



# MUNICIPAL EXECUTIVES 2013 HEALTH BENEFITS

Health Service System

CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

## Contents

### Open Enrollment

Open Enrollment Overview	2
What’s New January–December 2013	2
Open Enrollment Events	3
Open Enrollment FAQ	4

### Benefit Options and Information

Medical Plan Options	5
PPO vs. HMO	6
Medical Plan Service Areas	7
Medical Plan Benefits-at-a-Glance	8
Adult Preventive Care Summary	12
Wellness Benefits	13
Fitness Classes and Gym Discounts	14
Employee Assistance Program	15
Dental Plan Options	16
Dental Plan Service Areas	17
Dental Plan Benefits-at-a-Glance	18
Dental Plan Comparison	19
Vision Plan Benefits	20
Vision Plan Benefits-at-a-Glance	21
Flex Credits	22
Flexible Spending Accounts	24

### Member Rules and Guidelines

New or Returning Employees	26
Health Coverage Calendar	27
Eligibility	28
Required Eligibility Documentation	29
Changing Elections Outside of Open Enrollment	30
Domestic Partner and Same-Sex Spouse Taxation	33
Leaves of Absence and Health Coverage	34
Approaching Retirement	35
Medicare Requirements for Active Employees and Dependents	35
Holdover and COBRA Coverage	36
Glossary of Healthcare Terms	38
Privacy Policy	40

### Costs and Rates

Medical Plan Costs	42
Medical Plan Premium Rates	43
Key Contact Information	44

# Open Enrollment Overview

## Open Enrollment takes place October 1–31, 2012. Review your options and make informed choices.

### Things You Can Do During Open Enrollment

- Change medical or dental plan elections.
- Add or drop dependents from medical and/or dental coverage.
- Enroll or re-enroll in a Healthcare and/or Dependent Care Flexible Spending Account.

### Open Enrollment Deadline: October 31, 2012

To change your medical or dental plan elections, submit a completed Open Enrollment application and required documentation to HSS by 5:30PM, October 31, 2012. Open Enrollment applications can be delivered to HSS in person, sent through the mail or transmitted by fax. The HSS fax number is (415) 554-1721. (Please do not fax the same application multiple times.) Changes made during October 2012 Open Enrollment will be in effect from January to December 2013.

### EBS Flex Credits Allocation and Flexible Spending Account (FSA) Enrollment

Allocation of flex credits, including annual Flexible Spending Account (FSA) enrollment, is administered by Employee Benefits Specialists (EBS). If you wish to continue your current flex credit allocations for the 2013 plan year no EBS appointment is required. EBS will contact you with instructions. To change your current flex credit allocations, you must confer with EBS by phone or in person. If you do not complete your flex credit allocation with EBS during October 2012 Open Enrollment, your flex credits will be automatically distributed, effective January 1, 2013. (See page 22.) Questions? Call EBS at (800) 229-7683.

To make FSA contributions January–December 2013, you must enroll or re-enroll in an FSA during October 2012, via your flex credits allocation with EBS. If you do not take action during Open Enrollment, FSA contributions will cease the last payday in December 2012.

### What's New for January–December 2013

- Premium contribution rates will change, effective January 1, 2013. (See page 43.)
- In the Delta Dental plan, as of 2013, out-of-network services are covered at a lower percentage. Also, lifetime maximums for orthodontia services have changed. (See page 18.)
- Per the federal Affordable Care Act, effective 2013, coverage for some preventive women's health services with no cost sharing is expanded for all medical plans. See [www.hrsa.gov/womensguidelines](http://www.hrsa.gov/womensguidelines).
- Per the Affordable Care Act, there is a \$2,500 maximum healthcare Flexible Spending Account (FSA) contribution for 2013. (The annual maximum for a Dependent Care FSA remains at \$5,000.)
- City Health Plan deductible and out-of-pocket maximum costs incurred from October through December 2012 will be carried over to the 2013 plan year.
- The Affordable Care Act requires that employers report to the IRS the total cost of "applicable employer-sponsored coverage." This new item on year-end W-2 forms does not affect taxable income.
- Per the Affordable Care Act, the Medicare payroll tax is increased by .9% to 2.35% for individuals with wages over \$200,000 (\$250,000 married filing jointly; \$125,000 married filing separately).

# Open Enrollment Events

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

# Open Enrollment FAQ

	Flex Credits	Medical and Dental	Flexible Spending Accounts
What if I do not want to make any changes to my benefit elections for the January–December 2013 plan year?	You must allocate your flex credits every year. Call EBS at (800) 229-7683 during Open Enrollment for more information. If you do not take action, flex credits are automatically distributed. (See page 22.)	If you want to keep the same medical and dental elections and are not adding or dropping dependents, you do not need to submit an Open Enrollment application. Premium contribution rates will change January 1, 2013.	FSAs require re-enrollment every benefits period. To initiate or continue an FSA for the 2013 plan year call EBS during October 2012: (800) 229-7683. If you do not take action, FSA contributions cease the last payday of December 2012.
How do I make changes to my benefit elections for the January–December 2013 plan year?	Call EBS at (800) 229-7683 during Open Enrollment to make changes to your flex credits allocation for the 2013 plan year . Otherwise, credits are automatically distributed. (See page 22.)	You must submit a completed HSS Open Enrollment application and any required eligibility documentation to HSS no later than 5:30PM, October 31, 2012.	Call EBS at (800) 229-7683 during Open Enrollment to make changes to your FSA contributions for the 2013 plan year. If you don't take action, FSA contributions cease the last payday of December 2012.
How do I add or drop a dependent from my medical and/or dental plan during Open Enrollment?	If you are adding or dropping dependents during Open Enrollment, this may affect the allocation of your flex credits. Be sure to discuss these changes with EBS.	Submit a completed Open Enrollment application and eligibility documentation to HSS no later than 5:30PM, October 31, 2012. No documentation is required when dropping dependents during Open Enrollment.	
May I fax my enrollment information?	Call EBS at (800) 229-7683 to update your flex credits allocation, then return your signed confirmation to EBS by fax. If you do not take action, flex credits will be automatically distributed. (See page 22.)	You may fax your HSS Open Enrollment application and eligibility documentation to our secure fax line: (415) 554-1721. Do not fax the same application to HSS multiple times.	Call EBS at (800) 229-7683 to enroll in a healthcare and/or dependent care FSA, then return your signed confirmation to EBS by fax. If you don't take action, FSA contributions cease the last payday of December 2012.
Whom do I contact if I have questions?	If you have questions about flex credit allocations, contact EBS by calling (800) 229-7683.	If you have questions about medical and dental enrollment, contact HSS Member Services at (415) 554-1750.	If you have questions about Flexible Spending Accounts (FSAs), contact EBS at (800) 229-7683.

## Medical Plan Options

These medical plan options are available to active employee members and eligible dependents. Premium contributions are deducted from the employee's paycheck bi-weekly.

### Health Maintenance Organization (HMO)

An HMO is a medical plan that offers benefits through a network of participating physicians, hospitals, and other healthcare providers. For non-emergency care, you access service through your PCP (Primary Care Physician). You do not pay a deductible before accessing benefits, and co-pays at the point of service are set at a flat, contracted rate. This helps to limit out-of-pocket costs. HSS offers the following HMO plans:

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

### Preferred Provider Organization (PPO)

A PPO is a medical plan that offers benefits through in-network and out-of-network healthcare providers. (Going to an out-of-network provider will cost you more.) You are not assigned to a Primary Care Physician, so you have more responsibility for coordinating your care. You must pay a plan year deductible. You also pay a coinsurance percentage each time you access service. Compared to an HMO, enrolling in a PPO usually results in higher out-of-pocket costs. City Health Plan PPO is a self-insured plan. Individual premiums are determined by the total cost of services used by the plan's group of participants. HSS offers the following PPO plan:

- **City Health Plan PPO**  
(UnitedHealthcare Choice Plus)

The health plans administered by HSS do not guarantee the continued participation of any particular provider, such as a doctor, hospital or medical group, during the January to December 2013 plan year. After Open Enrollment, you won't be allowed to change your health benefit elections because a doctor, hospital or medical group chooses not to participate in your plan. You will be assigned or required to select another provider.

This benefits guide does not explain all the details of your plan contract. The Evidence of Coverage (EOC) contains a complete list of benefits and exclusions in effect for each plan from January to December 2013. Review your EOC for plan details. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Download plan EOCs at [www.myhss.org](http://www.myhss.org).

### Change of Address?

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 health benefit elections may result in the non-payment of claims for services received.

# PPO vs. HMO

## QUICK COMPARISON CHART

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

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

## Medical Plan Service Areas

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

County	Blue Shield HMO	Kaiser Permanente HMO
Alameda	■	■
Alpine		
Calaveras		
Contra Costa	■	■
Madera	■	○
Marin	■	■
Mariposa		○
Merced	■	
Mono		
Napa		○
Sacramento	■	■
San Francisco	■	■
San Joaquin	■	■
San Mateo	■	■
Santa Clara	■	○
Santa Cruz	■	
Solano	■	■
Sonoma	■	○
Stanislaus	■	■
Tuolumne		
Yolo	■	○
Outside of California	Urgent Care/ER Only	Urgent Care/ER Only

■ = Available in this county.

