2015

COMMUNITY COLLEGE DISTRICT

Health Benefits Guide

HEALTH SERVICE SYSTEM
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

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What's New 2015

New 2015 Health Deduction Calendars

SFCCD employees will have health benefit deductions based on a new schedule in 2015. Instead of taking 24 payroll deductions, the payments will be according to a new calendar based on the applicable contract agreement. See pages 22–25 of this guide.

New 2015 Health Rates

SFCCD employees will also have rates that are specific to their contract agreement. Premium rates paid during January–June will include pre-pay requirements to cover the summer benefit period.

HSS New Location

HSS has expanded. Come to our offices on the third floor of 1145 Market Street for new hire enrollment, new retiree processing, benefit election changes, premium payments, or to meet with a benefits analyst. On the first floor of the same building, we have the new Wellness Center where you can take group exercise classes and attend seminars and special wellness-related events.

Premium contribution rates are changing for most bargaining units in 2015

Under the guidance of the Health Service Board, the Health Service System has made significant progress over the past three years maintaining the same level of quality benefits while negotiating fair insurance premiums. This has lowered cost trend projections, reducing the total cost of providing health insurance coverage for over 110,000 of our employees, retirees, and their families.

The Bay area has some of the highest quality medical care in the country. But from a business perspective, our region's doctors and hospitals are consolidated into one market with just a few major players. Fair market competition between Kaiser and Blue Shield's provider networks is essential to spur the continuous innovation that drives quality and efficiency in patient care.

Bending the trend on healthcare costs requires a multifaceted strategy. This strategy includes implementing employer/employee premium contributions that allow HSS to continue offering the range of plan choices valued by our members. Some of you will see a narrower gap between the 2015 premium contribution for Kaiser and Blue Shield.

There are no simple solutions when it comes to maintaining healthcare quality while managing costs. Cities, states, and private businesses across the country are all wrestling with the same dilemma. If we all continue to do our part, we can increase the probability that the health benefits we all value and rely upon will be in place for a long time to come.

HSS Open Enrollment takes place October 1–31, 2014. Any benefit election changes are effective January 1, 2015.

During Open Enrollment you can:

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

Medical and Vision

There are no changes to plans or covered health services in 2015, with the exception of the inclusion of pharmacy costs to the out-of-pocket maximum. There are no increases in co-pays or deductibles.

Applications Due October 31

Completed Open Enrollment applications must be received at HSS by 5:00PM October 31, 2014. Deliver Open Enrollment applications in person, by mail, or by fax. The HSS fax is 415-554-1721.

The Path to Sustainable Benefits

The Health Service System is one of the largest purchasers of employer-sponsored healthcare in the Bay area. Our goal is to maintain quality benefits over the long term for HSS members. To reach this goal, HSS, labor leaders, elected officials, and individual members are working together to implement a sustainable benefits strategy.

Strategy for Sustainable Benefits

Competitive Marketplace

Drive a fair, free market where Bay area healthcare vendors compete on price and quality.

Continue attracting top-tier medical professionals to work in Bay area hospitals, doctors' offices, and other facilities.

Accountable Healthcare Vendors

Partner with HSS to improve care delivery, patient outcomes, and the patient/caretaker experience.

Participate in healthcare price and quality data transparency, and report initiatives to contain costs and drive improvements in the care delivery system.

Healthy People

Learn, grow, and make personal choices that improve well-being and promote healthy aging.

Participate in a culture of health and well-being in the workplace, at home, and in local neighborhoods and communities.

By working together, we are improving the healthcare delivery system in San Francisco and the Bay area, maintaining quality care and controlling health insurance costs. We are on the right track, but the work will need to continue to ensure these positive changes can be preserved over the long term.

City Influence On Sustainable Health Benefits

Elected Officials

- Regulate a fair and competitive regional healthcare marketplace.
- Support legislation to improve healthcare price and quality data transparency.
- Ensure health facility expansions serve the public good.
- Support a culture of health and well-being for all City residents and visitors.

