SFCCD Employees
2014 Health Benefits

Health Service System
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

Contents

What's New 2014

There are no changes to HSS medical plans or covered services in 2014.

2014 Health Benefits

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

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

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 health benefits are still taxed as imputed income.) See page 25.

No Maximums on Transgender Medical Services. Per California's Gender Nondiscrimination Act (IGNA) beginning in 2014 there is no lifetime maximum dollar limit for transgender outpatient visits and outpatient surgery. Check your plan contract (EOC) for details.

City Health Plan Optum Rx. In September 2013, City Health Plan prescription benefits switched to Optum Rx, If you are enrolled in City Health Plan, be sure to use the new medical ID card sent to City Plan enrollees in fall 2013 by UnitedHealthcare.

HSS Is Moving!

In December 2013 HSS will be re-locating to the third floor offices of 1145 Market Street. (HSS is currently on the second floor at the same address.) Members can still easily visit HSS by taking public transportation to Civic Center.

This move will allow HSS to better serve our members.

- New consulting rooms where members will meet with HSS Benefit Analysts.
- Improved and more easily accessible restroom facilities for HSS members.
- Expanded floor space for additional staff, including data analytics and vendor management personnel, who will help HSS effectively manage health premium costs.

New HSS Wellness Center. An HSS Wellness Center will also be opening 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.

2013 Open Enrollment

Open Enrollment takes place October 1-31, 2013. Any benefit election changes will be effective January 1, 2014. During Open Enrollment SFCCD members can:

- Change medical plan elections.
- Add or drop dependents from medical coverage.

Premiums Change in 2014. Medical premium contributions will change, effective January 1, 2014. See page 31 for 2014 premium contributions.

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

Medical and Vision Benefit Elections Roll Forward. If you do not make changes during 2013 Open Enrollment, your current HSS plan choices and the eligible dependents you have covered will remain the same in 2014.

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. SFCCD employees and family members who live in California may purchase insurance through Covered California. But review your options carefully. Any individual eligible for HSS medical coverage who purchases insurance through Covered California:

- must be disenrolled from HSS medical coverage
- gives up the employer contribution that helps pay HSS medical plan premiums
- may not be 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 Benefits Administered By HSS

The Health Service System offers these medical plan options to eligible SFCCD employees and family members.

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)

How To Enroll In Medical Benefits

Eligible full-time employees must enroll in an HSS medical plan within 30 calendar days of their start work date. (Part-time or temporary employees see page 20.) Submit a completed enrollment application and eligibility documentation to HSS. If you do not enroll by required deadlines, you can only apply during Open Enrollment or due to a qualifying event. (See page 22). Coverage will start the first day of the coverage period after eligibility has been approved by HSS. Verify the date coverage will start with HSS when you enroll. Once enrolled, you must pay all required employee premium contributions. Review your paycheck to make sure correct deductions are being taken.

HSS does not guarantee the continued participation of any particular doctor, hospital or medical group in a medical plan. You cannot change your benefit elections because a doctor, hospital or medical group chooses not to participate. You will be assigned or required to select another provider.

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 at 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 Nurselines

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 Benefit Highlights

HSS medical plans include coverage for behavioral health services and programs.

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

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.

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.

Behavioral Health Classes

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

City Health Plan

Locate Network Therapists and Facilities

To find behavioral health professionals and treatment centers in the City Health Plan network, visit myuhc.com and click on "Find Mental Health Clinician" under Links and Tools. City Health Plan enrollees can also call 1-866-282-0125.

Emergency?

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.

Wellness Benefits

Health Plan Wellness Tools

Blue Shield of California

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

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

City Health Plan (UnitedHealthcare)

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

Health Plan Nurse Hotlines

Blue Shield NurseHelp 24/7

English or Spanish: 1-877-304-0504

Kaiser San Francisco Nurse Advice

English: (415) 833-2200
Chinese: (415) 833-2239
Spanish: (415) 833-2203
For other Kaiser locations go to kp.org and click Locate Our Services.

UnitedHealthcare Nurseline

English or Spanish: 1-800-846-4678

Weight Watchers at Work

If you would like information about starting a Weight Watchers are Work group at your 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.

