Municipal Executives
2014 Health Benefits

Health Service System
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

Contents

Health Benefits

Member Rules and Guidelines

2014 Premium Contribution Rates

What's New 2014

There are no changes to HSS health plans or covered services in plan year 2014.

2014 Health Benefits

Medical, Dental and Vision. Good news! There are no changes to health plans or covered health services in 2014.

- Same medical, dental and vision plans
- Same covered medical, dental and vision services
- No increase in co-pays, deductibles or out-of-pocket maximums.

Flex Credits. 2014 flex credits not used to pay for benefits will be paid as taxable – but not pensionable – earnings. In 2014 you are not required to submit Miscellaneous Reimbursement receipts and are protected from forfeiting flex credit funds. (You must still submit Miscellaneous Reimbursement to EBS for 2013 flex credits; deadline March 31, 2014.)

Same-Sex Married Couples. As of June 26, 2013 all married couples enrolled in HSS plans have pre-tax coverage for eligible family members. (Domestic partner benefits are still taxed as imputed income.) See page 31.

City Plan Optum Rx. In September 2013, City Health Plan prescription benefits switched to Optum Rx. If you are a City Health Plan enrollee be sure to use your new ID card.

New 2014 Wellness Benefits

New HSS Wellness Center. The HSS Wellness Center will open in the first quarter of 2014 on the ground floor of 1145 Market Street. The center will provide classes and workshops to assist employees in maintaining good health. Watch for updates on myhss.org.

Wellness Coaching. In 2014 HSS will be offering free confidential wellness coaching by certified EAP staff, to provide employees with personal support in setting and reaching wellness goals. For more information call 1-800-795-2351.

Stress Management Workshops. Employees can learn simple tools, grounded in science, to enhance performance, strengthen resiliency and reduce stress. This 1 1/2 hour worksite workshop is presented by HSS and UCSF. Call (415) 554-0613 for information.

Smoking Cessation. HSS provides free 8-week group courses at the worksite to help City employees kick the habit. To schedule a smoking cessation course at your worksite call EAP at 1-800-795-2351.

2013 Open Enrollment

Open Enrollment takes place October 1-31, 2013. Any benefit election changes are effective January 1, 2014. During Open Enrollment you can:

- Change medical and/or dental plan elections.
- Add or drop dependents from medical and/or dental coverage.
- Enroll or re-enroll in a Flexible Spending Account (FSA).

Premiums Change in 2014. Medical and dental premium contributions will change, effective January 1, 2014. See page 39 for 2014 premium contribution rates.

Applications Due October 31. Completed Open Enrollment applications must be received at HSS by 5:30 PM, October 31, 2013. Deliver Open Enrollment applications in person, by mail or by fax. The HSS fax is (415) 554-1721.

Medical, Dental and Vision Elections Roll Forward. If you do not make changes during Open Enrollment, your current plan choices (except FSAs) and eligible dependents you have covered will remain the same in 2014.

MEA Flex Credit Allocations Will Also Roll Forward. If you do not reallocate flex credits during Open Enrollment, current flex benefit choices (except FSAs) roll forward in 2014. To change flex benefits or enroll in a 2014 FSA contact EBS in October 2013 at 1-800-229-7683.

Healthcare Reform 2014

Healthcare Reform 2014

Healthcare reform will provide more Americans with access to health insurance. Provisions which take effect in 2014 include:

Guaranteed Issue. Health plans cannot deny coverage or charge an individual higher premiums due to pre-existing condition or disability.

Individual Mandate. Almost all American citizens over the age of 18 must have health insurance or pay a federal penalty.

Health Insurance Marketplaces. By October 1, 2013 each state will open an insurance marketplace (or exchange), where uninsured or under-insured individuals can purchase health insurance, with coverage to begin January 2014.

Individual Subsidies. Individuals who purchase insurance through a state marketplace may qualify for a federal tax credit to help pay for premiums if household income is between 100% and 400% of the federal poverty level.

Individual Penalties. Federal penalties for individuals without health insurance will be phased in. In 2014, the penalty per person will be 1% of annual income, or $95, whichever is greater. By 2016, the penalty will be 2.5% of income or $695, whichever is greater.

Medicaid Expansion. Healthcare reform provides for an expansion of Medicaid for many people across the country who are at or below federal poverty levels and aren't currently eligible. In California see medi-cal.ca.gov.

The Patient Protection and Affordable Care Act is a federal law passed in 2010 to provide insurance for more Americans.

Healthcare Reform Provisions Already in Effect

The following key healthcare reform provisions are currently in effect.

- No cost to patient for many preventive services
- Coverage for children up to age 26
- No lifetime maximums
- Increased Medicare payroll taxes for higher income individuals

Covered California

Covered California is the state insurance marketplace created under federal healthcare reform.

Waiving Employer Premium Contributions. Employees and family members living in California may purchase insurance through Covered California. But review your options carefully. An individual eligible for HSS medical coverage who purchases insurance through Covered California:

- must be disenrolled from HSS medical coverage
- gives up the substantial premium contribution the City pays for your HSS medical coverage
- is not eligible for federal subsidy

Also, HSS will not be able to assist members or dependents enrolled in a Covered California plan or be a member advocate in resolving any plan grievances.

Ineligible For HSS Coverage. Individuals who are not eligible for HSS coverage, such as a child over age 26, a grandchild, or an ex-spouse or domestic partner, should consider obtaining health insurance through Covered California.

Individuals and families with low incomes who do not have access to employer-sponsored coverage may qualify for a federal premium tax credit and/or cost sharing reductions when purchasing insurance through Covered California.

Enrolling in Covered California. Covered California begins enrollment in October 2013, with coverage effective January 2014.

Contact Covered California. For information about Covered California health plans, call 1-888-975-1142 or visit coveredca.com.

COVERED CALIFORNIA

Medical Plan Options

These medical plan options are available to active employee members and eligible dependents.