Community College Board and Labor

- Support premium contribution strategies that address cost drivers and encourage sustainable benefits.
- Collaborate on strategies to promote a healthy and productive workforce.
- Collaborate on measuring and improving workforce well-being.
- Support policies that encourage wellness in the workplace.

HSS and Health Service Board

- Oversee actuarial premium projections, identify cost drivers, and negotiate rates and benefits.
- Manage vendor contracts with performance guarantees for meeting quality, cost, and transparency goals.
- Develop data analytics to monitor quality of care, cost, and population health.
- Implement workplace wellness programs.

Medical Plan Options

These medical plan options are available to eligible SFCCD employees and family members.

Health Maintenance Organization (HMO)

A 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)

An enrolled individual with End Stage Renal Disease may be prohibited by federal Medicare rules from changing health plans.

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 2015. 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.

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 19.) Submit a completed enrollment application and eligibility documentation to HSS. If you do not enroll by the required deadlines, you can only apply during Open Enrollment or due to a qualifying event. (see page 28). 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.

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

Change of Address?

You must keep your address current with your human resources personnel and HSS. 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.

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 HMO: Choosing a Primary Care Physician (PCP) and Medical Group

If you enroll in Blue Shield, carefully review your choice of Primary Care Physician (PCP). 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 Permanente

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 Permanente

San Francisco Nurse Advice: 415-833-2200

Call 415-833-2239 for Chinese

Call 415-833-2203 for Spanish

-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.

Blue Shield patients should call your Primary Care Physician (PCP) or Blue Shield Member Services to help you find the closest affiliated urgent care center. The Blue Shield Member Services and PCP phone numbers can be found on your Blue Shield member ID card. Blue Shield patients in the Brown & Toland or Hill Physician Medical Groups may also use the following resources to find an Urgent Care Center after hours:

- **Brown & Toland** patients in San Francisco, visit brownandtoland.com/get-care/after-hours-care
- **Hill Physicians** patients, visit HillPhysicians.com/Urgent

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

United Healthcare patients, call 1-866-282-0125 or visit myuhc.com and select the CCSF Choice Plus Network.

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 (Combined Pharmacy and Medical)	No deductible Plan year out-of-pocket maximum $2,000/individual; $4,000/family	No deductible Plan year out-of-pocket maximum $1,500/individual; $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 per 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 required.	Co-pays apply authorization required.	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

Preventive vs. Diagnostic Care

If you seek preventive care more often than these guidelines, or if you use an out-of-network provider, you may be billed for diagnostic treatment instead of preventive care (no charge).

The primary reason for the office visit usually determines if the visit is preventive. When the visit is not considered preventive, the appropriate plan co-pay will apply. For more questions about your benefit coverage, call your health plan's customer service department.

	Women age 20–49	Men age 20–49	Women age 50 and up	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

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

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 Permanente

Behavioral Health Classes

Kaiser offers classes on depression, anxiety, insomnia, couples communication, anger management, parenting, and more. Visit 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, 5:00AM to 1:00AM, to schedule.

Therapy and Substance Abuse Treatment

San Francisco Kaiser members, call 415-833-2292 or 415-833-9400 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.

Emergency

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

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*
Standard progressive lenses	$55 co-pay	Up to $85 After $25 copay; every 24 months*
Premium progressive lenses	$95–$105 co-pay	
Custom progressive lenses	$150–$175 co-pay Every 24 months*	
Scratch-resistant coating	Fully covered every 24 months*	Not covered
Frames	$150 allowance, $170 allowance for featured brands after $25 co-pay; 20% off total over $150; every 24 months*	$70 allowance after $25 co-pay; every 24 months*
Contacts (instead of glasses)	$150 allowance every 24 months*	$105 allowance for contacts and contact lens exam every 24 months*
Contact lens exam	Up to $60 co-pay after $60 copay; fitting and evaluation exam covered; 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 (anti-reflective coating, photochromic, polycarbonate)	Average 20%–25% savings after co-pay; available on most enhancements	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.

