If you do not complete the enrollment process **within 30 days** from the date of your marriage or certification of domestic partnership, you must wait until the next annual Open Enrollment period to add your new family members.

Domestic Partner Tax Alert: When you elect healthcare 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 healthcare coverage for these dependents, per IRS requirements. This is referred to as imputed income and may affect your net pay.

Birth or Adoption

To enroll your newborn/newly adopted child in your HSS healthcare coverage you must submit a completed HSS Enrollment Application and a copy of the birth certificate or adoption documentation **within 30 days** from the date of birth or placement for adoption. Coverage for your newborn child will be effective on the child's date of birth provided you meet the deadline and documentation requirements stated above. Coverage for your newly adopted child will be effective on the date the child is placed with you for adoption provided you meet the deadline and documentation requirements stated above. If you do not complete the enrollment process **within 30 days** from the date of birth or placement for adoption of a new child, you must wait until the next annual Open Enrollment period to do so.

Divorce, Separation and Dissolution of Partnership

To terminate healthcare coverage for your ex-spouse/domestic partner due to divorce, legal separation or dissolution of domestic partnership, you must submit a completed HSS Enrollment Application and a copy of your divorce decree, legal separation documents or dissolution of domestic partnership documents **within 30 days** from the date of divorce, legal separation or dissolution of domestic partnership. Coverage for your ex-spouse/domestic partner will terminate on the last day of the coverage period in which the divorce, legal separation or dissolution of domestic partnership occurred provided you meet the deadline and documentation requirements stated above. If you do not complete the coverage termination process **within 30 days** from the date of your divorce, legal separation or dissolution, coverage for your ex-spouse/domestic partner will terminate on the last day of the coverage period in which you submit a completed HSS Application and required documentation and you will be responsible for paying all required contributions up to the coverage termination date.

Qualifying Events in Family Status

Take note of the 30 day time period during which you can make healthcare coverage changes after one of these qualifying changes in your family status.

Loss of Other Healthcare Coverage

You can enroll an eligible dependent that loses other healthcare coverage by submitting a completed HSS Enrollment Application and proof of the loss of cover-age **within 30 days** from the date the other coverage terminates. Coverage for your dependent will be effective on the first day of the coverage period following the date HSS receives a completed HSS Enrollment Application provided you meet the deadline and documentation requirements stated above. Please note that there may be a break in healthcare coverage between the date that other coverage terminates and the date that HSS coverage begins. If you do not complete the enrollment process **within 30 days** from the date that other coverage terminates, you must wait until the next annual Open Enrollment period to add your eligible dependent.

Obtaining Other Coverage

You may terminate healthcare coverage for yourself and/or your enrolled dependents if you or they become eligible for other healthcare coverage by submitting a completed HSS Enrollment Application and proof of other healthcare coverage enrollment **within 30 days** from the date of your enrollment in another healthcare plan. Your HSS healthcare coverage will terminate on the last day of the coverage period in which HSS receives a completed HSS Enrollment Application provided you meet the deadline and documentation requirements stated above. Please note that there may be an overlap of healthcare coverage between the date your other coverage begins and the date your HSS coverage terminates. You are responsible for paying all required contributions up to the termination date of your HSS healthcare coverage. If you do not complete the coverage termination process **within 30 days** from the date of your enrollment in another healthcare plan, you must wait until the next annual Open Enrollment period to do so.

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 at midnight on the date of the dependent's death.

Death of a Member

In the event of a member's death, surviving dependent(s) or another designee should contact HSS **within 30 days** from the date of the member's death to obtain information about any available survivor benefits.

Mark Your Calendar: 30 Day Rule

If you have a qualifying change in your family status and fail to submit a completed HSS Enrollment Application within the 30 day time period you must wait until the next Open Enrollment to do so.

COBRA

COBRA is a Federal Law that provides for continuation of healthcare coverage when coverage may be lost due to specific qualifying events.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted in 1986 offers employees and their covered dependents the opportunity to elect a temporary extension of healthcare coverage in certain instances where coverage would otherwise end. The Health Service System offers this coverage continuation option to dependents of retired members who become ineligible for HSS healthcare coverage.

Time Limits for COBRA Elections

When a qualifying event occurs, the COBRA Administrator will notify you of your right to elect COBRA coverage. You will have 60 days from the date of this notification to elect COBRA coverage. The coverage will be continuous from the date of the qualifying event so you will not have a break in your healthcare coverage. While you are covered under COBRA, you have 30 days to add any newly eligible dependent (spouse, domestic partner, newborn or adopted child) to your COBRA coverage from the date of the event (birth, marriage, etc.).