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) or an affiliated urgent care center. You do not pay a deductible before accessing benefits, and co-pays at the point of service are set at a 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. (Out-of-network providers will cost you more.) You are not assigned to a Primary Care Physician, so you have more responsibility for coordinating your care. Compared to an HMO, enrolling in a PPO usually results in higher out-of-pocket costs. You must pay a plan year deductible. You also pay a coinsurance percentage each time you access service. Because 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 2014 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 2014. 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 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.

Medical Plan Service Areas

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	■	■
Tuolomne		
Yolo	■	❍
Outside of California	Urgent/ER Care Only	Urgent/ER Care Only

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

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. 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: 1-800-642-6155

Kaiser Permanente: 1-800-464-4000

Choosing Your Medical Plan

PPO vs. HMO

	Blue Shield HMO	Kaiser Permanente HMO	City Health Plan PPO
Must I select a PCP (Primary Care Physician)?	You can choose your PCP after you enroll, or Blue Shield will assign.	You can choose your PCP after you enroll, or Kaiser will assign.	No PCP– you have more responsibility for coordinating care.
Am I required to use the plan's contracted network of service providers?	Yes. Services must be received from the contracted network.	Yes. Services must be received from Kaiser.	No, but out-of-network providers will cost you more.
Is my access to hospitals and specialists determined by my PCP's medical group?	Yes. PCP referrals to specialists and hospitals will be determined by medical group affiliation.	Yes. All services must be received from a Kaiser facility.	No
Do I have to pay an annual deductible?	No	No	Yes
Do I have to file claim forms?	No	No	Only if you use an out-of-network provider.

Blue Shield of California: Choosing a Primary Care Physician (PCP) and Medical Group

If you enroll in Blue Shield, carefully review your choice of Primary Care Physician. Your PCP affects the network of providers and hospitals that will provide your care. You can change your PCP by calling Blue Shield at 1-800-642-6155.

Blue Shield Provider Networks in San Francisco

PCP Medical Group	Affiliated Hospitals
Hill Physicians hillphysicians.com	UCSF Medical Center
	St. Francis Memorial Hospital
	St. Mary's Medical Center
Brown & Toland brownandtoland.com	California Pacific Medical Center (CPMC)
Chinese Community Health Care Association cchca.com	Chinese Hospital

For more information about Blue Shield physicians and medical groups, including PCPs outside of San Francisco, visit: blueshieldca.com/fap/.

Tips to Improve Care and Reduce Costs

1 Mail Order Prescriptions

Mail order prescriptions can save you 30-50% on co-pays, plus there's no trip to the pharmacy. In most cases you can easily order prescription refills by phone or online. Register and get started.

Blue Shield

Call Blue Shield's online pharmacy partner PrimeMail: 1-866-346-7200

-or-

Log into blueshieldca.com, select the Pharmacy tab, then click Mail-Service Prescriptions

Kaiser

Call 1-888-218-6245

-or-

Log in to Kaiser online: kp.org/rxrefill

City Health Plan

Call Optum Rx at 1-866-282-0125

-or-

Log in online: optumrx.org

2 Nurseline 24/7

Not sure if you need to see a doctor? Need health advice after hours? There is no cost to call a nurseline.

Blue Shield

Blue Shield NurseHelp: 1-877-304-0504

-or-

Brown & Toland patients Ask-A-Nurse: 1-855-423-9974

Kaiser

San Francisco Nurse Advice: 415-833-2200

-or-

Other locations call: 1-800-464-4000

City Health Plan

UnitedHealthcare Nurseline: 1-800-846-4678

3 Urgent Care Centers

Need to see a doctor on weekends or during evening hours? If it's not a life-threatening emergency, consider visiting an urgent care center instead of your local hospital emergency room. That will mean a shorter wait time and lower co-pay for you.

Kaiser patients in San Francisco call 415-833-2200. For other locations call 1-800-464-4000.

Brown & Toland patients in San Francisco call 415-876-5762 or visit brownandtoland.com/afterhourscare.

Hill Physicians patients in San Francisco call 415-353-2602. For other locations visit hillphysicians.com.

4 Chronic Condition? Follow Your Doctor's Orders

Based on national data, only 50% of patients follow doctor's orders for managing chronic conditions. If you have a diagnosis of diabetes, heart disease, arthritis, HIV or another chronic condition, make sure you follow your doctor's advice about medication, diet and exercise. This could help you avoid serious complications and hospitalizations.

Medical Plan Benefits-at-a-Glance

	blue of california	KAISER PERMANENTE®	CITY HEALTH PLAN (UnitedHealthcare Choice Plus) In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
DEDUCTIBLES					
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
PREVENTIVE CARE					
Routine physical	No charge	No charge	100% covered no deductible	50% covered after deductible	100% covered no deductible
Immunizations and inoculations	No charge	No charge	100% covered no deductible	50% covered after 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
PHYSICIAN & OTHER PROVIDER CARE					
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
PRESCRIPTION DRUGS					
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
OUTPATIENT SERVICES					
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
EMERGENCY					
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
HOSPITAL/SURGERY					
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 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 (UnitedHealthcare Choice Plus)		
			In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
REHABILITATIVE					
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
PREGNANCY & MATERNITY					
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
INFERTILITY					
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
TRANSGENDER					
Office visits and outpatient surgery	Co-pays apply authorization req.	Co-pays apply authorization req.	85% covered after deductible; prior notification required	50% covered after deductible; prior notification required	85% covered after deductible; prior notification required
DURABLE MEDICAL EQUIPMENT					
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
MENTAL HEALTH					
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
CHEMICAL DEPENDENCY					
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
EXTENDED & END-OF-LIFE CARE					
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 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
Annual wellness exam height, weight, blood pressure; tobacco and alcohol use, depression	Yes	Yes	Yes	Yes
Annual well woman exam age appropriate preventive care	Yes		Yes	
AAA screening abdominal aortic aneurysm				Yes if man ever smoked; ages 65–75; one time
Colorectal cancer screening			Yes ages 50–75	Yes ages 50–75
Contraception birth control, sterilization, counseling	Yes		Yes until fertility ends	
Diabetes type 2 screening blood glucose	Yes	Yes	Yes	Yes
Domestic violence prevention screening and counseling	Yes		Yes	
Flu immunization seasonal flu	Yes annually, if at risk	Yes annually, if at risk	Yes	Yes
Hepatitis A and B immunization	Yes if at risk	Yes if at risk	Yes if at risk	Yes if at risk
Lipid screening 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
Mammogram breast cancer screening	Yes, over age 40 every 1–2 years		Yes every 1–2 years to age 75	
MMR immunization measles, mumps, rubella	Yes if no proof of immunity	Yes if no proof of immunity	Yes if at risk	Yes if at risk
Osteoporosis screening bone density			Yes over age 65; or high risk	
Pap smear cervical cancer screening	Yes every 2 years, after 3 normal screenings		Yes every 2 years, after 3 normal screenings	
Papillomavirus screening	Yes DNA test if high risk		Yes DNA test if high risk	
Pneumococcal immunization pneumonia			Yes age 65 and up; sooner if high risk	Yes age 65 and up; sooner if high risk
STD screenings and counseling sexually transmitted diseases	Yes if at risk	Yes if at risk	Yes if at risk	Yes if at risk
Tdap/Td immunization tetanus, diphtheria, whooping cough	Yes every 10 years	Yes every 10 years	Yes every 10 years	Yes every 10 years
Varicella immunization 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
Zoster immunization 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.

Behavioral Health Benefits

Behavioral Health Services

Blue Shield

LifeReferrals 24/7

Speak on the telephone to a counselor at any time at no cost. Three face-to-face visits with a licensed therapist in each six-month period are also included. Call 1-800-985-2405.

Non-Emergency Therapy Services

Call 1-877-263-9952 to schedule a visit with a mental health professional in the Blue Shield network for non-emergency therapy or to discuss concerns about substance abuse.

Residential Substance Abuse Treatment

To access residential treatment for substance abuse, you do not need a referral from your Blue Shield Primary Care Physician. Call 1-877-263-9952.

Kaiser

Behavioral Health Classes

Kaiser offers classes on depression, anxiety, insomnia, couples communication, anger management, parenting, and more. healthy.kaiserpermanente.org

Wellness Coaching

Speak with a wellness coach on the phone about issues like stress management and life balance. Call 1-866-251-4514, 6:00 AM to midnight, to schedule.

Therapy and Substance Abuse Treatment

San Francisco Kaiser members call (415) 833-2292 for information or to schedule service. You do not need a referral from your Kaiser PCP. If you live outside San Francisco, contact the mental health department of your regional Kaiser facility.

City Health Plan

Locate Network Therapists and Facilities

To find behavioral health therapists, visit myuhc.com and click on "Find Mental Health Clinician" under Links and Tools. Or call 1-866-282-0125.

Take advantage of behavioral health benefits before issues escalate to a crisis. But in the case of a life-threatening emergency, call 911 or go immediately to the nearest emergency room.

Health Service System EAP

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

Short-Term, Solutions-Oriented Counseling

Your first appointment with an EAP counselor usually takes place within 48 hours, and you can utilize up to six EAP sessions per year. Your EAP counselor can also assist you in taking advantage of behavioral health benefits covered by your medical plan. EAP appointments are available between the hours of 8:00 AM and 5:00 PM, Monday through Friday.

Mediation and Conflict Resolution

EAP provides mediation services to help resolve conflicts between co-workers, or between a manager and an employee. 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. For current calendar visit: myhss.org/events/seminars.html

Critical Incident Debriefing and Trauma Response

EAP critical incident debriefing and trauma response assists people as they process complex emotions, helps them return to a regular routine more quickly and reduces the likelihood of post-traumatic stress disorder. There is no cost for this service. Please contact EAP immediately if an individual or team in your department can benefit from this service.

Violence Prevention

EAP provides non-volent 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 workshop.

Contact EAP:

Phone: 1-800-795-2351

Dental Plan Options

Dental benefits are an important part of your healthcare coverage and are key to your overall health.

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

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.

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%.

Delta Dental Premier dentists charge higher out-of-pocket fees. Covered charges are based on pre-arranged charges with each contacted dentist. 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 16.) 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 1-888-335-8227.

HMO-Style Dental Plans

Similar to medical HMOs, Dental Maintenance Organization (DMO) 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. 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 DeltaCare USA or Pacific Union Dental, you must reside within a zip code serviced by the plan.

County	Delta Dental PPO	Delta Care 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	■	■	■
Tuolomne	■		
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: 1-888-335-8227

DeltaCare USA: 1-800-422-4234

Pacific Union Dental: 1-800-999-3367

Dental Plan Benefits-at-a-Glance

	Delta Dental			Deltacare USA	Pacific Union Dental
	PPO Providers	Premier Providers	Out-of-Network Providers		
Service					
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
Maximum					
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
Deductible					
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 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 dependents who are enrolled in an HSS medical plan are also enrolled in vision benefits.

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 vsp.com or contacting VSP Member Services at 1-800-877-7195.

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 vsp.com.

Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every 24 months, per last date of service. If examination reveals Rx change of .50 diopter or more after 12 months, replacement lenses 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 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
Types of Service		
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
Savings and Discounts		
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 myhss.org.

Flex Credits

2014 Dollar Value Of Flex Credits Bi-Weekly			
	Employee Only	Employee +1	Employee +2
MEA and Unrepresented Managers	$335.10	$356.69	$356.69
MEA Fire and Police	$356.69	$356.69	$356.69
MEA Superior Court	$823.00	$823.00	$823.00

How Flex Benefits Work

The City & County of San Francisco provides qualifying employees with flex credits, which can be spent on a variety of pre- and post-tax benefit options, paid via payroll deduction. If the premium contributions for your benefit choices cost more than your flex credits, you pay the balance from salary. If your benefits choices cost less than flex credits, you will receive cash back as taxable, non-pensionable earnings in your paycheck.

$50,000 Group Life Insurance

A $50,000 Group Term Life Insurance policy is also provided at no cost to employees who are eligible for flex credit benefits. You must enroll to take advantage of this benefit, and you are responsible for keeping your designated beneficiaries up-to-date. For details see myhss.org/benefits/ccsf_other_benefits.html.