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


If you do not see your county listed above, contact the medical plan to see if service is available to you:

Blue Shield of California: (800) 642-6155

Kaiser Permanente: (800) 464-4000



# Medical Plan Benefits-at-a-Glance


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

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

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

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

# Medical Plan Benefits-at-a-Glance

	blue  of california	KAISER PERMANENTE®	CITY HEALTH PLAN (United Healthcare Choice Plus)		
			In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
<b>REHABILITATIVE</b>					
Physical/Occupational therapy	\$25 co-pay	\$20 co-pay authorization required	85% covered after deductible; 60 visits max per plan year	50% covered after deductible; 60 visits max per plan year	85% covered after deductible; 60 visits max per plan year
Acupuncture	\$15 co-pay 30 visits max per plan year; ASH network only	Not covered	50% covered after deductible; \$1,000 max per plan year	50% covered after deductible; \$1,000 max per plan year	50% covered after deductible; \$1,000 max per plan year
Chiropractic	\$15 co-pay 30 visits max per plan year; ASH network only	\$15 co-pay 30 visits max calendar year; ASH network only	50% covered after deductible; \$1,000 max per plan year	50% covered after deductible; \$1,000 max per plan year	50% covered after deductible; \$1,000 max per plan year
<b>PREGNANCY &amp; MATERNITY</b>					
Routine pre- and post-partum physician care; for hospital stay, see Hospital	No charge newborn must be enrolled within 30 days of birth; visits limited; see EOC	No charge newborn must be enrolled within 30 days of birth; visits limited; see EOC	85% covered after deductible; newborn must be enrolled within 30 days of birth	50% covered after deductible; newborn must be enrolled within 30 days of birth	85% covered after deductible; newborn must be enrolled within 30 days of birth
<b>INFERTILITY</b>					
IVF, GIFT, ZIFT and artificial insemination	50% covered limitations apply	50% covered limitations apply	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
<b>TRANSGENDER</b>					
Office visits and outpatient surgery	Co-pays apply authorization req. \$75,000 lifetime max	Co-pays apply authorization req. \$75,000 lifetime max	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
<b>DURABLE MEDICAL EQUIPMENT</b>					
Home medical equipment	No charge	No charge as authorized by PCP according to formulary	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary	85% covered after deductible; when medically necessary; notification required	50% covered after deductible; when medically necessary; notification required	85% covered after deductible; when medically necessary; notification required
Hearing aids	Evaluation no charge 1 aid per ear every 36 months, up to \$2,500 each	Evaluation no charge 1 aid per ear every 36 months, up to \$2,500 each	85% covered after deductible; 1 aid per ear every 36 months, up to \$2,500 each	50% covered after deductible; 1 aid per ear every 36 months, up to \$2,500 each	85% covered after deductible; 1 aid per ear every 36 months, up to \$2,500 each
<b>MENTAL HEALTH</b>					
Inpatient hospitalization	\$200 co-pay per admission	\$100 co-pay per admission	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Outpatient treatment	\$25 co-pay non-severe and severe	\$10 co-pay group \$20 co-pay individual	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
<b>CHEMICAL DEPENDENCY</b>					
Inpatient detox	\$200 co-pay per admission	\$100 co-pay per admission	85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
Residential rehabilitation	\$200 co-pay per admission	\$100 co-pay per admission; physician approval required	85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
<b>EXTENDED &amp; END-OF-LIFE CARE</b>					
Skilled nursing facility	No charge up to 100 days per plan year	No charge up to 100 days per benefit period	85% covered after deductible; up to 120 days per plan year; notification required; custodial care not covered	50% covered after deductible; up to 120 days per plan year; notification required; custodial care not covered	85% covered after deductible; up to 120 days per plan year; notification required; custodial care not covered
Hospice	No charge authorization required	No charge when medically necessary	85% covered after deductible; prior notification required	50% covered after deductible; prior notification required	85% covered after deductible; prior notification required

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

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

# Adult Preventive Care Summary

	adult women age 20–49	adult men age 20–49	adult women age 50 and up	adult men age 50 and up
<b>Annual wellness exam</b> height, weight, blood pressure; tobacco and alcohol use, depression	Yes	Yes	Yes	Yes
<b>Annual well woman exam</b> age appropriate preventive care	Yes		Yes	
<b>AAA screening</b> abdominal aortic aneurysm				Yes if man ever smoked; ages 65–75; one time
<b>Colorectal cancer screening</b>			Yes ages 50–75	Yes ages 50–75
<b>Contraception</b> birth control, sterilization, counseling	Yes		Yes until fertility ends	
<b>Diabetes type 2 screening</b> blood glucose	Yes	Yes	Yes	Yes
<b>Domestic violence prevention</b> screening and counseling	Yes		Yes	
<b>Flu immunization</b> seasonal flu	Yes annually, if at risk	Yes annually, if at risk	Yes	Yes
<b>Hepatitis A and B immunization</b>	Yes if at risk	Yes if at risk	Yes if at risk	Yes if at risk
<b>Lipid screening</b> blood cholesterol	Yes, over age 45 frequency based on risk	Yes, over age 35 frequency based on risk	Yes frequency based on risk	Yes frequency based on risk
<b>Mammogram</b> breast cancer screening	Yes, over age 40 every 1–2 years		Yes every 1–2 years to age 75	
<b>MMR immunization</b> measles, mumps, rubella	Yes if no proof of immunity	Yes if no proof of immunity	Yes if at risk	Yes if at risk
<b>Osteoporosis screening</b> bone density			Yes over age 65; or high risk	
<b>Pap smear</b> cervical cancer screening	Yes every 2 years, after 3 normal screenings		Yes every 2 years, after 3 normal screenings	
<b>Papillomavirus screening</b>	Yes DNA test if high risk		Yes DNA test if high risk	
<b>Pneumococcal immunization</b> pneumonia			Yes age 65 and up; sooner if high risk	Yes age 65 and up; sooner if high risk
<b>STD screenings and counseling</b> sexually transmitted diseases	Yes if at risk	Yes if at risk	Yes if at risk	Yes if at risk
<b>Tdap/Td immunization</b> tetanus, diphtheria, whooping cough	Yes every 10 years	Yes every 10 years	Yes every 10 years	Yes every 10 years
<b>Varicella immunization</b> chicken pox	Yes if no proof of immunity	Yes if no proof of immunity	Yes if no proof of immunity	Yes if no proof of immunity
<b>Zoster immunization</b> shingles			Yes ages 60 and up; once	Yes ages 60 and up; once

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

## Wellness Benefits

### Health Plan Wellness Tools

#### Blue Shield of California

The Healthy Lifestyle Rewards Program provides financial incentives for completion of a Health Risk Assessment and condition management programs:

[www.blueshieldca.com/hlr](http://www.blueshieldca.com/hlr)

Wellness discounts and savings:

[www.blueshieldca.com/hw](http://www.blueshieldca.com/hw)

Quit For Life smoking cessation:

(866) 784-8454

[www.quitnow.net](http://www.quitnow.net)

#### Kaiser Permanente

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

[www.kp.org/healthyliving](http://www.kp.org/healthyliving)

ChooseHealthy discounts and savings:

[www.kp.org/healthyroads](http://www.kp.org/healthyroads)

#### UnitedHealthcare

Conditions A–Z, online symptom checker, Health Risk Assessment and more:

[www.myuhc.com](http://www.myuhc.com)

#### Delta Dental

Oral health A–Z, dental health education videos, kids' games and more:

[www.wekeepyoumiling.org/group\\_oral\\_health](http://www.wekeepyoumiling.org/group_oral_health)

[www.mysmilekids.com](http://www.mysmilekids.com)

#### Vision Service Plan (VSP)

Eye care recommendations by age, diabetes and vision information, and educational games:

[www.vsp.com/cms/edc/discovery.html](http://www.vsp.com/cms/edc/discovery.html)

[www.vsp.com/cms/edc/diabetes-discovery.html](http://www.vsp.com/cms/edc/diabetes-discovery.html)

### 24/7 Nurse Hotline

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

#### Kaiser San Francisco Nurse Advice:

English: (415) 833-2200

Chinese: (415) 833-2239

Spanish: (415) 833-2203

For other Kaiser locations go to [www.kp.org](http://www.kp.org) and click Locate Our Services.

#### Blue Shield NurseHelp 24/7:

English or Spanish: (877) 304-0504

#### Brown & Toland Ask-A-Nurse:

Brown & Toland patients only: (855) 423-9974

#### UnitedHealthcare Nurseline:

(800) 237-4936

### Weight Watchers at Work

Weight Watchers at Work groups have lost over 2,000 pounds since August 2010. Weight Watchers at Work provides a convenient way to lose weight and keep off the pounds. Weekly group meetings provide support and focus on practical strategies to help you reach your goals. You will be encouraged to develop healthy eating habits, exercise, make smarter food choices and have fun. You may attend one informational meeting at no cost. To join, sign up for a discounted monthly pass at <https://wellness.weightwatchers.com>. For this rate, enter company number 54552 and company passcode WW54552. Note: if you sign up online, you will be charged automatically each month until you cancel. For a calendar of current meetings, visit: [www.myhss.org/events/seminars.html](http://www.myhss.org/events/seminars.html).

### HSS eUpdates

The HSS monthly email newsletter offers benefits and wellness information. Sign up at [www.myhss.org](http://www.myhss.org).

# Fitness Classes and Gym Discounts








## Lunch Break and After Work Fitness Classes: Civic Center, 1 South Van Ness, SFGH and the Airport

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

Class schedule for San Francisco General Hospital: [www.sfghwellness.org/calendar](http://www.sfghwellness.org/calendar)

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

### Gym Membership Discounts

	<p>Group exercise classes, cardio machines, free weights, resistance training and more.</p>	<p>One Club Sport \$24.99/month All Club Sport \$29.99/month All Club Super \$44.99/month No sign-up fee; no contract.</p>	<p><a href="http://24hourfitness.com/corp/sanfranemps">24hourfitness.com/corp/sanfranemps</a> enter code 100961 (800) 224-0240</p>
	<p>Aerobic classes, dance classes, yoga, Pilates, spin cycling, free weights, machine weights.</p>	<p>One-time enrollment fee \$59.00 per person; unlimited California club access \$54.99 per month. Month-to-month, no contract.</p>	<p><a href="http://www.crunch.com">www.crunch.com</a> (415) 602-6193 San Francisco, Daly City, San Mateo, Redwood City</p>
	<p>Exercise equipment; group classes—yoga, Zumba, Pilates and more.</p>	<p>\$19 monthly; \$49 processing fee.</p>	<p><a href="http://www.bay1fitness.com">www.bay1fitness.com</a> (415) 255-0900 37 Grove Street San Francisco</p>
	<p>Cardio, strength and weight training equipment; free unlimited fitness training with membership.</p>	<p>\$15/month San Francisco only; \$29 sign-up fee and \$30 annual lock-in rate. \$19.99/month multi-club; no sign-up fee; \$39.99 annual lock-in rate. No contract.</p>	<p><a href="mailto:planetfitness@gmail.com">planetfitness@gmail.com</a> (415) 433-3033 San Francisco, Daly City, Hayward, Fremont and nationwide</p>
	<p>Cardio, strength and weight training; classes; massage, chiropractic and acupuncture treatments.</p>	<p>Basic gym \$47/month; gym and classes \$67/month; gym, classes and monthly massage \$85/month. No contract.</p>	<p><a href="http://www.livefitgym.com">www.livefitgym.com</a> (415) 525-4364 Hayes Valley and Mission district, San Francisco</p>
	<p>30,000 foot facility; 20+ classes daily; barre, boxing, boot camp, climbing, cross training, pilates, cycling, yoga, Zumba and more.</p>	<p>Unlimited club and class access. No sign-up fee; \$95/month. Month-to-month; no contract.</p>	<p><a href="http://www.studiomix.com">www.studiomix.com</a> (415) 926-6790 1000 Van Ness Avenue San Francisco</p>
	<p>Group classes, free and machine weights, heated pools, racquetball courts, onsite child care.</p>	<p>Waive \$150 initiation fee.</p>	<p><a href="http://www.sonorafitness.com">www.sonorafitness.com</a> (209) 532-1202 13760 Mono Way Sonora, CA</p>