Duration of COBRA Continuation Coverage

COBRA beneficiaries are generally eligible for group coverage for a maximum of 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

In the case of a dependent losing coverage (divorce or aging out of a plan) the employee or dependent must notify the COBRA Administrator within 30 days of the qualifying event.

Employees who are disabled on the date of their qualifying event or at any time during the first 60 days of continuation coverage, are eligible for a total of 29 months of COBRA coverage. The cost will be 150% of the group rate, beginning in the 19th month of coverage.

Termination of COBRA Continuation Coverage

COBRA coverage will end at the earliest of the date:

- 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 individual(s) to remit the required healthcare premium payments directly to the COBRA Administrator.

COBRA

Once COBRA is elected certain premium costs become the responsibility of the covered individuals.

COBRA Continuation Coverage Alternatives

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

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

COBRA Questions?

For questions about COBRA continuation coverage contact the COBRA Administrator FBMC at (800) 342-8017.

Frequently Asked Questions

What should I do if my healthcare contribution is incorrect or isn't being deducted from my monthly pension check?

When you select your initial retiree healthcare coverage or change your coverage during the annual Open Enrollment period or because of a qualifying change in family status, you should carefully check your pension check stub to verify that the correct healthcare contribution is being deducted.

If the deduction is incorrect or doesn't appear on your pension check stub, you should contact HSS Member Services at (415) 554-1750 for assistance. You are responsible for all required healthcare contributions, whether they are deducted from your paycheck or not.

Who should I contact if I need an insurance ID card or if I have a question about my coverage?

Contact the plan directly. Refer to the Key Contact Information section on page 44 of this guide for benefit plan telephone numbers and website addresses. You may also obtain a copy of your plan's Evidence of Coverage from the HSS website at www.myhss.org

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

If you move out of the service area covered by your plan, you must elect healthcare coverage under an option that provides coverage in your area. Failure to change your healthcare elections will result in the non-payment of claims for services received. Contact HSS Member Services for assistance.

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

Yes. Dependents who no longer meet the eligibility requirements for participation may be eligible to continue healthcare coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). See the COBRA section of this Benefit Guide on page 30 for more information.

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

Generally, surviving dependents of an employee may continue healthcare coverage after the death of the employee. Upon your death, covered dependents should contact HSS Member Services for information on available healthcare coverage options.

What if my healthcare provider chooses not to participate in my plan's network?

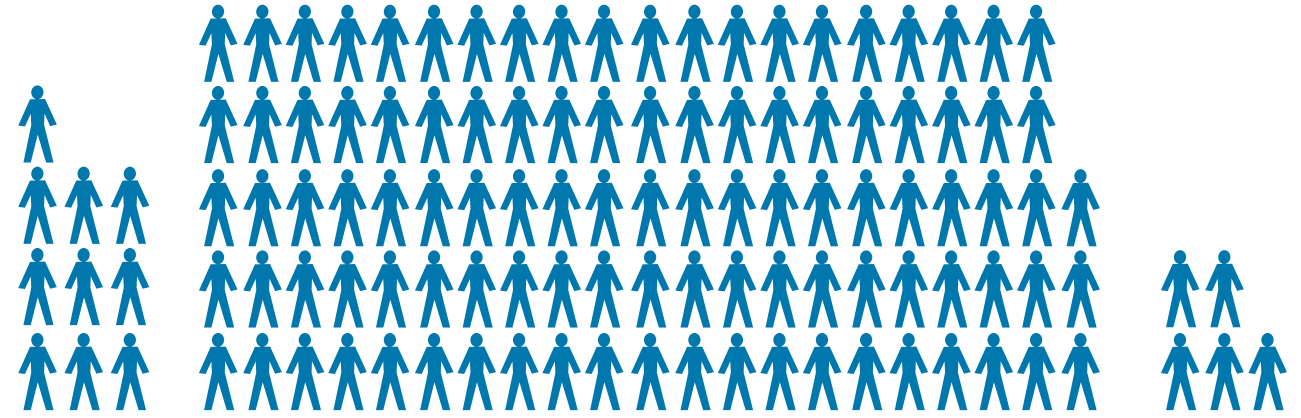
The healthcare plans administered by HSS do not guarantee the continued network participation of any particular doctor, dentist, hospital, medical group or other provider during the Plan Year

After the annual Open Enrollment deadline, you won't be allowed to change your healthcare 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.