New Hires

Flex credit benefit enrollment is handled by EBS, after the employee has been enrolled by HSS in medical, dental and vision benefits. Flex credit benefit choices with EBS must be made within 30 days of a new hire's start work date. If a new hire does not meet with EBS by required deadlines, payroll deductions will automatically be taken for any medical, dental and vision employee premium contributions. Flex credit dollars that remain after paying these premiums will be paid as taxable, non-pensionable earnings.

Open Enrollment

During Open Enrollment, municipal executives may change flex credit benefit elections, based on available pre- and post-tax options. Flex credit benefit changes are administered by EBS, and must be completed by Open Enrollment deadlines. During Open Enrollment contact EBS at 1-800-229-7683.

Flex Credit Benefit Options (Except FSAs) Will Roll Forward in 2014

If you are not making any changes to your benefit selections, and you do not wish to fund an FSA (Flexible Spending Account), you do not need to meet with EBS during 2013 Open Enrollment. Your current benefit elections (except FSAs) will roll forward in 2014. To continue making FSA contributions, or to change your benefit choices, you must contact EBS during Open Enrollment. Without re-enrollment, all FSA contributions will cease December 31, 2013.

No Miscellaneous Reimbursement in 2014

Beginning in 2014, flex credits not used to pay for benefits will be paid to you as taxable, non-pensionable earnings. You do not need to submit reimbursement claims to EBS, and there is no risk of forfeiting flex credit dollars. (Note: You must still submit claims to EBS no later than March 31, 2014 to receive Miscellaneous Reimbursement for 2013 flex credits.)

Qualifying Event Changes

Members may reallocate flex credits outside of Open Enrollment if there is a qualifying event. Contact HSS at (415) 554-1750 for more information.

Leaves of Absence

If you are going on an unpaid leave of absence, you may be responsible for making premium payments for selected benefits while no payroll deductions are taken. Contact HSS at (415) 554-1750 for more information.

Flex Benefit Options

Maximize Your Benefits

Flex benefits allow you to make choices that fit your needs and budget. For the greatest tax savings, you can elect pre-tax benefits that add up to more than your flex credits, and pay the balance pre-tax from salary. To maximize earnings, choose benefits that cost less than your flex credits, and the balance will be paid as taxable, non-pensionable earnings in each paycheck.

Pre-Tax Flex Credit Benefit Options

The benefits listed below are paid pre-tax for an enrolled employee, spouse, children and stepchildren. These benefits are paid post-tax for an enrolled domestic partner and the children of a domestic partner.

	Tax Status	EOI Required
Medical and Dental Premium Contributions	Pre-Tax	No
Healthcare Flexible Spending Account WageWorks	Pre-Tax	No
Dependent Care Flexible Spending Account WageWorks	Pre-Tax	No
Cancer Insurance Allstate Workforce Division	Pre-Tax	Yes
Heart and Stroke Insurance Allstate Workforce Division	Pre-Tax	Yes
Accident Insurance Allstate Workforce Division	Pre-Tax	Yes
Long-term Disability Insurance Aetna	Pre-Tax	Yes

Taxable Flex Credit Benefit Options

The benefits listed below are paid post-tax for all enrollees.

	Tax Status	EOI Required
Universal Life Insurance ING	Post-Tax	Yes
Short-term Disability Insurance ING	Post-Tax	Yes
Long-term Care Insurance John Hancock, MetLife, Mass Mutual	Post-Tax	Yes
Pet Insurance PetCare	Post-Tax	No
Group Legal Plan Pre-Paid Legal	Post-Tax	No
Supplemental Group Term Life Insurance Aetna	Post-Tax	Yes

Evidence of Insurability (EOI)

Some benefits require additional information from the applicant before enrollment is completed. This can include medical evidence. The insurer will contact you if specific records are required. It is your responsibility to provide all requested documentation. Enrollment may be denied by the insurer. In 2014, no payroll deductions will be taken until enrollment is approved by each insurer. If approved, there may be a catch-up payroll deduction retroactive to the date of your initial application, depending on the type of insurance. If denied coverage, no premiums for that benefit will be deducted from your paycheck.

Flexible Spending Accounts

An FSA is a tax-favored account that helps pay for eligible medical and dependent care expenses.

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. Flexible Spending Account benefits are administered by WageWorks: wageworks.com.

An FSA account can pay qualifying expenses incurred by you, your legal spouse, or qualifying child or relative (as defined in Internal Revenue Code Section 152). A domestic partner's medical expenses cannot be reimbursed under an FSA unless the domestic partner is a "qualifying relative". To determine who is a qualifying child or relative vist: wageworks.com/forms/hcdependents.pdf.

Before enrolling in your FSA you should calculate a detailed estimate of the eligible expenses you are likely to incur in 2014. Budget conservatively. Unreimbursed funds are forfeited at the end of the 2014 plan year and cannot be returned to you. FSA expenses must meet Internal Revenue Service (IRS) eligibility criteria: irs.gov/pub/irs-pdf/p502.pdf and irs.gov/pub/irs-pdf/p503.pdf.

Consult a tax advisor or the IRS for information about your individual situation and FSAs.

Healthcare FSA

A Healthcare FSA can pay for qualifying medical expenses pre-tax, such as medical, pharmacy, dental and vision co-pays and deductibles, for the enrolled employee and eligible dependents. For a complete list of eligible healthcare expenses, visit wageworks.com.

- Set aside between $260 and $2,500 pre-tax per employee for the 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 2014.
- Submit reimbursement documentation by mail, via the Internet or by smartphone app to WageWorks for eligible out-of-pocket expenses.
- When you elect a Healthcare FSA the total annual amount you designate becomes available for eligible healthcare expenses as of January 1, 2014. You do not have to wait for your contributions to accumulate in your account.

Dependent Care FSA

A Dependent Care FSA can pay for qualifying dependent care expenses pre-tax, such as certified day care, pre-school and elder care for your qualifying dependents. (Children in day care must be under age 13.) For a complete list of eligible dependent care expenses, visit wageworks.com.