You must show proof of City employment or retirement to participate in these special offers. Offers are subject to change. See complete list of current discounts: [myhss.org/downloads/wellness/HSS\\_2012\\_GymDiscounts.pdf](http://myhss.org/downloads/wellness/HSS_2012_GymDiscounts.pdf)

# Employee Assistance Program (EAP)

## What EAP Does

EAP provides confidential, voluntary, no-cost behavioral health services to City & County of San Francisco employees, their family members and their significant others. EAP is staffed by licensed, experienced therapists. Services include:

- Short-term, solution-oriented counseling for individuals, couples and families
- Supervisory/managerial consultations
- Group workshops
- Critical incident debriefing and trauma response
- Mediation and conflict resolution
- Violence prevention
- Resources and referrals

According to California state law, the interactions you have with EAP are completely confidential. (The only exceptions are if a life is in danger or a person is being abused.)

## Free, Confidential, Solution-Focused Counseling

Emotional stress can have a significant negative impact on physical health, family and social relationships, and work performance. Your first appointment with an EAP counselor usually takes place within 48 hours, and you can utilize up to six EAP sessions per year. If you need additional services, your EAP counselor will assist you in taking advantage of behavioral health benefits, including those covered by your medical plan. EAP appointments are available between the hours of 8:00AM and 5:00PM, Monday through Friday.

## Mediation/Conflict Resolution

Mediation takes place when a neutral party works with conflicting individuals to encourage reconciliation and compromise. EAP typically provides mediation services to help resolve conflicts between co-workers, or between manager and employee. The EAP mediator will help the individuals involved develop a shared understanding and work together to identify potential solutions. There is no cost for EAP mediation services. Call EAP to schedule.

## Group Workshops

Free EAP group workshops offer City employees the opportunity to share, learn and grow, with the goal of becoming more flexible and knowledgeable at all stages of life. EAP workshops include:

- Stress Management
- Managing Anger Effectively
- Communication and Conflict Resolution
- Dealing with Difficult People
- Bullying in the Workplace
- Smoking Cessation
- Advancing Your Supervisory Skills
- Active Parenting (age 2–12 and teens)

This is a partial list; there are many other workshops offered throughout the year. For the calendar of EAP group workshops, visit

[www.myhss.org/events/seminars.html](http://www.myhss.org/events/seminars.html)

## Critical Incident Debriefing and Trauma Response

Even emotionally resilient people may experience strong reactions when exposed to traumatic events. EAP critical incident debriefing and trauma response support people as they process complex emotions, help them return to a regular routine more quickly and reduce the likelihood of post-traumatic stress disorder. There is no cost for this service. Please call EAP immediately if an individual or team in your department can benefit from this service.

## Violence Prevention for City Employees Who Work with the Public

EAP provides a Non-Violent Crisis Intervention training for City employees who may come into contact with disruptive or potentially violent members of the public. There is a \$100 per person fee for this full-day workshop, which includes training materials. Call EAP for more information.

## Contact EAP

Phone: (800) 795-2351  
1145 Market Street, 2nd Floor  
San Francisco, CA 94103

## 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.

### PPO-Style Dental Plans

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

HSS offers the following PPO-style dental plan:

- **Delta Dental**

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

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

- With Delta Dental PPO dentists you pay less out-of-pocket costs. Most preventive services are covered at 100%; many other services are covered at 90%.
- A Delta Dental Premier dentist charges higher out-of-pocket costs. Covered charges are based on pre-arranged fees with contracted dentists. Most preventive services are covered at 100%; many other services are covered at 80%.

You can also choose any dentist outside of the PPO and Premier networks. When you receive service from an out-of-network dentist, many services are covered at a lower percentage, so you pay more. (See page 18.) Also, payment is based on reasonable and customary fees for the geographic area. Your out-of-pocket costs will be higher if your out-of-network dentist charges more than reasonable and customary fees.

Ask your Delta Dental dentist about costs before receiving services. You can request a pre-treatment estimate of costs before you receive care. For more information call Delta Dental at (888) 335-8227.

### HMO-Style Dental Plans

Similar to medical HMOs, Dental Maintenance Organization (DMO) dental plans require that you receive all of your dental care from within a network of participating dental offices. These networks are generally smaller than a dental PPO network.

You will be required to select a primary care dental office, and you must go to this office for all of your dental care. Before you elect a DMO plan, make sure that the plan's network includes the dentist of your choice.

HSS offers 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 the DeltaCare USA or Pacific Union Dental DMO, you must reside within a zip code serviced by the plan. Ask your dentist which plan(s) he or she contracts with before making your selection.

County	Delta Dental PPO	DeltaCare USA DMO	Pacific Union DMO
Alameda	■	■	■
Calaveras	■		
Contra Costa	■	■	■
El Dorado	■	■	
Madera	■	■	■
Marin	■	■	■
Mariposa	■		
Merced	■	■	■
Mono	■		
Monterey	■	■	■
Napa	■	■	■
Sacramento	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Clara	■	■	■
Santa Cruz	■	■	■
Solano	■	■	■
Sonoma	■	■	■
Stanislaus	■	■	■
Tuolumne	■		
Yolo	■	■	■
Outside of California	■		

■ = Available in this county

If you do not see your county listed above, contact the dental plan to see if service is available to you:

Delta Dental: (888) 335-8227

DeltaCare USA: (800) 422-4234

Pacific Union Dental: (800) 999-3367



# Dental Plan Benefits-at-a-Glance

	DELTA DENTAL			DELTACARE USA	PACIFIC UNION DENTAL
	PPO Providers	Premier Providers	Out-of-Network Providers		
<b>Service</b>					
Cleanings and exams	100% covered 2x/year; pregnant women 3x/year	100% covered 2x/year; pregnant women 3x/year	80% covered 2x/year; pregnant women 3x/year	100% covered 1 every 6 months	100% covered 1 every 6 months
X-rays	100% covered full mouth 1x/5 yrs bitewing 2x/yr to age 18; 1x/yr over age 18	100% covered full mouth 1x/5 yrs bitewing 2x/yr to age 18; 1x/yr over age 18	80% covered full mouth 1x/5 yrs bitewing 2x/yr to age 18; 1x/yr over age 18	100% covered	100% covered
Extractions	90% covered	80% covered	60% covered	100% covered	100% covered
Fillings	90% covered	80% covered	60% covered	100% covered Limitations apply to resin materials	100% covered Limitations apply
Crowns	90% covered	80% covered	50% covered	100% covered Limitations apply to resin materials	100% covered Limitations apply
Dentures, pontics and bridges	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	100% covered Full and partial dentures 1x/5 yrs; fixed bridgework, limitations apply	100% covered Full and partial dentures 1x/5 yrs; fixed bridgework, limitations apply
Endodontic/ Root Canals	90% covered	80% covered	60% covered	100% covered Excluding the final restoration	100% covered
Oral surgery	90% covered	80% covered	60% covered	100% covered	100% covered
Implants	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	Not covered	Not covered
Orthodontia	50% covered 6-month wait; child \$2,500 lifetime max; adult \$1,500 lifetime max	50% covered 6-month wait; child \$2,000 lifetime max; adult \$1,000 lifetime max	50% covered 6-month wait; child \$1,500 lifetime max; adult \$500 lifetime max	Employee pays: \$1,600/child \$1,800/adult \$350 startup fee; limitations apply	Employee pays: \$1,660/child \$1,880/adult \$350 startup fee; limitations apply
<b>Maximum</b>					
Annual total dental benefits	\$2,500 per person Per year, excluding orthodontia benefits	\$2,500 per person Per year, excluding orthodontia benefits	\$2,500 per person Per year, excluding orthodontia benefits	None	None
<b>Deductible</b>					
Before accessing benefits	None	None	None	None	None

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

# Dental Plan Comparison

## DENTAL PLAN QUICK COMPARISON

	Delta Dental PPO	DeltaCare USA DMO	Pacific Union Dental DMO
Can I choose to receive services from any dentist?	Yes. You can use any licensed dental provider. You pay less when you choose a PPO in-network 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, except for dentures, pontics, bridges, implants and orthodontia, which require a 6-month wait.	No waiting period.	No waiting period.
Will I pay a flat rate for most services?	No. Your out-of-pocket costs are based on a percentage of applicable charges.	Yes	Yes
Must I live in a certain service area to enroll in the plan?	No	Yes. To enroll, you must live in this DMO's service area.	Yes. To enroll, you must live in this DMO's service area.

## Vision Plan Benefits

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

### Vision Plan Benefits

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

### Choice of Providers

You have the choice of using a VSP network doctor or a non-VSP doctor. You can find a VSP network doctor in your area by visiting [www.vsp.com](http://www.vsp.com) or contacting VSP Member Services at (800) 877-7195.

### Accessing Your Vision Benefits

No ID cards are issued for the vision plan. To receive service from a VSP network doctor, contact the doctor, identify yourself as a VSP member, and make an appointment. VSP will provide benefit authorization to the doctor. Services must be received prior to the benefit authorization expiration date. If you receive services from a VSP network doctor without prior authorization or obtain services from a vision care service provider outside of the VSP network (including Kaiser), you are responsible for payment in full to the provider. You may then submit an itemized bill directly to VSP for partial reimbursement. Compare the costs of out-of-network vision services to VSP in-network costs before choosing. Download claim forms at [www.vsp.com](http://www.vsp.com).

### Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every 24 months, per last date of service. If retractor examination reveals an Rx change of .50 diopter or more after 12 months, replacement is covered.
- Eligible dependent children are covered in full for polycarbonate prescription lenses.
- Cosmetic extras, including progressive, tinted or oversize lenses, will cost you more.

### Vision Plan Expenses Not Covered

- Orthoptics or vision training and any associated supplemental testing, plano (non-prescription) lenses or two pairs of glasses in lieu of bifocals.
- Replacement of lenses or frames furnished under this plan that are lost or broken, except at the contracted intervals.
- Medical or surgical treatment of the eyes, except for limited acute eye care described below.
- Corrective vision treatments such as, but not limited to, LASIK and PRK laser surgery. (You may be eligible for discounts from a VSP doctor.)

### Acute and Urgent Eye Care

With a \$5 co-pay, VSP offers limited coverage for urgent and acute eye conditions, including pink eye, sudden onset of flashers and floaters, and diagnosis of eye pain or sudden changes in vision. Visit any VSP network doctor; no appointment is necessary. VSP acute eye care does not cover chronic eye conditions like diabetes-related eye disease or glaucoma. Chronic eye disease may be covered by your medical plan. (Check your medical plan's Evidence of Coverage, available on [www.myhss.org](http://www.myhss.org).)

### No Medical Plan, No Vision Benefits

If you do not enroll in an HSS medical plan, you and your enrolled dependents cannot access VSP vision benefits.

# Vision Plan Benefits-at-a-Glance

	VSP Network	Out-of-Network
<b>Types of Service</b>		
Well vision exam	\$10 co-pay Every 12 months*	up to \$50 After \$10 co-pay; every 12 months*
Single vision lenses	\$25 co-pay Every 24 months*	Up to \$45 After \$25 co-pay; every 24 months*
Lined bifocal lenses	\$25 co-pay Every 24 months*	Up to \$65 After \$25 co-pay; every 24 months*
Lined trifocal lenses	\$25 co-pay Every 24 months*	Up to \$85 After \$25 co-pay; every 24 months*
Scratch-resistant coating	Fully covered Every 24 months*	Not covered
Frames	Up to \$150 After \$25 co-pay; 20% off total over \$150; every 24 months*	Up to \$70 After \$25 co-pay; every 24 months*
Contact lenses, fitting and evaluation	Up to \$150 Every 24 months*; fitting and evaluation exam fully covered after a maximum \$60 co-pay	Up to \$105 Every 24 months*
Urgent eye care	\$5 co-pay Limited coverage for urgent and acute eye conditions	Not covered
<b>Savings and Discounts</b>		
Non-covered lens options (progressives, anti-reflective coating, photochromic, polycarbonate)	Average 20–25% off Of provider's usual and customary charges; every 24 months*	Not applicable
Laser Vision Correction	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities	Not applicable

\*Based on your last date of service.

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

# Flex Credits

## 2013 DOLLAR VALUE OF FLEX CREDITS BI-WEEKLY

	Employee Only	Employee +1	Employee +2
MEA and Unrepresented Managers	\$335.10	\$338.89	\$338.89
MEA Fire and Police	\$338.89	\$338.89	\$338.89
MEA Superior Court	\$755.00	\$755.00	\$755.00

### Flex Credits

In lieu of dependent coverage subsidized by the City, MEA and unrepresented managers are allocated a dollar value in flex credits to apply to a variety of pre- and post-tax options. Flex credit options are listed on page 23.

### Initial Enrollment

Eligible employees may allocate available flex credits to any combination of available pre- or post-tax benefit options. Enrollment is handled through EBS. If 100% of flex credits are applied toward employee health premium contributions and the cost of the required contribution exceeds the total credits available, the additional amount will be covered by bi-weekly payroll deduction. Credits applied to post-tax benefits will result in taxable, imputed income.

### Miscellaneous Reimbursement

For credits allocated to Miscellaneous Reimbursement, you must provide proof of qualifying expenses incurred between January 1 and December 31, 2013 no later than March 31, 2014. Claim forms and proof of expenditures must be filed directly with EBS for reimbursement. Download claim forms at [www.myhss.org](http://www.myhss.org). If you elect to allocate credits toward Miscellaneous Reimbursement but do not submit sufficient eligible claims to EBS against your credits by the required deadlines, you will forfeit those flex credit dollars.

### Denied Coverage

Members who allocate flex credits toward insurance but are denied coverage may elect one of the following:

- The member may reallocate 100% of the flex credit amount that was allocated to the denied benefit option(s) to the Miscellaneous Reimbursement option. Imputed income will be calculated.

- The member may elect to forfeit 100% of the flex credit amount that was allocated to the denied benefit option(s) for 2013 plan year.

Members who elect to reallocate flex credits to the Miscellaneous Reimbursement option will not receive the retroactive value of the applicable flex credits but will have the applicable amount applied to Miscellaneous Reimbursement moving forward.

### Qualifying Event Changes

Members may elect to reallocate flex credits if the reallocation relates directly to a qualifying event. Contact HSS at (415) 554-1750 for more information.

### Open Enrollment

Members must allocate flex credits annually during Open Enrollment. Call EBS at (800) 229-7683. If a member does not allocate flex credits during Open Enrollment, credits will be allocated as follows:

- If the member has medical and/or dental plan coverage, flex credits for the 2013 plan year will be automatically applied to the employee premium contribution cost at the level of coverage currently in place. Any additional amount required to cover the cost of employee premium contributions will be covered by payroll deductions. Remaining flex credits, if any, will be allocated to the Miscellaneous Reimbursement Account and will be subject to taxable, imputed income.
- If the member currently has no medical or dental plan coverage, all credits will be allocated to the Miscellaneous Reimbursement Account and will be subject to taxable, imputed income.

# Flex Credits

## SECTION 125 PRE-TAX BENEFIT OPTIONS

	Tax Status	Flex Credit	Payroll Deduction
<b>Employee Health Premium Contributions</b>	Pre-Tax	Yes	Yes
<b>Healthcare Flexible Spending Account</b> WageWorks	Pre-Tax	Yes	Yes
<b>Dependent Care Flexible Spending Account</b> WageWorks	Pre-Tax	Yes	Yes
<b>Cancer Insurance</b> Allstate Workforce Division	Pre-Tax	Yes	Yes
<b>Heart and Stroke Insurance</b> Allstate Workforce Division	Pre-Tax	Yes	Yes
<b>Accident Insurance</b> Allstate Workforce Division	Pre-Tax	Yes	Yes
<b>Long-term Disability Insurance</b> Aetna	Pre-Tax	Yes	No

## OTHER TAXABLE BENEFIT OPTIONS

	Tax Status	Flex Credit	Payroll Deduction
<b>Universal Life Insurance</b> ING	Post-Tax	Yes	Yes
<b>Short-term Disability Insurance</b> ING	Post-Tax	Yes	Yes
<b>Long-term Care Insurance</b> John Hancock, MetLife, Mass Mutual	Post-Tax	Yes	Yes
<b>Pet Insurance</b> PetCare	Post-Tax	Yes	Yes
<b>Group Legal Plan</b> Pre-Paid Legal	Post-Tax	Yes	Yes
<b>Supplemental Group Term Life Insurance</b> Aetna Note: a \$50,000 Group Term Life Insurance policy is provided at no cost to employees eligible for flex credit benefits.	Post-Tax	Yes	No
<b>Commuter Transit Reimbursement</b> EBS Note: A separate pre-tax Commuter Check benefit administered by WageWorks is also available to all City employees.	Post-Tax	Yes	No
<b>Miscellaneous Reimbursement Account</b> Submit receipts to EBS for qualifying expenses, including: <ul style="list-style-type: none"> <li>• MEA dues</li> <li>• Auto insurance</li> <li>• Prior service buyback</li> <li>• Professional coaching</li> <li>• Tuition reimbursement when an employee has exceeded the \$2,000 allocation from the MEA training fund.</li> <li>• Memberships or tickets to cultural events at institutions funded or operated by the City of San Francisco Hotel Tax Fund.</li> </ul> Visit <a href="http://myhss.org">myhss.org</a> for details about these and other qualifying expenses. Note: Contributions to 457(b) deferred comp accounts do not qualify.	Post-Tax	Yes	No

**More detailed benefit summaries for these flex credit options are available online at [myhss.org](http://myhss.org). You must contact EBS at (800) 229-7683 during Open Enrollment to allocate flex credits.**

## Flexible Spending Accounts

An FSA is an IRS-approved tax-favored account to pay for eligible medical and dependent care expenses. Funds are deducted from your salary pre-tax.

### How an FSA Works

Flexible Spending Accounts (FSAs) let you set aside money pre-tax to pay for eligible healthcare and/or dependent care expenses. You can enroll in either a Healthcare FSA, a Dependent Care FSA, or both.

You can realize tax savings with an FSA, but any unused FSA dollars are forfeited at the end of the plan year, per IRS rules. To calculate potential FSA tax savings, visit [www.wageworks.com/employee/calculators.htm](http://www.wageworks.com/employee/calculators.htm). Consult a tax advisor or the IRS for information about your individual situation.

The following information provides an overview of your FSA benefits. Flexible Spending Account benefits are administered by WageWorks. For details about FSA benefits, visit [www.wageworks.com](http://www.wageworks.com).

### Healthcare FSA

- Set aside between \$260 and \$2,500 pre-tax per member for this plan year. Depending on the amount you elect, deductions between \$10.00 and \$96.15 will be taken bi-weekly from your paycheck January–December 2013.
- Submit reimbursement documentation to WageWorks for eligible out-of-pocket expenses, including medical, pharmacy, dental and vision co-pays and deductibles.
- When you elect a Healthcare FSA the total annual amount you designate becomes available for eligible healthcare expenses as of January 1, 2013. You do not have to wait for your contributions to accumulate in your account.

### Dependent Care FSA

- Set aside between \$260 and \$5,000 pre-tax per household for the plan year. (\$2,500 each if you are married filing separate federal tax returns.) Depending on the amount you elect, deductions between \$10.00 and \$192.30 will be taken bi-weekly from your paycheck in 2013.
- If you have a stay-at-home spouse, you may not enroll in the Dependent Care FSA.
- Submit reimbursement documentation to WageWorks for eligible out-of-pocket expenses, such as certified day care, pre-school and elder care for your qualifying dependents. (Children in day care must be under age 13.)
- Funds for a Dependent Care FSA are available after being deducted from your paycheck and received by the plan administrator. Unlike a Healthcare FSA, the entire annual amount for a Dependent Care FSA is not available January 1, 2013.