More Questions?

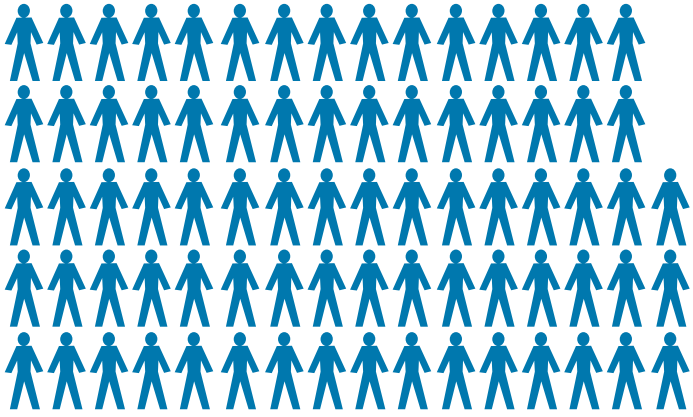
The information in this FAQ is general in nature and is not intended to be a complete source of information for HSS members. Please contact HSS Member Services for assistance with your particular situation.

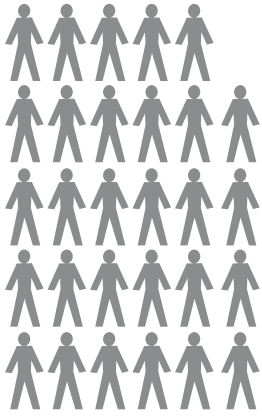
Membership Demographics



SFUSD	SF CITY & COUNTY	CCD
15,865 = 15%	87,059 = 81%	4,482 = 4%

TOTAL LIVES COVERED = 107,406





TOTAL ACTIVE MEMBERS	TOTAL RETIRED MEMBERS
78,224 = 73%	29,182 = 27%

The Health Service System provides medical benefits to eligible employees and retirees of four major San Francisco public-sector employers–the City and County of San Francisco, the San Francisco Unified School District, the City College of San Francisco and the San Francisco Superior Court. As of July 1, 2007, HSS members totaled 107,406 covered lives. This reflected an increase of 1,857 in total covered lives under HSS medical plans since July 1, 2006.

Glossary of Healthcare Terms

Brand Name Drug
FDA approved prescription drugs marketed under a specific brand name by the company that manufactures it.

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

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

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

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

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

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

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

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

Explanation of Benefits (EOB)
Written, formal statement sent to PPO enrollees that lists the services provided and costs billed by their health plan.

Evidence of Coverage (EOC)
The Evidence of Coverage gives details about the benefits and exclusions of your health plan and explains how to get the care you need. The EOC is an important legal document and is your contract with your Plan provider. It explains your rights, benefits and responsibilities as a member of your Plan. It also explains the Plan Providers responsibilities to you. The EOC should be reviewed in conjunction with this benefits guide because the guide does not list every service, every limitation or every exclusion of your Plan.

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.

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.

Glossary of Healthcare Terms

In-Network
Providers or healthcare facilities which are part of a health plan's network of providers with which it has negotiated a discount. Enrollees usually pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts.

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

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

Out-of-Network
Providers or healthcare facilities which are not in your health plan's provider network. Some plans do not cover Out-of-Network service costs. Others charge a higher co-payment for this type of service.