- 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 2014.
- If you have a stay-at-home spouse, you may not enroll in the Dependent Care FSA.
- Submit reimbursement documentation to WageWorks by mail, via the Internet or by smartphone app for eligible out-of-pocket expenses.
- 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, 2014.

FSA Rules

- You must re-enroll in Flexible Spending Account(s) every Open Enrollment.
- Expenses for services incurred before January 2014 or after December 2014 are not eligible.
- 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: myhss.org/benefits/fsa.html
- If your employment ends, in some cases you have the option of continuing your FSA with COBRA. (See page 35.) Without COBRA, you can only file claims for eligible FSA expenses that were incurred while you were actively employed.

For FSA account information visit wageworks.com or call 1-877-924-3967, Monday-Friday, 8:00AM–8:00PM Eastern Time.

Avoid Forfeiting FSA Contributions

FSA expenses for the 2014 plan year must be incurred between January 1, 2014 and December 31, 2014. Reimbursement claims must be received by the plan administrator no later than March 31, 2015. Per IRS rules, you forfeit money remaining in an FSA at the end of the claim filing period–no exceptions.

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 2014.

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–December 2014. If you increase deductions, total contributions from January to December 2014 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 2014, a suspended Healthcare or Dependent Care FSA initiated during 2014 cannot be reinstated–no exceptions.

Wellness Benefits

Health Plan Wellness Tools

Blue Shield of California

NurseHelp 24/7:
1-877-304-0504

Wellness discounts and savings:
blueshieldca.com/hw

Quit For Life smoking cessation:
1-866-784-8454
quitnow.net

Symptom checker and wellness information:
blueshieldca.com/bsca/health-wellness/tools

Kaiser Permanente

Nurse Advice San Francisco:
(415) 833-2200
For other Kaiser locations go to kp.org
and click Locate Our Services.

Hundreds of classes, Health Risk Assessment, audio podcasts and more:
kp.org/healthyliving

ChooseHealthy discounts and savings:
kp.org/healthyroads

Free one-on-one telephone wellness coaching to help you set and reach personalized health goals:1-866-251-4514

UnitedHealthcare

Nurseline:
1-800-846-4678

Health4Me Phone App to find a doctor, check claims and estimate costs:

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

Fitness Club Discounts

HSS offers gym discounts at many Bay area clubs, including 24 Hour Fitness, Crunch, Planet Fitness, LiveFit and Sonora Sports. You must show proof of retirement from the City, SFUSD or SFCCD to participate in these special offers. See myhss.org for the most updated list of fitness club discounts.

Weight Watchers at Work

If you would like information about starting a Weight Watchers are Work group at your work location, call (415) 554-0613. Weight Watchers at Work has helped City employees lose over 3,600 pounds. A discounted monthly pass is available at https://wellness.weightwatchers.com. Enter company number 54552 and company passcode WW54552. Note: if you sign up online, you will be charged automatically each month until you cancel.

HSS Wellness Events

Learn about classes and workshops by signing up for the HSS monthly email newsletter:
myhss.org/community/eupdates.html.

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 2014 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 21, 2013–January 3, 2014	January 14, 2014	January 1, 2014–January 17, 2014
January 4, 2014–January 17, 2014	January 28, 2014	January 18, 2014–January 31, 2014
January 18, 2014–January 31, 2014	February 11, 2014	February 1, 2014–February 14, 2014
February 1, 2014–February 14, 2014	February 25, 2014	February 15, 2014–February 28, 2014
February 15, 2014–February 28, 2014	March 11, 2014	March 1, 2014–March 14, 2014
March 1, 2014–March 14, 2014	March 25, 2014	March 15, 2014–March 28, 2014
March 15, 2014–March 28, 2014	April 8, 2014	March 29, 2014–April 11, 2014
March 29, 2014–April 11, 2014	April 22, 2014	April 12, 2014–April 25, 2014
April 12, 2014–April 25, 2014	May 6, 2014	April 26, 2014–May 9, 2014
April 26, 2014–May 9, 2014	May 20, 2014	May 10, 2014–May 23, 2014
May 10, 2014–May 23, 2014	June 3, 2014	May 24, 2014–June 6, 2014
May 24, 2014–June 6, 2014	June 17, 2014	June 7, 2014–June 20, 2014
June 7, 2014–June 20, 2014	July 1, 2014	June 21, 2014–July 4, 2014
June 21, 2014–July 4, 2014	July 15, 2014	July 5, 2014–July 18, 2014
July 5, 2014–July 18, 2014	July 29, 2014	July 19, 2014–August 1, 2014
July 19, 2014–August 1, 2014	August 12, 2014	August 2, 2014–August 15, 2014
August 2, 2014–August 15, 2014	August 26, 2014	August 16, 2014–August 29, 2014
August 16, 2014–August 29, 2014	September 9, 2014	August 30, 2014–September 12, 2014
August 30, 2014–September 12, 2014	September 23, 2014	September 13, 2014–September 26, 2014
September 13, 2014–September 26, 2014	October 7, 2014	September 27, 2014–October 10, 2014
September 27, 2014–October 10, 2014	October 21, 2014	October 11, 2014–October 24, 2014
October 11, 2014–October 24, 2014	November 4, 2014	October 25, 2014–November 7, 2014
October 25, 2014–November 7, 2014	November 18, 2014	November 8, 2014–November 21, 2014
November 8, 2014–November 21, 2014	December 2, 2014	November 22, 2014–December 5, 2014
November 22, 2014–December 5, 2014	December 16, 2014	December 6, 2014–December 19, 2014
December 6, 2014–December 19, 2014	December 30, 2014	December 20, 2014–December 31,2014

If you take an approved unpaid leave of absence, 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 32 for more information about medical, dental and vision coverage during a leave of absence. See page 23 for details about Flexible Spending Accounts and leaves of absence.

Eligibility

These rules govern which employees and dependents may be eligible for HSS health coverage.

Member Eligibility

The following are eligible to participate in the Health Service System as members:

- All permanent employees of the City & County of San Francisco whose normal work week is not less than 20 hours;
- All regularly scheduled provisional employees of the City & County of San Francisco whose normal work week is not less than 20 hours;
- All other employees of the City & 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 & 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.
- All other employees who are deemed 'full-time employees' under the shared responsibility provision of the federal Patient Protection and Affordability Care Act (section 4980H).

Dependent Eligibility

Spouse or Domestic Partner

A member's legal spouse or domestic partner may be eligible for HSS healthcare coverage. Proof of legal marriage or domestic partnership is required, as well as the dependent's Social Security number. Proof of Medicare enrollment must also be provided for a 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. A legal spouse or domestic partner 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 of age 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 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 2014 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
Marriage Legal Domestic Partnership	Add new spouse or partner to medical and/or dental coverage	• HSS enrollment application • Legal marriage certificate or certification of partnership • Proof of Medicare enrollment for Medicare-eligible domestic partner of either gender	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	• HSS enrollment application • Legal marriage certificate or certification of partnership • Child's birth certificate	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	• HSS enrollment application • Legal marriage certificate or certification of partnership • Proof of member enrollment in other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.
Divorce Legal Separation Dissolution of Partnership Annulment	Drop former spouse, partner and associated stepchilden from coverage	• HSS enrollment application • Divorce decree or legal documents proving separation, dissolution of partnership or annulment	These individuals are no longer eligible for HSS coverage; failure to drop may result in penalties. Coverage terminates the last day of the coverage period in which the legal divorce, dissolution or separation was granted.
Birth of a Child Adoption of a Child Child Placed for Adoption	Add child to medical and/or dental coverage	• HSS enrollment application • If newborn, birth verification letter from hospital; birth certificate when issued • If adopted, adoption certificate or proof of adoption	Coverage is effective the day of the child's birth, or, for an adoption, the date of legal custody. Documentation must be submitted within 30-day deadline.
Legal Guardianship of a Child	Add child to medical and/or dental coverage	• HSS enrollment application • Court decree	Coverage effective the date guardianship takes effect, if documentation submitted within 30-day deadline.
Court-Ordered Coverage for a Child	Add child to medical and/or dental coverage	• HSS enrollment application • Court order to add child	Coverage effective the date of court order, if documentation submitted within 30-day deadline.
	Drop child from medical and/or dental coverage	• HSS enrollment application • Court order for other coverage • Proof child has other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 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
Member Loses Other Coverage	Enroll member (and dependents who also lost coverage) in medical and/or dental coverage	• HSS enrollment application • Proof of loss of coverage • All required dependent eligibility documentation. (See page 27.)	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.
Spouse or Partner Loses Other Coverage	Enroll spouse or partner in medical and/or dental coverage	• HSS enrollment application • Proof of loss of coverage • Legal marriage certificate or certification of partnership	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.
Dependent Child or Stepchild Loses Other Coverage	Enroll child or stepchild in medical and/or dental coverage	• HSS enrollment application • Proof of loss of coverage • Child's birth certificate • Legal marriage certificate or certification of partnership (if stepchild)	Coverage is effective the first day of the coverage period following submission of required documentation within 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
Member Gains Other Coverage	Waive member's medical and/or dental coverage	• HSS enrollment application • Proof of other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.
Spouse or Partner Gains Other Coverage	Drop spouse or partner from medical and/or dental coverage	• HSS enrollment application • Proof of other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.
Dependent Child or Stepchild Gains Other Coverage	Drop child or stepchild from medical and/or dental coverage	• HSS enrollment application • Proof of other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.

continued on page 30

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** of 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 legally 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 26–27.)

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 2014 plan year. (See page 22 for FSA information.) For a list of qualifying events and corresponding authorized FSA contribution changes, call HSS at (415) 554-1750 OR visit: myhss.org/benefits/fsa.html.

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 Health Benefits Taxation

Health coverage for a domestic partner and a partner's children is typically a taxable benefit.

Tax Treatment of Health Benefits

The federal government does not recognize domestic partnership for tax purposes. Employer contributions to health premiums for an employee's domestic partner and children of a domestic partner are taxable (imputed) income. Also, employee premium contributions are taken post-tax. By comparison, if an employee is legally married, 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.

Note: Effective June 26, 2013 health premium contributions for all married spouses (including same-sex) and their families is no longer taxable imputed income. (Proof of legal marriage is required.) This is due to the Supreme Court ruling which declared the federal Defense of Marriage Act unconstitutional.

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), and children of a domestic partner qualify for favorable tax treatment if:

1. Partner or child receives more than half of his or her financial support from the employee; and
2. Partner 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 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 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. To receive favorable tax treatment, you must file the declaration annually with HSS by required deadlines.

Equitable California State Tax Treatment

If a domestic partner and associated dependents do not meet the IRS code section 152 requirements for favorable tax treatment under federal law, you may be able to take advantage of equitable California state tax treatment. This California law only applies to same-sex domestic partners–not opposite-sex domestic partners. To obtain equitable tax treatment under California state law, you are required to have a Declaration of Domestic Partnership issued by the Secretary of the State of California. You will need to deduct the value of the employer-paid health insurance premiums for your same-sex domestic partner, 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 and their children at the time this guide was printed. Laws are subject to change. Please consult with a professional tax advisor before taking any action. It is your responsibility to comply with state and federal tax law.

Leaves of Absence and Health Coverage

Type of Leave	Eligibility	Your Responsibilities
Family and Medical Leave (FMLA) Worker's Compensation Leave Family Care Leave Military Leave	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. You may have additional rights under an approved FMLA leave. Contact your departmental personnel representative for details.	1. Notify your department's personnel officer. They will provide HSS with important information about your leave. 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. 3. Contact HSS immediately (within 30 days of return to work) to request that premium contributions return to active status.
Personal Leave Following Family Care Leave	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: - The reason for the Personal Leave is the same as the reason for the prior Family Care Leave. - Your required employee premium contribution payments, if any, are current. - You notify HSS before your leave begins.	1. Notify your department's personnel officer. They will provide HSS with important information about your leave. 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. 3. Contact HSS immediately (within 30 days of return to work) to request that premium contributions return to active status.
Educational Leave Personal Leave Leave for Employment as an Employee Organization Officer or Representative	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.	1. Notify your department's personnel officer. They will provide HSS with important information about your leave. 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. 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. 4. Contact HSS immediately (within 30 days of return to work) to request that premium contributions return to active status.

