# Retired Employees


# Benefits Guide 2010-2011

Health Service System
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

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2010
2011

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

## Open Enrollment Events

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

April 1-16, 2010
Monday - Friday
8:00AM to 5:00PM

April 19-30, 2010
Monday - Friday
Plan vendors on-site
7:30AM to 5:30PM

- No appointment necessary
- Application drop-off
- Application review
- Consult with HSS Benefits Analysts

## The Last Day To Submit Open Enrollment Changes Is April 30, 2010

Open Enrollment is your annual opportunity to make health benefit election changes without any qualifying events. Completed Open Enrollment applications for Plan Year 2010-2011 and required documentation must be received at HSS by 5:30PM, April 30, 2010. Open Enrollment applications can be delivered to HSS in person, sent through the mail or sent by fax to (415) 554-1721. See page 33 for a checklist of required eligibility documentation.

## April 2010 Ineligible Dependent Amnesty

It is the responsibility of HSS members to notify the Health Service System when an enrolled dependent becomes ineligible due to divorce, dissolution of partnership, age or any other reason. (See pages 32-33.) Per HSS rules, if a member fails to notify HSS when an enrolled dependent becomes ineligible, the member will be held responsible for the costs of all health premiums and medical service provided, dating back to the date of the dependent's initial ineligibility. Avoid incurring penalties from the dependent audits that are being planned for later this year. Drop ineligible dependents during April 2010 Open Enrollment and HSS will give you amnesty from penalties.

## Mental Health Parity Act

Effective July 1, 2010, all Health Service System administered plans are in compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides for parity between some types of mental health and medical benefits. Contact your plan if you have questions.

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

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

# Open Enrollment Alerts

## Retiree Premium Contributions Will Increase Effective July 1, 2010

The retiree premium contributions for Blue Shield, Kaiser and City Plan will increase in 2010-2011. The amount of the increase is dependent upon the medical plan you elect. Check the rate charts on pages 43-47 before deciding what action to take during Open Enrollment.

## Medical Plan Benefit Changes Effective July 1, 2010

| | |
|---|---|
| Blue Shield of California<br>65 Plus HMO (Medicare Advantage) | $20 office visit co-pay<br>$15 co-pay for routine services |
| Blue Shield of California<br>Access+ HMO (Medicare Coordinated)<br>This plan is only available to Medicare enrolled members living outside a 65 Plus service area. | $20 office visit co-pay<br>$15 co-pay for routine services<br>$100 emergency room co-pay |
| Blue Shield of California<br>Access+ HMO (No Medicare) | $20 office visit co-pay<br>$15 co-pay for routine services<br>$100 emergency room co-pay |
| Kaiser<br>Senior Advantage HMO (Medicare Advantage) | $15 office visit co-pay |
| Kaiser<br>Traditional HMO (No Medicare) | $15 office visit co-pay<br>$100 emergency room co-pay |
| City Plan<br>UnitedHealthcare PPO | No plan changes |
| VSP Vision | $5 VSP eye doctor visit co-pay<br>for some acute eye conditions |

## Medicare Advantage Enrollment Requirement

Per Health Service System Rules, retired members and their dependents with Medicare Part A and Part B who are enrolled in an HMO must participate in a group Medicare Advantage plan. This year Blue Shield of California is providing a group Medicare Advantage plan: 65 Plus HMO. Effective July 1, 2010, if you have elected Blue Shield, are enrolled in Medicare, and you permanently reside in the 65 Plus HMO service area, you and any Medicare eligible dependents will be enrolled in the 65 Plus HMO plan. Blue Shield will be contacting enrolled members with more information about this plan. Note: retired Kaiser members already meet this requirement. Kaiser Senior Advantage is Kaiser's Medicare Advantage plan and has been in place for the past several years.

## Selecting a Primary Care Physician

After you are newly enrolled in any Blue Shield or Kaiser HMO plan you should contact the plan to select your Primary Care Physician (PCP). (You can contact your plan to request a change of Primary Care Physician at any time throughout the year.) If you do not select a PCP a doctor will be assigned to you and you will need to use the PCP assigned by your plan until you request a change.

These alerts include highlights only and may not cover every plan change. Please read the Evidence of Coverage (EOC) document for details about your plan's benefits. EOCs are available on myhss.org.

# Open Enrollment

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

## Things You Can Do During Open Enrollment

During Open Enrollment you can:

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

To make changes you must submit a completed Open Enrollment application in person, by mail or fax to HSS no later than 5:30PM on April 30, 2010.

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

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

Any changes you elect to make during April 2010 Open Enrollment period will take effect July 1, 2010, and remain in effect through June 30, 2011.

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, 2010. If you do not receive your card by July 1, contact your plan. Newly enrolled Kaiser and Blue Shield members should also confirm their Primary Care Physician (PCP) selection with their plan.

## If You Don't Make Any Changes During Open Enrollment

If you are currently enrolled in Blue Shield, Kaiser or City Plan and don't make changes during Open Enrollment, your current medical and dental plan elections and the eligible dependents you have covered will remain the same. Per HSS rules, Medicare eligible Blue Shield participants who do not choose another insurer during Open Enrollment and live in the Blue Shield of California 65 Plus Medicare Advantage plan service area will be enrolled in the 65 Plus plan effective July 1, 2010.

## Pension Deduction Amounts

The amount deducted from your monthly pension check will change in accordance with any approved changes to the rates for Plan Year 2010-2011. (See pages 43-47 of this guide for 2010-2011 rates.) Review your check to be sure the correct deduction is being taken. You are responsible for making sure required healthcare contributions are paid.

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

## No Dual HSS Plan Coverage

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

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

# Open Enrollment

## FREQUENTLY ASKED QUESTIONS

| Open Enrollment Medical & Dental Coverage | |
|---|---|
| What if I don't want to make any changes to my medical and/or dental coverage? | If you do not want to choose a different medical or dental plan, and you are not adding or dropping dependents for the Plan Year effective July 1, 2010 you do not need to take action during Open Enrollment. Note: Blue Shield participants enrolled in Medicare who live in a 65 Plus service area will be enrolled in the Blue Shield 65 Plus Medicare Advantage plan effective July 1, 2010. |
| How do I choose a different medical and/or dental plan? | Review the plan options carefully, then submit a completed Open Enrollment application form and any required eligibility documentation to HSS no later than 5:30PM, April 30, 2010. See page 33. |
| How do I add a dependent to my medical and/or dental plan? | You must submit a completed Open Enrollment application form and any required eligibility documentation to HSS no later than 5:30PM, April 30, 2010. For a list of required eligibility documentation see page 33. |
| How do I drop a dependent from my medical and/or dental plan? | You must submit a completed Open Enrollment application form to HSS no later than 5:30PM, April 30, 2010. No additional documentation is required when you are dropping a dependent from coverage during Open Enrollment. Note: dependents dropped during Open Enrollment are not eligible for COBRA. |
| **Your Open Enrollment Application** | |
| May I fax my Open Enrollment application to HSS? | Yes, you may fax your Open Enrollment application and required eligibility documentation. The HSS fax number is (415) 554-1721. Please keep a copy of your fax confirmation. Do not fax the same application multiple times. HSS will email confirmations of fax receipt within two business days. Faxed applications must be received by HSS no later than 5:30PM, April 30, 2010. |
| 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 33 of this guide. Required documentation must be received by HSS no later than 5:30PM, April 30, 2010. A Social Security number is also required for each enrolled individual. |
| May I get Open Enrollment materials online? | Yes, you may download the Open Enrollment application form and 2010-2011 Benefits Guide for retirees from myhss.org. |
| Will I receive a confirmation from HSS after I submit my enrollment application? | 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 2010 after the close of Open Enrollment. |

# Medicare Part A & Part B and Your HSS Benefits

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

Medicare is a federal health insurance program for people age 65 years or older. Medicare also covers eligible people under age 65 with Social Security-qualified disabilities or End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant). Medicare has three parts that are important for you to understand.

- Medicare Part A is hospital insurance.
- Medicare Part B covers the cost of doctor visits and other outpatient medical provider services.
- Medicare Part D provides prescription drug coverage.

## Medicare Part A

HSS rules require that all members enroll in premium-free Medicare Part A as soon as they are eligible. Medicare Part A is federally administered hospital insurance that may help pay for inpatient hospital stays, skilled nursing facilities, hospice, and some home health care. You are eligible for premium-free Medicare Part A if you are age 65 or older and have worked for at least 10 years (40 quarters) in Social Security and/or Medicare-covered employment. You may also qualify for Medicare Part A through a current, former, or deceased spouse. If you are under age 65 and have End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant) or a Social Security-qualified disability you may also qualify for Medicare Part A. If you are under age 65 with a qualifying disability, Medicare coverage generally begins 24 to 30 months following eligibility. If you have questions about your eligibility for premium-free Medicare Part A, contact the Social Security Administration.

## Medicare Part B

HSS rules require that all retired members and their dependents enroll in Medicare Part B as soon as they are eligible. Part B is federally administered medical insurance that may help pay for outpatient health care expenses such as doctor visits. Part B coverage has a monthly premium, which is usually deducted from your Social Security check. This premium is tiered based on income per Centers for Medicare & Medicaid Services (CMS) regulations. If you do not enroll in Medicare Part B when you first become eligible, your premium will be higher when you do enroll. This higher premium will continue for the entire time you are on Medicare.

## Enrolling in Medicare Part A & Part B

If you are 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 Social Security-qualified disability or you have End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant), you should contact the Social Security Administration immediately to apply for Medicare.

HSS rules require all eligible retired members and any covered eligible dependents to enroll in Medicare Part A and Part B. Failure by you or your enrolled dependents to comply with this rule by the required deadlines will mean a change in or loss of medical plan coverage. (See page 10.)

# Medicare Part D and Your HSS Benefits

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

## Medicare Part D

Medicare Part D is a federal program created to subsidize the costs of prescription drugs for Medicare beneficiaries. **There are two types of Medicare Part D prescription drug plans - individual and group.** Individual Part D prescription drug coverage is purchased directly by an individual from an insurer or pharmacy. HSS members should NOT enroll in any individual Medicare Part D plan. The medical plans offered through HSS include enhanced group Medicare Part D coverage. Enrolling in an individual Part D plan will result in the termination of your HSS group medical coverage.

## Kaiser Senior Advantage HMO and Blue Shield 65 Plus HMO (Medicare Advantage)

Group Medicare Part D coverage is part of the Kaiser Senior Advantage and Blue Shield 65 Plus Medicare Advantage plans offered through HSS. This enhanced group Part D benefit offers better prescription drug coverage than what is available through any individual Part D plan. (Do not enroll in any individual Part D plan.) If you are enrolled in either Kaiser Senior Advantage or Blue Shield 65 Plus HSS and your plan will notify you if and when you need to take any action regarding your prescription drug benefits.

## Blue Shield of California Access+ HMO (Medicare Coordinated)

This plan is only available to Blue Shield of California enrollees and their dependents who are Medicare eligible and live outside of a Blue Shield 65 Plus plan service area. If you are enrolled in the Blue Shield Access+ (Medicare Coordinated) HMO, you will be enrolled in an enhanced group Medicare Part D prescription drug plan called the Blue Shield of California Medicare Rx Plan. This plan is better than any individual Medicare Part D prescription drug coverage. You will be enrolled in this enhanced group Medicare prescription drug plan through the Health Service System once you submit documentation to HSS of enrollment in Medicare Part A and Part B and complete any other HSS enrollment requirements. You will receive more information about this enhanced Part D prescription drug benefit from Blue Shield of California.

## Medicare Contact Information

The Social Security Administration handles Medicare eligibility and enrollment.

**Social Security Administration** (SSA)
(800) 772-1213
TTY (800) 325-0778
www.ssa.gov

The Centers for Medicaid & Medicare Services administers Medicare benefits.

**Centers for Medicaid & Medicare Services** (CMS)
(800) 633-4227
TTY (877) 486-2048
www.medicare.gov

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

# Kaiser Members & Medicare

Kaiser members must enroll in Medicare Part A and Medicare Part B as soon as they are eligible. You are eligible for Medicare at age 65. Individuals under age 65 with Social Security-qualified disabilities or End-Stage Renal disease may also qualify for Medicare. If you retired before you turned age 65, you should receive advance notification from HSS and Kaiser reminding you that it is time for you to enroll in Medicare. Whether or not you receive a reminder, it is your responsibility to enroll in premium-free Medicare Part A (if you are eligible), and Medicare Part B. Once you complete your enrollment, you must submit a copy of your Medicare card to HSS. For information about enrolling in Medicare call the Social Security Administration at (800) 772-1213.

In addition, once you are enrolled in Medicare you will be enrolled in the Kaiser Senior Advantage plan. Under this Medicare Advantage plan, you assign your Medicare benefits to Kaiser. Enrollees in this plan must use the Kaiser network of doctors and hospitals. Senior Advantage includes enhanced group Medicare Part D prescription drug coverage.

If you fail to enroll in Medicare or the Kaiser Senior Advantage plan when you are eligible, or fail to provide HSS with proof of your Medicare enrollment, your health coverage will be terminated by Kaiser. HSS will then automatically enroll you in the City Plan 20 until you provide proof of your Medicare enrollment to HSS. Enrollment in City Plan 20 will significantly increase your out-of-pocket costs. Under City Plan 20 you will be responsible for paying the 80% that Medicare would have paid for any Medicare eligible claim, plus any amounts above usual and customary fees. In addition, your yearly out-of-pocket limits will increase to $10,950.

If you have questions about HSS requirements regarding Medicare and Kaiser Senior Advantage enrollment contact HSS Member Services at (415) 554-1750.

### KAISER & MEDICARE: HSS REQUIREMENTS AT-A-GLANCE

| MEMBER TYPE | MEDICARE PART A | MEDICARE PART B | KAISER SENIOR ADVANTAGE | INDIVIDUAL MEDICARE PART D |
|---|---|---|---|---|
| Enrollee Age 65 or Older | Must enroll. | Must enroll. | Must enroll; this plan includes enhanced group Medicare Part D prescription drug coverage. | Do not enroll in any individual Medicare Part D plan. |
| Enrollee with Social Security Qualified Disability | Must enroll as soon as eligible. | Must enroll as soon as eligible. | Must enroll when eligible for Medicare; this plan includes enhanced group Medicare Part D prescription drug coverage. | Do not enroll in any individual Medicare Part D plan. |
| Enrollee with End-Stage Renal Disease | Must enroll. | Must enroll. | Must enroll; this plan includes enhanced group Medicare Part D prescription drug coverage. | Do not enroll in any individual Medicare Part D plan. |

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

# Blue Shield Members & Medicare

Blue Shield members must enroll in Medicare Part A and Medicare Part B as soon as they are eligible. In general, you are eligible for Medicare at age 65. Individuals under age 65 with Social Security-qualified disabilities or End-Stage Renal disease may also qualify for Medicare. For information about enrolling in Medicare call the Social Security Administration at (800) 772-1213.

In addition, you must enroll in the Blue Shield of California 65 Plus (Medicare Advantage) plan if you are eligible for Medicare and you permanently reside in a zip code serviced by this plan. When you are enrolled in Blue Shield 65 Plus, you assign your Medicare benefits to the plan. You must obtain service from within the Blue Shield network of providers. If you seek medical services outside the HMO network those services will not be covered by Medicare or Blue Shield. 65 Plus includes enhanced group Medicare Part D prescription drug coverage.

Some Medicare eligible Blue Shield of California enrollees may permanently reside in a service area not covered by Blue Shield 65 Plus. These members will be enrolled the Blue Shield Access+ (Medicare Coordinated) plan and will not assign Medicare benefits to Blue Shield. In this case, if you go outside the Blue Shield network Medicare benefits will apply and you will be responsible for costs not covered by Medicare. Participants in this plan are required to enroll in Blue Shield of California Medicare Rx, an enhanced group Medicare Part D plan. This group Part D prescription drug plan is part of your HSS administered coverage. Do not enroll in any individual Medicare Part D prescription drug plan. See page 10 for more information.

If you retired before age 65, you must enroll in Medicare in advance of your 65th birthday. Once enrolled in Medicare you must enroll in Blue Shield 65 Plus (Medicare Advantage) if you live in an area serviced by this plan. If you reside outside the 65 Plus plan service area you will be enrolled in Blue Shield Access+ (Medicare Coordinated). Whether or not you receive a reminder, it is your responsibility to enroll in Medicare Part A (if you are eligible), Medicare Part B and the appropriate Blue Shield of California plan for members over age 65. Once you complete Medicare enrollment, you must submit a copy of your Medicare card to the Health Service System.

If you fail to enroll in Medicare when you are eligible, or fail to provide HSS with proof of Medicare enrollment, your Blue Shield coverage will be terminated. HSS will automatically enroll you in City Plan 20 until you provide proof of your Medicare enrollment to HSS. As a result, your out-of-pocket costs will significantly increase. You will be responsible for paying the 80% that Medicare would have paid for any Medicare eligible claim, plus any amounts above usual and customary fees. In addition, your yearly out-of-pocket limits will increase to $10,950.

### BLUE SHIELD & MEDICARE: HSS REQUIREMENTS AT-A-GLANCE

| MEMBER TYPE | MEDICARE PART A | MEDICARE PART B | BLUE SHIELD PLANS | INDIVIDUAL MEDICARE PART D |
|---|---|---|---|---|
| Eligible for Medicare due to age, Social Security qualified disability or End Stage Renal Disease; living in the Blue Shield 65 Plus service area | Must enroll. | Must enroll. | If you live in a service area covered by this plan you must enroll in Blue Shield 65 Plus (Medicare Advantage) HMO; includes enhanced group Medicare Part D benefits. | Do not enroll in any individual Medicare Part D plan. |
| Eligible for Medicare due to age, Social Security qualified disability or End Stage Renal Disease; living outside the Blue Shield 65 Plus service area | Must enroll. | Must enroll. | If you live outside the 65 Plus HMO service area you will be enrolled in Access+ (Medicare Coordinated) HMO and Blue Shield of California Medicare Rx, which is an enhanced group Medicare Part D plan. | Do not enroll in any individual Medicare Part D plan. |

# Medicare & Your HSS Medical Benefits FAQ

### What are the Health Service System rules for Medicare participation?

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

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

You must submit a statement to HSS from the Social Security Administration indicating that you are not eligible for premium-free Medicare Part A coverage. We will update our records accordingly. HSS requires you to enroll in Medicare Part B, even if you are not eligible for Medicare Part A.

### What if I didn't enroll in Medicare Part B when I was originally eligible?

If you were eligible but did not enroll in Medicare Part A and Part B when you attained the age of 65, or upon retirement after age 65, you may be assessed a penalty by the Social Security Administration for each year in which you failed to enroll when eligible. Nevertheless, you're still required to enroll in Medicare in accordance with the HSS rules.

### What if I don't enroll in Medicare A & Part B?

If you're retired, 65 years old and eligible for both Medicare Part A and/or Part B but don't enroll, you and your enrolled dependents will lose your current HSS administered medical plan coverage. Your existing HSS coverage will be terminated and you will automatically be enrolled in the City Health Plan 20. City Plan 20 will significantly increase your out-of-pocket costs. Under City Plan 20 you will be responsible for paying the 80% that Medicare would have paid for any covered service, plus any amounts above usual and customary fees. In addition, your yearly out-of-pocket limits will increase to $10,950.

### What if my enrolled eligible dependent does not enroll in Medicare Part A & Part B?

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

### Should I enroll in Medicare Part D?

**Do not enroll in an individual Medicare Part D prescription drug plan.** The medical coverage you and your dependents are enrolled in through HSS administered plans includes enhanced group Medicare Part D prescription drug coverage. This group Part D is better than what is offered through any individual Medicare Part D plan. HSS and your plan will contact you if you need to take any action regarding the prescription drug benefits included with your HSS administered medical coverage.

Be aware that you may receive marketing information from private insurers, pharmacies and other entities trying to sell individual Medicare Part D prescription drug coverage. Ignore these third-party solicitations. It is important that you and your dependents do not enroll in an individual Medicare Part D plans. Doing so could result in termination of your HSS coverage.

**Do Not Enroll in an Individual Medicare Part D Plan**

The enhanced group Part D coverage provided by your HSS administered plan offers better prescripton drug coverage than individual Part D plans.

# 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 be 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, 2010

# 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 13.)

## 2 Plan Service Areas

Find out which plans offer service to you based on the home address of the primary HSS member. See the chart on page 15 of this guide or contact the plan.

## 3 Medical Groups, Doctors and Hospitals

Identify which doctors, hospitals and other medical services that you and your family prefer. If you are enrolled in the Blue Shield HMO, the Primary Care Physician you select may have an impact on which doctors and hospitals you can access.

## 4 Vendor Report Cards & Quality Ratings

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

HSS Vendor Report Cards
www.myhss.org

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

Integrated Healthcare Association
www.iha.org

National Committee for Quality Assurance
www.ncqa.org

Agency for Healthcare Research & Quality
www.ahrq.gov

CalHospitalCompare
www.CalHospitalCompare.org

## 5 Medical Needs & Services Covered

Make sure you understand how your plan works by reviewing the benefits summary and Evidence of Coverage (EOC) 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?
- 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?
- Will you or any family members be seeking mental health care?
- How are benefits paid?

## 6 Plan Costs

Compare the costs of each available medical plan. See pages 43-47 of this guide for cost comparison charts.

# PPO vs. HMO

## QUICK COMPARISON CHART

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

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

# Medical Plan Options

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

## Health Maintenance Organization (HMO)

An HMO is a medical plan that 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 | |
|---|---|
| 65 Plus<br>(Medicare Advantage) | Medicare eligible retirees & dependents who live in a 65 Plus service area must enroll in 65 Plus |
| Access+<br>(Medicare Coordinated) | Only available to Medicare eligible retirees & dependents who do not live in a 65 Plus service area |
| Access+<br>(No Medicare) | Only available to retirees & dependents who are not eligible for Medicare |

| Kaiser Permanente HMO | |
|---|---|
| Senior Advantage<br>(Medicare Advantage) | Medicare eligible retirees & dependents must enroll in Senior Advantage |
| Traditional Plan<br>(No Medicare) | Only available to retirees & dependents not eligible for Medicare |

## 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 Plan PPO | |
|---|---|
| UnitedHealthcare | Available to all retiree members and eligible dependents |

The healthcare plans administered by HSS do not guarantee the continued participation of any particular doctor, hospital or medical group. 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 may result in the non-payment of claims for services received.

This benefits guide does not cover every detail of your plan contract. The Evidence of Coverage (EOC) contains a complete list of benefits and exclusions in effect for each plan from July 1, 2010 through June 30, 2011. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. EOCs are available on myhss.org.

# Medical Plan Service Areas

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

■ = Available in this County. ❍ = Available in some zip codes. Contact the medical plan to confirm availability in your zip code.

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

If you are enrolled in Medicare, the Blue Shield of California Access+ plan is only available to you if you do not live in a service area covered by the Blue Shield of California 65 Plus plan.

# Retired Employees with Medicare Parts A & B

| | blue of california<br>**65 Plus**<br>Medicare Advantage HMO | blue of california<br>**Access+ (Medicare Coordinated)**<br>HMO only for enrollees living outside the 65 Plus plan service area | KAISER PERMANENTE®<br>**Senior Advantage**<br>Medicare Advantage HMO |
|---|---|---|---|
| **DEDUCTIBLES** | | | |
| Plan-year deductible<br>Includes Medicare deductible | None | None | None |
| Lifetime maximum | None | None | None |
| **PREVENTATIVE & GENERAL CARE** | | | |
| Routine physical | $15 co-pay | $15 co-pay | $15 co-pay |
| Immunizations & inoculations | No charge | No charge | No charge |
| Gynecologic exam | $15 co-pay | $15 co-pay | $15 co-pay |
| **PHYSICIAN CARE** | | | |
| Office & home visits | $20 co-pay | $20 co-pay | $15 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 | $20 co-pay 30 day supply | $20 co-pay 30 day supply | $15 co-pay 30 day supply |
| Pharmacy - non-formulary drugs | $35 co-pay 30 day supply | $35 co-pay 30 day supply | Physician authorized only |
| Mail order - generic drugs | $10 co-pay 90 day supply | $10 co-pay 90 day supply | $10 co-pay 100 day supply |
| Mail order - brand-name drugs | $40 co-pay 90 day supply | $40 co-pay 90 day supply | $30 co-pay 100 day supply |
| Mail order - non-formulary drugs | $70 co-pay 90 day supply | $70 co-pay 90 day supply | Physician authorized only |
| **OUTPATIENT SERVICES** | | | |
| Diagnostic x-ray & laboratory | No charge | No charge | No charge |
| **EMERGENCY** | | | |
| Hospital emergency room | $50 co-pay | $100 co-pay | $50 co-pay waive if hospitalized |
| Urgent care facility | $20 co-pay within CA | $20 co-pay within CA | $15 co-pay |
| **HOSPITALIZATION** | | | |
| Inpatient | $100 co-pay per admittance | $100 co-pay per admittance | $100 co-pay per admittance |
| Outpatient | $50 co-pay | $50 co-pay | $15 co-pay |
| **SURGERY** | | | |
| In hospital | $100 co-pay per admittance | $100 co-pay per admittance | $100 co-pay per admittance |
| In doctor's office | $20 co-pay | $20 co-pay | $15 co-pay |

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

## CITY HEALTH PLAN

**UnitedHealthcare PPO**

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

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

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

# Retired Employees with Medicare Parts A & B

| | blue of california<br>**65 Plus**<br>Medicare Advantage HMO | blue of california<br>**Access+ (Medicare Coordinated)**<br>HMO only for enrollees living outside the 65 Plus plan service area | KAISER PERMANENTE®<br>**Senior Advantage**<br>Medicare Advantage HMO |
|---|---|---|---|
| **REHABILITATIVE** | | | |
| Physical/Occupational therapy | $20 co-pay | $20 co-pay | $15 co-pay authorization req. |
| Acupuncture | $15 co-pay 30 visits/yr; ASH network only | $15 co-pay 30 visits/yr; ASH network only | Not covered |
| Chiropractic | $15 co-pay 30 visits/yr; ASH network only | $15 co-pay 30 visits/yr; ASH network only | $15 co-pay 30 visits/yr; ASH network only |
| **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 | No charge as authorized by PCP according to formulary |
| Prosthetics/orthotics | No charge when medically necessary | No charge when medically necessary | No charge when medically necessary |
| Hearing evaluation and aids | Eval. no charge aids 1 per ear; $2,500 max every 36 months | Eval. no charge aids 1 per ear; $2,500 max every 36 months | Eval. no charge aids 1 per ear; $2,500 max every 36 months |
| **MENTAL HEALTH** | | | |
| Inpatient hospitalization | $100 co-pay per admittance | $100 co-pay per admittance | $100 co-pay per admittance |
| Outpatient treatment | $20 co-pay non-severe and severe | $20 co-pay non-severe and severe | $7 co-pay group<br>$15 co-pay individual |
| **SUBSTANCE ABUSE** | | | |
| Inpatient | $100 co-pay per admittance for acute short-term detox | $100 co-pay per admittance for acute short-term detox | $100 co-pay per admittance |
| Outpatient | $20 co-pay | $20 co-pay | $5 co-pay group<br>$15 co-pay individual |
| **EXTENDED & END-OF-LIFE CARE** | | | |
| Extended care / Skilled nursing facility | No charge up to 100 days per benefit period | No charge up to 100 days per benefit period | No charge up to 100 days per benefit period |
| Hospice | No charge authorization required | No charge authorization required | No charge when medically necessary |
| **OUTSIDE SERVICE AREA** | | | |
| Care access and limitations | Urgent care $50 co-pay; guest membership benefits for college student dependents in some areas. | Urgent care $50 co-pay; guest membership benefits for college student dependents in some areas. | Limited to emergency services before condition permits transfer to nearest Kaiser facility. Co-pays apply. |

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

## CITY HEALTH PLAN

**UnitedHealthcare PPO**

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

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

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

# Retired Employees Not Eligible for Medicare

| | blue of california Access+ HMO | KAISER PERMANENTE® Traditional Plan HMO |
|---|---|---|
| **DEDUCTIBLES** | | |
| Plan-year deductible | None | None |
| Lifetime maximum | None | None |
| **PREVENTIVE & GENERAL CARE** | | |
| Routine physical | $15 co-pay | $15 co-pay |
| Immunizations & innoculations | No charge | No charge |
| Gynecologic exam | $15 co-pay | $15 co-pay |
| Well baby care | $15 co-pay | $15 co-pay |
| **PHYSICIAN CARE** | | |
| Office & home visits | $20 co-pay | $15 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 | $100 co-pay waived if hospitalized | $100 co-pay waived if hospitalized; |
| Urgent care facility | $20 co-pay within CA service area | $15 co-pay |
| **HOSPITALIZATION** | | |
| Inpatient | $100 co-pay per admittance | $100 co-pay per admittance |
| Oupatient | $50 co-pay | $15 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 (PPO administered by United Healthcare)

| In-Network Providers | Out-of-Network Providers* | Out-of-Area Providers* |
|---|---|---|
| $250 retiree only<br>$500 retiree + 1<br>$750 retiree + 2 or more | $250 retiree only<br>$500 retiree + 1<br>$750 retiree + 2 or more | $250 retiree only<br>$500 retiree + 1<br>$750 retiree + 2 or more |
| $2,000,000 per covered person for any combination of In-Network, Out-of-Network and Out-of-Area options utilized | | |
| 85% covered after deductible | Not covered | 85% covered after deductible |
| 100% covered no deductible | 50% covered no deductible | 100% covered no deductible |
| 85% covered after deductible | 50% covered after deductible | 85% covered after deductible |
| 85% covered after deductible | 50% covered after deductible | 85% covered after deductible |
| 85% covered after deductible | 50% covered after deductible | 85% covered after deductible |
| 85% covered after deductible | 50% covered after deductible | 85% covered after deductible |
| $5 co-pay 30 day supply | 50% covered after $5 co-pay; 30 day supply | $5 co-pay 30 day supply |
| $20 co-pay 30 day supply | 50% covered after $20 co-pay; 30 day supply | $20 co-pay 30 day supply |
| $35 co-pay 30 day supply | 50% covered after $35 co-pay; 30 day supply | $35 co-pay 30 day supply |
| $10 co-pay 90 day supply | Not covered | $10 co-pay 90 day supply |
| $40 co-pay 90 day supply | Not covered | $40 co-pay 90 day supply |
| $70 co-pay 90 day supply | Not covered | $70 co-pay 90 day supply |
| 85% covered after deductible; may require prior notification | 50% covered after deductible; may require prior notification | 85% covered after deductible; may require prior notification |
| 85% covered after deductible; if non-emergency 50% after deductible | 85% covered after deductible: if non-emergency 50% after deductible | 85% covered after deductible: if non-emergency 50% after deductible |
| 85% covered after deductible | 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 |
| 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 Access+ HMO | KAISER PERMANENTE® Traditional Plan HMO |
|---|---|---|
| **REHABILITATIVE** | | |
| Physical/Occupational therapy | $20 co-pay | $15 co-pay authorization req. |
| Acupuncture | $15 co-pay 30 visits/yr; ASH network only | Not covered |
| Chiropractic | $15 co-pay 30 visits/yr; ASH network only | $15 co-pay 30 visits/yr; ASH network only |
| **PREGNANCY & MATERNITY** | | |
| Pre/post-natal physician care<br>For hospital stay, see Hospitalization. | $15 co-pay newborn must be enrolled within 30 days | $15 co-pay newborn must be enrolled within 30 days |
| **INFERTILITY** | | |
| IVF, GIFT, ZIFT & Artificial Insemination | 50% covered of the allowable amount; limitations apply | 50% covered limitations apply |
| **TRANSGENDER** | | |
| Office visits & outpatient surgery | Co-pays apply authorization req. $75,000 lifetime max | Co-pays apply authorization req. $75,000 lifetime max |
| **DURABLE MEDICAL EQUIPMENT** | | |
| Home medical equipment | No charge | No charge as authorized by PCP according to formulary |
| Prosthetics/orthotics | No charge when medically necessary | No charge when medically necessary |
| Hearing evaluation and aids | Evaluation no charge hearing aids 1 per ear; $2,500 max every 36 months | Evaluation no charge hearing aids 1 per ear; $2,500 max every 36 months |
| **MENTAL HEALTH** | | |
| Inpatient hospitalization | $100 co-pay per admittance | $100 co-pay per admittance |
| Outpatient treatment | $20 co-pay non-severe and severe | $7 co-pay group<br>$15 co-pay individual |
| **SUBSTANCE ABUSE** | | |
| Inpatient | $100 co-pay per admittance for acute short-term detox | $100 co-pay per admittance |
| Outpatient | $20 co-pay | $5 co-pay group<br>$15 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 (PPO administered by United Healthcare)

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

# Medical Plan Wellness Benefits

## BLUE SHIELD

www.blueshieldca.com/hw/

**LifeReferrals 24/7**
Telephone advice and self-directed online decision guides to assist members in making informed healthcare decisions.

**Life Stage Health Articles**
Topical Information and articles about women's, men's, children's and senior health issues.

**Ask the Pharmacist**
Email a UCSF pharmacist your drug-related questions and receive a personal, confidential response within 2 business days.

**NurseHelp 24/7**
Call (877)304-0504. Experienced nurses are available to answer questions, listen to concerns and provide information.

**Online Nurse Chat**
Chat privately with a registered nurse in a secure online environment.

**Healthy Lifestyle Rewards**
www.blueshieldca.com/hlr
An interactive, online program that helps you adopt and maintain healthy lifestyle habits like good nutrition, stress management and regular exercise.

**Discounts & Savings**
www.blueshieldca.com/bsc/hw/hw_375.jhtml
Discounts and savings on Weight Watchers®, 24 Hour Fitness, Drugstore.com as well as reduced rates on massage, chiropractic and acupuncture services from select ASH network practictioners and more.

Online registration is required to take advantage of some of the Blue Shield tools and programs listed.

## KAISER PERMANENTE

kp.org/healthyliving

**Personalized Health Assessment**
Take an in-depth look at the choices you make each day and get a personal plan to help improve your health and quality of life, including:

**Classes**
Kaiser offers hundreds of classes for all ages on a wide variety of health and wellness topics.

**Health Calculators**
Use online calculators for healthy weight, calorie counting, disease risk and more.

**Health Encyclopedia**
Research health conditions and learn more about treatment options.

**Nutrition**
Learn how to cook tasty and nutritious food.

**Audio Podcasts**
Download a wide range of health related audio, including guided meditations on stress reduction, healthy sleep, easing pain and more.

**Videos**
www.permanente.net/homepage/kaiser/pages/f50506.html

Connect to better health with a variety of Healthy Living videos that you can watch online.

**Discounts & Savings**
kp.org/healthyroads
Discounts and savings on 10,000 Steps®, ASH massage, chiropractic and acupuncture services and more.

Online registration is required to take advantage of some of the Kaiser tools and programs listed.

# Medical Plan Wellness Benefits

## UNITEDHEALTHCARE (CITY PLAN)

www.myuhc.com

**Health Information**
Conditions A-to-Z Encyclopedia, drug dictionary, health-related articles and a Lifestyles directory, which categorizes information about nutrition, health and mental wellness for men, women and children based on life stage.

**Health Calculators**
A wide range of online calculators, including healthy weight, target heart rate, calories burned, heart attack risk, smoking risk and drinking risk.

**Live Nurse Chat**
Via online chat, ask a nurse confidential questions and receive references to additional educational online resources.

**Symptom Checker**
Access an interactive visual and form-based tool to help you make decisions about first aid and assess common physical symptoms.

**Personalized Health Assessment**
Take an in-depth look at the health choices you make each day and get a personal plan to help improve well-being and quality of life.

Online registration is required to take advantage of some of the UHC tools and programs listed.

### Five Ways To Get Involved In Your Healthcare

1. Get an annual checkup and know your numbers - blood pressure, blood sugar, cholesterol and BMI.
2. Get the recommended health screenings that are appropriate for your age and gender. Early diagnoses often result in better outcomes.
3. Make a list of your health concerns before an office visit so you remember to discuss them with your doctor.
4. If you have a chronic condition, follow your doctor's advice regarding nutrition and physical activity. Take medication as prescribed and monitor your condition with regular check-ups.
5. Make your care wishes known to your family and loved ones by completing an Advance Healthcare Directive.

# Dental Plan Options

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

## PPO-Style Dental Plans

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

HSS offers you the following PPO dental plan:

- **Delta Dental**

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

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

You may go to any dentist in either network. You may also go to any dentist outside of these networks. When you go to a licensed dentist not in one of the networks described above, the plan pays the same percentage of cost that it pays a Delta network dentist. However, payment is based on what is considered reasonable and customary (R&C) for the geographical area. This means that your share of the expenses will be higher if your out-of-network dentist charges more than R&C. Don't be shy about asking a dentist financial questions before receiving services. Delta can also help you estimate costs before you receive treatment. Call Delta at (888) 335-8227.

## HMO-Style Dental Plans

Similar to 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 smaller than a dental PPO network.

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

HSS offers you the following DMO plans:

- **DeltaCare® USA**
- **Pacific Union Dental**

**Dental Plan Only?**

Yes, you can elect to enroll in an HSS dental plan even if you elect not to enroll in an HSS medical plan.

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

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

Refer to the chart above to determine whether or not you live in the plan's service area. If you do not see your County listed above please contact the dental plan to confirm that service is available to you.

# Dental Plan Benefits-at-a-Glance

| | DELTA DENTAL | | DELTACARE USA | PACIFIC UNION DENTAL |
|---|---|---|---|---|
| | Preferred In-Network Providers | Out-of-Network & Premier Providers | | |
| **Types of Service** | | | | |
| Cleanings & Exams | 100% covered<br>Limit 2x per plan year; Periodontal clean 50% | 80% covered<br>Limit 2x per plan year; Periodontal clean 50% | 100% covered<br>Limit 1 every 6 months | 100% covered<br>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<br>Limitations apply to resin materials. | $5 co-pay |
| Crowns | 50% covered | 50% covered | 100% covered<br>Limitations apply to resin materials. | $85 co-pay |
| Dentures, Pontics & Bridges | 50% covered | 50% covered | No charge<br>Full and partial dentures 1x every 5 yrs; fixed bridgework; certain limitations apply. | $85 - $100 co-pay |
| Endodontic/ Root Canals | 50% covered | 50% covered | 100% covered<br>Excluding the final restoration | $50 co-pay |
| Orthodontia | Not Covered | Not Covered | Member pays:<br>$1,600/child<br>$1,880/adult<br>$350 startup fee; limitations apply. | Member pays:<br>$1,600/child<br>$1,800/adult<br>$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<br>$150 for family<br>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, read the Evidence of Coverage to get specific details about benefits, costs and way the plan works. Plan EOCs are available on myhss.org.

# Dental Plan Benefits At-a-Glance

## DENTAL PLAN QUICK COMPARISON

| | Delta Dental PPO | Pacific Union DMO | Deltacare USA DMO |
|---|---|---|---|
| May 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 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 with a VSP network doctor every 12 months, helps you and your eligible dependents cover the cost of visual correction eyewear, such as glasses or contacts, and offers limited coverage for some acute eye conditions.

## Choice of Providers

Under the vision plan, you have the choice of using a VSP network doctor or a non-VSP doctor. It may be to your advantage financially to use a VSP network doctor because covered services are provided to you at a higher benefit and you may 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. When you wish to receive service from a VSP network doctor, contact the doctor, identify yourself as a VSP member, and make an appointment. VSP will provide benefit authorization to the doctor. Services must be received prior to the benefit authorization expiration date. If you receive services from a VSP network doctor without 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 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*<br>after the $10 co-pay | up to $40 every 12 months*<br>after the $10 co-pay |
| **Single Vision Lenses** | Covered in full once every 24 months*<br>after the $25 co-pay | up to $45 every 24 months*<br>after the $25 co-pay |
| **Lined Bifocal Lenses** | Covered in full once every 24 months*<br>after the $25 co-pay | up to $65 once every 24 months*<br>after the $25 co-pay |
| **Lined Trifocal Lenses** | Covered in full once every 24 months*<br>after the $25 co-pay | up to $85 once every 24 months*<br>after the $25 co-pay |
| **Frames** | Covered up to $150 every 24 months*<br>after the $25 co-pay; there may be a network discount for amount exceeding allowance | up to $55 once every 24 months*<br>after the $25 co-pay |
| **Contact Lenses** | Covered up to $150 every 24 months*<br>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*<br>no co-pay; in lieu of frames/lenses; allowance applies toward contact lens fitting, evaluation exam and contacts |
| **Urgent Eye Care** | $5 co-pay<br>limited coverage for urgent and acute eye conditions | Not covered |

*Based on your last date of service.

## Acute and Urgent Eye Care

With a $5 co-pay, VSP now offers limited coverage for urgent and acute eye conditions, including treatment of pink eye, sudden onset of flashers and floaters and diagnosis of eye pain or sudden changes in vision. You can visit any VSP network doctor; no appointment is necessary. VSP acute eye care does not cover chronic conditions like diabetes-related eye disease or glaucoma. VSP doctors will refer you to your primary medical doctor for treatment of uncovered eye conditions.

## 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, except for limited acute eye care described above.
- 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 – call VSP.)

## Coordinating Vision Benefits with Medical Plan Benefits

Some HMOs also offer optometry and eyecare services such as eye exams, glasses and lenses. HSS recommends that you compare the out-of-pocket cost you will incur using HMO vision services to out-of-pocket costs when using a VSP network doctor.

## 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.

# 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.

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 Member Eligibility

Newly eligible retirees must enroll in an available medical and/or dental plan within 30 days of their retirement effective date. You must provide HSS with your completed enrollment application and all required eligibility documentation within the initial 30 day enrollment period. If you fail to do so you must wait until the next Open Enrollment period to enroll in retiree coverage.

Your retirement effective date will determine when your retiree healthcare coverage takes 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.

The 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.

HSS also requires a valid Social Security number for all individuals enrolled in an HSS administered health plan.

## Retiree Dependent Eligibility

**Spouse/Domestic Partner**

A member's legal spouse or domestic partner may be eligible for HSS healthcare coverage. Proof of marriage or registered domestic partnership is required. Enrollment must occur within 30 days of the date of marriage or partnership; in that case coverage begins on the first day of the month after the completed application is filed with HSS. Legal spouses and partners can also be added to coverage during annual Open Enrollment.

**Natural Children, Step-Children, Adopted Children**

To be eligible, a natural child, step-child or adopted child of a member, or a member's spouse or domestic partner, must meet all of the following 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. (Some exceptions are allowed in the event of a member's divorce or dissolution if natural or adopted child is declared by a former spouse/partner.)

**Legal Guardianships and Other Children Residing in a Member's Home (IRS Exemption)**

Children under legal guardianship and other children residing full time in a member's home may be eligible if they meet all of the following criteria:

1. Child must be under 19 years of age.
2. Child must be unmarried.

# Eligibility

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 beyond the age limits stated previously provided all of the following criteria are met:

1. Child was continuously enrolled in an HSS administered medical plan from age 19-25.
2. Child was enrolled in an HSS administered medical plan on the child's 19th birthday and continuously for one year prior to age 19.
3. Child sustained a qualifying disability prior to reaching age 25.
4. Child is incapable of self-sustaining employment due to the qualifying disability.
5. Child is unmarried.
6. Child permanently resides with the member.
7. Child is economically dependent on the member for all of his or her economic support and is declared on member's IRS tax return.
8. Member submits required documentation of the disability at least 60 days prior to the child's attainment of age 25 and every year thereafter.

## Social Security Numbers Required

Members and dependents who do not have a Social Security number on file at HSS risk having benefits terminated.

## Financial Penalties for Failing to Disenroll Ineligible Dependents

It is the responsibility of the member to notify HSS within 30 days and cancel coverage for a dependent who becomes ineligible due to divorce, dissolution of partnership, age or any other reason. If a member fails to notify HSS the member may be held responsible for payment of the costs of all health premiums and any medical service provided.

## REQUIRED ELIGIBILITY DOCUMENTATION

| | EVIDENCE OF RETIREMENT | MARRIAGE CERTIFICATE | DOMESTIC PARTNER REG. | BIRTH CERTIFICATE | ADOPTION CERTIFICATE | COURT ORDER | INCOME TAX RETURN | MEDICAL EVIDENCE | SOCIAL SECURITY # |
|---|---|---|---|---|---|---|---|---|---|
| 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 | | | | | | | ■ | ■ | ■ |

# Changing Benefit Elections

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 is effective on the first day of the month following the submission of the required application and documentation within the 30 day time frame. 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 or same sex spouse (and any dependent(s) of that partner or spouse), 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

Coverage for your newborn child is effective on the child's date of birth provided you meet the deadline and documentation requirements stated below. Coverage for your newly adopted child is effective on the date the child is placed with you provided you meet the deadline and documentation requirements stated below. To enroll your newborn or newly adopted child 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. 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. A Social Security number must be provided within 6 months of the date of birth or adoption, or your child's coverage may be terminated. Visit ssa.gov/pubs/10023.html for more information.

## Loss of Other Healthcare Coverage

Employees and eligible dependents who lose other coverage may be enrolled by submitting a completed HSS enrollment application and proof of the loss of coverage **within 30 days** from the date 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.

## Divorce, Separation and Dissolution of Partnership

Termination of HSS health coverage for your ex-spouse or domestic partner due to divorce, legal

separation or dissolution of domestic partnership is required by law. 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. You will be responsible for paying all required premium contributions up to the coverage termination date. Failure to notify HSS of a divorce or dissolution of partnership may result in financial penalties equal to the total cost of benefits and services provided for the ineligible ex-partner or ex-spouse covered on your plan.

## 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. Submit 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 eligibility for survivor healthcare benefits.

Whenever you update your coverage because of a qualifying change in family status, carefully check your pension check to verify that the correct premium contribution is being deducted. If the deduction is incorrect or doesn't appear on your check, contact HSS Member Services at (415) 554-1750. If a required retiree premium contribution is not made within 30 days from the date it is due, coverage will be terminated and you will not be permitted to re-enroll until Open Enrollment in spring 2011, with coverage to begin July 1, 2011.

### Ineligible Dependent Penalty

Members who fail to notify HSS when an enrolled dependent becomes ineligible are responsible for paying the total cost of premiums and services provided back to the original date of the dependent's ineligibility.

# COBRA

## COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted in 1986 may offer retirees and their covered dependents the opportunity to elect a temporary extension of healthcare coverage in certain instances where coverage would end. Such as:

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

## Time Limits for COBRA Elections

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

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

## Duration of COBRA Continuation Coverage

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 an enrollee to be covered for up to 36 months.

Retirees 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 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 if:

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

## Paying for COBRA

Once COBRA continuation coverage is elected, it is the responsibility of the covered individual(s) to remit the required healthcare premium payments directly to the COBRA Administrator.

## COBRA Continuation Coverage Alternatives

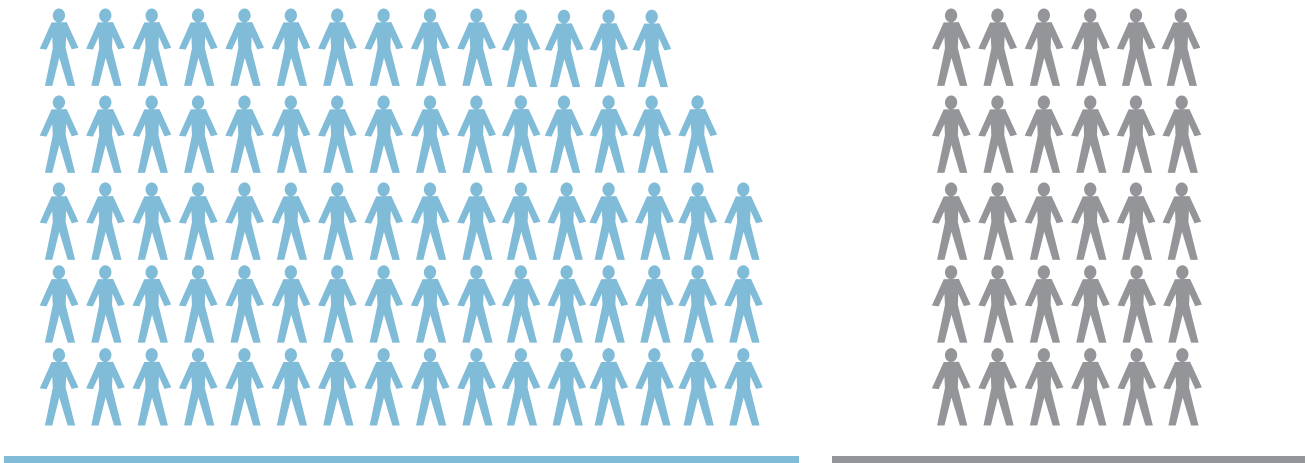
As an alternative to COBRA continuation coverage, you may be able to purchase individual health coverage, if available, from your healthcare plan or another insurer. Contact plans directly for details and costs.

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

This information does not reflect all the changes to COBRA resulting from the 2009 federal American Recovery and Reinvestment Act and subsequent federal legislation that temporarily expands and/or subsidizes COBRA coverage for some participants. For more information about how federal legislation may impact your COBRA benefits contact FBMC at (800) 342-8017.

# Membership Demographics

## Medical Plan Enrollment: Active and Retired Lives




76,922 = 72%

30,359 = 28%

**Total Covered Lives = 107,281**

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, 2009, HSS members totaled 107,281 covered lives. This reflected a decrease of 708 in total covered lives under HSS medical plans since July 1, 2008.

In addition, the Health Service System provides dental benefits to eligible active employees of the City and County of San Francisco and the San Francisco Superior Court and to all retired members and their dependents. Between July 1, 2008 and July 1, 2009, the System reported an increase of 222 in total covered lives under HSS dental plans.

# Glossary of Healthcare Terms

**Brand Name Drug**
FDA approved prescription drugs marketed under a specific brand name by manufacturers.

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

**Co-Insurance**
Co-insurance refers to the amount of money that a member is required to pay for healthcare services, after any required deductible has been paid. Co-insurance is often specified by a percentage. For example, the 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 Premium 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; this guide does not list every service, limitation and 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 (EOC).

**Formulary**
A comprehensive list of prescription drugs that are covered by a medical plan. The formulary is designed to assist physicians in prescribing drugs that are medically necessary and cost effective for members. The formulary is updated periodically.

**Generic Drug**
FDA approved prescription drugs that are a therapeutic equivalent to the brand name drug, contain the same active ingredient as the Brand Name Drug, and cost less than the brand name drug equivalent.

**Health Maintenance Organization (HMO)**
An entity that provides health services through a closed network. Unlike PPOs, HMOs either employ their own staff or contract with groups of providers. HMO participants typically need pre-approval from a primary care provider before seeing a specialist.

**Imputed Income**
Federal IRS regulations require that the value of non-cash compensation, such as an employer's contribution to the health insurance of an employee's domestic partner, be reported as taxable income on a federal income tax return.

**In-Network**
These providers or facilities are contracted with a health plan to provide services at pre-negotiated fees. Enrollees usually pay less

# Glossary of Healthcare Terms

when using an in-network provider, because these 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.

**Medical Group**
An independent group of physicians and other healthcare providers that contract to provide services to members of an HMO.

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

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

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

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

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

**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, co-payments and deductibles–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.

**PDP**
A prescription drug plan.

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

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

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

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

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

**Retiree Premium Contribution**
The amount a retiree must pay toward the cost of retiree health premiums.

# 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

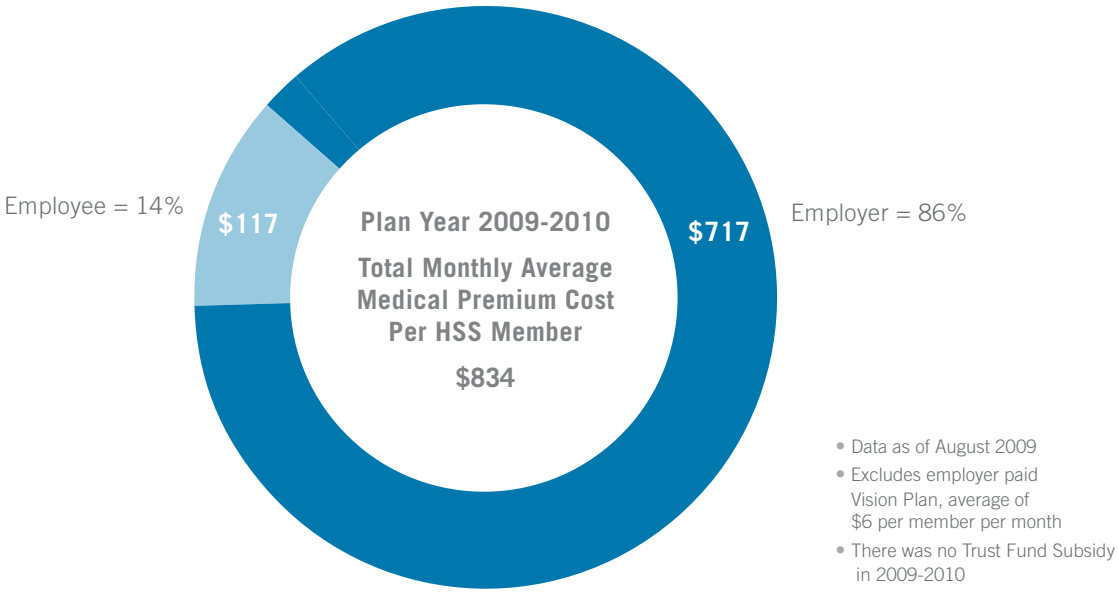
Any written authorizations or requests regarding your health information as described above should be directed to:

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, 2010

# 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

### Monthly Contributions Effective July 1, 2010 - June 30, 2011

| MEDICAL | BLUE SHIELD HMO | | KAISER HMO | | CITY PLAN PPO | |
|---|---|---|---|---|---|---|
| | City Pays | Retiree Pays | City Pays | Retiree Pays | City Pays | Retiree Pays |
| Retiree Only | 1,257.90 | 60.44 | 963.17 | 4.42 | 842.49 | 226.90 |
| Retiree + 1 Dependent with no Medicare | 1,554.27 | 356.80 | 1,203.47 | 244.72 | 1,356.54 | 740.95 |
| Retiree + 2 or More Dependents with no Medicare | 1,554.27 | 848.75 | 1,203.47 | 643.61 | 1,356.54 | 1,471.71 |
| Retiree + 1 Dependent with Medicare Part A Only | 1,554.27 | 356.80 | X | X | 1,303.93 | 688.34 |
| Retiree + 1 Dependent with Medicare Part B Only | 1,554.27 | 356.80 | 1,203.47 | 244.72 △ | 1,085.20 | 469.61 |
| Retiree + 1 Dependent with Medicare Part A and Part B | 1,449.31 | 251.84 | 1,136.15 | 177.39 | 1,009.40 | 393.80 |
| Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents | 1,554.27 | 848.74 | X | X | 1,303.93 | 1,419.10 |
| Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents | 1,554.27 | 848.74 | X | X | 1,085.20 | 1,200.37 |
| Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents | 1,449.31 | 743.78 | 1,136.15 | 576.34 | 1,009.40 | 1,124.56 |

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

△ = New enrollees not allowed.

### Monthly Contributions Effective July 1, 2010 - June 30, 2011

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

All rates that appear in this Benefits Guide are subject to final approval by the San Francisco Board of Supervisors.

# Rates: Retiree Eligible for Medicare Part A & Part B

### Monthly Contributions Effective July 1, 2010 - June 30, 2011

| MEDICAL | BLUE SHIELD HMO | | KAISER HMO | | CITY PLAN PPO | |
|---|---|---|---|---|---|---|
| | City Pays | Retiree Pays | City Pays | Retiree Pays | City Pays | Retiree Pays |
| Retiree Only | 383.84 | 0 | 346.99 | 0 | 367.88 | 0 |
| Retiree + 1 Dependent with no Medicare | 680.21 | 296.36 | 587.29 | 240.30 | 881.93 | 514.05 |
| Retiree + 2 or More Dependents with no Medicare | 680.21 | 788.31 | 587.29 | 639.19 | 881.93 | 1,244.81 |
| Retiree + 1 Dependent with Medicare Part A Only | 680.21 | 296.36 | X | X | 829.32 | 461.44 |
| Retiree + 1 Dependent with Medicare Part B Only | 680.21 | 296.36 | X | X | 610.59 | 242.71 |
| Retiree + 1 Dependent with Medicare Part A and B | 575.25 | 191.40 | 519.97 | 172.97 | 534.79 | 166.90 |
| Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents | 680.21 | 788.30 | X | X | 829.32 | 1,192.20 |
| Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents | 680.21 | 788.30 | X | X | 610.59 | 973.47 |
| Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents | 575.25 | 683.34 | 519.97 | 571.92 | 534.79 | 897.66 |

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

### Monthly Contributions Effective July 1, 2010 - June 30, 2011

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

# Rates: Retiree Eligible for Medicare Part A Only

### Monthly Contributions Effective July 1, 2010 - June 30, 2011

| MEDICAL | BLUE SHIELD HMO | | KAISER HMO | | CITY PLAN PPO | |
|---|---|---|---|---|---|---|
| | City Pays | Retiree Pays | City Pays | Retiree Pays | City Pays | Retiree Pays |
| Retiree Only | 1,257.90 | 60.44 | X | X | 737.31 | 226.90 |
| Retiree + 1 Dependent with no Medicare | 1,554.27 | 356.80 | X | X | 1,251.36 | 740.95 |
| Retiree + 2 or More Dependents with no Medicare | 1,554.27 | 848.75 | X | X | 1,251.36 | 1,471.71 |
| Retiree + 1 Dependent with Medicare Part A Only | 1,554.27 | 356.80 | X | X | 1,198.75 | 688.34 |
| Retiree + 1 Dependent with Medicare Part B Only | 1,554.27 | 356.80 | X | X | 980.02 | 469.61 |
| Retiree + 1 Dependent with Medicare Part A and B | 1,449.31 | 251.85 | X | X | 904.22 | 393.80 |
| Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents | 1,554.27 | 848.74 | X | X | 1,198.75 | 1,419.10 |
| Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents | 1,554.27 | 848.74 | X | X | 980.02 | 1,200.37 |
| Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents | 1,449.31 | 743.78 | X | X | 904.22 | 1,124.57 |

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

### Monthly Contributions Effective July 1, 2010 - June 30, 2011

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

# Rates: Retiree Eligible for Medicare Part B Only

### Monthly Contributions Effective July 1, 2010 - June 30, 2011

| MEDICAL | BLUE SHIELD HMO | | KAISER HMO | | CITY PLAN PPO | |
|---|---|---|---|---|---|---|
| | City Pays | Retiree Pays | City Pays | Retiree Pays | City Pays | Retiree Pays |
| Retiree Only | 1,318.34 | 0 | 967.59 | 0 △ | 526.63 | 0 |
| Retiree + 1 Dependent with no Medicare | 1,614.71 | 296.36 | 1,207.89 | 240.30 | 1,040.68 | 514.05 |
| Retiree + 2 or More Dependents with no Medicare | 1,614.71 | 788.31 | 1,207.89 | 639.25 | 1,040.68 | 1,244.81 |
| Retiree + 1 Dependent with Medicare Part A Only | 1,614.71 | 296.36 | X | X | 988.07 | 461.44 |
| Retiree + 1 Dependent with Medicare Part B Only | 1,614.71 | 296.36 | 1,207.89 | 240.30 △ | 769.34 | 242.71 |
| Retiree + 1 Dependent with Medicare Part A and B | 1,509.75 | 191.40 | 1,140.57 | 172.97 | 693.54 | 166.91 |
| Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents | 1,614.71 | 788.30 | X | X | 988.07 | 1,192.20 |
| Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents | 1,614.71 | 788.30 | 1,207.89 | 639.25 △ | 769.34 | 973.47 |
| Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents | 1,509.75 | 683.34 | 1,159.00 | 590.35 | 693.54 | 897.67 |

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

△ = New enrollees not allowed.

### Monthly Contributions Effective July 1, 2010 - June 30, 2011

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

# Rates: Eligible Surviving Spouse/Domestic Partner

**Monthly Contributions Effective July 1, 2010 - June 30, 2011**

| MEDICAL | BLUE SHIELD HMO | | KAISER HMO | | CITY PLAN PPO | |
|---|---|---|---|---|---|---|
| | City Pays | Retiree Pays | City Pays | Retiree Pays | City Pays | Retiree Pays |
| Survivor Not Eligible for Medicare | 1,257.90 | 60.44 | 963.17 | 4.42 | 842.49 | 226.90 |
| Survivor + 1 Dependent with no Medicare | 1,257.90 | 653.17 | 963.17 | 485.07 | 842.49 | 1,255.00 |
| Survivor + 1 Dependent with Medicare Part A and Part B | 1,257.90 | 443.24 | 963.17 | 350.37 | 842.49 | 560.71 |
| Survivor + 2 or More Dependents with no Medicare | 1,257.90 | 1,145.11 | 963.17 | 884.02 | 842.49 | 1,985.76 |
| | BLUE SHIELD HMO | | KAISER HMO | | CITY PLAN PPO | |
| Survivor with Medicare Part A and B | 383.84 | 0 | 346.99 | 0.00 | 367.88 | 0 |
| Survivor with Medicare A&B + 1 Dependent with no Medicare | 383.84 | 592.73 | 346.99 | 480.65 | 367.88 | 1,028.10 |
| Survivor with Medicare A&B + 1 Dependent with Medicare A&B | 383.84 | 382.81 | 346.99 | 345.95 | 367.88 | 333.81 |
| Survivor with Medicare A&B + 2 or more Dependents with no Medicare | 383.84 | 1,084.67 | 346.99 | 879.60 | 367.88 | 1,758.56 |

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

**Monthly Contributions Effective July 1, 2010 - June 30, 2011**

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

# 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) 554-1721
www.myhss.org

## MEDICAL PLANS

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

**Blue Shield of California 65 Plus (Medicare Advantage) HMO**
Tel: (800) 776-4466
Group No. MA0002
www.blueshieldca.com/sfhss

**Blue Shield of California Access+ HMO**
Tel: (800) 642-6155
Group No. H11054
www.blueshieldca.com/sfhss

**Kaiser Permanente**
Tel: (800) 464-4000
Group No. 888
my.kp.org/ca/cityandcountyofsanfrancisco

## VISION PLAN

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

## DENTAL PLANS

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

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

**Pacific Union Dental**
Tel: (800) 999-3367
(925) 363-6000
Group No. 705287-0048
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.sfers.org

## FEDERAL AGENCIES

**Social Security Administration**
Tel: (800) 325-0778
www.ssa.gov

**Medicare**
Tel: (800) 633-4227
www.medicare.gov