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	■	■	❖	■	❖	❖
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 for coverage. 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 covered 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 or her 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.

Medicare Enrollment Requirements

Under Social Security law, Medicare is the primary coverage for an active employee's domestic partner who becomes Medicare-eligible at age 65. The domestic partner must have Medicare Part A and Part B in effect when first eligible at 65.

Medicare also provides primary coverage for a disabled dependent who has been entitled to Social Security Disability Insurance (SSDI) benefits for more than 24 months, or when Medicare eligibility is due to End Stage Renal Disease (ESRD). Medicare primary coverage begins approximately 30 months after the diagnosis of ESRD.

When you retire, you and your dependents must have Medicare Parts A and B in effect when first eligible for Medicare primary coverage. Failure to enroll when first eligible may result in a late-enrollment penalty from Medicare. HSS Rules require members to enroll when eligible for Medicare primary coverage. Proof of Medicare coverage is required by HSS.

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	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 required for a domestic partner at age 65 and any employee or dependent who is Medicare eligible due to disability or End Stage Renal Disease (ESRD). If you have questions about eligibility or required documentation, contact HSS Member Services at 415-554-1750.

Part-time Faculty and Classified Temporary Employee Eligibility

Take note of this important information for part-time faculty and classified temporary employees.

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 classified 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.

Full-time employees must enroll in a HSS medical plan within 30 calendar days of their start work date (see page 4).

*In order to continue medical coverage through the summer months, additional premiums will be taken from employee's paychecks from January–June.

Eligibility and Summer Healthcare Coverage Questions?

Contact the SFCCD Benefits Office at 415-241-2246, or visit 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 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.

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

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

COVERED CALIFORNIA

Covered California

Individuals who are not eligible for HSS coverage should consider obtaining health insurance through the state insurance exchange, Covered California.

Based on income, individuals and families who do not have access to employer-sponsored coverage may qualify for a federal premium tax credit and/or cost sharing reductions when purchasing health insurance through Covered California. For information about Covered California health plans, call 1-888-975-1142 or visit coveredca.com.

Compare the plans and premiums available through Covered California before making a decision about enrolling in COBRA.

Health Coverage Calendars

SFCCD Classified Bi-weekly Employees

Employee premium contributions are deducted from paychecks bi-weekly for a total of 26 payroll deductions for the January–December 2015 plan year.

Work Dates	Pay Date	Benefits Coverage Period
January 3, 2015–January 16, 2015	January 27, 2015	January 1–January 16, 2015
January 17, 2015–January 30, 2015	February 10, 2015	January 17–January 30, 2015
January 31, 2015–February 13, 2015	February 24, 2015	January 31–February 13, 2015
February 14, 2015–February 27, 2015	March 10, 2015	February 14–February 27, 2015
February 28, 2015–March 13, 2015	March 24, 2015	February 28–March 13, 2015
March 14, 2015–March 27, 2015	April 7, 2015	March 14–March 27, 2015
March 28, 2015–April 10, 2015	April 21, 2015	March 28–April 10, 2015
April 11, 2015–April 24, 2015	May 5, 2015	April 11–April 24, 2015
April 25, 2015–May 8, 2015	May 19, 2015	April 25–May 8, 2015
May 9, 2015–May 22, 2015	June 2, 2015	May 9–May 22, 2015
May 23, 2015–June 5, 2015	June 16, 2015	May 23–June 5, 2015
June 6, 2015–June 19, 2015	June 30, 2015	June 6–June 19, 2015
June 20, 2015–July 3, 2015*	July 14, 2015	June 20–July 3, 2015
July 4, 2015–July 17, 2015	July 28, 2015	July 4–July 17, 2015
July 18, 2015–July 31, 2015	August 11, 2015	July 18–July 31, 2015
August 1, 2015–August 14, 2015	August 25, 2015	August 1–August 14, 2015
August 15, 2015–August 28, 2015	September 8, 2015	August 15–August 28, 2015
August 29, 2015–September 11, 2015	September 22, 2015	August 29–September 11, 2015
September 12, 2015–September 25, 2015	October 6, 2015	September 12–September 25, 2015
September 26, 2015–October 9, 2015	October 20, 2015	September 26–October 9, 2015
October 10, 2015–October 23, 2015	November 3, 2015	October 10–October 23, 2015
October 24, 2015–November 6, 2015	November 17, 2015	October 24–November 6, 2015
November 7, 2015–November 20, 2015	December 1, 2015	November 7–November 20, 2015
November 21, 2015–December 4, 2015	December 15, 2015	November 21–December 4, 2015
December 5, 2015–December 18, 2015	December 29, 2015	December 5–December 18, 2015
December 19, 2015–January 1, 2016	January 12, 2016	December 19–December 31, 2015