Fitness Club Discounts

24 Hour Fitness	Group exercise classes, cardio machines, free weights, resistance training and more.	One Club Sport $26.99/month All Club Sport $29.99/month All Club Super $44.99/month No sign-up fee; no contract.	24hourfitness.com/corporate discount code 100961 1-800-224-0240
Bally Total Fitness	Exercise equipment; group classes–spinning, yoga, Pilates and more.	Access to one club $9.99 first month and last month $29.00 one time fee Month-to-month; no contract	ballyfitness.com (650) 583-4247 South San Francisco, Hayward, and nationwide
Crunch	Aerobic classes, dance classes, yoga, Pilates, spin cycling, free weights, machine weights.	One-time enrollment fee $59.00 per person; unlimited California club access $54.99 per month. Month-to-month, no contract.	crunch.com (415) 292-8470 San Francisco, Daly City, San Mateo, Redwood City
Civic Center Fitness	Exercise equipment; group classes–yoga, Zumba, Pilates and more.	$24 monthly; $49 processing fee.	civiccenterfitness.com (415) 255-0900 37 Grove Street San Francisco
planet fitness	Cardio, strength and weight training equipment; free unlimited fitness training with membership.	$15/month San Francisco only; $29 sign-up fee and $30 annual lock-in rate. $19.99/month multi-club; no sign-up fee; $39.99 annual lock-in rate. No contract.	planetfitness.com (415) 433-3033 San Francisco, Daly City, Hayward, Fremont and nationwide
LiveFit Wellness Club	Cardio, strength and weight training; classes; massage, chiropractic and acupuncture treatments.	Basic gym $47/month; gym and classes $67/month; gym, classes and monthly massage $85/month. No contract.	livefitgym.com (415) 525-4364 Hayes Valley and Mission district, San Francisco
Studiomix	30,000 foot facility; 20+ classes daily; barre, boxing, boot camp, climbing, cross training, pilates, cycling, yoga, Zumba and more.	Unlimited club and class access. No sign-up fee; $95/month. Month-to-month; no contract.	studiomix.com (415) 926-6790 1000 Van Ness Avenue San Francisco
Sonora Sports & Fitness Center	Group classes, free and machine weights, heated pools, racquetball courts, onsite child care.	Waive $150 initiation fee.	sonorafitness.com (209) 532-1202 13760 Mono Way Sonora, CA

You must show proof of SFCCD employment or retirement to participate in these special offers. Offers are subject to change. See complete list of current discounts: myhss.org/downloads/wellness/GymDiscounts.pdf

Vision Benefits Administered by HSS

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.

Medical and Vision Plan Eligibility

Eligibility for health coverage is determined by the Governing Board of the Community College District.

AVAILABLE BENEFITS BY EMPLOYEE TYPE

	FT FACULTY	LTS FACULTY	PT FACULTY	PERMANENT CLASSIFIEDS	TEMP STO CLASSIFIEDS	TEMPORARY CLASSIFIEDS
Medical	■	■	❖	■	❖	❖
Flexible Spending Account	■	■	■	■	■	■
Employer Paid Dental	■	■	❖	■	❖	❖
Rx Co-pay Reimbursement	■	■		■	❖	❖
Life Insurance	■	■		■	❖	❖
Transit One (Parking and Commute)	■	■	■	■	■	■

❖ = Certain Restrictions Apply

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.

Eligibility

Take note of this important information for part-time and full-time faculty, classified temporary employees and administrators approaching retirement.

Part-Time Faculty and Classified Temporary School Term Only Employees

Eligible part-time faculty who are currently enrolled in a medical plan and meet the FTE eligibility for the spring semester will retain coverage through the summer months.*

Eligible classifieds and temporary school term only employees who are currently enrolled in a medical plan and meet the 20-hour or more per week assignment will retain coverage through the summer months.*

Part-time faculty and classified temporary school term only employees who lose eligibility for healthcare coverage during any semester may continue medical and dental coverage through COBRA.

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

*In order to continue medical coverage through the summer months, additional premiums will be taken from employee's paychecks in April and May.

Full-Time Faculty and Administrators Approaching Retirement

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

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

Eligibility and Summer Healthcare Coverage Questions?