### Estimating FSA Expenses

Before enrolling in your FSA you should work out a detailed estimate of the eligible expenses you are likely to incur during January to December 2013. Budget conservatively. Unreimbursed funds are forfeited at the end of the 2013 plan year and cannot be returned to you. For a list of eligible expenses, the definition of qualifying family members and how to submit reimbursements, visit [www.wageworks.com](http://www.wageworks.com). FSA expenses must meet Internal Revenue Service (IRS) eligibility criteria. Please refer to IRS publications 502 and 503: [www.irs.gov/pub/irs-pdf/p502.pdf](http://www.irs.gov/pub/irs-pdf/p502.pdf) and [www.irs.gov/pub/irs-pdf/p503.pdf](http://www.irs.gov/pub/irs-pdf/p503.pdf).

### FSA Rules

- You must re-enroll in Flexible Spending Account(s) every Open Enrollment.
- Expenses for services incurred before January 2013 or after December 2013 are not eligible for reimbursement in this plan year.
- You cannot transfer money between Healthcare and Dependent Care Flexible Spending Accounts.
- You cannot change FSA contributions during the January to December plan year unless you have a qualifying event. For details visit the HSS website: [www.myhss.org/benefits/fsa.html](http://www.myhss.org/benefits/fsa.html)
- If your employment ends, in some cases you have the option of continuing your FSA with COBRA (Consolidated Omnibus Budget Reconciliation Act). Without COBRA, you can only file claims for eligible FSA expenses that were incurred while you were actively employed. (See page 37.)

### FSA Account Information

Visit [www.wageworks.com](http://www.wageworks.com) or call (877) 924-3967, Monday–Friday, 8:00 AM–8:00 PM Eastern Time to get information about your FSA.

### FSAs and Unpaid Leaves of Absence

#### Healthcare FSA

During an unpaid leave of absence, no payroll deductions can be taken. You may suspend your Healthcare FSA if you notify HSS at the beginning of your leave. Accounts that remain unpaid for three consecutive pay periods will be suspended retroactively to the first missed pay period. To reinstate your Healthcare FSA you must notify HSS within 30 days of your return to work. A retroactive reinstatement back to the FSA suspension date allows claims incurred during your leave to be reimbursable. In this case, you must increase your bi-weekly FSA deductions (up to a maximum of \$96.15) for the remainder of the January to December plan year, so your annual FSA contribution is equal to the

total designated during Open Enrollment. You also have the option of reinstating a Healthcare FSA on a go-forward basis, at the original bi-weekly deduction amount. This will reduce your total FSA contribution for January–December 2013.

#### Dependent Care FSA

A Dependent Care FSA must be suspended while you are on leave. Claims incurred during leave are not reimbursable. To reinstate your FSA, you must notify HSS within 30 days of your return to work. Reinstatement of a Dependent Care FSA is only allowed on a go-forward basis. You may reinstate at the original bi-weekly FSA deduction amount or you can increase bi-weekly FSA deductions (up to a maximum of \$192.30) for January to December 2013. If you increase deductions, total contributions from January to December 2013 must equal, and cannot exceed, the amount that you designated during Open Enrollment.

#### FSA Reinstatement Rules

If you do not notify HSS within 30 days of your return to work and request reinstatement of your FSA payroll deduction, FSA(s) will be cancelled—no exceptions. If you return to work after December 2013, a suspended Healthcare or Dependent Care FSA initiated during January–December 2013 cannot be reinstated—no exceptions.

#### Avoid Forfeiting FSA Contributions

FSA expenses for the 2013 plan year must be incurred between January 1, 2013, and December 31, 2013. Reimbursement claims must be received by the plan administrator no later than March 31, 2014. Per IRS rules, you forfeit money remaining in an FSA at the end of the claim filing period—no exceptions.



## New or Returning Employees

### New or Rehired Employees Must Enroll within 30 Days

Eligible new and rehired employees must enroll in an HSS medical and/or dental plan within **30 calendar days** of their start work date. If you do not enroll within this 30-day period, you can only apply for benefits during the next Open Enrollment or within 30 days of losing other coverage.

### Newly Eligible Temporary Exempt Employees

Temporary exempt employees who have worked more than 1040 hours in any consecutive 12-month period and whose normal work week is not less than 20 hours typically become eligible to enroll in an HSS medical and/or dental plan. (The determination of eligibility is made by the Department of Human Resources; documentation is required.) These employees must enroll within **30 calendar days** of the date they met eligibility requirements per DHR. Otherwise they will need to wait until the next Open Enrollment or when a qualifying event occurs. (See pages 30–32.)

### How To Enroll

To enroll in an HSS healthcare plan, new or returning employees must submit a completed enrollment application and any required eligibility documentation to HSS. For a checklist of required eligibility documentation, see page 29. Please submit copies of eligibility documentation—not your original documents. If you choose not to hand in an application during your new employee orientation, applications and supporting documentation can be mailed, faxed or dropped off at the HSS office **within 30 calendar days** of your official start work date. See page 44 for HSS phone, fax and address details.

### When Coverage Begins

Coverage starts on the first day of the coverage period following your eligibility date, provided you have submitted the required application and eligibility documentation to HSS within the 30-day deadline. Contact HSS Member Services at (415) 554-1750 if you have questions about when your coverage will begin.

### Employee Responsibility for Healthcare Premium Contributions

Employee premium contributions are deducted from paychecks bi-weekly. Carefully review your paycheck to verify that the correct employee premium contribution is being deducted. If the deduction is incorrect or does not appear on your paycheck, contact HSS Member Services at (415) 554-1750. You are responsible for all required employee premium contributions, whether or not they are deducted from your paycheck. (See chart on page 27 for contribution due dates.) If you fail to make a required employee premium contribution by the date it is due, your coverage will be terminated and you will not be permitted to re-enroll in coverage until Open Enrollment in October 2013, with coverage to begin January 1, 2014.

# Health Coverage Calendar

## Payroll Deductions Taken Bi-Weekly

Employee premium contributions are deducted from paychecks bi-weekly—a total of 26 payroll deductions for the January to December 2013 plan year. All employee premium contributions for any benefits coverage period must be paid in advance of the coverage period for a member and dependents to be covered during that period.

WORK DATES	PAY DATE	BENEFITS COVERAGE PERIOD
December 8, 2012–December 21, 2012	January 1, 2013	January 1, 2013–January 4, 2013
December 22, 2012–January 4, 2013	January 15, 2013	January 5, 2013–January 18, 2013
January 5, 2013–January 18, 2013	January 29, 2013	January 19, 2013–February 1, 2013
January 19, 2013–February 1, 2013	February 12, 2013	February 2, 2013–February 15, 2013
February 2, 2013–February 15, 2013	February 26, 2013	February 16, 2013–March 1, 2013
February 16, 2013–March 1, 2013	March 12, 2013	March 2, 2013–March 15, 2013
March 2, 2013–March 15, 2013	March 26, 2013	March 16, 2013–March 29, 2013
March 16, 2013–March 29, 2013	April 9, 2013	March 30, 2013–April 12, 2013
March 30, 2013–April 12, 2013	April 23, 2013	April 13, 2013–April 26, 2013
April 13, 2013–April 26, 2013	May 7, 2013	April 27, 2013–May 10, 2013
April 27, 2013–May 10, 2013	May 21, 2013	May 11, 2013–May 24, 2013
May 11, 2013–May 24, 2013	June 4, 2013	May 25, 2013–June 7, 2013
May 25, 2013–June 7, 2013	June 18, 2013	June 8, 2013–June 21, 2013
June 8, 2013–June 21, 2013	July 2, 2013	June 22, 2013–July 5, 2013
June 22, 2013–July 5, 2013	July 16, 2013	July 6, 2013–July 19, 2013
July 6, 2013–July 19, 2013	July 30, 2013	July 20, 2013–August 2, 2013
July 20, 2013–August 2, 2013	August 13, 2013	August 3, 2013–August 16, 2013
August 3, 2013–August 16, 2013	August 27, 2013	August 17, 2013–August 30, 2013
August 17, 2013–August 30, 2013	September 10, 2013	August 31, 2013–September 13, 2013
August 31, 2013–September 13, 2013	September 24, 2013	September 14, 2013–September 27, 2013
September 14, 2013–September 27, 2013	October 8, 2013	September 28, 2013–October 11, 2013
September 28, 2013–October 11, 2013	October 22, 2013	October 12, 2013–October 25, 2013
October 12, 2013–October 25, 2013	November 5, 2013	October 26, 2013–November 8, 2013
October 26, 2013–November 8, 2013	November 19, 2013	November 9, 2013–November 22, 2013
November 9, 2013–November 22, 2013	December 3, 2013	November 23, 2013–December 6, 2013
November 23, 2013–December 6, 2013	December 17, 2013	December 7, 2013–December 31, 2013

If you take an approved leave of absence, in most cases you must pay HSS directly for the premium contributions that were being deducted from your paycheck. Employee premium contributions are due no later than the first day of the benefits coverage periods above. See page 34 for more information about medical, dental and vision coverage during a leave of absence. See page 25 for details about Flexible Spending Accounts and leaves of absence.

## Eligibility

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

### Member Eligibility

The following are eligible to participate in the Health Service System as members, per San Francisco Administrative Code Section 16.700:

- City and County Employees
  - All permanent employees of the City and County of San Francisco whose normal work week is not less than 20 hours;
  - All regularly scheduled provisional employees of the City and County of San Francisco whose normal work week is not less than 20 hours;
  - All other employees of the City and County of San Francisco, including temporary exempt or “as needed” employees, who have worked more than 1,040 hours in any consecutive 12-month period and whose normal work week is not less than 20 hours.
- Elected Officials of the City & County of San Francisco
- All members of designated boards and commissions during their time in service to the City and County of San Francisco as defined in San Francisco Administrative Code Section 16.700(c).
- All officers and employees as determined eligible by the governing bodies of the San Francisco Transportation Authority, San Francisco Parking Authority, Treasure Island Development Authority, San Francisco Superior Court and any other employees as determined eligible by ordinance.

### Dependent Eligibility

#### Spouse or 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, as well as the dependent’s Social Security number. Proof of Medicare enrollment must also be provided for a same-sex spouse or domestic partner (of either gender) who is age 65 or older, or who is Medicare-eligible due to a disability. Enrollment in HSS benefits must be completed within 30 days of the date of marriage or partnership. In that case, coverage begins on the first day of the coverage period after a completed application and eligibility documentation is filed with HSS. Legal spouses and domestic partners can also be added to a member’s coverage during annual Open Enrollment.

#### Natural Children, Stepchildren, Adopted Children

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

#### Legal Guardianships and Court-Ordered Children

Children under 19 years old who are placed under the legal guardianship of an enrolled member, a member’s spouse, or domestic partner are eligible. If a member is required by a court’s judgement, decree or order to provide health coverage for a child, that child is eligible up to age 19. Coverage terminates at the end of the coverage period in which the child turns 19. The member must provide HSS with proof of guardianship, court order or decree by required deadlines.

### Adult Disabled Children

Children who are disabled may be covered beyond the age limits stated previously, provided all of the following criteria are met. (A newly hired employee who enrolls an adult disabled child age 26 or older must meet all requirements below except 1 and 2.)

1. Adult child was enrolled in an HSS medical plan on the child’s 19th birthday and continuously for at least one year prior to the child’s 19th birthday;
2. Adult child was continuously enrolled in an HSS-administered medical plan from age 19 to 26;
3. Adult child is incapable of self-sustaining employment due to the disability;
4. Adult child is unmarried;
5. Adult child permanently resides with the employee member;
6. Adult child is dependent on the member for substantially all of his economic support, and is declared as an exemption on the member’s federal income tax;
7. Member submits to HSS acceptable medical documentation—a certification that an adult child is enrolled in Medicare due to a

Social Security-qualifying disability, or HSS disabled dependent forms completed and signed by a physician—at least 60 days prior to child’s attainment of age 26 and every year thereafter as requested;

8. All enrolled dependents who qualify for Medicare due to a disability are required to enroll in Medicare. Members must notify HSS of any dependent’s eligibility for, and enrollment in, Medicare;
9. Once enrolled, the member must continuously enroll the disabled adult child in HSS coverage and Medicare (if eligible) to maintain future eligibility.

### Financial Penalties for Failing to Disenroll Ineligible Dependents

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

### REQUIRED ELIGIBILITY DOCUMENTATION

	EVIDENCE OF HIRE	BENEFIT AUTH. FORM	MARRIAGE CERTIFICATE	DOMESTIC PARTNER CERT	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	PROOF OF PLACEMENT	COURT ORDER OR DECREE	MEDICAL EVIDENCE	SOCIAL SECURITY #
Employee: Permanent/Provisional	■									■
Employee: Temporary/Exempt		■								■
Spouse			■							■
Domestic Partner				■						■
Child: Natural					■					■
Stepchild: Spouse			■		■					■
Stepchild: Domestic Partner				■	■					■
Child: Adopted						■				■
Child: Placed for Adoption							■			■
Child: Legal Guardianship								■		■
Child: Court Ordered								■		■
Adult Child: Disabled									■	■

Note: Proof of Medicare enrollment is also required for a Medicare-eligible same-sex spouse, domestic partner or disabled child.

# Changing Elections Outside of Open Enrollment

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

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

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

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

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

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

*continued on page 32*

# Changing Elections Outside of Open Enrollment

## Death of a Dependent

If an enrolled dependent dies, you should notify HSS as soon as possible and submit a copy of the death certificate **within 30 days** from the date of death. Coverage for your deceased dependent will terminate the day after the dependent's death.

## Death of a Member

In the event of a member's death, the surviving dependent or survivor's designee should contact HSS to obtain information about eligibility for survivor health benefits. To be eligible for health benefits, the surviving spouse or domestic partner of an employee must have been married to the member, or registered as the member's domestic partner, for at least one year prior to the death of the member. Other restrictions apply.

After being notified of a member's death, HSS will send instructions to the spouse or partner, including a list of documentation required for enrolling in surviving dependent health coverage. To avoid a break in coverage for survivors who were enrolled in HSS benefits at the time of the member's death, the following must be submitted to HSS **within 30 days** of the member's death date of death:

- Completed surviving dependent enrollment form
- Copy of member's death certificate
- Copy of certificate of marriage or partnership (if not already on file at HSS)
- Copy of survivor's Medicare card (if survivor is Medicare-eligible)

A surviving spouse or partner who is not enrolled on the deceased member's health plan at the time of the member's death may be eligible for coverage, but must wait until Open Enrollment to enroll. Surviving dependent children of a member must meet eligibility requirements for dependent children. (See pages 28–29.) Eligible surviving dependent children may be enrolled, but do not qualify for employer-subsidized benefits.

## Moving Out of a Plan's Service Area

If you move your primary residence to a location outside your health plan's service areas, you will no longer be able to obtain services through that plan. You will need to enroll in a different HSS plan that offers service based on your new address. You must complete an HSS application to elect a new plan **within 30 days** of your move. Coverage under the new plan will be effective the first day of the coverage period following the date HSS receives your completed enrollment application. If you do not enroll in a new plan **within 30 days** of your move, you must wait until the next Open Enrollment.

## Changing Contributions to a Flexible Spending Account (FSA)

Per IRS regulations, some qualifying events allow you to initiate or modify contributions to a Healthcare and/or Dependent Care Flexible Spending Account during the January to December 2013 plan year. (See page 24 for FSA information.) For a list of qualifying events and corresponding authorized FSA contribution changes, please visit: [www.myhss.org/benefits/fsa.html](http://www.myhss.org/benefits/fsa.html), or call Member Services at (415) 554-1750 for assistance.

## Financial Penalties for Failing to Disenroll Ineligible Dependents

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

# Domestic Partner and Same-Sex Spouse Taxation

Health coverage for your domestic partner, same-sex spouse, and children of that partner or spouse through an HSS plan is typically a taxable benefit.

## Tax Treatment of Health Benefits

The federal government does not recognize domestic partnership or same-sex marriage for tax purposes. Employer contributions to health premiums for an employee's domestic partner, same-sex spouse, and children of a domestic partner or same-sex spouse, are taxable (imputed) income. Also, employee premium contributions are taken post-tax. By comparison, if an employee is married to a member of the opposite sex, no taxable imputed income results from employer contributions to the spouse's health premium costs and employee premium contributions for the spouse are paid pre-tax.

## IRS Exemption for Enrolled Health Plan Dependents Who Meet Certain Requirements

The Internal Revenue Service (IRS) offers a tax break for health-related expenses incurred by a “qualifying relative.” Under IRS code section 152, a domestic partner (of either gender), a same-sex spouse, and children of a domestic partner or same-sex spouse qualify for favorable tax treatment if:

1. Partner, spouse or child receives more than half of his or her financial support from the employee, and
2. Partner, spouse or child lived with the employee as a member of his or her household for the entire calendar year (January 1–December 31), with the exception of temporary absences due to vacation, education or military service, and
3. Partner, spouse or child is a citizen of the United States, or a resident of the United States, Canada or Mexico.

If an enrolled dependent meets all these requirements the employee may submit an annual declaration to HSS, and there will be no imputed income for

the employer contribution to dependent health premiums and employee premium contributions will be paid pre-tax. To take advantage of this favorable tax treatment, you must file the HSS declaration annually with HSS by required deadlines.

## Equitable California State Tax Treatment

If your dependent does not meet the IRS code section 152 requirements for favorable tax treatment under federal law, you may still take advantage of equitable California state tax treatment if your dependent qualifies under California state law. (This California law only applies to same-sex domestic partners and same-sex spouses—not opposite-sex domestic partners.) To obtain equitable tax treatment under California state law, you are required to have either a valid California marriage license or a Declaration of Domestic Partnership issued by the Secretary of the State of California. In this case, you will need to deduct the value of the employer-paid health insurance premiums for your same-sex domestic partner or same-sex spouse, and his or her children, when filing your California state income tax return.

## Consult with Your Tax Advisor

This is a brief overview regarding the tax treatment of health benefits for domestic partners, same-sex spouses and their children. Please consult with a professional tax advisor before taking any action. You remain subject to all state and federal tax law and will be responsible for any consequences that result from the forms, documents or declarations you submit to the Health Service System.

Learn more online:

[www.myhss.org/member\\_services](http://www.myhss.org/member_services)



# Leaves of Absence and Health Coverage

Type of Leave	Eligibility	Your Responsibilities
<p>Family and Medical Leave (FMLA)</p> <p>Worker’s Compensation Leave</p> <p>Family Care Leave</p> <p>Military Leave</p>	<p>If you notify HSS within 30 days of when your leave begins, you may be eligible to continue or discontinue (waive) your healthcare coverage for the duration of your approved leave of absence.</p> <p>You may have additional rights under an approved FMLA leave. Contact your departmental personnel representative for details.</p>	<ol style="list-style-type: none"> <li>1. Notify your department’s personnel officer. They will provide HSS with important information about your leave.</li> <li>2. Contact HSS within 30 days of when leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits.</li> <li>3. Contact HSS immediately (within 30 days of return to work) to request that premium contributions return to active status.</li> </ol>
<p>Personal Leave Following Family Care Leave</p>	<p>If you have been on an approved Family Care Leave and elect to extend your leave period as a Personal Leave, you may be eligible to continue (or waive) your healthcare coverage for the duration of your approved Personal Leave, if:</p> <ul style="list-style-type: none"> <li>- The reason for the Personal Leave is the same as the reason for the prior Family Care Leave.</li> <li>- Your required employee premium contribution payments, if any, are current.</li> <li>- You notify HSS before your leave begins.</li> </ul>	<ol style="list-style-type: none"> <li>1. Notify your department’s personnel officer. They will provide HSS with important information about your leave.</li> <li>2. Contact HSS within 30 days of when leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits.</li> <li>3. Contact HSS immediately (within 30 days of return to work) to request that premium contributions return to active status.</li> </ol>
<p>Educational Leave</p> <p>Personal Leave</p> <p>Leave for Employment as an Employee Organization Officer or Representative</p>	<p>If you notify HSS within 30 days of when your leave begins, you may be eligible to continue (or waive) your healthcare coverage for the duration of your approved leave of absence.</p>	<ol style="list-style-type: none"> <li>1. Notify your department’s personnel officer. They will provide HSS with important information about your leave.</li> <li>2. Contact HSS within 30 days of when leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits.</li> <li>3. If your leave lasts beyond 12 weeks, you must pay the total cost of medical and dental coverage for yourself and any covered dependents. This includes your employee premium contribution amount plus the City and County of San Francisco’s contribution. Contact HSS for details.</li> <li>4. Contact HSS immediately (within 30 days of return to work) to request that premium contributions return to active status.</li> </ol>

See page 25 for information about Flexible Spending Accounts and leaves of absence.

# Approaching Retirement

## Transition to Retirement

The transition of health benefits from active to retiree status does not happen automatically. You must elect to continue retiree health coverage by submitting the retiree enrollment form and supporting documents to HSS. Contact HSS at (415) 554-1750 three months before your retirement date to learn about enrolling in retiree benefits. You are required to notify HSS of your retirement even if you are not planning to elect HSS coverage on your retirement date.

Depending on your retirement date, there can be a gap between when active employee coverage ends and retiree coverage begins. Setting a retirement date at the end of the month will help avoid a gap in HSS coverage. Call HSS at (415) 554-1750 to review your options before deciding on your retirement date.

If you choose to continue medical and/or dental coverage through HSS after you retire, your retiree premium contribution may be higher than your active employee contributions. As a retired member, you will also be required to pay for dental coverage. Costs will depend on your plan choices, number of dependents covered and your Medicare status. **If you choose to take a lump sum pension distribution, your retiree healthcare premium contributions will be unsubsidized, and you will pay the full cost.**

A retiree must have been a member of HSS at some time during his or her active employment in order to be eligible for retiree health benefits. Other restrictions may apply.

Health premium contributions will be taken from your pension check. If required monthly contributions are greater than the total amount of your pension check, you must contact HSS to make payment arrangements. Premium contribution rates are subject to change every Open Enrollment.

All retirees and dependents who are Medicare-eligible due to age or disability are required to enroll. Failure of a retired member or dependent to enroll in Medicare when eligible will result in penalties, limitations in retiree member coverage and the termination of retiree dependent coverage.

## Medicare Enrollment Requirements for Employees and Dependents

### Active Employees and Opposite-Sex Spouses Medicare Enrollment Optional

If you are working and eligible for HSS health coverage at age 65 or older, the federal government and HSS do not require that you enroll in Medicare. However, even though it is not required, you are eligible for Medicare at age 65 and can enroll if you choose to do so. Many active employees over age 65 choose to enroll in premium-free Medicare Part A while they are still working. If you enroll in Part A, remember you must contact the Social Security Administration and enroll in Medicare Part B when you retire or otherwise leave City employment. If you are over age 65 and not enrolled in both Medicare Part A and Part B upon retirement, you may be charged penalties by the federal government. These same rules apply to an opposite-sex spouse covered on your HSS plan.

### Same-Sex Spouses and Domestic Partners Medicare Enrollment Required

A same-sex spouse or domestic partner (of either gender) of an active employee must enroll, and remain enrolled, in both premium-free Medicare Part A and Medicare Part B upon reaching age 65. Proof of Medicare enrollment, such as a copy of the Medicare card, must be provided to HSS. Your spouse or partner will then be enrolled in the appropriate Medicare Advantage or Medicare Coordinated plan from your insurer. A same-sex spouse or domestic partner who is age 65 or older and eligible for Medicare but not enrolled in Part A and Part B cannot be enrolled in HSS coverage. If enrolled in HSS medical coverage without Medicare, spouse or partner benefits can be terminated. The federal government charges a premium for Medicare Part B, and in some cases for group employer Part D. All Medicare premium payments must be paid to maintain Medicare enrollment. Also, a same-sex spouse or domestic partner who fails to enroll in Medicare Part B as soon as he or she is eligible may be charged penalties by the federal government.

## Holdover and COBRA Coverage

If you are placed on an eligible holdover roster, you may be eligible to continue your enrollment in HSS health coverage.

If you are not on a holdover list, you may be eligible for COBRA.

### Employees with Holdover Rights

Employees who are placed on a permanent holdover roster may be eligible to continue HSS-administered medical, dental and vision coverage for themselves and their covered dependents. HSS holdover eligibility requirements include:

1. Employees must certify, on an annual basis, that they are unable to obtain healthcare coverage from another source.
2. Premium contributions must be paid.  
(Rates are subject to increase.)

Note: COBRA continuation benefits may be available when holdover benefits have been exhausted.

### Employees with No Holdover Rights

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), employees with no holdover rights, or whose holdover rights have ended, may be eligible to continue medical, dental and vision coverage for themselves and eligible dependents. Active employee healthcare coverage ends on the last day of the coverage period in which employment terminates.

### COBRA Continuation Coverage

COBRA, a federal law enacted in 1986, allows employees and their covered dependents to elect a temporary extension of healthcare coverage in certain instances where coverage would otherwise end. COBRA is administered by Fringe Benefits Management Company, a division of Wageworks.

### COBRA Qualifying Events

Under COBRA, employees may elect to continue healthcare coverage if it is lost due to any of the following qualifying events:

- Voluntary or involuntary termination of employment (except for gross misconduct).
- Hours of employment reduced, making the employee ineligible for employer health coverage.

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

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

Covered dependent children may elect COBRA coverage if healthcare coverage is lost due to any of the following qualifying events:

- Loss of dependent child status under the plan rules.
- Voluntary or involuntary termination of the employee's employment (except for gross misconduct).
- Hours of employment reduced, making the employee ineligible for employer health coverage.
- Parent's divorce, legal separation or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

Dependents dropped from coverage during Open Enrollment are not eligible for COBRA.

### COBRA Notification and Election Time Limits

When a qualifying event occurs, the COBRA Administrator will notify you of the opportunity to elect COBRA coverage. You have 60 days from the notification date to complete enrollment for

yourself and any dependents who were covered on your employer-provided plan at the time of your termination. Coverage will be retroactive to the date of the COBRA qualifying event, so there is no break in your coverage. While covered under COBRA, you have 30 days to add a newly eligible dependent to your COBRA coverage based on the date of the qualifying event. If a dependent loses coverage (due to divorce or aging out of a plan) the employee or dependent must notify the COBRA Administrator within 30 days of the qualifying event.

### Duration of COBRA Continuation Coverage

Group COBRA coverage is generally available for a maximum of 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a coverage extension for up to 36 months. Employees and dependents who are eligible for less than 36 months of federal COBRA may be eligible for Cal-COBRA. Continuation coverage under both federal and California state COBRA will not exceed 36 months.

Employees who are disabled on the date of their qualifying event, or at any time during the first 60 days of COBRA coverage, are eligible for 29 months of coverage. Beginning the 19th month of coverage, the cost will rise to 150 percent of the group rate.

### Termination of COBRA Continuation Coverage

COBRA coverage will end if:

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

### Paying for COBRA

Once COBRA continuation coverage is elected, it is the responsibility of the covered individuals to remit the required healthcare premium payments directly

to the COBRA Administrator. For COBRA rate information contact HSS at (415) 554-1750 or visit [www.myhss.org](http://www.myhss.org).

### Flexible Spending Accounts and COBRA

To continue FSA benefits under COBRA, year-to-date FSA contributions must exceed year-to-date claims as of your employment termination date. To keep your FSA open, you apply under COBRA and continue making the bi-weekly contribution plus a 2% administrative charge. COBRA FSA contributions are made post-tax.

### COBRA Continuation Coverage Alternatives

As an alternative to COBRA continuation coverage, you may be able to purchase individual health coverage from your healthcare plan or other insurers. Contact plans directly for details and costs. All employees and dependents who were covered under an HSS-administered health plan are entitled to a certificate that will show evidence of prior health coverage. This certificate of prior coverage may assist the employee and/or dependents in purchasing new health coverage that excludes pre-existing medical conditions.

### Federal Legislation and COBRA

This information may not reflect changes to COBRA resulting from federal legislation. For the most up-to-date information about how federal legislation may impact COBRA benefits, please contact Fringe Benefits Management Company, a Division of WageWorks, at (800) 342-8017.

#### COBRA Questions?

For questions about COBRA continuation coverage contact the COBRA Administrator, Fringe Benefits Management Company, a Division of WageWorks, at (800) 342-8017.

# Glossary of Healthcare Terms

## **Brand-Name Drug**

FDA-approved prescription drugs marketed under a specific brand name by the manufacturer.

## **COBRA**

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

## **Co-Insurance**

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

## **Co-Payment**

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

## **Deductible**

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

## **Dependent**

A family member who meets the eligibility criteria established by HSS for health plan enrollment.

## **Dental Maintenance Organization (DMO)**

Entity that provides dental services through a closed network. DMO participants only obtain service from network dentists and need pre-approval from a primary care dentist before seeing a specialist.

## **Effective Date**

The calendar date your healthcare coverage will begin. You are not covered until the effective date.

## **Employee Premium Contribution**

The amount you must pay toward the health plan premiums.

## **Employer Premium Contribution**

The amount your employer pays toward health plan premiums.

## **Employer-Subsidized Benefits**

Benefits that are paid for, all or in part, with money contributed by the employer.

## **Enrollee**

Individual enrolled in a health plan.

## **Explanation of Benefits (EOB)**

Written, formal statement sent to PPO enrollees listing the services provided, amounts paid and costs billed by the health plan.

## **Evidence of Coverage (EOC)**

The Evidence of Coverage is a legal document that gives details about plan benefits, exclusions and how to get the care you need. It explains your rights, benefits and responsibilities as a member of your plan and the plan providers' responsibilities to you. EOCs are available on [www.myhss.org](http://www.myhss.org).

## **Exclusions**

The list of conditions, injuries, or treatments that are not covered under your health insurance policy. Exclusions are listed in the Evidence of Coverage.

## **Flexible Spending Account (FSA)**

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

## **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. 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**

IRS regulations require that the value of non-cash compensation, such as the employer’s contribution toward health premiums for an employee’s domestic partner or same-sex spouse, be reported as taxable income on federal tax returns.