*This 2 week coverage period may be split for payroll purposes.

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 pay date for the benefits coverage period above.

SFCCD Classified School Term Employees

Employee premium contributions are deducted from paychecks bi-weekly for a total of 21 payroll deductions for the January–December 2015 plan year. Employee premium deductions from January–June 2015 will include an additional premium amount to fund benefit coverage during the summer months. During the summer months with no paycheck, benefit coverage will continue as long as all summer premium amounts have been funded.

Work Dates	Pay Date	Benefits Coverage Period
January 3, 2015–January 16, 2015	January 27, 2015	January 1–January 16, 2015
January 17, 2015–January 30, 2015	February 10, 2015	January 17–January 30, 2015
January 31, 2015–February 13, 2015	February 24, 2015	January 31–February 13, 2015
February 14, 2015–February 27, 2015	March 10, 2015	February 14–February 27, 2015
February 28, 2015–March 13, 2015	March 24, 2015	February 28–March 13, 2015
March 14, 2015–March 27, 2015	April 7, 2015	March 14–March 27, 2015
March 28, 2015–April 10, 2015	April 21, 2015	March 28–April 10, 2015
April 11, 2015–April 24, 2015	May 5, 2015	April 11–April 24, 2015
April 25, 2015–May 8, 2015	May 19, 2015	April 25–May 8, 2015
May 9, 2015–May 22, 2015	June 2, 2015	May 9–May 22, 2015
May 23, 2015–June 5, 2015	June 16, 2015	May 23–June 5, 2015
OFF FROM REGULAR WORK (extra deductions taken January–June to pre-pay the Summer[1] Benefit Period)	June 30, 2015 July 14, 2015 July 28, 2015 August 11, 2015 August 25, 2015	SUMMER[1] COVERAGE BENEFIT PERIOD
August 15, 2015–August 28, 2015	September 8, 2015	August 15–August 28, 2015
August 29, 2015–September 11, 2015	September 22, 2015	August 29–September 11, 2015
September 12, 2015–September 25, 2015	October 6, 2015	September 12–September 25, 2015
September 26, 2015–October 9, 2015	October 20, 2015	September 26–October 9, 2015
October 10, 2015–October 23, 2015	November 3, 2015	October 10–October 23, 2015
October 24, 2015–November 6, 2015	November 17, 2015	October 24–November 6, 2015
November 7, 2015–November 20, 2015	December 1, 2015	November 7–November 20, 2015
November 21, 2015–December 4, 2015	December 15, 2015	November 21–December 4, 2015
December 5, 2015–December 18, 2015	December 29, 2015	December 5–December 18, 2015
December 19, 2015–January 1, 2016	January 12, 2016	December 19–December 31, 2015

[1] January–June deduction (11 pay periods) include a 1.454 rate to pre-pay premiums for summer coverage benefit period.

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 pay date for the benefits coverage period above.

SFCCD Faculty & Certificated Monthly Employees

Employee premium contributions are deducted from paychecks monthly for a total of 12 payroll deductions for the January–December 2015 plan year.