See page 23 for information about Flexible Spending Accounts and leaves of absence.

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 28–30.)

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 27. 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 40 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 25 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 2014, with coverage to begin January 1, 2015.

Approaching Retirement

Transition to Retirement

The transition of health benefits from active to retiree status does not happen automatically. If eligible, 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.

Active Employee Medicare Enrollment

If you are working and eligible for HSS health coverage at age 65 or older, you are not required to 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 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.

Married Spouse Medicare Enrollment

A legally married spouse covered on an employee's HSS plan is not required to enroll in Medicare. If you have a same-sex spouse, HSS recommends you get a written statement from Social Security confirming Medicare late enrollment penalties will not apply to your same-sex spouse as long as he or she is covered on your employer-sponsored plan. When you retire, a Medicare-eligible spouse must be enrolled in Medicare to be covered on a retiree's health plan.

Domestic Partner Medicare Enrollment

A domestic partner of an active employee who is eligible for Medicare must be enrolled in Medicare to qualify for HSS medical coverage. If enrolled in HSS medical coverage without Medicare, 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 continuous Medicare enrollment. Be aware that domestic partners who fail to enroll in Medicare Part B when first eligible may later be charged significant late enrollment penalties by the federal government.

Holdover and COBRA Coverage

Employees with Holdover Rights

Employees placed on a permanent holdover roster may be eligible to continue HSS-administered health coverage for themselves and 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.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows employees and covered dependents to elect temporary extension of health coverage in instances where coverage would end.

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

Time Limits for COBRA Elections

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

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

Duration of COBRA Continuation Coverage

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. COBRA enrollees who are disabled on the date of their qualifying event, or at any time during thefirst 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. Retirees 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.

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 is elected, you must pay premiums directly to the COBRA administrator. For COBRA rate information, visit myhss.org or contact HSS.

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.

This is only a summary. For more details information about COBRA benefits, contact WageWorks, at 1-877-502-6272.

Glossary of Healthcare Terms

Accountable Care Organization (ACO)
A payment and healthcare delivery model that aligns provider reimbursements with meeting quality and cost targets.

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-Pay
The 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 begins. You are not covered until the effective date.

Employee Premium Contribution
The amount you must pay toward 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 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 a brand-name drug, contain a 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, 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 facilities that are not in your health plan's provider network. Some plans do not cover out-of-network services. Others charge a higher co-insurance.

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

Out-of-Pocket Maximum
The highest total amount you will spend in a year on out-of-pocket medical costs. Once you reach out-of-pocket maximum, your plan pays 100% of covered service costs.

Preferred Provider Organization (PPO)
Provides in-network services to subscribers at negotiated rates, but allows subscribers to seek service from out-of-network providers, at a higher cost.

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.

Privacy
HSS complies with federal and state laws that protect personal health information. For details visit: myhss.org/health_service_board/privacy_policy.html

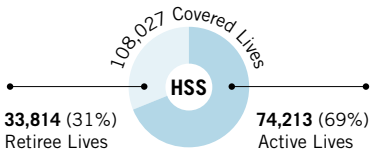
Qualifying Event
A life event that allows you to make a change in your benefit elections outside Open Enrollment. This includes marriage, domestic partnership, separation, divorce or dissolution of partnership, the birth or adoption of a child, and the death of a dependent, as well as obtaining or losing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

Reasonable and Customary
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.

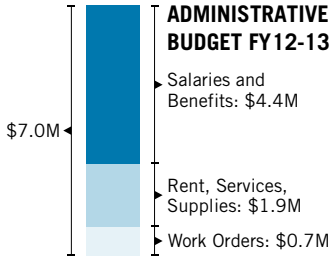
Health Service System Overview

Governed by the Health Service Board, the Health Service System designs health and wellness benefits for employees, retirees and their families, and works to improve care while controlling premium costs.

COVERED LIVES

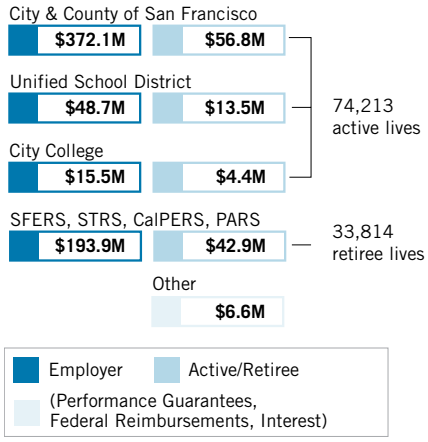


ADMINISTRATIVE BUDGET FY12-13



FUNDING and GOVERNANCE

$754M TRUST FUND CONTRIBUTIONS FY12-13



HEALTH SERVICE SYSTEM FY12-13

Health Service Board

7 Commissioners:
- 3 Elected Members
- 3 Appointees
- 1 City Supervisor

28 Plans From 10 Vendors

Medical: 6 HMO; 4 PPO
Dental: 2 DMO; 2 DPO
Vision: 1
FSA: 2
Group Life: 6
Long-Term Disability: 2
Flex Credits: 2
COBRA: 1

Health Service Staff

Operations
22 staff members
10,000 annual enrollment transactions
53,000 annual member interactions

Finance
7 staff members
12,500 annual financial transactions
2,740 annual rate calculations

Administration
3 staff members
15 annual public meetings

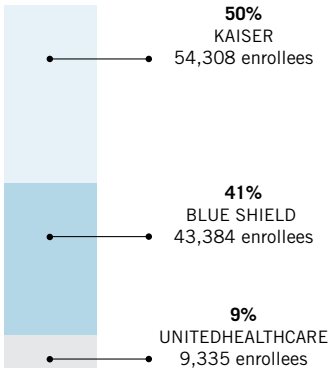
IT/PeopleSoft
4 staff members
500 annual data queries

Wellness/EAP
3 staff members
7,490 employees in depts w/wellness councils
3,314 EAP visits

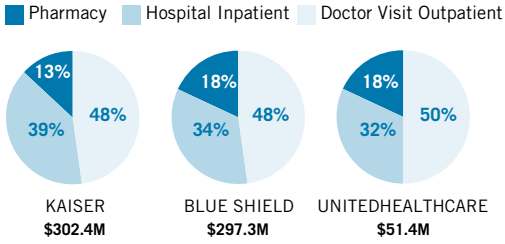
Communications
1 staff member
65,000 open enrollment packets mailed
56,000 website visits

HEALTH PLANS

MEDICAL PLAN ENROLLMENT FY12-13



HEALTH PREMIUM COSTS BY VENDOR FY 12-13



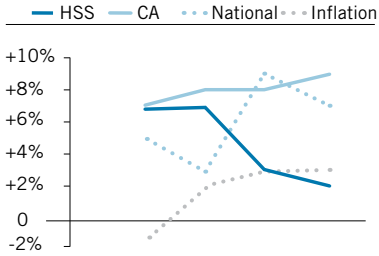
Dental and Vision

Delta Dental: $54.8M
DeltaCare USA: $1.0M
Pacific Union: $0.4M
VSP: $4.4M

Other

WageWorks (FSA/COBRA): $5.8M
UNUM (LTD): $7.1M
ING (Group Life): $0.4M
EBS (Flex Credits): $4.7M

YEAR-OVER-YEAR HEALTH PREMIUM BENCHMARKING



	09–10	10–11	11–12	12–13
HSS Premiums	+7%	+7%	+3%	+2%
CA Premiums	+7.5%	+8%	+8%	+9%
Ntl Premiums	+5%	+3%	+9%	+7.5%
Ntl Inflation	-2%	+2%	+3%	+3%

Dollar amounts are unaudited totals, available as of August 1, 2013 for FY 2012-2013.
As of January 1, 2013, LTD and Group Life insurance plans are administered by Aetna.

Premium Contribution Rates

Medical Plan Bi-Weekly Premium Contribution Rates			January–December 2014	
Kaiser Permanente HMO	**City & County of San Francisco**		**Superior Court**	
	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS
Employee Only	258.99	1.83	0.69	260.13
Employee + 1 Dependent	258.70	262.00	0.40	520.30
Employee + 2 or More Dependents	265.53	470.87	7.22	729.18
Blue Shield of California HMO	**City & County of San Francisco**		**Superior Court**	
	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS
Employee Only	260.41	38.38	2.11	296.68
Employee + 1 Dependent	261.76	334.88	3.46	593.18
Employee + 2 or More Dependents	271.69	572.17	13.39	830.47
City Health Plan PPO	**City & County of San Francisco**		**Superior Court**	
	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS
Employee Only	259.22	307.34	0.92	565.64
Employee + 1 Dependent	259.19	854.25	0.89	1,112.55
Employee + 2 or More Dependents	258.97	1,315.03	0.66	1,573.34

Dental Plan Bi-Weekly Premium Contribution Rates			January–December 2014	
Delta Dental	**City & County of San Francisco**		**Superior Court**	
	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS
Employee Only	28.13	2.31	30.44	0
Employee + 1 Dependent	59.30	4.62	63.92	0
Employee + 2 or More Dependents	84.39	6.92	91.31	0
DeltaCare USA	**City & County of San Francisco**		**Superior Court**	
	EMPLOYER PAYS	EMPLOYEE PAYS	EMPLOYER PAYS	EMPLOYEE PAYS
Employee Only	12.44	0	12.44	0
Employee + 1 Dependent	20.52	0	20.52	0
Employee + 2 or More Dependents	30.35	0	30.35	0
Pacific Union Dental	**City & County of San Francisco**		**Superior Court**	
	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

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 myhss.org.

See pages 20-21 for information about flex credits, which can be allocated toward employee premium contributions.

Key Contact Information

HEALTH SERVICE SYSTEM

Member Services
1145 Market Street, 3rd Floor
San Francisco, CA 94103
(Civic Center Station between 7th and 8th)
Tel: (415) 554-1750
1-800-541-2266 (outside 415)
Fax: (415) 554-1721
myhss.org

EAP (Employee Assistance Program)
Tel: 1-800-795-2351

MEDICAL PLANS

City Health Plan (UnitedHealthcare)
Tel: 1-866-282-0125
Group 752103
myuhc.com

Blue Shield of California
Tel: 1-800-642-6155
Group H12187
blueshieldca.com/sfhss

Kaiser Permanente
Tel: 1-800-464-4000
Group 888 (Northern California)
Group 231003 (Southern California)
my.kp.org/ca/cityandcountyofsanfrancisco

DENTAL PLANS

Delta Dental
Tel: 1-888-335-8227
Group 9502-0003
deltadentalins.com/ccsf

DeltaCare USA Dental
Tel: 1-800-422-4234
Group 01797-0001
deltadentalins.com/ccsf

Pacific Union Dental (UnitedHealthcare)
Tel: 1-800-999-3367
Group 705287-0046
myuhcdental.com

FLEX CREDIT BENEFITS

Employee Benefits Specialists (EBS)
Tel: 1-800-229-7683
ebsbenefits.com

VISION PLAN

Vision Service Plan (VSP)
Tel: 1-800-877-7195
Group 12145878
vsp.com

FLEXIBLE SPENDING ACCOUNTS (FSAs) and COBRA

WageWorks
FSAs: 1-877-924-3967
COBRA: 1-877-502-6272
wageworks.com

LONG TERM DISABILITY (LTD) and GROUP LIFE INSURANCE

Aetna
LTD: 1-866-326-1380
Life Insurance: 1-800-541-2266
Group 839201
aetna.com/group/aetna_life_essentials

OTHER AGENCIES

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

Department of the Environment (Commuter Benefits)
Tel: (415) 355-3729
sfenvironment.org

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

CalPERS
Tel: 1-888-225-7377
calpers.ca.gov

Covered California
Tel: 1-888-975-1142
coveredca.com