**In-Network**

Providers or facilities that contract with a health plan to provide services at pre-negotiated fees. Enrollees usually pay less when using an in-network provider.

**Medical Group**

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

**Lifetime Maximum Benefit**

The maximum amount a health plan will pay in benefits to an insured individual during that individual’s lifetime.

**Member**

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

**Non-Formulary Drug**

A drug that is not on the insurer’s list of approved medications. Non-formulary drugs can only be prescribed with a physician’s special authorization.

**Open Enrollment**

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

**Out-of-Area**

A location outside the geographic area covered by a health plan’s network of providers.

**Out-of-Network**

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

**Out-of-Pocket Costs**

The actual costs you pay—including premiums, co-payments and deductibles—for your healthcare.

**Out-of-Pocket Maximum**

The amount of money that an individual must pay out of his or her own pocket, before an insurance company will pay 100% for that individual’s healthcare expenses.

**Preferred Provider Organization (PPO)**

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

**Premium**

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

**Primary Care Physician (PCP)**

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

**Qualifying Event**

A life event 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.

# Privacy Policy

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

## Use and Disclosure of Health Information

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

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

## To Make or Obtain Payment

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

## To Conduct Healthcare Operations

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

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

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

## For Treatment Alternatives

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

## For Distribution of Health-Related Benefits and Services

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

## For Disclosure to the Plan Actuaries

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

## When Legally Required

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

## To Conduct Health Oversight Activities

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

## In Connection with Judicial and Administrative Proceedings

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

## For Law Enforcement Purposes

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

## In the Event of a Serious Threat to Health or Safety

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

### **For Specified Government Functions**

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

### **For Worker's Compensation**

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

### **Authorization to Use or Disclose Health Information**

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

### **Your Rights with Respect to Your Health Information**

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

#### **Right to Request Restrictions**

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

#### **Right to Receive Confidential Communications**

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

#### **Right to Inspect and Copy Your Health Information**

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

#### **Right to Amend Your Health Information**

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

### **Right to an Accounting**

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

### **Right to a Paper Copy of this Notice**

You have a right to request in writing and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. You also may obtain a copy of the current version of this notice from the Health Service System website at [www.myhss.org](http://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 and 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, 2012



## Medical Plan Costs

In the next year, the Health Service System will spend over \$700 million on health benefits for over 109,000 members and dependents. Here are things you can do to help contain healthcare costs.

### Stay Healthy

- **Quit smoking.** On average, smokers die 12 years sooner than non-smokers. In 2007, the national cost to treat tobacco-related illness was over \$50 billion.
- **Manage stress.** Take advantage of stress reduction classes offered by your health plan and HSS.
- **Exercise.** Incorporate 30 minutes of moderate exercise, such as walking, into your daily routine.
- **Eat more fruits, vegetables and whole grains.** Eat less sugar and saturated fat (red meat, dairy). Eliminate trans fats and fried foods.
- **Avoid heavy drinking.** National expenditures for alcohol-related illness amount to \$22.5 billion. Heavy drinkers have higher healthcare costs. All HSS health plans cover alcohol abuse treatment.
- **Get an annual check-up and preventative screenings.** Most are covered at no co-pay cost.
- **Keep track of your health concerns.** Write them down; do not forget to discuss with your doctor.
- **Follow doctor's orders.** Listen to your doctor; work together to speed recovery or manage a condition.
- **Complete a Health Risk Assessment (HRA).** Identify medical needs, share results with your doctor and be proactive about your care. All HSS plans offer free, confidential HRAs.
- **Complete an Advance Directive.** You do not need a lawyer. Document your medical care wishes for your loved ones, in case you can't speak for yourself.  
[www.ag.ca.gov/consumers/general/adv\\_hc\\_dir.htm](http://www.ag.ca.gov/consumers/general/adv_hc_dir.htm)

### Work with Your Doctor and Your Health Plan

- **Compare health plans.** Service areas, provider networks and out-of-pocket costs vary, for the same benefits. Choose the plan that's best for you.
- **24/7 nurse hotlines.** Make use of your plan's free, 24/7 hotline to consult with a nurse about care options. For hotline phone numbers see page 13.
- **Wellness education.** Your plan and/or medical group may offer free or low-cost fitness seminars or classes on wellness-related topics.
- **Generic drugs, by mail order.** Take advantage of your plan's reduced costs for generic and mail order prescriptions.
- **Email your doctor.** Make use of any online tools provided by your doctor's office for communicating concerns or appointment scheduling.
- **Pay attention to appointment reminders.** Don't skip appointments. If you must cancel, notify your doctor's office in advance.
- **Outpatient surgery.** When possible, your doctor may schedule you to have surgery on an outpatient (non-hospitalized) basis.
- **Chronic condition management programs.** These services can help you and your family become better educated and coordinate care for diabetes, asthma, heart health, cancer, obesity and other conditions.
- **Vision Service Plan (VSP) coverage for urgent eye conditions.** See a VSP network eye doctor for urgent or acute eye ailments—just a \$5 co-pay.

For more information about HSS finances and membership demographics, visit [www.myhss.org/finance](http://www.myhss.org/finance).

## Municipal Executives January–December 2013

MEDICAL PLAN BI-WEEKLY PREMIUM CONTRIBUTION RATES			JANUARY–DECEMBER 2013	
<b>City Health Plan PPO</b>	<b>City &amp; County of San Francisco</b>		<b>Superior Court</b>	
	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS
Employee Only	246.83	334.23	0	581.06
Employee + 1 Dependent	246.83	894.85	0	1,141.68
Employee + 2 or More Dependents	246.83	1,363.83	0	1,610.66
<b>Blue Shield of California HMO</b>	<b>City &amp; County of San Francisco</b>		<b>Superior Court</b>	
	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS
Employee Only	253.02	45.67	6.20	292.49
Employee + 1 Dependent	259.22	337.23	12.40	584.05
Employee + 2 or More Dependents	264.36	579.23	17.54	826.05
<b>Kaiser Permanente HMO</b>	<b>City &amp; County of San Francisco</b>		<b>Superior Court</b>	
	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS
Employee Only	246.83	1.03	0	\$247.86
Employee + 1 Dependent	246.83	247.94	0	\$494.77
Employee + 2 or More Dependents	246.83	452.89	0	\$699.72

DENTAL PLAN BI-WEEKLY PREMIUM CONTRIBUTION RATES			JANUARY–DECEMBER 2013	
<b>Delta Dental</b>	<b>City &amp; County of San Francisco</b>		<b>Superior Court</b>	
	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS
Employee Only	26.98	2.31	29.29	0
Employee + 1 Dependent	56.90	4.62	61.52	0
Employee + 2 or More Dependents	80.97	6.92	87.89	0
<b>DeltaCare USA</b>	<b>City &amp; County of San Francisco</b>		<b>Superior Court</b>	
	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS
Employee Only	12.00	0	12.00	0
Employee + 1 Dependent	19.80	0	19.80	0
Employee + 2 or More Dependents	29.28	0	29.28	0
<b>Pacific Union Dental</b>	<b>City &amp; County of San Francisco</b>		<b>Superior Court</b>	
	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS
Employee Only	12.83	0	12.83	0
Employee + 1 Dependent	21.18	0	21.18	0
Employee + 2 or More Dependents	31.32	0	31.32	0

The information printed on this page for Superior Court is subject to change due to upcoming collective bargaining.

All rates, including flex credit amounts, published in this Guide are subject to final approval of employers and the San Francisco Board of Supervisors. To learn of any changes to rates, please visit [www.myhss.org](http://www.myhss.org).

See pages 22-23 for information about flex credits, which can be allocated toward employee premium contributions.

# Key Contact Information

## HEALTH SERVICE SYSTEM

### Member Services

1145 Market Street, Suite 200  
San Francisco, CA 94103  
(Civic Center Station between 7th and 8th)

Tel: (415) 554-1750  
(800) 541-2266 (outside 415)

Fax: (415) 554-1721

[www.myhss.org](http://www.myhss.org)

### EAP (Employee Assistance Program)

Tel: (800) 795-2351

## MEDICAL PLANS

### City Health Plan (UnitedHealthcare)

Tel: (866) 282-0125  
Group Number 705287

[www.myuhc.com](http://www.myuhc.com)

### Blue Shield of California

Tel: (800) 642-6155  
Group Number H12187

[www.blueshieldca.com/sfhss](http://www.blueshieldca.com/sfhss)

### Kaiser Permanente

Tel: (800) 464-4000  
Group No. 888 (Northern California)  
Group No. 231003 (Southern California)

[my.kp.org/ca/cityandcountyofsanfrancisco](http://my.kp.org/ca/cityandcountyofsanfrancisco)

## DENTAL PLANS

### Delta Dental

Tel: (888) 335-8227  
Group Number 9502-0003

[www.deltadentalins.com/ccsf](http://www.deltadentalins.com/ccsf)

### DeltaCare USA Dental

Tel: (800) 422-4234  
Group Number 01797-0001

[www.deltadentalins.com/ccsf](http://www.deltadentalins.com/ccsf)

### Pacific Union Dental

Tel: (800) 999-3367  
Group Number 705287-0046

[www.myuhcdental.com](http://www.myuhcdental.com)

## VISION PLAN

### Vision Service Plan (VSP)

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

[www.vsp.com](http://www.vsp.com)

## FLEXIBLE SPENDING ACCOUNTS

### WageWorks

Tel: (877) 924-3967 Customer Service

[www.wageworks.com](http://www.wageworks.com)

## COBRA

### Fringe Benefits Management Company a Division of WageWorks

Tel: (800) 342-8017

[www.myfbmc.com](http://www.myfbmc.com)

## CITY AGENCIES

### Department of Human Resources

Tel: (415) 557-4800

[www.sfgov.org/dhr](http://www.sfgov.org/dhr)

### Department of the Environment (Commuter Benefits)

Tel: (415) 355-3729

[www.sfenvironment.org](http://www.sfenvironment.org)

### San Francisco Employees' Retirement System (SFERS)

Tel: (415) 487-7000

[www.sfers.org](http://www.sfers.org)

## STATE AGENCIES

### CalPERS

Tel: (888) 225-7377

[www.calpers.ca.gov](http://www.calpers.ca.gov)