Work Dates	Pay Date	Benefits Coverage Period
January 1, 2015–January 31, 2015	January 30, 2015	January 1–January 31, 2015
February 1, 2015–February 28, 2015	February 27, 2015	February 1–28, 2015
March 1, 2015–March 31, 2015	March 31, 2015	March 1–31, 2015
April 1, 2015–April 30, 2015	April 30, 2015	April 1–30, 2015
May 1, 2015–May 31, 2015	May 29, 2015	May 1–31, 2015
June 1, 2015–June 30, 2015	June 30, 2015	June 1–30, 2015
July 1, 2015–July 31, 2015	July 31, 2015	July 1–31, 2015
August 1, 2015–August 31, 2015	August 31, 2015	August 1–31, 2015
September 1, 2015–September 30, 2015	September 30, 2015	September 1–30, 2015
October 1, 2015–October 31, 2015	October 30, 2015	October 1–31, 2015
November 1, 2015–November 30, 2015	November 30, 2015	November 1–30, 2015
December 1, 2015–December 31, 2015	December 31, 2015	December 1–December 31, 2015

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 pay date for the benefits coverage period above.

SFCCD Faculty & Certificated School Term Monthly Employees

Employee premium contributions are deducted from paychecks monthly for a total of nine payroll deductions for the January–December 2015 plan year. Employee premium deductions from January–May 2015 will include an additional premium amount to fund benefit coverage during the summer months. During the summer months with no paycheck, benefit coverage will continue as long as all summer premium amounts have been funded.

Work Dates	Pay Date	Benefits Coverage Period
January 1, 2015–January 31, 2015	January 30, 2015	January 1–January 31, 2015 + Summer[1]
February 1, 2015–February 28, 2015	February 27, 2015	February 1–28, 2015 + Summer[1]
March 1, 2015–March 31, 2015	March 31, 2015	March 1–31, 2015 + Summer[1]
April 1, 2015–April 30, 2015	April 30, 2015	April 1–30, 2015 + Summer[1]
May 1, 2015–May 31, 2015	May 29, 2015	May 1–31, 2015 + Summer[1]
OFF FROM REGULAR WORK (extra deductions taken January–May to pre-pay the Summer[1] Benefit Period)	June 30, 2015 July 31, 2015 August 31, 2015	SUMMER[1] COVERAGE BENEFIT PERIOD
September 1, 2015–September 30, 2015	September 30, 2015	September 1–30, 2015
October 1, 2015–October 31, 2015	October 30, 2015	October 1–31, 2015
November 1, 2015–November 30, 2015	November 30, 2015	November 1–30, 2015
December 1, 2015–December 31, 2015	December 31, 2015	December 1–December 31, 2015

[1] January–May deductions (five pay periods) include a 1.6 rate to pre-pay premiums for summer coverage benefit period.

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 pay date for the benefits coverage period above.

Approaching Retirement

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.

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 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 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 plan year.

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, domestic 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.

Hired after January 9, 2009

If you were hired after January 9, 2009, you will retire under new rules for retiree health benefits that are separate and distinct from your retirement pension rules. As you approach retirement, it is important that you meet with an HSS representative to verify that you have met the new eligibility criteria for retiree health benefits and that you are prepared for the higher premium contributions that will be required. Call HSS to schedule an appointment. Visit myhss.org for more information on the new rules in the HSS Retiree Benefit Guide.

Changing Elections Outside of Open Enrollment

A member may make a benefits election change due to a qualifying event during the January–December 2015 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 • 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 or placement	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 18.)	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.

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. The surviving spouse or domestic partner of an active member hired after January 9, 2009, may not be eligible for HSS benefits. 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 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 and be enrolled at the time of the member's death and are only eligible for benefits under a surviving spouse or surviving domestic partner.

Moving Out of a Plan's Service Area

If you move your primary residence to a location outside your health plan's service area 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.

Please note that you or any covered dependent with End Stage Renal Disease may be prohibited from changing health plan enrollment.