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

COBRA

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted in 1986 allows employees and their covered dependents to elect temporary extension of healthcare coverage in certain instances where coverage would end. These include:

- 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 healthcare coverage. While covered under COBRA, you have 30 days to add newly eligible dependents (spouse, domestic partner, newborn or adopted child) to COBRA coverage, based 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 the first 60 days of COBRA coverage, are eligible for 29 months of coverage. Beginning the 19th month of coverage, the cost will rise to 150 percent of the group rate. 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 continuation coverage is elected, it is the responsibility of the covered individuals to remit the required healthcare premium payments directly lto 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.

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

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

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 (SSN) is required for all newly enrolled individuals.

Family Status	Enrollment Change	Documentation	Coverage
Marriage Legal Domestic Partnership	Add new spouse or partner to medical coverage	• HSS enrollment application • Marriage certificate or certificate 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 coverage	• HSS enrollment application • Legal marriage certificate or certificate 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 coverage	• HSS enrollment application • Legal marriage certificate or certificate 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 stepchildren 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 coverage	• HSS enrollment application • If newborn, birth verification letter from hospital; birth certificate and SSN when issued • If adopted, proof of legal adoption; SSN when issued	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 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 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 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 coverage	• HSS enrollment application • Proof of loss of coverage • All required dependent eligibility documentation. (See page 19.)	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 coverage	• HSS enrollment application • Proof of loss of coverage • Legal marriage certificate or certificate 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 coverage	• HSS enrollment application • Proof of loss of coverage • Child's birth certificate • Legal marriage certificate or certificate 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 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 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 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.

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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 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 18–19.)

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.

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.

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.

Other Benefits Administered by SFCCD

SFCCD employees may be eligible for dental coverage, Flexible Spending Accounts and other vountary benefits administered by SFCCD.

Dental Plan (Delta Dental)

As an eligible employee of the San Francisco Community College District (SFCCD), you may be offered district-paid dental coverage through Delta Dental. You must enroll in dental benefits through the SFCCD Benefits Office. See page 32 of this guide for SFCCD Benefits Office and Delta Dental contact information. Refer to the Delta Dental Evidence of Coverage (EOC) for a detailed list of covered expenses, exclusions and limitations under this plan.

Flexible Spending Accounts (FSAs) Transit One (Parking and Commute)

Flexible Spending Accounts and Transit One (Parking and Commute) benefits are offered through AFLAC (American Family Life Assurance Company). Participation in any of these programs allows a portion of your salary to be redirected on a pre-tax basis to provide reimbursement for certain types of expenses. This may allow you to save money by reducing your taxable income. Taxes will be calculated after the elected amount is deducted from your salary. New or existing employees must enroll annually.

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

Short-Term Disability Insurance, Tax Shelter Investments

Refer to the SFCCD Benefits website ccsf.edu/hr or the SFCCD Employees Summary of Benefits packet for a list of voluntary supplemental benefit programs available through SFCCD.

Questions About Other Benefits?

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

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 plan participants be assigned to a Primary Care Physician.

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

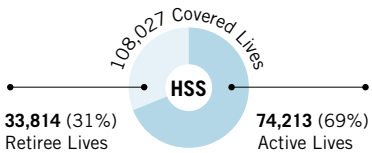
Qualifying Event
A life event that allows you to make a change in your benefit elections outside Open Enrollment. This includes marriage, domestic partnership, separation, divorce or dissolution of partnership, the birth or adoption of a child, and the death of a dependent, as well as obtaining or losing 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 reasonable and customery, the individual receiving the service is responsible for paying the difference.

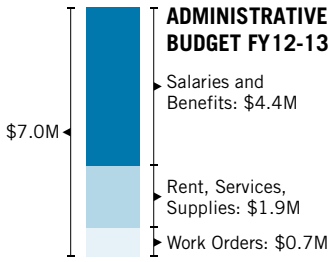
Health Service System Overview

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

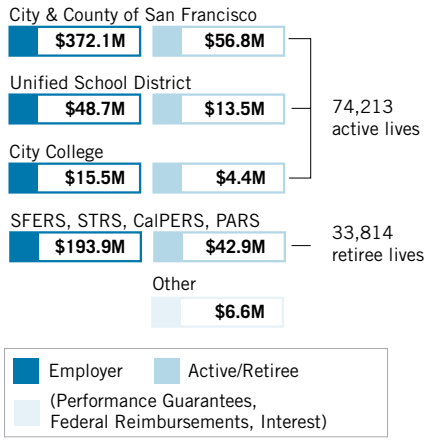


ADMINISTRATIVE BUDGET FY12-13



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

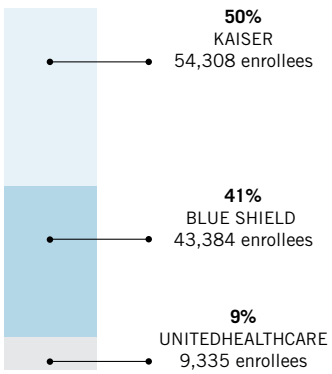
IT/PeopleSoft
4 staff members
500 annual data queries

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

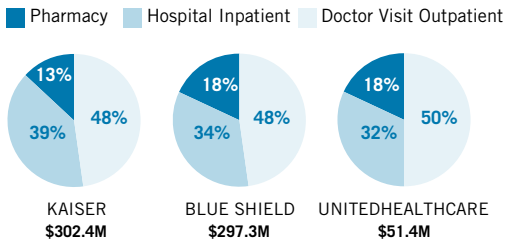
Communications
1 staff member
65,000 open enrollment packets mailed
56,000 website visits

HEALTH PLANS

MEDICAL PLAN ENROLLMENT FY12-13



HEALTH PREMIUM COSTS BY VENDOR FY 12-13



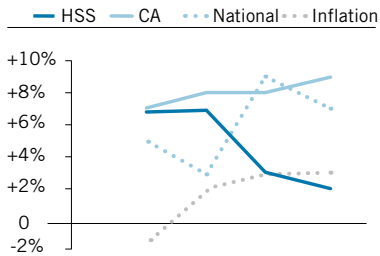
Dental and Vision

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.

This chart only includes benefits administered by the Health Service System. It does not include benefits administered by SFCCD.

2014 Medical Plan Rates

CERTIFICATED (BOARD MEMBERS) SEMI-MONTHLY

	BLUE SHIELD HMO		KAISER HMO		CITY HEALTH PLAN PPO	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Employee Only	296.29	27.40	282.08	0.48	273.75	340.03
Employee + 1 Dependent	502.62	143.75	468.22	95.88	458.39	747.84
Employee + 2 or More Dependents	584.21	329.97	532.45	265.32	525.19	1,179.98

CLASSIFIED SEMI-MONTHLY

	BLUE SHIELD HMO		KAISER HMO		CITY HEALTH PLAN PPO	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Employee Only	300.30	23.39	282.56	0	278.46	335.32
Employee + 1 Dependent	473.01	173.36	436.38	127.72	481.51	724.72
Employee + 2 or More Dependents	541.85	372.33	486.93	310.84	556.64	1,148.53

CERTIFICATED (ADMINISTRATORS) MONTHLY

	BLUE SHIELD HMO		KAISER HMO		CITY HEALTH PLAN PPO	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Employee Only	592.56	54.81	564.15	0.96	547.50	680.05
Employee + 1 Dependent	1,005.24	287.49	936.44	191.75	916.78	1,495.67
Employee + 2 or More Dependents	1,168.42	659.94	1,064.91	530.63	1,050.38	2,359.95

FACULTY MONTHLY

	BLUE SHIELD HMO		KAISER HMO		CITY HEALTH PLAN PPO	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Employee Only	592.56	54.81	565.11	0	547.50	680.05
Employee + 1 Dependent	1,024.26	268.47	966.98	161.21	935.80	1,476.65
Employee + 2 or More Dependents	1,203.22	625.14	1,116.01	479.53	1,085.18	2,325.15

Rates apply to eligible enrollees of the San Francisco Community College District. Rate updates will be posted on myhss.org.

Employer premium contributions include Health Service Trust subsidy dollars.

All rates published in this guide are subject to approval by the Health Service Board, the San Francisco Board of Supervisors and SFCCD.

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

MEDICAL PLANS

City Health Plan (UnitedHealthcare)
Tel: 1-866-282-0125
Group 705287
myuhc.com

Blue Shield of California
Tel: 1-800-642-6155
Group H11054
blueshieldca.com/sfhss

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

VISION PLAN

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

COBRA

WageWorks
Tel: 1-877-502-6272
wageworks.com

SFCCD

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

DENTAL PLAN

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

FLEXIBLE SPENDING ACCOUNTS

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

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