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

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

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

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

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

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

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

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

Privacy Policy

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

To Make or Obtain Payment

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

To Conduct Healthcare Operations

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

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

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

For Treatment Alternatives

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

For Distribution of Health-Related Benefits and Services

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

For Disclosure to the Plan Actuaries

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

When Legally Required

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

To Conduct Health Oversight Activities

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

In Connection With Judicial and Administrative Proceedings

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

For Law Enforcement Purposes

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

In the Event of a Serious Threat to Health or Safety

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

Privacy Policy

For Specified Government Functions

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

For Worker's Compensation

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

Authorization To Use Or Disclose Health Information

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

Your Rights With Respect to Your Health Information

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

Right to Request Restrictions

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

Right to Receive Confidential Communications

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

Right to Inspect and Copy Your Health Information

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

Right to Amend Your Health Information

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

Right to an Accounting

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

Right to a Paper Copy of this Notice

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

Duties of the Health Plan

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

Written Authorizations & Requests

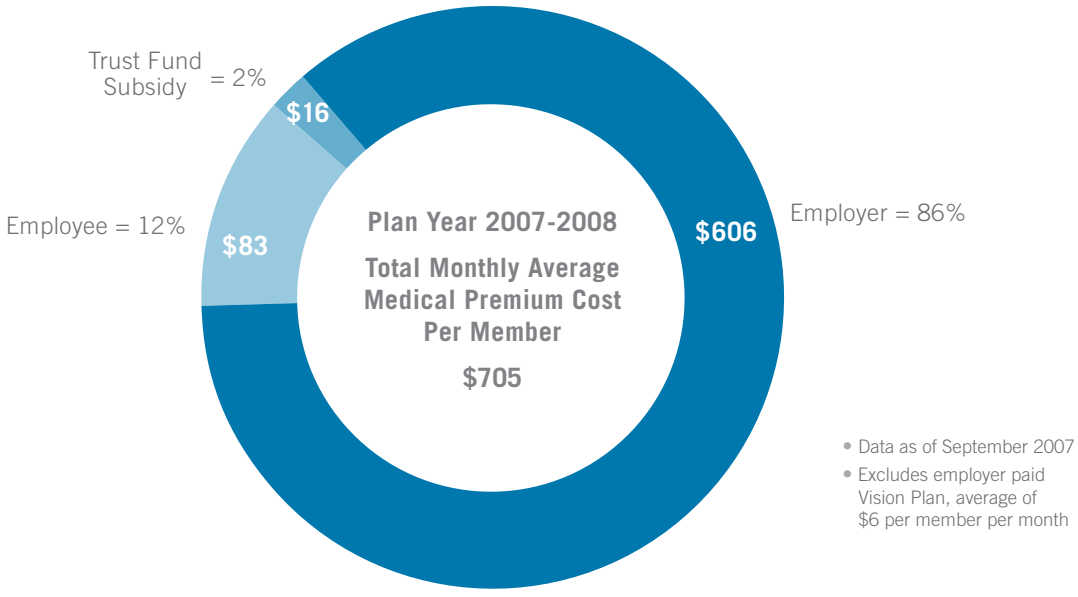
Any written authorizations or requests regarding your health information as described above should be directed to:

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

Effective Date

Original Effective Date: April 14, 2003
Revised January 1, 2008

Medical Plan Costs



The San Francisco Health Service System provides medical and other non-pension benefits to City and County employees, City College and San Francisco Unified School District employees, San Francisco Superior Court employees, and retirees and dependents. The Health Service System is responsible for designing healthcare benefits, selecting and managing plan providers and determining some aspects of benefit eligibility to supplement the eligibility rules contained in the City Charter and applicable ordinances. In addition, the Health Service System is responsible for administration of health benefits, including maintaining employee membership and financial accounting records. Additional financial information, including audited Health Service System Trust Fund Financial Statements, is available online at myhss.org.

Rates: Retiree Not Eligible for Medicare

MEDICAL: LEVEL OF COVERAGE	BLUE SHIELD		KAISER		PACIFICARE		CITY PLAN	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	1,013.86	24.79	870.07	9.76	1,062.86	43.30	797.47	73.74
Retiree + 1 Dependent with no Medicare	1,247.54	258.48	1,088.72	228.41	1,315.04	295.48	1,300.31	407.87
Retiree + 2 or More Dependents with no Medicare	1,247.54	646.38	1,088.72	591.36	1,315.04	714.12	1,359.47	935.72
Retiree + 1 Dependent with Medicare Part A Only	1,247.54	258.48	X	X	X	X	1,254.95	377.71
Retiree + 1 Dependent with Medicare Part B Only	1,247.54	258.48	1,088.72	228.41△	X	X	1,081.66	262.56
Retiree + 1 Dependent with Medicare Part A and Part B	1,159.34	170.28	1,043.96	183.65	1,209.10	189.54	942.87	218.96
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,247.54	646.38	X	X	X	X	1,314.11	905.56
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,247.54	646.38	X	X	X	X	1,140.82	790.41
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,159.34	558.18	1,043.96	546.60	1,209.10	608.18	1,002.03	746.81

X = Not available. Dependents must be enrolled in Medicare Part A and B to be eligible.

△ = New enrollees not allowed.

DENTAL: LEVEL OF COVERAGE	DELTA DENTAL		PACIFIC UNION		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	36.90	0	16.47	0	29.65
Retiree + 1 Dependent	0	73.86	0	27.20	0	48.93
Retiree + 2 or More Dependents	0	111.57	0	40.22	0	72.37

Note: All rates that appear in this Benefit Guide are subject to final approval by The San Francisco Board of Supervisors.

Rates: Retiree Eligible for Medicare Part A & Part B

MEDICAL: LEVEL OF COVERAGE	BLUE SHIELD		KAISER SR. ADV.		SECURE HORIZONS		CITY PLAN	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	292.00	0	348.81	0.00	293.51	0	317.17	0.00
Retiree + 1 Dependent with no Medicare	525.68	233.69	567.46	218.65	545.69	252.18	820.01	334.13
Retiree + 2 or More Dependents with no Medicare	525.68	621.59	567.46	581.60	545.69	670.82	879.17	861.98
Retiree + 1 Dependent with Medicare Part A Only	525.68	233.69	X	X	X	X	774.65	303.97
Retiree + 1 Dependent with Medicare Part B Only	525.68	233.69	X	X	X	X	601.36	188.82
Retiree + 1 Dependent with Medicare Part A and B	437.48	145.49	522.70	173.89	439.75	146.24	462.57	145.22
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	525.68	621.59	X	X	X	X	833.81	831.82
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	525.68	621.59	X	X	X	X	660.52	716.67
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	437.48	533.39	522.70	536.84	439.75	564.88	521.73	673.07

X = Not available. Dependents must be enrolled in Medicare Part A and B to be eligible.

DENTAL: LEVEL OF COVERAGE	DELTA DENTAL		PACIFIC UNION		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	36.90	0	16.47	0	29.65
Retiree + 1 Dependent	0	73.86	0	27.20	0	48.93
Retiree + 2 or More Dependents	0	111.57	0	40.22	0	72.37

Rates: Retiree Eligible for Medicare Part A Only

MEDICAL: LEVEL OF COVERAGE	BLUE SHIELD		KAISER SR. ADV.		SECURE HORIZONS		CITY PLAN	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	1,013.86	24.79	X	X	X	X	744.51	73.74
Retiree + 1 Dependent with no Medicare	1,247.54	258.48	X	X	X	X	1,247.35	407.87
Retiree + 2 or More Dependents with no Medicare	1,247.54	646.38	X	X	X	X	1,306.51	935.72
Retiree + 1 Dependent with Medicare Part A Only	1,247.54	258.48	X	X	X	X	1,201.99	377.71
Retiree + 1 Dependent with Medicare Part B Only	1,247.54	258.48	X	X	X	X	1,291.26	262.56
Retiree + 1 Dependent with Medicare Part A and B	1,159.34	170.28	X	X	X	X	889.91	218.96
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,247.57	646.38	X	X	X	X	1,261.15	905.56
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,247.57	646.38	X	X	X	X	1,878.27	790.41
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,159.34	558.18	X	X	X	X	949.07	746.81

X = Not available. Retiree and/or dependents must be enrolled in Medicare Part A and B to be eligible.

DENTAL: LEVEL OF COVERAGE	DELTA DENTAL		PACIFIC UNION		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	36.90	0	16.47	0	29.65
Retiree + 1 Dependent	0	73.86	0	27.20	0	48.93
Retiree + 2 or More Dependents	0	111.57	0	40.22	0	72.37

Rates: Retiree Eligible for Medicare Part B Only

MEDICAL: LEVEL OF COVERAGE	BLUE SHIELD		KAISER		SECURE HORIZONS		CITY PLAN	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	1,038.65	0	879.83	0 △	X	X	507.54	0
Retiree + 1 Dependent with no Medicare	1,272.33	233.69	1,098.48	218.65	X	X	1,010.38	334.13
Retiree + 2 or More Dependents with no Medicare	1,272.33	621.59	1,098.48	581.60	X	X	1,069.54	861.98
Retiree + 1 Dependent with Medicare Part A Only	1,272.33	233.69	X	X	X	X	965.02	303.97
Retiree + 1 Dependent with Medicare Part B Only	1,272.33	233.69	1,098.48	218.65 △	X	X	791.73	188.82
Retiree + 1 Dependent with Medicare Part A and B	1,184.13	145.49	1,053.72	173.89	X	X	652.94	145.22
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,272.33	621.59	X	X	X	X	1,024.18	831.82
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,272.33	621.59	1,098.48	581.60 △	X	X	850.89	716.67
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,184.13	533.39	1,053.72	536.84	X	X	712.10	673.07

X = Not available. Retiree and/or dependents must be enrolled in Medicare Part A and B to be eligible.

△ = New enrollees not allowed.

DENTAL: LEVEL OF COVERAGE	DELTA DENTAL		PACIFIC UNION		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	36.90	0	16.47	0	29.65
Retiree + 1 Dependent	0	73.86	0	27.20	0	48.93
Retiree + 2 or More Dependents	0	111.57	0	40.22	0	72.37

Rates: Eligible Surviving Spouse/Domestic Partner

MEDICAL: LEVEL OF COVERAGE	BLUE SHIELD		KAISER		PACIFICARE		CITY PLAN	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Survivor Not Eligible for Medicare	1,013.86	24.79	870.07	9.76	1,062.86	43.30	797.47	73.74
Survivor + 1 Dependent with no Medicare	1,013.86	492.16	870.07	447.06	1,062.86	547.66	797.47	826.35
Survivor + 1 Dependent with Medicare Part A and Part B	1,013.86	315.76	870.07	357.54	1,062.86	335.78	797.47	364.17
Survivor + 2 or More Dependents with no Medicare	1,013.86	880.06	870.07	810.01	1,062.86	966.29	797.47	1,354.20
	BLUE SHIELD		KAISER SR. ADV.		SECURE HORIZONS		CITY PLAN	
Survivor with Medicare Part A and B	292.00	0	348.81	0	293.51	0	317.17	0
Survivor with Medicare A&B + 1 Dependent with no Medicare	292.00	467.37	348.81	437.30	293.51	504.36	317.17	752.61
Survivor with Medicare A&B + 1 Dependent with Medicare A&B	292.00	290.97	348.81	347.78	293.51	292.48	317.17	290.43
Survivor with Medicare A&B + 2 or more Dependents with no Medicare	292.00	855.27	348.81	800.25	293.51	922.99	317.17	1,280.46

The rates above apply to eligible survivors who receive a monthly survivor's pension from a participating retirement system.
Note: City Plan rates above were amended March 18, 2008, after the Benefit Guides were printed.

DENTAL: LEVEL OF COVERAGE	DELTA DENTAL		PACIFIC UNION		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	36.90	0	16.47	0	29.65
Retiree + 1 Dependent	0	73.86	0	27.20	0	48.93
Retiree + 2 or More Dependents	0	111.57	0	40.22	0	72.37

Key Contact Information

HEALTH SERVICE SYSTEM

Member Services
1145 Market Street, 2nd Floor
San Francisco, CA 94103
(Civic Center Station between 7th & 8th Streets)
Tel: (415) 554-1750
(800) 541-2266 (outside 415 area code)
Fax: (415) 554-1752
www.myhss.org

MEDICAL PLANS

City Health Plan (UnitedHealthcare)
Tel: (866) 282-0125
Group No. 705287
www.myuhc.com

Blue Shield of California
Tel: (800) 642-6155
Group No. H11054
www.blueshieldca.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

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

VISION PLAN

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

DENTAL PLANS

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

DeltaCare USA Dental
Tel: (800) 422-4234
Group No. 01797-0003
www.deltadentalins.com

Pacific Union Dental
Tel: (800) 999-3367
(925) 363-6000
Group No. 705287
www.myuhcdental.com

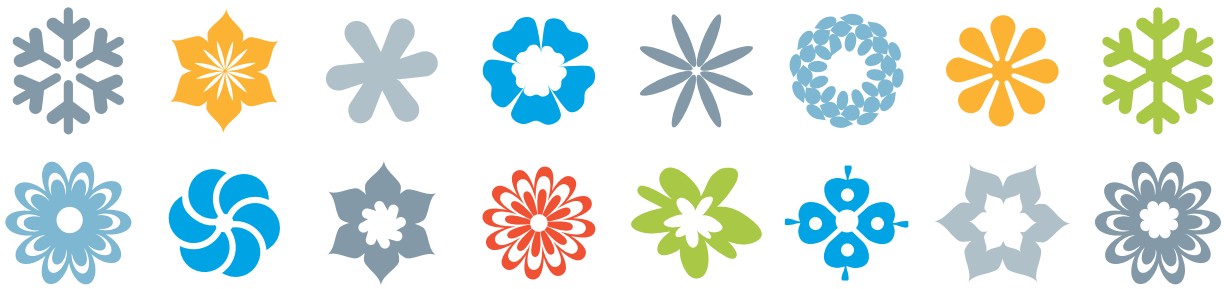
COBRA

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

CITY AGENCIES

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

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



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Health Service System
CITY & COUNTY OF SAN FRANCISCO

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