Domestic Partner Health Benefits Taxation

Health coverage for a domestic partner and a partner's children is a taxable benefit under federal law.

Tax Treatment of Domestic Partner 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.

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 must 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 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.

Same-Sex Spouses

Health premium contributions for same-sex spouses and their children are no longer taxable imputed income under federal law, due to the Supreme Court ruling, which declared the federal Defense of Marriage Act unconstitutional.

Consult with Your Tax Advisor

This is a brief overview regarding the tax treatment of health benefits for domestic partners. 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.

Other Benefits Administered by SFCCD

SFCCD employees may be eligible for dental coverage, Flexible Spending Accounts and other voluntary 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 35 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 Take Care WageWorks (call 1-888-342-3532). 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 35 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 ccsf.edu/hr.

2015 Medical Plan Rates

CERTIFICATED (BOARD MEMBERS) AND CLASSIFIED ADMINISTRATORS

BI-WEEKLY 26 PAY PERIODS

	BLUE SHIELD HMO			KAISER HMO			CITY HEALTH PLAN PPO		
	Premium	District Pays	Employee Pays	Premium	District Pays	Employee Pays	Premium	District Pays	Employee Pays
Employee Only	298.79	273.49	25.30	255.68	255.68	0	467.27	153.40	313.87
Employee +1	596.64	463.95	132.69	510.43	421.93	88.50	917.24	226.93	690.31
Employee +2 or more	843.86	539.27	304.59	721.87	476.96	244.91	1292.22	203.01	1089.21

CLASSIFIED EMPLOYEES

BI-WEEKLY 26 PAY PERIODS

	BLUE SHIELD HMO			KAISER HMO			CITY HEALTH PLAN PPO		
	Premium	District Pays	Employee Pays	Premium	District Pays	Employee Pays	Premium	District Pays	Employee Pays
Employee Only	298.79	277.20	21.59	255.68	255.68	0	467.27	157.74	309.53
Employee +1	596.64	436.62	160.02	510.43	392.53	117.90	917.24	248.27	668.97
Employee +2 or more	843.86	500.17	343.69	721.87	434.94	286.93	1292.22	232.04	1060.18

CLASSIFIED SCHOOL TERM EMPLOYEES

BI-WEEKLY 21 PAY PERIODS

	BLUE SHIELD HMO			KAISER HMO			CITY HEALTH PLAN PPO		
	Premium	District Pays	Employee Pays	Premium	District Pays	Employee Pays	Premium	District Pays	Employee Pays
Employee Only									
Jan 3– Jun 5	298.79	403.20	31.40	255.68	371.90	0	467.27	229.44	450.23
Aug 15 – Dec 31	298.79	277.20	21.59	255.68	255.68	0	467.27	157.74	309.53
Employee +1									
Jan 3– Jun 5	596.64	635.08	232.76	510.43	570.95	171.49	917.24	361.12	973.05
Aug 15 – Dec 31	596.64	436.62	160.02	510.43	392.53	117.90	917.24	248.27	668.97
Employee +2 or more									
Jan 3– Jun 5	843.86	727.52	499.91	721.87	632.64	417.35	1292.22	337.51	1542.08
Aug 15 – Dec 31	843.86	500.17	343.69	721.87	434.94	286.93	1292.22	232.04	1060.18

Note: Classified School Term Employees January to May deductions (5 pay periods) include a 1.454 rate to pre-pay premiums for the summer coverage benefit period.

2015 Medical Plan Rates

CERTIFICATED (ADMINISTRATORS)

MONTHLY 12 PAY PERIODS

	BLUE SHIELD HMO			KAISER HMO			CITY HEALTH PLAN PPO		
	Premium	District Pays	Employee Pays	Premium	District Pays	Employee Pays	Premium	District Pays	Employee Pays
Employee Only	647.37	592.56	54.81	553.98	553.98	0	1012.41	332.36	680.05
Employee +1	1292.73	1005.24	287.49	1105.93	914.18	191.75	1987.35	491.68	1495.67
Employee +2 or more	1828.36	1168.42	659.94	1564.05	1033.42	530.63	2799.82	439.87	2359.95

FACULTY

MONTHLY 12 PAY PERIODS

	BLUE SHIELD HMO			KAISER HMO			CITY HEALTH PLAN PPO		
	Premium	District Pays	Employee Pays	Premium	District Pays	Employee Pays	Premium	District Pays	Employee Pays
Employee Only	647.37	592.56	54.81	553.98	553.98	0	1012.41	332.36	680.05
Employee +1	1292.73	1024.26	268.47	1105.93	944.72	161.21	1987.35	510.70	1476.65
Employee +2 or more	1828.36	1203.22	625.14	1564.05	1084.52	479.53	2799.82	474.67	2325.15

PART-TIME FACULTY

MONTHLY 9 PAY PERIODS

	BLUE SHIELD HMO			KAISER HMO			CITY HEALTH PLAN PPO		
	Premium	District Pays	Employee Pays	Premium	District Pays	Employee Pays	Premium	District Pays	Employee Pays
Employee Only									
January–May	647.37	948.10	87.70	553.98	886.37	0	1012.41	531.78	1088.08
Sept–December	647.37	592.56	54.81	553.98	553.98	0	1012.41	332.36	680.05
Employee +1									
January–May	1292.73	1638.82	429.55	1105.93	1511.55	257.94	1987.35	817.12	2362.64
Sept–December	1292.73	1024.26	268.47	1105.93	944.72	161.21	1987.35	510.70	1476.65
Employee +2 or more									
January–May	1828.36	1925.15	1000.22	1564.05	1735.23	767.25	2799.82	759.47	3720.24
Sept–December	1828.36	1203.22	625.14	1564.05	1084.52	479.53	2799.82	474.67	2325.15

Note: Part-Time Faculty January to May deduction (5 pay periods) include a 1.6 rate to pre-pay premiums for the summer coverage benefit period.

These rates have been approved by the Health Service Board, San Francisco City College and the San Francisco Board of Supervisors

Health Service Board

Per the San Francisco City Charter, the Health Service Board conducts an annual review of health benefit costs, ensures benefits are applied without favor or privilege, and administers the business of the Health Service System. One commissioner is a City Supervisor, two commissioners are appointed by the Mayor and one is appointed by the City Controller. Three commissioners are elected from the HSS membership to serve five-year terms.

2015 Health Service Board Commissioners

Karen Breslin
Elected

Retired
San Francisco
Probation Department

Sharon Ferrigno
Elected

Deputy Chief
San Francisco
Police Department

Wilfredo Lim
Elected

Accounting Manager
San Francisco
General Hospital

Mark Farrell
Appointee (by the Board of Supervisors)

San Francisco
Board of Supervisors

Jean S. Fraser (President)
Appointee (by the Mayor)

Health System Chief
San Mateo County

Randy Scott
Appointee (by the Controller)

Vice President
Human Resources
Institute on Aging

Jordan Shlain, M.D.
Appointee (by the Mayor)

Internal Medicine
Private Practice
San Francisco

Health Service Board meetings are held the second Thursday of the month at 1:00PM in San Francisco City Hall Room 416. Meeting announcements are posted at myhss.org/health_service_board.

Watch Health Service Board meetings on SFGovTV at sanfrancisco.granicus.com/ViewPublisher.php?view_id=168.

Submit a comment to the Health Service Board at surveymonkey.com/s/hssboard.

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

VISION PLAN

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

SFCCD

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

DENTAL PLAN

Delta Dental
Tel: 1-866-499-3001
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

Take Care WageWorks
Tel: 1-888-342-3532
takecarewageworks.com

COBRA (Medical and Vision)

Tel: 1-877-502-6272

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.

RECYCLE

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The Health Service System of the City & County of San Francisco is dedicated to preserving and improving sustainable, quality health benefits and enhancing the well-being of employees, retirees and their families.

HEALTH SERVICE SYSTEM
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG