

SFCCD Benefits Guide

2009
2010



Health Service System

CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

Contents

Open Enrollment Alerts	2
Open Enrollment Rules & Guidelines	4
Open Enrollment FAQ	5
Eligibility	6
Benefits Administered by SFCCD	9
Choosing a Medical Plan	10
PPO vs. HMO	11
Medical Plan Options	12
Medical Plan Service Areas	13
Medical Plan Benefits-At-A-Glance	14
Vision Plan Benefits	18
Qualifying Changes In Family Status	20
COBRA	22
Frequently Asked Questions	24
Glossary of Healthcare Terms	26
Privacy Policy	28
Medical Plan Costs	30
Medical Plan Rates	31
Key Contact Information	32

PacifiCare Plan No Longer Being Offered

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

Blue Shield Office Visit Co-Pays Increase To \$15

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

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

Blue Shield and City Plan enrollees will pay more for brand-name and non-formulary prescriptions. Changes will take effect on July 1, 2009. The cost of prescriptions for generic drugs will not change. See pages 14-17 for details.

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

No Changes To Kaiser Benefits

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

Employee Contributions Will Increase For All Medical Plans

Employee contributions for Blue Shield, Kaiser and City Plan will be increasing in Plan Year 2009-2010. The amount of the increase is dependent upon the medical plan you elect and what bargaining unit you are represented by. Be sure to check the Rates charts on page 31 so that you are aware what your contribution costs will be for 2009-2010 before deciding what action to take during Open Enrollment.

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

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

Completed Open Enrollment Applications for Plan Year 2009-2010 must be received by HSS by 5^{PM}, April 30, 2009. Open Enrollment Applications can be delivered to HSS in person, sent through the mail or transmitted by fax. Applications must be delivered with required eligibility documentation or they cannot be processed. See page 7 for a checklist of required eligibility documentation.

HSS Address:

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

HSS Fax:

(415) 554-1752

Things You Can Do During Open Enrollment

During Open Enrollment you can:

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

HSS Open Enrollment Open House April 1-30, 2009

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

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

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

Social Security Numbers Are Required For All Members & Dependents

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

Open Enrollment

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

Things You Can Do During Open Enrollment

During Open Enrollment you can:

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

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

If you are enrolling new dependents you must provide documentation to HSS proving that your dependents meet eligibility requirements for the upcoming year. A Social Security number for each enrolled individual is also required.

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

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

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

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

If You Don't Make Any Changes During Open Enrollment

If you don't make any changes during April 2009 Open Enrollment and you are currently enrolled in Blue Shield, Kaiser or the City Plan, your current medical plan elections as well as the eligible dependents you have covered on your plan will

remain the same. PacifiCare members who do not elect an alternate medical plan during April 2009 Open Enrollment will be automatically enrolled in City Plan as of July 1, 2009.

Payroll Deduction Amounts

The amount deducted from your paycheck will change in accordance with any approved changes to the rates for Plan Year 2009-2010. (See pages 30-31 of this guide for 2009-2010 rates.) Check your paystub to be sure the correct deduction is being taken. You are responsible for making sure all required healthcare contributions are paid.

Benefit Election Changes Outside of Open Enrollment

Outside of Open Enrollment you must have a qualifying event in order to make changes to your healthcare elections. See pages 20-21 of this guide.

No Dual HSS Plan Coverage

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

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

Open Enrollment

FREQUENTLY ASKED QUESTIONS

Medical Coverage	
What if I don't want to make any changes to my medical coverage?	If you do not want to choose a different medical plan and you are not adding or dropping dependents you do not need to take any action. PacifiCare will be discontinued in 2009-2010. All PacifiCare participants must enroll in an alternate medical plan.
How do I change my choice of medical plan?	Review the plan options carefully, then submit a completed Open Enrollment Application form and any required eligibility documentation to HSS no later than 5PM, April 30, 2009. For a list of required eligibility documentation see page 7.
How do I add a dependent to my medical plan?	You must submit a completed Open Enrollment Application form and any required eligibility documentation to HSS no later than 5PM, April 30, 2009. For a list of required eligibility documentation see page 7.
How do I drop a dependent from my medical plan?	You must submit a completed Open Enrollment Application form to HSS no later than 5PM, April 30, 2009. No additional documentation is required when you are dropping a dependent from coverage.
Your Open Enrollment Application	
May I fax my Open Enrollment application to HSS?	You can mail, fax or drop-off your Open Enrollment Application and any required eligibility documentation to HSS at 1145 Market Street, 2nd Floor. The HSS fax number is (415) 554-1752. If you fax your application, please keep a copy of your fax confirmation as proof of your submission.
What else is required in addition to my Application form?	Your application must be accompanied by any required eligibility documentation. For a list of required eligibility documentation see page 7.
May I get Open Enrollment materials online?	Yes, you can download the Open Enrollment Application form and 2009-2010 Benefits Guide from our website myhss.org .
After I submit my Enrollment Application will I receive a confirmation from HSS?	Yes, HSS will mail a letter to the home address that is on file with HSS, confirming your benefit elections. These letters are sent in June 2009.

Eligibility

Employee eligibility for healthcare coverage is determined by the Governing Board of the San Francisco Community College District.

AVAILABLE BENEFITS BY EMPLOYEE TYPE

	FT FACULTY	LTS FACULTY	PT FACULTY	PERMANENT CLASSIFIEDS	TEMP STO CLASSIFIEDS	TEMPORARY CLASSIFIEDS
Medical	■	■	❖	■	❖	❖
Flexible Spending Account	■	■	❖	■	❖	❖
Employee Paid Dental	■	■		■	❖	❖
Rx Copay Reimbursement	■	■		■	❖	❖
Life Insurance	■	■		■	❖	❖

❖ = Certain Restrictions Apply

Spouse/Domestic Partner

- A 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 member is not eligible.

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

Children who may be covered under an HSS plan include a member’s natural child, a 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 or currently under legal guardianship.
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.

Other Children Residing in a Member’s Home (IRS Exemption)

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 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 health plan on a continuous basis prior to the child's 19th birthday.
- 6. Member submits acceptable medical documentation of the disability at least 60 days prior to child's attainment of age 25. HSS may periodically request documentation of the disability.

REQUIRED ELIGIBILITY DOCUMENTATION

	EVIDENCE OF HIRE	BENEFIT AUTH. FORM	MARRIAGE CERTIFICATE	DOMESTIC PARTNER REG.	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	COURT ORDER	INCOME TAX RETURN	MEDICAL EVIDENCE
Employee: Permanent/Provisional	■								
Employee: Temporary/Exempt		■							
Spouse			■						
Domestic Partner				■					
Child: Natural					■				
Child: Step-child			■		■				
Child: Domestic Partner				■	■				
Child: Adopted						■			
Child: Legal Guardianship							■		
Child: IRS Exemption								■	
Child: Court Ordered							■		
Child: Disabled									■

A Social Security number must also be provided for all enrolled individuals.

Eligibility

Take note of this important information for Part-Time Faculty, Classified Temporary Employees and Full-Time Faculty and Administrators Approaching Retirement.

Part-Time Faculty & Classified Temporary School Term Only Employees

Eligible Part-Time Faculty who are currently enrolled in a medical plan and meet the FTE eligibility for the spring semester will retain coverage through the summer months.

Eligible Classifieds who are currently enrolled in a medical plan and meet the 20-hour or more per week assignment will retain coverage through the summer months.

Part-Time Faculty and Classified Temporary School Term Only Employees who are enrolled in a medical plan and have a spring assignment are not required to re-enroll for the summer. If you wish to make changes to your healthcare elections to be effective July 1, you must complete and submit an application during the annual Open Enrollment period.

Part-Time faculty and Classified Temporary School Term Only Employees who lose eligibility for healthcare coverage during any semester may continue medical and dental coverage through COBRA.

Part-time faculty who later become eligible for healthcare coverage must re-enroll for available healthcare benefits.

Faculty and Administrators Approaching Retirement

The Health Service System will not process medical coverage for new retirees without authorization from San Francisco SFCCD. Please contact the SFCCD Benefits Office at (415) 241-2246 to determine your eligibility for retiree healthcare coverage and to obtain your retirement packet.

Part-time faculty are not eligible to retain medical coverage upon retirement but have the option to continue coverage through COBRA. Please contact the San Francisco SFCCD Benefits Office for more details at (415) 241-2246.

Eligibility and Summer Healthcare Coverage Questions?

Contact the SFCCD Benefits Office at (415) 241-2246 or visit www.ccsf.edu/hr.

Benefits Administered By SFCCD

SFCCD employees may be eligible for dental coverage, flexible spending accounts and other benefits through SFCCD. Check with the SFCCD Benefits office for details.

Dental Plan (Delta Dental)

As an eligible employee of SFCCD, you may be offered district-paid dental coverage through Delta. Please refer to the Key Contact Information section of this guide for your Delta group number and contact telephone number. Refer to the Delta Plan Document (EOC) for a detailed list of covered expenses, exclusions and limitations under this plan.

Flexible Spending Accounts (FSAs)

Healthcare and Dependent Care Flexible Spending Accounts are offered through AFLAC (American Family Life Assurance Company). Participation in an FSA program allows a portion of your salary to be redirected on a pre-tax basis to provide reimbursement for certain types of expenses. Participation in one or both FSAs can save you money by reducing your taxable income; this is because taxes will be calculated after the elected amount is deducted from your salary.

Your taxable income will be reduced for Social Security purposes; therefore, there may be a corresponding reduction in Social Security benefits. Please refer to the Key Contact information section on page 32 of this guide for plan telephone numbers. Refer to the FSA participant handbook for a detailed list of covered expenses, exclusions and limitations under this plan.

Short-Term Disability Insurance, Tax Shelter Investments and Pre-Paid Legal Plans

Refer to the SFCCD Benefits website and/or the Employees' Summary of Benefits packet for a list of voluntary supplemental programs available through SFCCD.

Questions About Other Benefits?

To verify your eligibility for other SFCCD benefits contact the SFCCD Benefits Office at (415) 241-2246 or visit www.ccsf.edu/hr.

Choosing a Medical Plan

1 PPO vs. HMO

Learn about the differences between a PPO plan and an HMO plan. (See the chart on page 11.)

2 Plan Service Areas

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

3 Doctors and Hospitals

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

4 Vendor Report Cards & Quality Ratings

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

HSS
www.myhss.org

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

Integrated Healthcare Association
www.iha.org/p4ptopr.htm

National Committee for Quality Assurance
www.ncqa.org

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

5 Medical Needs & Services Covered

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

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

6 Plan Costs

Compare the costs of each available medical plan. See pages 30-31 of this guide for cost comparison charts.

PPO vs. HMO

QUICK COMPARISON CHART

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

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

Medical Plan Options

These medical plan options are available to active HSS members and eligible dependents. Required contributions, if any, are deducted from the member's paycheck.

Health Maintenance Organization (HMO)

An HMO is a medical plan that requires you receive all of your care from 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 PCP (Primary Care Physician).

HSS offers the following HMO plans:

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

Preferred Provider Organization (PPO)

A PPO is a medical plan that gives you freedom of choice by allowing you to go to any in-network or out-of-network healthcare provider. When you go to in-network providers the plan pays higher benefits and you pay less out-of-pocket. A PPO doesn't assign you a Primary Care Physician, so you have more responsibility for coordinating your care.

HSS offers the following PPO plan:

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

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

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

This benefits guide cannot cover every detail of your plan contract. The EOC (Evidence of Coverage) contains a complete list of benefits and exclusions in effect for each plan from July 1, 2009 through June 30, 2010. Review your EOC for plan details. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. You can download plan EOCs at myhss.org.

PacifiCare Discontinued

The PacifiCare plan is no longer being offered in 2009-2010. PacifiCare participants must elect an alternate medical plan by April 30, 2009.

Medical Plan Service Areas

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

COUNTY	CITY HEALTH PLAN	BLUE SHIELD	KAISER
Alameda	■	■	■
Alpine	■		
Calaveras	■		
Contra Costa	■	■	■
Madera	■	■	○
Marin	■	■	■
Mariposa	■		○
Merced	■	■	
Mono	■		
Napa	■		○
Sacramento	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Clara	■	■	○
Santa Cruz	■	■	
Solano	■	■	■
Sonoma	■	■	○
Stanislaus	■	■	■
Tuolumne	■		
Yolo	■	■	○
Outside of California	■	Urgent Care/ER Only	Urgent Care/ER Only

■ = Available in this County.

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

If you do not see your County listed above please contact the medical plan to see if service is available to you.

Medical Plan Benefits-at-a-Glance

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

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

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers

Out-of-Network Providers*

Out-of-Area Providers*

\$250 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

\$20 co-pay 30 day supply

50% covered after \$20 co-pay; 30 day supply

\$20 co-pay 30 day supply

\$35 co-pay 30 day supply

50% covered after \$35 co-pay; 30 day supply

\$35 co-pay 30 day supply

\$10 co-pay 90 day supply

Not covered

\$10 co-pay 90 day supply

\$40 co-pay 90 day supply

Not covered

\$40 co-pay 90 day supply

\$70 co-pay 90 day supply

Not covered

\$70 co-pay 90 day supply

85% covered after deductible;
 may require prior notification

50% covered after deductible;
 may require prior notification

85% covered after deductible;
 may require prior notification

85% covered after deductible;
 if non-emergency 50% after deductible

85% covered after deductible;
 if non-emergency 50% after deductible

85% covered after deductible;
 if non-emergency 50% after deductible

85% covered after deductible;
 may require prior notification

50% covered after deductible;
 may require prior notification

85% covered after deductible;
 may require prior notification

85% covered after deductible

50% covered after deductible

85% covered after deductible

85% covered after deductible;
 may require prior notification

50% covered after deductible;
 may require prior notification

85% covered after deductible;
 may require prior notification

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

Medical Plan Benefits-at-a-Glance

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

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

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
85% covered after deductible; 60 visits / year	50% covered after deductible; 60 visits / year	85% covered after deductible; 60 visits / year
50% covered after deductible; \$1,000 / year	50% covered after deductible; \$1,000 / year	50% covered after deductible; \$1,000 / year
50% covered after deductible; \$1,000 / year	50% covered after deductible; \$1,000 / year	50% covered after deductible; \$1,000 / year
85% covered after deductible; newborn must be enrolled within 30 days of birth	50% covered after deductible; newborn must be enrolled within 30 days of birth	85% covered after deductible; newborn must be enrolled within 30 days of birth
50% covered after deductible; limitations apply; prior notification required	50% covered after deductible; limitations apply; prior notification required	50% covered after deductible; limitations apply; prior notification required
85% covered after deductible; prior notification required; \$75,000 lifetime max	50% covered after deductible; prior notification required; \$75,000 lifetime max	85% covered after deductible; prior notification required; \$75,000 lifetime max
85% covered after deductible; 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.

Vision Plan Benefits

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

VSP Vision

All HSS members and eligible dependent(s) who enroll in the City Health Plan, Blue Shield HMO or Kaiser 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 visual correction 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 can then submit an itemized bill directly to VSP for partial reimbursement. Download a claim form from the VSP website at www.vsp.com.

Plan Benefits, Limits and Exclusions

- The vision plan covers one set of contacts or eyeglass lenses every 24 months, based on your last date of service. If retractor examination reveals an Rx change of .50 diopter or more after 12 months, replacement lenses are covered.
- Eligible dependent children are covered in full for polycarbonate prescription lenses.
- 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 VSP Schedule of Benefits.
 - Blended or UV protected 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

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; there may be a network discount for amount exceeding allowance	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 Expenses Not Covered

- Orthoptics or vision training and any associated supplemental testing, plano (non-prescription) lenses or two pairs of glasses in lieu of bifocals.
- Replacement of lenses or frames furnished under this plan that are lost or broken, except at the contracted intervals.
- Medical or surgical treatment of the eyes.
- 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. Also note 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 and your dependents will not have the vision benefits available through VSP.

Qualifying Changes in Family Status

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

Marriage or Domestic Partnership

To enroll a new spouse or domestic partner and his or her 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 the child(ren) to the Health Service System **within 30 days** from the date of your marriage or certification of domestic partnership. HSS also requires a Social Security number for all enrolled members. Coverage for your spouse or domestic partner and his or her 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 by the federal government on the value of the City and County of San Francisco's contribution toward the cost of healthcare coverage for these dependents, in keeping with IRS requirements. This is referred to as imputed income and may affect your net pay. The State of California does not tax these benefits.

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 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 Enrollment Application

and required documentation and you will be responsible for paying all required contributions up to the coverage termination date.

Loss of Other Healthcare Coverage

You can enroll an eligible dependent who loses other healthcare coverage by submitting a completed HSS Enrollment Application and proof of the loss of coverage **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 30 day deadline and eligibility documentation requirements. 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 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.

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 healthcare benefits.

Whenever you update your coverage because of a qualifying change in family status, you should carefully check your paycheck to verify that the correct healthcare contribution is being deducted. If the deduction is incorrect or doesn't appear on your paycheck, contact the SFCCD Benefits Office for assistance. You are responsible for all required healthcare contributions, whether they are deducted from your paycheck or not.

It is also your responsibility to notify HSS when any dependent covered on your plan becomes ineligible.

30 Day Rule

If you have a qualifying change in your family status and do not submit a completed HSS Enrollment Application within 30 days 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 is 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.

COBRA Qualifying Events

Employees have the right to elect continuation of coverage if healthcare coverage is lost due to any of the following qualifying events:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct.
- Reduction in number of hours of employment that makes the employee ineligible for healthcare coverage.

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

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

Covered dependent children have the right to elect continuation coverage if healthcare coverage is lost due to any of the following qualifying events:

- Loss of dependent child status under the plan rules.

- Voluntary or involuntary termination of the employee's employment for reasons other than gross misconduct.
- Reduction in number of hours of employment that makes the employee ineligible for healthcare coverage.
- Parent's divorce, legal separation or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

COBRA Notification

When a qualifying event occurs, the COBRA Administrator FBMC will notify you of your right to elect COBRA coverage.

Time Limits for COBRA Elections

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 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 who 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 Administrator

The COBRA administrator is Fringe Benefits Management Company (FBMC). For questions about COBRA continuation coverage contact FBMC at (800) 342-8017.

This information does not reflect any changes to COBRA resulting from the federal American Recovery and Reinvestment Act, signed into law on February 17, 2009. For more information about how this legislation might impact your COBRA benefits contact FBMC.

Continuing Dental Coverage

SFCCD employees who wish to continue dental plan coverage under COBRA must contact the SFCCD Benefits Office. HSS does not administer dental benefits for SFCCD employees.

Frequently Asked Questions

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

When you select your initial 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 paycheck stub to verify that the correct healthcare contribution is being deducted.

If the deduction is incorrect or doesn't appear on your paycheck stub, you should contact the SFCCD Benefits Office at (415) 241-2246 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 32 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: www.myhss.org.

What happens if I move outside the service area covered by my medical 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 at (415) 554-1750 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 (pages 20-21) 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 happens to my coverage when I retire?

Employees who retire from SFCCD may be eligible to continue healthcare coverage at the rates then in effect for retired employees. Contact the SFCCD Benefits Office to verify your eligibility for retiree healthcare coverage.

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.

When do I lose coverage if I leave employment with the District?

When you leave SFCCD employment, your coverage and your dependents' coverage will terminate at the end of the coverage period in which your termination date occurs. If your termination date falls between the 1st and the 15th day of the month your coverage will terminate on the 15th of the month. If your termination date falls between the 16th and the last day of the month your coverage will terminate on the last day of the month. You may be eligible to continue your healthcare coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). (See pages 20-21 of this guide.)

What if I don't pay the required healthcare contributions while I'm on an unpaid leave?

If you don't pay the required healthcare contributions directly to HSS while you are on an unpaid leave of absence, your healthcare coverage, including enrolled dependents, will be terminated. Once coverage is terminated for non-payment of required healthcare contributions, you will not be eligible to reinstate your coverage until:

- You return to work and request a reinstatement of healthcare coverage from the SFCCD Benefits Office within 30 days from your return to work.
OR
- You submit a completed HSS Enrollment Application during the next available Open Enrollment period for coverage to be effective the following plan year.

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.

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 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.

Flexible Spending Account (FSA)

An account that you contribute to pre-tax and reimburses you for qualified healthcare expenses.

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.

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.

Use and Disclosure of Health Information

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

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

To Make or Obtain Payment

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

To Conduct Healthcare Operations

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

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

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

For Treatment Alternatives

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

For Distribution of Health-Related Benefits and Services

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

For Disclosure to the Plan Actuaries

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

When Legally Required

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

To Conduct Health Oversight Activities

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

In Connection With Judicial and Administrative Proceedings

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

For Law Enforcement Purposes

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

In the Event of a Serious Threat to Health or Safety

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

For Specified Government Functions

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

For Worker's Compensation

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

Authorization To Use Or Disclose Health Information

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

Your Rights With Respect to Your Health Information

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

Right to Request Restrictions

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

Right to Receive Confidential Communications

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

Right to Inspect and Copy Your Health Information

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

Right to Amend Your Health Information

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

Right to an Accounting

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

Right to a Paper Copy of this Notice

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

Duties of the Health Plan

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

Written Authorizations & Requests

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

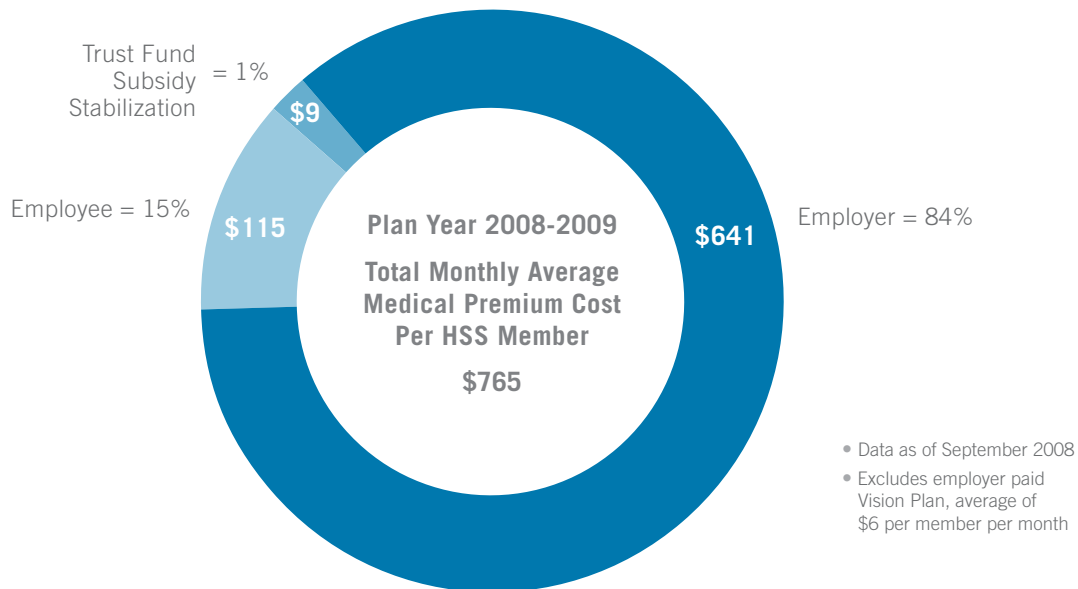
Health Service System
 1145 Market Street, Suite 200
 San Francisco, CA 94103
 Attn: Privacy Officer

Effective Date

Original Effective Date: April 14, 2003
 Revised January 1, 2009

Medical Plan Costs

The San Francisco Health Service System provides medical and other non-pension benefits to City and County employees, SFCCD 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 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.



Medical Plan Rates

MEDICAL: LEVEL OF COVERAGE	BLUE SHIELD		KAISER		CITY PLAN	
	CCD Pays	Employee Pays	CCD Pays	Employee Pays	CCD Pays	Employee Pays
Employee Only						
SFCCD Employees						
Board of Trustees Board Members	238.19	28.26	230.99	1.19	238.19	165.95
Employee + 1 Dependent						
SFCCD Employees						
Board of Trustees Board Members	380.19	152.19	357.63	106.22	380.19	407.12
Employee + 2 or More Dependents						
SFCCD Employees						
Board of Trustees Board Members	415.19	337.91	380.18	275.94	415.19	690.14

The rates above apply to all eligible enrollees of SFCCD. Deductions are taken from the first two paychecks of each month.

The medical plan rates published in this Benefits Guide are subject to the approval of the San Francisco Board of Supervisors

The rates that appear here may be subject to change by SFCCD due to ongoing labor negotiations. Contact SFCCD for additional information.

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
Tel: (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

VISION PLAN

Vision Service Plan (VSP)

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

SFCCD

Benefits Office

33 Gough Street
San Francisco, CA 94103
Tel: (415) 241-2246
www.ccsf.edu/hr

DENTAL PLAN

Delta Dental

Tel: (866) 499-3001
Group Numbers:
7071-0006 = FT Faculty & Administrators
7071-0007 = Classifieds
7071-0008 = COBRA
7071-0009 = PT Faculty
7071-0010 = Board of Trustees
7071-0011 = AB528 Retirees
www.deltadentalins.com

FLEXIBLE SPENDING ACCOUNTS

AFLAC

Tel: 800-323-5391
www.aflac.com

COBRA

Fringe Benefits Management Company (FBMC)

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

Employees may be eligible for additional and/or supplemental benefits administered by the SFCCD. For information about and assistance with these additional benefits please contact the SFCCD Benefits Office.

This guide was printed in the USA on ancient forest friendly, recycled paper comprised of 40% post-consumer waste. When it has outlived its usefulness to you, please recycle.

Health Service System

CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG