2016 HEALTH BENEFITS

Retirees

HEALTH SERVICE SYSTEM
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

This guide provides an overview of the Health Service System rules approved by the Health Service Board. The rules can be found at myhss.org/member_services/rules.html. To request a paper copy of the rules call 1-415-554-1750.

Enrolling In Retiree Health Benefits

Learn about retiree health benefits options by reading this Guide and visiting **myhss.org**. You may also visit the Health Service System office at 1145 Market Street, 3rd Floo , San Francisco and speak with a Benefits Analyst. No appointment is necessary.

Once you are enrolled, **retiree premium contributions are deducted from pension checks** monthly. Review your pension check to verify that the correct premium contribution is being deducted. If your pension check does not cover your required premiums you must contact the Health Service System for options on how to make your monthly payments. 2016 retiree premium contributions are on pages 44–47.

All Medicare-eligible retirees and dependents must maintain continuous enrollment in Medicare. To ensure there is no break in your medical coverage, you must pay all Medicare premiums that are due to the federal government on time.

Open Enrollment is your annual opportunity to change benefit elections for you and your eligible family members without any qualifying events. Changes made during October Open Enrollment are effective the following January.

You may only make changes to benefit elections during the plan year if there is a **qualifying event**. For more information about qualifying events see pages 38–39.

Questions about your health benefits or premium contributions? Call **Member Services at 1-415-554-1750**.

New Retirees: Don't Miss the 30-day Deadline

Contact HSS three months before your retirement date to learn about enrolling in retiree benefits. The transition of health benefits from active to retiree status does not happen automaticall . If eligible, you must elect to continue retiree health coverage by submitting the retiree enrollment form and supporting documents to HSS by required deadlines.

Eligible new retirees must complete enrollment in retiree health coverage within **30 calendar days** of their retirement date. If you do not enroll **within this 30-day period**, you can only apply for retiree benefits during the next Open Enrollment.

New retirees should plan ahead. **To enroll in retiree health benefits you must be enrolled in Medicare** if you are Medicare-eligible. The Social Security Administration may take up to three months to process Medicare enrollment.

To be eligible for retiree health benefits, employees hired after January 9, 2009 must have at least five years of credited service with a City employer: City & County of San Francisco, San Francisco Unifi d School District, San Francisco City College or San Francisco Superior Court. Other government service is not credited. If this applies to you, make sure you understand the **City Charter rules that determine your eligibility** and retiree premium contributions before finalizing your retirement date. See page 7 of this guide.

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.

Questions about health benefits in retirement? **Call HSS Member Services at 1-415-554-1750** or visit the HSS office at 1145 Market Street, 3rd Floo , San Francisco. No appointment is necessary.

What's New in 2016

Retirees With Medicare Have An Additional Plan Option In 2016

Blue Shield of California	**65 Plus**	Medicare Advantage HMO	• Care delivered through Blue Shield's contracted network. • Enrollee must live in a 65 Plus service area. • Primary care physician assignment required. • No annual deductible; co-pays apply. • Includes Silver Sneakers.
Blue Shield of California	**Access+**	Medicare Coordinated HMO	• Only for enrollees who live outside 65 Plus service area. • Enrollee must live in Access+ service area. • Care delivered through Blue Shield's contracted network. • Primary care physician assignment required. • No annual deductible; co-pays apply.
Kaiser Permanente	**Senior Advantage**	Medicare Advantage HMO	• Care delivered through Kaiser's integrated network. • Enrollee must live in a Kaiser service area. • Primary care physician assignment required. • No annual deductible; co-pays apply.
UnitedHealthcare® NEW!	**Group Medicare Advantage National PPO**	Medicare Advantage PPO	• Care delivered nationwide by any provider who accepts Medicare. • No primary care physician assignment. • No annual deductible; co-pays apply. • Enhanced coverage for diabetic supplies. • Includes Silver Sneakers.
UnitedHealthcare® City Plan	**Choice Plus with Medicare Rx for Groups PDP**	Medicare Coordinated PPO	• Care delivered nationwide by any licensed provider. Out-of-network service costs more. • No primary care physician assignment. • This plan has an annual deductible and out-of-pocket co-insurance costs.

Retirees Not Yet Eligible For Medicare Have The Same Plan Options In 2016

Retirees and family members who are not yet eligible for Medicare have the same medical plan choices in 2016 as they had in 2015: Kaiser Permanente Traditional HMO, Blue Shield of California Access+ HMO and UnitedHealthcare City Plan PPO. There are no changes to covered benefits, plan maximums or co-pays for these plans in 2016.

No Changes to Retiree Dental Plan Options

The same retiree dental plans are being offered in 2016: Delta Dental, DeltaCareUSA and UnitedHealthcare Dental (formerly called Pacific Union Dental). There are no changes to covered services, plan maximums or out-of-pocket costs for any of the retiree dental plans in 2016.

Retiree Medical and Dental Premium Contributions Will Change in 2016

See pages 44-47 for details about 2016 retiree premium contributions, which are paid monthly. Premium contributions for the retiree Delta Dental plan will decrease in 2016.

Eligibility

These rules govern which retirees and dependents may be eligible for Health Service System health coverage.

Retiree Member Eligibility

An employee must meet age and minimum service requirements and have been enrolled in HSS health benefits at some time during active employment to be eligible for retiree health coverage. HSS calculates service. Service requirements vary. If hired on or after January 9, 2009, Proposition B applies. (See page 7.) If a retiree chooses to take a lump sum pension distribution, retiree health premium contributions will be unsubsidized and paid at full cost. Other restrictions may apply. For an assessment of eligibility for retiree health benefits contact the Health Service System.

Newly eligible retirees must enroll in retiree medical and/or dental coverage **within 30 days** of their retirement effective date. To enroll you must provide HSS with a completed enrollment application and all required eligibility documentation, including retirement system paperwork. Members eligible for Medicare at the time of retirement must also provide proof of Medicare enrollment. Medicare applications take three to four months to process, so plan ahead. If you fail to meet required deadlines, you must wait until the next Open Enrollment.

New retiree coverage will take effect on the first day of the month following the retirement effective date. Depending on your retirement date, there can be a gap between when employee coverage ends and retiree coverage begins. Setting a retirement date at the end of the month will help avoid a coverage gap.

Contact HSS Member Services at 415-554-1750 three months before your retirement date to prepare for enrollment in retiree benefits. ou must notify HSS of retirement even if you are not planning to elect HSS coverage on your retirement date.

For more information, visit: myhss.org/member_services/new_retirees.html.

Dependent Eligibility

Spouse or Registered Domestic Partner

A member's spouse or registered domestic partner may be eligible for HSS healthcare coverage. Proof of marriage or domestic partnership is required, as well as the dependent's Social Security number. 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 cove - age period after a completed application and eligibility documentation is filed with HSS. A spouse or registered domestic partner can also be added to a member's coverage during Open Enrollment. Proof of Medicare enrollment must be provided for a spouse or registered domestic partner who is Medicare-eligible due to age or disability.

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 Guardianship 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.

Eligibility

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 HSS 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.

An adult disabled child who is Medicare-eligible must be enrolled in Medicare. In general, a person is eligible for Medicare if they have been receiving Social Security Disability Insurance (SSDI) benefits for more than 24 months or due to End Stage Renal Disease (ESRD). Medicare primary coverage begins approximately 30 months after the diagnosis of ESRD.

Medicare Enrollment is Required

Retiree members and dependents covered on a Health Service System plan must be enrolled in Medicare as soon as they are eligible due to age, disability or End Stage Renal Disease (ESRD).

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 dependents' health premiums and any medical service provided.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted in 1986 allows retirees 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.
- Retiree'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

For more information about COBRA visit myhss.org/benefits/cobra.html or call HSS at 1-415-554-1750.

Eligibility

Required Eligibility Documentation

	EVIDENCE OF RETIREMENT	MARRIAGE CERTIFICATE	DOMESTIC PARTNER CERT.	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	PROOF OF PLACEMENT	COURT DECREE OR ORDER	MEDICAL EVIDENCE	SOCIAL SECURITY #	MEDICARE CARD
Retiree	■								■	■
Spouse		■							■	■
Domestic Partner			■						■	■
Child: Natural				■					■	
Child: Adopted					■				■	
Child: Placed for Adoption						■			■	
Stepchild: Spouse		■		■					■	
Stepchild: Domestic Partner			■	■					■	
Child: Legal Guardianship							■		■	
Child: Court Ordered							■		■	
Adult Child: Disabled				■				■	■	■

Note: Proof of Medicare enrollment is required for any retiree or dependent who is Medicare eligible due to disability or End Stage Renal Disease (ESRD). A member who is not eligible for Medicare must provide a letter from Social Security Administration.

Split Families

If you have some family members with Medicare coverage and others not currently eligible for Medicare, you're considered a split family. When this occurs you will cover yourself and your dependents with the same insurer. For those who have Medicare, the coverage will be on a Medicare plan. For those without Medicare, coverage will be provided by the corresponding non-Medicare plan (where applicable). Contact HSS at 1-415-554-1750 for details.

Make sure to check the premium rates for split family enrollment on pages 44-47. Your premium contributions will change during the plan year if there is a change in Medicare enrollment for you or an enrolled dependent.

If Member With Medicare is Enrolled In:	Dependent Not Yet Eligible for Medicare Will Be Enrolled In:
Blue Shield of California 65 Plus HMO Medicare Advantage	Blue Shield of California Access+ HMO No Medicare
Blue Shield of California Access+ HMO Medicare Coordinated	Blue Shield of California Access+ HMO No Medicare
Kaiser Permanente Senior Advantage HMO Medicare Advantage	Kaiser Permanente Traditional HMO No Medicare
City Plan PPO UnitedHealthcare City Plan Choice Plus PPO with UnitedHealthcare MedicareRx for Groups Medicare Coordinated	City Plan PPO UnitedHealthcare Choice Plus PPO No Medicare
Medicare Advantage National PPO UnitedHealthcare Medicare Advantage	City Plan PPO UnitedHealthcare Choice Plus PPO No Medicare

City Charter Amendments and Retiree Benefits

2008 Proposition B: Employees Hired After January 9, 2009

To be eligible for retiree health benefits, employees hired after January 9, 2009 must have at least five years of credited service with a City employer: City & County of San Francisco, San Francisco Unifi d School District, San Francisco City College or San Francisco Superior Court. Other government service is not credited.

Also under this Charter amendment, employees hired after January 9, 2009 must retire within 180 days of separation from employment to be eligible for retiree health benefits. That means an employee must have the credited service and the age required for retirement at the time of separation from service to be eligible for retiree health benefits.

A surviving dependent may be eligible for retiree health benefits if a deceased employee accrued 10 or more years of credited service with City employers.

If eligible, different premium contribution rates apply for employees hired after January 9, 2009, based on years of credited service with the City employers. See pages 44-47 for retiree premium contributions based on Proposition B.

- With at least five years but less than 10 years of credited service, the retiree member must pay the full premium rate and does not receive any employer premium contribution.
- With at least 10 years but less than 15 years of credited service, the retiree will receive 50% of the employer premium contribution for themselves and eligible dependents.
- With at least 15 years but less than 20 years of credited service, the retiree will receive 75% of the employer premium contribution for themselves and eligible dependents.
- With 20 or more years of credited service or disability retirement, the retiree will receive 100% of the employer premium contribution for themselves and eligible dependents.

2011 Proposition C: Employees Separated From Service Before June 30, 2001 and Retired After January 6, 2012

Employees who separated service from a City employer before June 30, 2001 and retire after January 6, 2012 receive the employer health premium subsidies in effect at the time of their separation.

View retiree premium contribution amounts based on Proposition C: myhss.org/benefits/retirees.html.

If enrolled in retiree health benefits administered by the Health Service System:

- The retiree member receives 100% of the employer premium contribution defined by the City Charte .
- The retiree's spouse or registered domestic partner will receive 50% of the employer premium contribution defined by the City Charte .
- The retiree pays the full premium for any other enrolled dependents. There is no employer premium contribution.

Getting Ready to Retire?

Make an informed decision. Confirm your years of credited service with a City employer with your retirement system (SFERS, CalPERS, CalSTRS or PARS). Remember–if you were hired after January 9, 2009 other government service is not credited for retiree health benefits eligibility.

Then contact the Health Service System. A benefits analyst will review your service credits, health benefits eligibility, retiree health plan options and premium contributions.

If you are Medicare-eligible due to age or disability you must contact the Social Security Administration to apply for Medicare before you retire. Plan ahead. It can take up to three months to complete processing of your Medicare enrollment.

2016 Retiree Medical Plans

HMO

An HMO (Health Maintentance Organization) offers benefits through a network of participating phys - cians, hospitals and healthcare providers. For non-emergency care, you access service through your Primary Care Physician or an urgent care center.

Blue Shield of California HMO Plans:

65 Plus
(Medicare Advantage HMO)

- Must be eligible for Medicare Part A and Part B
- Must live in 65 Plus service area
- In-network service only
- Out-of-pocket, fixed co-pay
- No deductible

Access+
(Medicare Coordinated HMO)

- Must be eligible for Medicare Part A and Part B
- Only available to retirees who live outside the 65 Plus service area
- Must live in Access+ service area
- In-network service only
- Out-of-pocket, fixed co-pay
- No deductible

Access+
(No Medicare HMO)

- Must not be eligible for Medicare
- Must live in Access+ service area
- In-network service only
- Out-of-pocket, fixed co-pay
- No deductible

Kaiser Permanente HMO Plans:

Senior Advantage
(Medicare Coordinated HMO)

- Must be eligible for Medicare Part B
- Must live in Kaiser service area
- In-network service only
- Out-of-pocket, fixed co-pay
- No deductible

Traditional Plan
(No Medicare HMO)

- Must not be eligible for Medicare
- Must live in Kaiser service area
- In-network service only
- Out-of-pocket, fixed co-pay
- No deductible

PPO

A PPO (Preferred Provider Organization) offers a wider choice of physicians because you can access service in-network or out-of-network. You are not assigned a Primary Care Physician so you have more responsibility for coordinating your care.

UnitedHealthcare PPO Plans:

Medicare Advantage National PPO
(Medicare Advantage PPO)

- Must be eligible for Medicare Part A and Part B
- Live anywhere in the USA
- Obtain service from any willing Medicare provider in the USA
- Out-of-pocket, fixed co-pay
- No deductible

City Plan
Choice Plus PPO with MedicareRx for Groups
(Medicare Coordinated PPO)

- Must be eligible for Medicare Part A and Part B
- Live anywhere in the world
- Access covered services worldwide
- Annual deductible must be reached before coverage begins
- Out-of-pocket co-insurance %
- Lower rate of co-insurance for out-of-network providers
- Reasonable and customary fee reimbursement limits

City Plan
Choice Plus PPO
(No Medicare PPO)

- Must not be eligible for Medicare
- Live anywhere in the world
- Access covered services worldwide
- Annual deductible must be reached before coverage begins
- Out-of-pocket co-insurance %
- Lower rate of co-insurance for out-of-network providers
- Reasonable and customary fee reimbursement limits

Note: City Plan enrollees who live in a zip code where in-network providers are not available may access out-of-area providers with the same in-network co-insurance. Your out-of-area status may change as doctors join or leave the City Plan network.

2016 Retiree Medical Plans

ELIGIBLE FOR MEDICARE

Plan Features	Blue Shield of California		Kaiser Permanente	UnitedHealthcare	
	65 Plus MEDICARE ADVANTAGE HMO	**Access+** MEDICARE COORDINATED HMO	**Senior Advantage** MEDICARE ADVANTAGE HMO	**Medicare Advantage** NATIONAL PPO	**City Plan** CHOICE PLUS MEDICARE COORDINATED PPO
Kaiser only integrated care delivery system			■		
Bay area network of doctors and hospitals	■	■	■	■	■
National network of doctors and hospitals				■	■
Primary Care Physician required	■	■	■		
Medicare Advantage	■		■	■	
Medicare Coordinated		■			■
Silver Sneakers membership	■			■	
Enhanced coverage for diabetic supplies				■	
No annual deductible and fixed co-pay	■	■	■	■	
Annual deductible and co-insurance					■

NOT ELIGIBLE FOR MEDICARE

Plan Features	Blue Shield of California	Kaiser Permanente	UnitedHealthcare
	Access+ NO MEDICARE HMO	**Traditional** NO MEDICARE HMO	**City Plan** NO MEDICARE CHOICE PLUS PPO
Kaiser only integrated care delivery system		■	
Bay area network of doctors and hospitals	■	■	■
National network of doctors and hospitals			■
Primary Care Physician required	■	■	
Silver Sneakers membership			
No annual deductible and fixed co-pay	■	■	
Annual deductible and co-insurance			■

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2016. If any discrepancy exists between this guide and the EOC, the EOC will prevail. EOCs are available on myhss.org.

2016 Retiree Medical Plans: Service Areas

	ELIGIBLE FOR MEDICARE					NOT ELIGIBLE FOR MEDICARE		
County	**Blue Shield of California**		**Kaiser Permanente**	**United Healthcare**		**Blue Shield of California**	**Kaiser Permanente**	**United Healthcare**
	65 Plus MEDICARE ADVANTAGE HMO	**Access+** MEDICARE COORDINATED HMO	**Senior Advantage** MEDICARE ADVANTAGE HMO	**Medicare Advantage** NATIONAL PPO	**City Plan** CHOICE PLUS MEDICARE COORDINATED PPO	**Access+** NO MEDICARE HMO	**Traditional** NO MEDICARE HMO	**City Plan** CHOICE PLUS NO MEDICARE PPO
Alameda		■	■	■	■	■	■	■
Alpine				■	■			■
Amador			❍	■	■		❍	■
Butte		■		■	■	■		■
Calaveras				■	■			■
Colusa				■	■			■
Contra Costa	■		■	■	■	■	■	■
Del Norte				■	■			■
El Dorado		❍	❍	■	■	❍	❍	■
Fresno	■	■	❍	■	■	■	❍	■
Glenn				■	■			■
Humboldt				■	■			■
Imperial	❍	■	❍	■	■	■	❍	■
Inyo				■	■			■
Kern	❍	❍	❍	■	■	❍	❍	■
Kings		■	❍	■	■	■	❍	■
Lake				■	■			■
Lassen				■	■			■
Los Angeles	■		❍	■	■	■	❍	■
Madera	❍	■	❍	■	■	■	❍	■
Marin		■	■	■	■	■	■	■
Mariposa			❍	■	■		❍	■
Mendocino				■	■			■
Merced		■		■	■	■		■
Modoc				■	■			■
Mono				■	■			■
Monterey				■	■			■
Napa			❍	■	■		❍	■
Nevada	❍	❍		■	■	❍		■

■ = Available in this county. ❍ = Available in some zip codes.

Only Medicare retirees who live outside the Blue Shield of California 65 Plus service area may enroll in Blue Shield of California Access+.

2016 Retiree Medical Plans: Service Areas

County	ELIGIBLE FOR MEDICARE					NOT ELIGIBLE FOR MEDICARE		
	Blue Shield of California		Kaiser Permanente	United Healthcare		Blue Shield of California	Kaiser Permanente	United Healthcare
	65 Plus MEDICARE ADVANTAGE HMO	**Access+** MEDICARE COORDINATED HMO	**Senior Advantage** MEDICARE ADVANTAGE HMO	**Medicare Advantage** NATIONAL PPO	**City Plan** CHOICE PLUS MEDICARE COORDINATED PPO	**Access+** NO MEDICARE HMO	**Traditional** NO MEDICARE HMO	**City Plan** CHOICE PLUS NO MEDICARE PPO
Orange	■		■	■	■	■	■	■
Placer		❍	❍	■	■	❍	❍	■
Plumas				■	■			■
Riverside	❍	■	❍	■	■	■	❍	■
Sacramento	■		■	■	■	■	■	■
San Benito				■	■			■
San Bernardino	❍	❍	❍	■	■	❍	❍	■
San Diego	■	❍	❍	■	■	❍	❍	■
San Francisco	■		■	■	■	■	■	■
San Joaquin	■		■	■	■	■	■	■
San Luis Obispo	■			■	■	■		■
San Mateo	■		■	■	■	■	■	■
Santa Barbara	❍			■	■	■		■
Santa Clara	■		■	■	■	■	■	■
Santa Cruz	■			■	■	■		■
Shasta				■	■			■
Sierra				■	■			■
Siskiyou				■	■			■
Solano		■	■	■	■	■	■	■
Sonoma		■	❍	■	■	■	❍	■
Stanislaus		■	■	■	■	■	■	■
Sutter			❍	■	■		❍	■
Tehama				■	■			■
Trinity				■	■			■
Tulare		■	❍	■	■	■	❍	■
Tuolumne				■	■			■
Ventura	■		❍	■	■	■	❍	■
Yolo		■	❍	■	■	■	❍	■
Yuba			❍	■	■		❍	■
Outside CA				■	■			■

■ = Available in this county. ❍ = Available in some zip codes.

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. Contact the Health Service System at 1-415-554-1750 to update your information and review plan options if you are changing your address.

Eligible for Medicare

2016 Medical Plan Benefits-at-a-Glance

	blue of california **Blue Shield 65 Plus** Medicare Advantage HMO	blue of california **Access+ (Medicare Coordinated)** HMO only for enrollees living outside the 65 Plus plan service area	KAISER PERMANENTE® **Senior Advantage** Medicare Advantage HMO	UNITEDHEALTHCARE **Medicare Advantage National PPO**	UNITEDHEALTHCARE **City Plan Choice Plus PPO and UnitedHealthcare MedicareRx for Groups (PDP)** In-Network or Out-of-Area*	 Out-of-Network*
DEDUCTIBLES						
Deductible and out-of-pocket maximum	No deductible Annual out-of-pocket maximum $6,700/individual	No deductible Annual out-of-pocket maximum $2,000/individual; $4,000/family	No deductible Annual out-of-pocket maximum $1,500/individual; $3,000/family	No deductible Annual out-of-pocket maximum $3,750/individual	$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $3,750/person	$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $7,500/person
PREVENTIVE CARE						
Routine physical	No charge limits apply; see EOC	No charge	No charge	$0 co-pay	100% covered no deductible	50% covered after deductible
Immunizations and inoculations	No charge limits apply; see EOC	No charge	No charge	$0 co-pay	100% covered no deductible	50% covered no deductible
Well woman exam and family planning	No charge limits apply; see EOC	No charge	No charge	$0 co-pay	100% covered no deductible	50% covered after deductible
Routine pre/post-partum care	No charge visits limited; see EOC	No charge visits limited; see EOC	No charge visits limited; see EOC	Cost share per type and location of service	85% covered after deductible	50% covered after deductible
PHYSICIAN & OTHER PROVIDER CARE						
Office and home visit	$25 co-pay	$25 co-pay	$20 co-pay	$5 co-pay PCP; $15 co-pay specialist	85% covered after deductible	50% covered after deductible
Hospital visits	No charge	No charge	No charge	$150 co-pay per admission	85% covered after deductible	50% covered after deductible
PRESCRIPTION DRUGS						
Pharmacy: generic drugs	$10 co-pay 30-day supply	$10 co-pay 30-day supply	$5 co-pay 30-day supply	$5 co-pay 30-day supply	$5 co-pay 30-day supply	Not covered except emergency service; see EOC
Pharmacy: brand-name drugs	$25 co-pay 30-day supply	$25 co-pay 30-day supply	$15 co-pay 30-day supply	$20 co-pay 30-day supply	$20 co-pay 30-day supply	Not covered except emergency service; see EOC
Pharmacy: non-formulary drugs non-preferred brands	$50 co-pay 30-day supply	$50 co-pay 30-day supply	Physician authorized only	$45 co-pay 30-day supply	$45 co-pay 30-day supply	Not covered except emergency service; see EOC
Mail order: generic drugs	$20 co-pay 90-day supply	$20 co-pay 90-day supply	$10 co-pay 100-day supply	$10 co-pay 90-day supply	$10 co-pay 90-day supply	Not covered except emergency service; see EOC
Mail order: brand-name drugs	$50 co-pay 90-day supply	$50 co-pay 90-day supply	$30 co-pay 100-day supply	$40 co-pay 90-day supply	$40 co-pay 90-day supply	Not covered except emergency service; see EOC
Mail order: non-formulary drugs non-preferred brands	$100 co-pay 90-day supply	$100 co-pay 90-day supply	Physician authorized only	$90 co-pay 90-day supply	$90 co-pay 90-day supply	Not covered except emergency service; see EOC
Specialty drugs	20% up to $100 co-pay 30-day supply	20% up to $100 co-pay 30-day supply	Same as all above limitations apply; see EOC	Same as all above limitations apply; see EOC	Same as all above limitations apply; see EOC	Not covered except emergency service; see EOC
OUTPATIENT SERVICES						
Diagnostic X-ray and laboratory	No charge	No charge	No charge	$0 co-pay	85% covered after deductible	50% covered after deductible
EMERGENCY						
Hospital emergency room	$50 co-pay	$100 co-pay	$50 co-pay waive if hospitalized	$65 co-pay	85% covered after deductible; 50% after deductible if non-emergency	85% covered after deductible; 50% after deductible if non-emergency
Urgent care facility	$25 co-pay within CA	$25 co-pay within CA	$20 co-pay	$35 co-pay	85% covered after deductible	50% covered after deductible
HOSPITAL/SURGERY						
Inpatient	$200 co-pay per admission	$200 co-pay per admission	$100 co-pay per admission	$150 co-pay per admission	85% covered after deductible	50% covered after deductible
Outpatient	$100 co-pay per surgery	$100 co-pay per surgery	$35 co-pay	$100 co-pay	85% covered after deductible	50% covered after deductible

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City Plan co-insurance amounts shown reflect what will be covered after Medicare has paid its portion of a claim
*In some cases, billed amounts may exceed reasonable and customary fees, resulting in higher out-of-pocket costs.

Eligible for Medicare

2016 Medical Plan Benefits-at-a-Glance

	blue of california **Blue Shield 65 Plus** Medicare Advantage HMO	blue of california **Access+ (Medicare Coordinated)** HMO only for enrollees living outside Blue Shield 65 Plus service area	KAISER PERMANENTE® **Senior Advantage** Medicare Advantage HMO	UNITEDHEALTHCARE **Medicare Advantage National PPO**	UNITEDHEALTHCARE **City Plan Choice Plus PPO and UnitedHealthcare MedicareRx for Groups (PDP)** In-Network or Out-of-Area*	 Out-of-Network*
REHABILITATIVE						
Physical/Occupational therapy	$25 co-pay	$25 co-pay	$20 co-pay authorization req.	$25 co-pay	85% covered after deductible; 60 visits/year	50% covered after deductible; 60 visits/year
Acupuncture	$15 co-pay 30 visits/year; ASH network only	$15 co-pay 30 visits/year; ASH network only	Not covered 25% discount at kp.org/choosehealthy	$15 co-pay 24 visits/year	50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year
Chiropractic	$15 co-pay 30 visits/year; ASH network only	$15 co-pay 30 visits/year; ASH network only	$15 co-pay 30 visits max per plan year; ASH network only; 25% discount at kp.org/choosehealthy	$15 co-pay Medicare-covered care unlimited; 24 visits per year maximum routine care	50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year
TRANSGENDER						
Office visits and outpatient surger	Co-pays apply authorization req. $75,000 lifetime max	Co-pays apply authorization req.	Co-pays apply authorization req. $75,000 lifetime max	Co-pays apply authorization req. $75,000 lifetime max for surgery	85% covered after deductible; prior notific - tion required; $75,000 lifetime max	50% covered after deductible; prior notifica tion required; $75,000 lifetime max
DURABLE MEDICAL EQUIPMENT						
Home medical equipment	No charge when medically necessary	No charge when medically necessary	No charge as authorized by PCP according to formulary	$15 co-pay	85% covered after deductible; notification require	50% covered after deductible; notification require
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary	No charge when medically necessary	$15 co-pay	85% covered after deductible; when medically necessary; notification require	50% covered after deductible; when medically necessary; notification require
Diabetic monitoring supplies	Co-pays apply per prescription tier; $25 co-pay at PCP; does not include blood glucose monitors	Co-pays apply per prescription tier; $25 co-pay at PCP; does not include blood glucose monitors	No charge see EOC	$0 co-pay	Co-pays apply per prescription drug tier	Co-pays apply per prescription drug tier
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	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
MENTAL HEALTH						
Inpatient hospitalization	$200 co-pay per admission	$200 co-pay per admission	$100 co-pay per admission	$150 co-pay per admission	85% covered after deductible; notification require	50% covered after deductible; notification require
Outpatient treatment	$25 co-pay non-severe and severe	$25 co-pay non-severe and severe	$10 co-pay group $20 co-pay individual	$5 co-pay group $15 co-pay individual	85% covered after deductible; notification require	50% covered after deductible; notification require
Inpatient detox	$200 co-pay per admission	$200 co-pay per admission	$100 co-pay per admission	$150 co-pay per admission	85% covered after deductible; notification require	50% covered after deductible; notification require
Residential rehabilitation	$200 co-pay per admission	$200 co-pay per admission	$100 co-pay per admission; physi- cian approval required	$150 co-pay per admission	85% covered after deductible; authorization required	50% covered after deductible; authorization required
EXTENDED & END-OF-LIFE CARE						
Skilled nursing facility	No charge up to 100 days/year	No charge up to 100 days/year	No charge up to 100 days per year	No charge up to 100 days/benefit period; no custodial care	85% covered after deductible; up to 120 days/ year; notification required; no custodial car	50% covered after deductible; up to 120 days/ year; notification required; no custodial car
Hospice	No charge authorization required	No charge authorization required	No charge when medically necessary	No charge when medically necessary	85% covered after deductible; authorization required	50% covered after deductible; authorization required
OUTSIDE SERVICE AREA						
Care access and limitations	Urgent care $50 co-pay; guest membership benefits for college students in some areas.	Urgent care $50 co-pay; guest membership benefits for college students in some areas	Only emergency services before condition permits transfer to Kaiser facility. Co-pays apply.	Nationwide coverage. In-Network and Out- of-Network benefits are the same	Worldwide coverage. In-network and out-of- network percentages and co-pays apply.	Worldwide coverage. In-network and out-of- network percentages and co-pays apply.

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

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

Not Yet Eligible for Medicare

2016 Medical Plan Benefits-at-a-Glance

	blue of california Access+ HMO	KAISER PERMANENTE® Traditional HMO	UNITEDHEALTHCARE City Plan Choice Plus PPO	
			In-Network or Out-of Area*	Out-of-Network*
DEDUCTIBLES				
Deductible and out-of-pocket maximum (medical)	No deductible Annual out-of-pocket maximum $2,000/individual; $4,000 family	No deductible Annual out-of-pocket maximum $1,500/person; $3,000 family	$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $3,750/person	$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $7,500/person
PREVENTIVE CARE				
Routine physical	No charge	No charge	100% covered no deductible	50% covered after deductible
Immunizations and inoculations	No charge	No charge	100% covered no deductible	50% covered after deductible
Well woman exam and family planning	No charge	No charge	100% covered no deductible	50% covered after deductible
Routine pre/post-partum care	No charge visits limited; see EOC	No charge visits limited; see EOC	85% covered after deductible	50% covered after deductible
PHYSICIAN & OTHER PROVIDER CARE				
Office and home visit	$25 co-pay	$20 co-pay	85% covered after deductible	50% covered after deductible
Hospital visits	No charge	No charge	85% covered after deductible	50% 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
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
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
Mail order: generic drugs	$20 co-pay 90-day supply	$10 co-pay 100-day supply	$10 co-pay 90-day supply	Not covered
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
Mail order: non-formulary drugs	$100 co-pay 90-day supply	Physician authorized only	$90 co-pay 90-day supply	Not covered
Specialty drugs	20% up to $100 co-pay 30-day supply	Same as all 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	50% covered after deductible; prior notificatio
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
Urgent care facility	$25 co-pay within CA service area	$20 co-pay	85% covered after deductible	50% covered after deductible
HOSPITAL/SURGERY				
Inpatient	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; notification require	50% covered after deductible; notification require
Outpatient	$100 co-pay per surgery	$35 co-pay	85% covered after deductible	50% covered after deductible

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2016. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Find EOCs on myhss.org.

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

Not Yet Eligible for Medicare

2016 Medical Plan Benefits-at-a-Glance

	blue of california Access+ HMO	KAISER PERMANENTE® Traditional Plan HMO	UNITEDHEALTHCARE City Plan Choice Plus PPO	
			In-Network or Out-of Area*	Out-of-Network*
REHABILITATIVE				
Physical/Occupational therapy	$25 co-pay per visit	$20 co-pay authorization req.	85% covered after deductible; 60 visits/year	50% covered after deductible; 60 visits/year
Acupuncture	$15 co-pay 30 visits/year; ASH network only	Not covered 25% discount at kp.org/choosehealthy	50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year
Chiropractic	$15 co-pay 30 visits/year; ASH network only	$15 co-pay 30 visits max per plan year; ASH network only; 25% discount at kp.org/choosehealthy	50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000max/year
TRANSGENDER				
Office visits and outpatient surger	Co-pays apply authorization required	Co-pays apply authorization required	85% covered after deductible; notification require	50% covered after deductible; notification require
DURABLE MEDICAL EQUIPMENT				
Home medical equipment	No charge	No charge as authorized by PCP according to formulary	85% covered after deductible; notification require	50% covered after deductible; notification require
Diabetic monitoring supplies	No charge based upon allowed charges	No charge see EOC	Co-pays apply see pharmacy benefit	Co-pays apply see pharmacy benefit
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary	85% covered after deductible; when medically necessary; notification require	50% covered after deductible; when medically necessary; notification require
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
MENTAL HEALTH				
Inpatient hospitalization	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; notification require	50% covered after deductible; notification require
Outpatient treatment	$25 co-pay non-severe and severe	$10 co-pay group $20 co-pay individual	85% covered after deductible; notification require	50% covered after deductible; notification require
Inpatient detox	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; notification require	50% covered after deductible; notification require
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
EXTENDED & END-OF-LIFE CARE				
Skilled nursing facility	No charge up to 100 days/year	No charge up to 100 days/year	85% covered after deductible; up to 120 days/year; notification required; custodial care not covered	50% covered after deductible; up to 120 days/year; notification required; custodial care not covered
Hospice	No charge authorization required	No charge when medically necessary	85% covered after deductible; authorization required	50% covered after deductible; authorization required
OUTSIDE SERVICE AREA				
Care access and limitations	Urgent care $50 co-pay; guest membership benefits for college students in some areas.	Only emergency services before condition permits transfer to Kaiser facility. Co-pays apply.	Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. In-network and out-of-network percentages and co-pays apply.

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2016. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Find EOCs on myhss.org.

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

Medicare and Health Service System Benefits

The Health Service System requires all eligible retiree members and dependents to enroll in Medicare Part A and Part B.

The Social Security Administration is the federal agency responsible for Medicare eligibility, enrollment and premiums.

Medicare Basics

Medicare is a federal health insurance program administered by the Centers for Medicare & Medicaid Services (CMS) for people age 65 years or older, under age 65 with Social Security-qualified disabilities and people of any age with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant). The different parts of Medicare help cover specific services:

- Medicare Part A: Hospital Insurance
- Medicare Part B: Medical Insurance
- Medicare Part D: Prescription Drug Coverage

All eligible retired members and covered eligible dependents must enroll in Medicare Part A and Part B. **Failure by a member or dependent to enroll in Medicare by required deadlines will result in a change in or loss of medical coverage.**

If you are age 65 or older or disabled and receiving Social Security benefits, the Social Security Administration will notify you about Medicare eligibility. If you are not currently receiving Social Security, it is your responsibility to contact the Social Security Administration to apply for Medicare at least three months prior to your 65th birthday or when you become disabled. Failure to do so could result in penalties being assessed by the Social Security Administration and the Health Service System. If you have a Social Security-qualifi d disability or End Stage Renal Disease (ERSD, permanent kidney failure requiring dialysis or transplant), you should contact the Social Security Administration immediately to apply for Medicare.

An HSS member and his or her covered dependents may not all be eligible for Medicare. In that case, the individual with Medicare will be covered under the insurer's plan for Medicare enrollees and any individuals without Medicare will be covered by the same insurer's non-Medicare plan.

Medicare Part A: Hospital Insurance

HSS rules require all retired members and dependents to enroll in premium-free Medicare Part A as soon as they are eligible. Most people do not pay a premium for Part A because they made sufficient contributions via payroll taxes while working.

Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals and skilled nursing facilities (but not custodial or long-term care). It also helps cover hospice care and some home healthcare. Beneficiaries must meet certain cond - tions to qualify for these benefits.

You are eligible for premium-free Medicare Part A if you are age 65 or older and have worked and contributed to Social Security for at least 10 years (40 quarters). You may also qualify for Medicare Part A through a current, former or deceased spouse. If you are under age 65 and have End Stage Renal Disease or a Social Security-qualified disabilit , you may also qualify for Medicare Part A. If you are under age 65 with a qualifying disability, Medicare coverage generally begins 24 to 30 months following eligibility. If you have questions about your eligibility for premium-free Medicare Part A, contact the Social Security Administration at 1-800-772-1213.

Download the *Medicare and You* handbook at: medicare.gov.

Medicare and Health Service System Benefits

What if I'm not eligible for premium-free Medicare Part A?

If you are not eligible for premium-free Medicare Part A, you are not required to enroll in Medicare Part A. You must submit a statement to HSS from the Social Security Administration verifying that you are not eligible for premium-free Medicare Part A. HSS still requires you to enroll in Medicare Part B, even if you are not eligible for Medicare Part A.

Medicare Part B: Medical Insurance

HSS rules require that all retired members and their dependents enroll in Medicare Part B as soon as they are eligible. Medicare Part B helps cover the cost of doctors' services and outpatient medical services. Most people pay a monthly premium to the federal government for Part B. The Medicare Part B monthly premium, which is based on your income per CMS regulations, is usually deducted from your Social Security check. If your income falls after you enroll in Part B, you may be eligible for a Part B premium reduction. For information on Medicare Part B premiums or to request a Part B premium reduction, contact the Social Security Administration. If you do not enroll in Medicare Part B when you first become eligible, your Part B premium will be higher and penalties may be charged when you do enroll. This higher premium and/or penalty will continue for the entire time you are enrolled in Medicare.

What if either I or my dependent did not enroll in Medicare Part A and/or Part B when originally eligible?

If you or a dependent were eligible at age 65 or sooner due to a disability, but did not enroll in Medicare Part A and/or Part B, the Social Security Administration may assess a late enrollment penalty for each year in which the individual was eligible but failed to enroll. HSS members and dependents are required to enroll in Medicare in accordance with HSS rules, even if they are paying a federal penalty for late Medicare enrollment.

Enrolling after age 65 or changing HSS plans during Open Enrollment?

If you enroll in Medicare after age 65 or change Medicare plans during Open Enrollment, your plan may ask you for information about your current prescription drug coverage. If you fail to respond timely, CMS may assess a Part D Late Enrollment Penalty (LEP). Contact your new plan OR HSS if you have questions.

What is the HSS penalty for not enrolling in Medicare Part A and B when eligible or failing to pay Medicare premiums after enrollment?

For Medicare-eligible HSS members without Medicare, existing HSS medical plan coverage will be terminated and the member will be automatically enrolled in City Plan 20. For eligible dependents without Medicare, HSS medical coverage will be terminated. Full HSS coverage for a member or dependent may be reinstated the beginning of the next available coverage period after HSS receives proof of Medicare enrollment.

What is the City Plan 20 for Medicare-eligible HSS members who do not enroll in Medicare or who fail to pay Medicare premiums?

An HSS member who does not enroll in Medicare when eligible or who loses Medicare coverage due to non-payment of Medicare premiums, will lose existing HSS medical coverage and be automatically enrolled in City Plan 20. City Plan 20 significantly increases premium and out-of-pocket costs. Under City Plan 20, you will be responsible for paying the 80% that Medicare would have paid for a covered service, plus any amounts above usual and customary fees. In addition, under City Plan 20, yearly out-of-pocket limits increase to $10,950.

Medicare and Health Service System Benefits

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

Medicare Part D: Prescription Drug Insurance

There are two types of Medicare Part D prescription plans: individual and group. Individual Part D prescription drug coverage is purchased directly by an individual from an insurer or pharmacy. HSS members should **not** enroll in any individual Medicare Part D plan. HSS members are automatically enrolled in group prescription drug coverage under Medicare Part D when they enroll in any medical plan offered through HSS. HSS medical plans offer enhanced group Medicare Part D prescription drug coverage.

Should either I or my dependents enroll in Medicare Part D?

Do not enroll in an individual Medicare Part D prescription drug plan. If you are Medicare-eligible, HSS retiree medical coverage includes enhanced group Medicare Part D prescription drug coverage. You may receive marketing information from private insurance companies, pharmacies and other entities trying to sell individual Medicare Part D prescription drug plans. If you enroll in any of these private, individual Medicare Part D prescription drug plans, your Medicare coverage will be assigned to that individual plan and your HSS group medical coverage will be terminated.

City Plan enrollees please take note:

City Plan Medicare-eligible members will receive a Medicare Part D prescription drug card. UnitedHealthcare provides prescription drug coverage through an Employer Group Waiver Plan (EGWP) governed by Medicare. If you opt out of the EGWP, you will be financially responsible for all your prescription drug costs and you will be enrolled in City Plan 20. (See page 21.)

Medicare enrollees with income exceeding certain thresholds are charged a quarterly Part D premium, also known as the Income Related Monthly Adjusted Amount (IRMAA). In most cases, this Part D premium will be deducted from your Social Security check. For information on Medicare Part D premiums, visit medicare.gov or call Social Security: 1-800-772-1213.

Is there a premium for Medicare Part D?

Most people are not required to pay a Medicare Part D premium. However, if your income exceeds a certain threshold (see Medicare.gov), you may be required to pay a Part D premium to the Social Security Administration. If you are charged a Part D premium, but your income changes and falls below the threshold, contact the Social Security Administration to request an adjustment.

Medicare and Health Service System Benefits

What is the HSS penalty if either I or my dependent fails to pay a Part D premium to the Social Security Administration?

Retirees and dependents who fail to pay a required Part D premium will result in Part D coverage being terminated by the Social Security Administration. Consequently, HSS medical coverage will also be terminated. HSS members who have lost Part D eligibility due to lack of payment will be automatically enrolled in City Plan 20 member only coverage and their dependent coverage will be terminated. Full HSS medical coverage for a member or dependent may be reinstated at the beginning of the next available coverage period after HSS receives proof of Medicare Part D reinstatement.

What are the financial penalties I can incur if I move out of my plan's service area but fail to notify HSS of my new address?

If you move out of your plan's service area, you must notify HSS before your move and enroll in a different HSS plan that offers coverage at your new address. **Medicare does not allow retroactive termination of coverage.** If you do not contact HSS and enroll in a different plan before your move, you may be held responsible for paying the costs of any medical services that you or your dependents obtained after you moved out of your plan's service area.

Medicare Eligibility

A retiree member or dependent is eligible for Medicare at age 65 or due to a Social Security-qualified disability or End Stage Renal Disease

Medicare Part A

Retiree members and dependents must enroll in premium-free Medicare Part A as soon as they are eligible.

Medicare Part B

Retiree members and dependents must enroll in Medicare Part B when eligible and pay premiums to the federal government to maintain continuous enrollment in Medicare Part B.

Group Medicare Part D

Medical plans for Medicare-eligible retirees include enhanced employer group Medicare Part D. This prescription coverage is better than individual Medicare Part D. **You must not enroll in any individual Part D plan offered by a pharmacy, association or insurer.** Depending on your income you may be required to pay Part D premiums to the federal government to maintain your enrollment.

If you have questions about enrolling in Medicare contact the Social Security Administration at 1-800-772-1213.

How Medicare Works With Your Medical Plan

Blue Shield of California

A Health Service System member may enroll with Blue Shield of California as a new retiree or during annual Open Enrollment. If you are eligible for Medicare Part A and Part B and live in a 65 Plus service area, you will be enrolled in the 65 Plus HMO. If you or a dependent becomes eligible for Medicare while enrolled with Blue Shield, the Health Service System must automatically enroll you in 65 Plus, providing you live in a 65 Plus service area.

65 Plus HMO:

Physician and Pharmacy Networks

The contracted network for 65 Plus differs from the network for the Blue Shield non-Medicare plan. So you may be required to seek service from different doctors, hospitals and pharmacies under 65 Plus. Contact Blue Shield for information about the 65 Plus network.

Medicare Assignment

65 Plus is a Medicare Advantage plan. You must obtain service from within the Blue Shield network. When enrolled you assign your Medicare to Blue Shield of California. If you change medical plans for any reason, you will be required to re-assign your Medicare. Complete any forms required by your new plan. If your Medicare is not properly assigned, you could be held responsible for the costs that Medicare would have paid Medicare does not allow retroactive terminations and reassignments.

Prescription Formulary

65 Plus uses an EGWP formulary, which differs from the formulary for the Blue Shield non-Medicare plan. Contact Blue Shield for more information.

ID Cards

65 Plus is a Medicare Advantage plan. You will obtain medical, hospital and pharmacy services from the 65 Plus provider and pharmacy network using one Blue Shield medical ID card.

Payments

You must pay any required monthly premium contributions to the Health Service System. You must also pay required monthly premiums to Medicare. You also pay fixed co-pays out-of-pocket as required, up to a set plan maximum, at the point of service.

Access+ HMO:

Physician and Pharmacy Network

The contracted network for Access+ is the same as the network for the Blue Shield non-Medicare plan. So you may seek service from the same doctors, hospitals and pharmacies. Contact Blue Shield for information about the Access+ network for Medicare eligible enrollees.

Medicare Assignment

Access+ is a Medicare coordinated plan. You retain your Medicare assignment and may receive service outside the Access+ network, paying whatever is required for Medicare only coverage

Prescription Formulary

The formulary for the Access+ Medicare coordinated plan is the same as the formulary for the Access+ without Medicare. Contact Blue Shield for more information.

ID Cards

You will use three different cards–your Medicare card, a Blue Shield medical ID card and a Blue Shield prescription plan card, when obtaining service through the Access+ plan for Medicare enrollees.

Payments

You must pay any required monthly premium contributions to the Health Service System. You must also pay required monthly premiums to Medicare. You also pay fixed co-pays out-of-pocket, up to a set plan maximum, as required at the point of service.

How Medicare Works With Your Medical Plan

Kaiser Permanente

A Health Service System member may enroll with Kaiser Permanente as a new retiree or during annual Open Enrollment. You must live in a Kaiser service area in Northern or Southern California. If you are eligible for Medicare, you will be enrolled in Kaiser Senior Advantage. If you or a dependent becomes eligible for Medicare during the plan year while enrolled with Kaiser, the Health Service System must automatically enroll you in Senior Advantage. Even if you or your dependent are not eligible for premium-free Part A, you are still eligible for Senior Advantage when enrolled in Part B.

Senior Advantage HMO:

Physician and Pharmacy Network

With Kaiser Senior Advantage you receive service from the same network of Kaiser Permanente doctors, hospitals and pharmacies. You do not have to change providers when moving into the Senior Advantage plan.

Medicare Assignment

Senior Advantage is a Medicare Advantage plan. You must obtain service from within the Kaiser integrated network. When enrolled you assign your Medicare to Kaiser Permanente. If you change medical plans for any reason, you will be required to re-assign your Medicare. Complete any forms required by your new plan and contact Kaiser to disenroll your Senior Advantage. If your Medicare is not properly assigned, you could be held responsible for the costs that Medicare would have paid. Medicare does not allow retroactive terminations and reassignments.

Prescription Formulary

The formulary for Kaiser Senior Advantage includes all the drugs that can be included based on Medicare requirements. The Senior Advantage formulary may differ from the Kaiser Traditional plan formulary for non-Medicare enrollees. For more information, contact Kaiser.

ID Cards

You will obtain medical, hospital and pharmacy services from Kaiser facilities using one Kaiser medical ID card.

Payments

You must pay any required monthly premium contributions to the Health Service System. You must also pay required monthly premiums to Medicare. You also pay fixed co-pays out-of-pocket as required, up to a set plan maximum, at the point of service.

How Medicare Works With Your Medical Plan

UnitedHealthcare

A Health Service System member may enroll with UnitedHealthcare as a new retiree or during annual Open Enrollment. UnitedHealthcare provides two plan choices for Medicare-eligible enrollees. These plans do not have service area requirements.

National Medicare Advantage PPO:

Physician and Pharmacy Networks

With UnitedHealthcare Group Medicare Advantage (PPO) plan you can receive service nationwide from any willing Medicare provider, hospital or pharmacy.

Prescription Formulary

UnitedHealthcare Group Medicare Advantage (PPO) uses an EGWP formulary. Contact UnitedHealthcare for more information.

Medicare Assignment

When enrolling with UnitedHealthcare Group Medicare Advantage (PPO) you assign your Medicare to UnitedHealthcare. If you change medical plans for any reason, you will be required to re-assign your Medicare. Complete any forms required by your new plan. If your Medicare is not properly assigned, you could be held responsible for the costs that Medicare would have paid. Medicare does not allow retroactive terminations and reassignments.

ID Cards

With UnitedHealthcare National Medicare Advantage you will obtain medical, hospital and pharmacy services using one UnitedHealthcare medical ID.

Payments

You must pay any required monthly premium contributions to the Health Service System. You must also pay required monthly premiums to Medicare. You also pay fixed co-pays out-of-pocket as required, up to a set plan maximum, at the point of service. With this plan you pay the same cost-share for in-network and out-of-network providers.

City Plan PPO:

Physician and Pharmacy Networks

With City Plan you can receive service worldwide from any licensed provider, hospital or pharmacy.

Prescription Formulary

Medicare-eligible enrollees in City Plan are covered by UnitedHealthcare MedicareRx for Groups, which is an EGWP (Employer Group Waiver Plan). Contact UnitedHealthcare for more information.

Medicare Assignment

City Plan is a Medicare coordinated plan. You retain your Medicare assignment and may receive service outside this plan, paying whatever is required for Medicare only coverage. If Medicare-eligible, you will be enrolled in UnitedHealthcare MedicareRx for Groups prescription coverage. If you or a dependent becomes eligible for Medicare during the plan year while enrolled in City Plan, you must automatically be enrolled in MedicareRx for Groups.

ID Cards

Medicare enrollees will use three cards–Medicare card, UnitedHealthcare Choice Plus PPO medical ID card and UnitedHealthcare MedicareRx for Groups prescription card– when obtaining service.

Payments

You must pay any required monthly premium contributions to the Health Service System. You must also pay required premiums to Medicare. This plan also has a deductible, which you must pay out-of-pocket before coverage begins. After paying the deductible, you pay co-insurance at the point of service, based on a percentage after Medicare pays its part. For example, for in-network service that costs $100, if Medicare pays $50, then you may pay 15% of the remaining $50, which equals $7.50. Your costs at the point of service will vary based on your deductible, reasonable and customary thresholds, what Medicare pays and the percentage of applicable co-insurance.

Medical Coverage If You Travel or Reside Outside of the United States

Traveling Outside Your Health Plan Service Area

Contact your health plan before traveling to determine available coverage and for information about how to contact your plan from outside the United States. In general, if you are travelling outside the United States:

- Blue Shield of California plans only cover emergency services outside of their California service areas.
- Kaiser Permanente plans only cover emergency services outside of their California service areas.
- UnitedHealthcare Group Medicare Advantage (PPO) provides coverage throughout the United States. Only emergency services are covered outside the United States.
- UnitedHealthcare City Plan Choice Plus PPO provides coverage outside the United States. If you obtain service outside the United States, you will pay out-of-area co-insurance.

In most cases, Medicare does not provide coverage for healthcare services obtained outside of the United States. For more information visit: medicare.gov/coverage/travel-need-health-care-outside-us.html

Medicare Enrollment Is Required for Retirees Traveling or Residing Temporarily Outside of the United States

To ensure continued healthcare coverage when you return to the United States, you must maintain your Medicare Part B and Part D enrollment while you are out of the country. If you choose to cancel your Medicare Part B and/or Part D or if you are dropped because you have not paid Medicare premiums, you may have a penalty assessed when you re-enroll with the Social Security Administration. Failure to maintain continuous enrollment in Medicare will also disrupt the coverage you have through the Health Service System.

Medicare Enrollment Is Optional for Retirees Residing Permanently Outside the U.S.

Retiree members and dependents who reside permanently outside the United States must either enroll in UnitedHealthcare City Plan Choice Plus PPO or waive Health Service System coverage.

Medicare enrollment is not required for retired members residing outside the United States. However, healthcare services within the United States will not be covered for foreign residents who are not enrolled in Medicare. Members who choose to live out of the country and not enroll in Medicare must complete an HSS form certifying that they are waiving Medicare enrollment and waiving health coverage within the United States.

If you are a foreign resident, please contact the Social Security Administration for more information before choosing to disenroll from Medicare. The federal government may charge you significant penalties if you disenroll from Medicare now but decide to re-enroll in the future. For retiree members and dependents who reside outside the United States, are enrolled in City Plan and continue Medicare enrollment, services within the United States will be covered and HSS premium contribution rates for Medicare enrollees will apply. Services outside the United States will be covered by the City Plan PPO at the out-of-area reimbursement rate.

Condition Management

Chronic Conditions Are Long-Term Diseases That Can Be Controlled But Not Cured

If you are living with a chronic condition, your health plan may offer chronic condition management at no cost to you. The most common conditions facing Health Service System members are diabetes, COPD, congestive heart failure, obesity and depression. With proper treatment, monitoring, education and motivation those who manage their chronic condition will have an improved quality of life, can avoid getting worse, are able to continue working and have reduced long-term medical costs.

Having a Chronic Condition Puts You at Greater Risk of Depression

It is common to overlook the symptoms of depression, but it is vital that you prioritize your mental health when you have a chronic condition. Untreated depression in people with a chronic condition is associated with twice as many days of limited activity, increased mortality and a 50% to 100% increase in healthcare costs.

Working Together to Manage Conditions and Costs

1. Communicate openly and regularly with your physician. Your doctor provides the best care when he or she knows what is going on.
2. Keep your appointments and follow treatments including taking medications as prescribed.
3. Be a proactive patient. Track your lab results and request copies of lab tests or view them online. Learn more about your condition so you can manage it and feel better about it.
4. Live a healthy lifestyle. Be physically active each day, eat nutritious foods, limit alcohol, avoid tobacco and strive for a healthy weight. Take advantage of health plan and workplace programs that can help you manage stress.
5. Plan for the future. Consider preparing an advance directive to document your wishes regarding medical treatment options.

Condition Management From Your Health Plan

Blue Shield of California HMO	Kaiser Permanente HMO	UnitedHealthcare Group Medicare Advantage PPO	City Plan PPO
Receive nurse support, educational resources and online tools to help you manage a variety of conditions including asthma, diabetes, coronary artery disease, heart failure and chronic obstructive pulmonary disease. Visit blueshieldca.com/hw or call 1-866-954-4567. Your physician's medical group may also have condition management programs–ask your PCP.	Care teams work together using a single electronic health record to coordinate care for asthma, arthritis, cancer, CAD, COPD, chronic pain, CHF, depression, diabetes and low back pain. Members are automatically enrolled Call the nurse advice line 24/7 at 1-866-454-8855 or email your Primary Care Physician (PCP).	Access tools and support if you have diabetes, heart failure, CAD, COPD, hypertension or ESRD. Call 1-877-714-0178 or visit welcometouhc.com/sfhss.	Receive treatment decision support and advice for conditions such as COPD, CAD, diabetes, heart failure and pregnancy. Call 1-888-688-4043 for Disease Management.

Mental Health and Well-being

Mental Health Condition Management

Changes in thought patterns, mood or behavior can signal a mental health condition. Mental health conditions are the second largest cause of disability nationwide. Depression is the most common. It affects more than 26% of the U.S. adult population.

Blue Shield of California HMO	Kaiser Permanente HMO	UnitedHealthcare Group Medicare Advantage PPO	City Plan PPO
Mental Health Inpatient/outpatient mental health, professional services. **Substance Abuse** Inpatient/outpatient including detox and residential rehabilitation. **How to Access** 1-877-263-9952	**Mental Health** Inpatient/outpatient mental health, professional services. **Substance Abuse** Inpatient/outpatient including detox and residential rehabilitation. **How to Access** Call 1-800-464-4000 or speak with your PCP.	**Mental Health** Inpatient/outpatient, partial hospitalization and professional services. **Substance Abuse** Inpatient/outpatient including detox and residential rehabilitation. **How to Access** Call the number on the back of your ID card.	**Mental Health** Outpatient counseling, immediate care and intensive case management. **Substance Abuse** Inpatient/outpatient including detox and residential rehabilitation. **How to Access** 1-866-282-0125

Mental Well-being Services

What is mental well-being? Being satisfied with your life, having positive relationships, coping with stress and working productively. The Health Service System and your health plans offer mental well-being services. To learn more visit myhss.org/well-being/peaceofmind.

Blue Shield of California HMO	Kaiser Permanente HMO	UnitedHealthcare Group Medicare Advantage PPO	City Plan PPO
Counseling LifeReferrals is available 24/7 for mental health, marriage, family and relationship services. Also find resources to help you manage the impact of home, health and career. Call 1-800-985-2405. **Online Coaching** Take well-being one day at a time with the Daily Challenge: myhss.org/well-being/dailychallenge. **Tobacco Cessation** Visit QuitNet at mywellvolution.com for the online smoking cessation program.	**Counseling** Call 1-800-464-4000. **Classes, Support Groups** Contact your local Kaiser facility for a comprehensive list or visit kp.org/mentalhealth. **Telephone/Online Coaching** Call 1-866-251-4514 or visit kp.org and search for HealthMedia Relax. **Tobacco Cessation** Contact your local Kaiser facility for classes. Call 1-866-251-4514 for a telephonic coach. For HealthMedia Breathe and other resources visit kp.org/quitsmoking.	**Counseling/Therapy** Individual and group therapy, screenings and education. Call the number on the back of your ID card.	**Online Coaching** Visit welcometouhc.com/sfhss for the online stress management program. **Tobacco Cessation** Visit welcometouhc.com/sfhss for the online smoking cessation program.

Nurseline and Urgent Care

Save Time and Money – Call for Nurse Advice, Visit an Urgent Care Center, Email Your Doctor

Call a free nurse advice line and speak to a registered nurse. Get answers to your questions about health problems, illness or injury. The nurse can also help you decide if you need routine, urgent or emergency service.

Visit an urgent care center when your physician is not available, after hours and on weekends. Urgent care offers the convenience of same-day appointments and walk-in service. Use urgent care when you need prompt attention for an illness or injury that is not life-threatening.

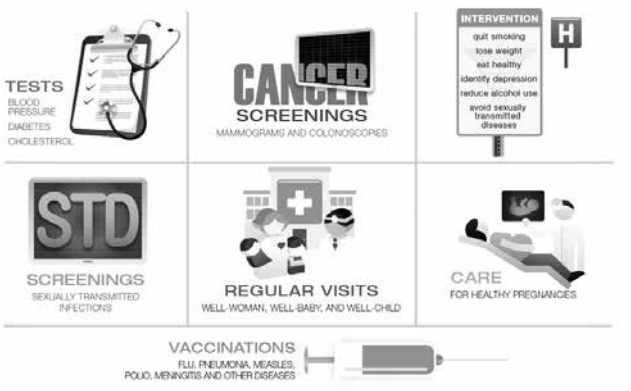
If available, take advantage of your doctor's online patient portal. Email your physician, view lab results, make appointments and renew your prescriptions online.

Blue Shield of California HMO	Kaiser Permanente HMO	UnitedHealthcare Group Medicare Advantage PPO	City Plan PPO
NurseHelp 24/7 1-877-304-0504	**Nurse Advice 24/7** 1-866-454-8855	**Nurseline** 1-877-365-7949	**Nurseline 24/7** 1-800-846-4678
Urgent After Hours Care For the urgent after hours care nearest you contact Blue Shield: 1-855-256-9404 blueshieldca.com	**Urgent After Hours Care** San Francisco 1-415-833-2200 Adult and Pediatric Oakland 1-510-752-1190 Adult 1-510-752-1200 Pediatric Redwood City 1-650-299-2015 Adult and Pediatric Walnut Creek 1-925-295-4070 Adult 1-925-295-4200 Pediatric San Rafael 1-415-444-2940 Adult 1-415-444-4460 Pediatric This is a partial list. For additional Kaiser urgent care facilities call 1-866-454-8855.	**Urgent After Hours Care** For urgent care facilities call UnitedHealthcare at 1-877-714-0178 welcometouhc.com/sfhss	**Urgent After Hours Care** San Francisco Golden Gate Urgent Care 1-415-746-1812 Hayward St. Francis Urgent Care 1-510-780-9400 Rohnert Park Concentra 1-866-944-6046 For more current and additional urgent care facilities call 1-866-282-0125 or visit wellcometouhc.com/sfhss.

Preventive Care

If Everyone in the United States Received Recommended Clinical Preventive Care, We Could Save 100,000 Lives Each Year

Most preventive care services are covered 100%, at no cost to you. Preventive care services include regular checkups, screenings, vaccinations and healthy lifestyle programs. Preventive care and healthy lifestyle choices are small steps that can improve your well-being. With appropriate preventive care you may avoid or delay the onset of a condition. Early diagnosis increases the probability that treatment will be effective. Members who receive appropriate preventive care also help the Health Service System manage costs. For more information, visit myhss.org/well-being/prevention.



Get Started With Your Preventive Care

1. Go to cdc.gov/prevention, enter your sex and age to receive a personalized list of recommended preventive care.

2. Contact your health care provider to schedule your preventive care and learn about services they offer to help you live a healthy lifestyle. Don't forget to take care of your teeth and eyes with routine dental and vision checkups too.

Alternative and Complementary Care

Blue Shield of California HMO	Kaiser Permanente HMO	UnitedHealthcare Group Medicare Advantage PPO	City Plan PPO
Acupuncture and Chiropractic Self-refer up to 30 visits per year at a $15 co-pay per visit. Find a practitioner at: ashcompanies.com or call 1-800-678-9133. After the 30 visits covered by your plan, you can book additional visits using the discount program below. **Acupuncture, Chiropractic, Massage and Wellness Discounts** 25% off usual and customary fees for acupuncture, chiropractic and massage. Visit choosehealthy.com/Default.aspx?hp=BSCA or call 1-888-999-9452	**Chiropractic** Self-refer up to 30 visits per year at a $15 co-pay per visit. Find a practitioner at: ashcompanies.com/kp or call 1-800-678-9133. After the 30 visits covered by your plan, you can book additional visits using the discount program below. **Acupuncture, Chiropractic, Massage and Wellness Discounts** 25% off usual and customary fees for acupuncture, chiropractic and massage. Visit kp.org/choosehealthy or call 1-877-335-2746.	**Acupuncture** $15 co-pay per visit, 24 visit maximum per year. **Chiropractic** $15 co-pay; Medicare-covered care is unlimited; 24 visits per year maximum for routine care. **Massage** Not covered	**Acupuncture and Chiropractic** Self-refer to a licensed practitioner at 50% reasonable and customary co-insurance, up to $1,000 maximum per year, after paying your deductible. **Acupuncture, Chiropractic, Massage and Wellness Discounts** Up to 50% off fees for acupuncture, chiropractic, massage and other wellness resources. Visit unitedhealthallies.com.

Domestic Partner Health Benefits Taxation

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

Federal Tax Treatment of Domestic Partner Health Benefits

The federal government does not recognize domestic partnership for tax purposes. Employer contributions to registered domestic partner health premiums, including domestic partner children, are counted as taxable imputed income by the Internal Revenue Service (IRS). By comparison, no taxable imputed income results from employer contributions to a spouse's health premiums. In addition, retiree premium contributions for registered domestic partner health benefits are paid post-tax. Retiree premium contributions for a spouse are paid pre-tax.

Federal Tax Exemption for Dependents Who Meet Certain Requirements

The Internal Revenue Service offers a tax break for health-related expenses incurred by a "qualifying relative." Under IRS code section 152 (as modified by Code 105 (b)), a registered domestic partner, 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 or retiree; and
2. Partner or child lived with the employee or retiree 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 these requirements the employee or retiree can submit a declaration form to HSS and there will be no imputed income for the employer contribution to dependent health premiums.

The HSS declaration form must be filed by required deadlines and is valid for one tax year. An individual declaration must be submitted every year for each qualifying dependent. The Declaration for Pre-Tax Premium Deduction can be downloaded here: myhss.org/downloads/forms_guides/dp.pdf

If the dependent of a retiree does not qualify for favorable federal tax treatment under the IRS requirements described above, employer contributions will accrue as imputed income and will be taxed by the federal government. Also, retiree premium contributions will be paid post-tax.

Equitable California State Tax Treatment

Health benefits of a registered domestic partner age 62 or older and children of a registered domestic partner are entitled to equitable tax treatment under California state law. Equitable tax treatment under state law requires obtaining the California State Declaration of Domestic Partnership from the Secretary of the State of California. A retiree can deduct the value of employer paid health insurance premiums for a registered domestic partner and his or her children, when filing a California state income tax return. A retiree with a registered domestic partner may take advantage of equitable California state tax treatment even if a domestic partner does not qualify for the federal tax exemption per IRS code section 152.

Consult with Your Tax Advisor

This is a brief overview regarding the tax treatment of health benefits for registered domestic partners. Laws are subject to change. Please consult with a professional tax advisor. It is your responsibility to comply with state and federal tax law.

Dental Plan Options

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

PPO-Style Dental Plans

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

HSS offers the following PPO-style dental plan:

- **Delta Dental**

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

The Delta Dental plan has two different networks. Ask your dentist if he or she is PPO or Premier. Both networks are held to the same quality standards. But choosing a PPO dentist will save you money.

You can also choose any dentist outside of the PPO and Premier networks. However, many services may be covered at a lower percentage, so you pay more. Also, payment is based on reasonable and customary fees for the geographic area.

Diagnostic and Preventative Benefits are not counted towards the annual maximum..

Ask your Delta Dental dentist about costs before receiving services. You can request a pre-treatment estimate of costs before you receive care. For more information, call Delta Dental at 1-888-335-8227.

HMO-Style Dental Plans

Similar to medical HMOs, Dental Maintenance Organization (DMO) plans require that you receive all of your dental care from within a network of participating dental offices. These networks are generally smaller than a dental PPO network. Before you elect a DMO plan, make sure that the plan's network includes the dentist of your choice.

Under these plans, services are covered either at no cost or a fixed co-pa . So there are generally lower out-of-pocket costs for these plans compared to the PPO style dental plan.

HSS offers the following DMO plans:

- **DeltaCare USA**
- **UnitedHealthcare Dental**
  (formerly called Pacific Union Dental

Dental Plan Quick Comparison

	Delta Dental PPO	DeltaCare USA DMO	UnitedHealthcare Dental DMO
Can I receive service from any dentist?	Yes. You can use any dental provider. You pay less when you choose a PPO in-network provider.	No. All services must be received from a contracted network dentist.	No. All services must be received from a contracted network dentist.
Do I need a referral for specialty dental care?	No	Yes	Yes
Will I pay a flat rate for most services?	No. You pay a percentage of applicable charges.	Yes	Yes
Must I live in a certain service area to enroll?	No	Yes. You must live in this DMO's service area.	Yes. You must live in this DMO's service area.

Dental Plan Service Areas

To enroll in either DeltaCare USA or UnitedHealthcare Dental, you must reside in a zip code serviced by the plan.

County	Delta Dental	DeltaCare USA	UnitedHealthcare
Alameda	■	■	■
Alpine			
Amador	■	■	
Butte	■	■	■
Calaveras	■		
Colusa	■		
Contra Costa	■	■	■
Del Norte	■		
El Dorado	■	■	■
Fresno	■	■	■
Glenn	■		■
Humboldt	■	■	
Imperial	■	■	■
Inyo	■		
Kern	■	■	■
Kings	■	■	■
Lake	■	■	
Lassen	■		
Los Angeles	■	■	■
Madera	■	■	■
Marin	■	■	■
Mariposa	■		
Mendocino	■		
Merced	■	■	■
Modoc	■		
Mono	■		
Monterey	■	■	■
Napa	■	■	■
Nevada	■		

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

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

Delta Dental: 1-888-335-8227

DeltaCare USA: 1-800-422-4234

UnitedHealthcare Dental: 1-800-999-3367

Note: you can enroll in a Health Service System dental plan even if you choose not to enroll in a medical plan.

Dental Plan Benefits At-a-Glance 2016

	DELTA DENTAL PPO		DELTACARE USA DMO	UNITEDHEALTHCARE DENTAL DMO
	PPO In-Network Providers	Premier and Out-of-Network Providers		
Diagnostic and Preventive Services				
Cleanings and exams	100% covered Not subject to annual maximum	80% covered Not subject to annual maximum	100% covered Limit 1 every 6 months	100% covered Limit 1 every 6 months
X-rays	100% covered Not subject to annual maximum	80% covered Not subject to annual maximum	100% covered Some limitations apply	100% covered certain limitations apply
Services Covered up to Annual Maximum				
Extractions	80% covered	80% covered	100% covered	$5 co-pay
Fillings	80% covered	80% covered	100% covered Limitations apply to resin materials.	$5 co-pay
Crowns	50% covered	50% covered	100% covered Limitations apply to resin materials.	$85 co-pay
Dentures, pontics and bridges	50% covered	50% covered	No charge Full and partial dentures 1x every 5 yrs; fixed bridgework; certain limitations apply.	$85–$100 co-pay
Endodontic/ Root Canals	50% covered	50% covered	100% covered Excluding the final restoration	$50 co-pay
Oral surgery	80% covered	80% covered	100% covered	Co-pays vary
Implants	50% covered	50% covered	Not covered	Not covered
Orthodontia	Not Covered	Not Covered	Member pays: $1,600/child $1,800/adult $350 startup fee; limitations apply.	Member pays: $1,660/child $1,880/adult $350 startup fee; limitations apply.
Annual Maximum				
Total dental benefit	$1,000 per person	$1,000 per person	None	None
Annual Deductible				
Before accessing benefit	None	$50 per person $150 for family for all services except diagnostic and preventative care.	None	None

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

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 Plan PPO, Blue Shield HMO or Kaiser HMO can access vision coverage administered by Vision Service Plan (VSP).

In addition, Kaiser members may also receive a 25% discount on frames, lenses and materials at Kaiser facilities.

Choice of Providers

You have the choice of using a VSP in-network optometrist or an out-of-network optometrist. Find a VSP network doctor in your area by visiting vsp.com or contacting VSP 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 and frames every 24 months, per last date of service. If examination reveals prescription 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 diagnosi 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 will not have vision benefits

Vision Service Plan Benefits At-a-Glance 2016

	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 co-pay; 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 frames $80 allowance for Costco $25 co-pay applies; 20% savings on the amount over the allowance; 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 fitting and evaluation exam covered; every 24 months*	
Urgent eye care	$5 co-pay	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.

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

Changing Benefit Elections: Qualifying Events

You may change health benefit elections outside of Open Enrollment if there is a qualifying event.

To change benefit elections, you must complete the election change process, including the submission of all required documentation, no later than **30 calendar days** after the qualifying event occurs. If the election change process is not completed **within 30 days** of the date of the qualifying event, you must wait until the next Open Enrollment to make the change.

Marriage or Domestic Partnership

To enroll a new spouse or domestic partner and eligible children of a spouse or partner in Health Service System (HSS) healthcare coverage, submit a completed HSS enrollment application, a copy of the marriage certificate or certificate of domest partnership and a birth certificate for each chil to HSS **within 30 days of the legal date of the marriage or partnership**. A Social Security number must be provided for each of the family members being enrolled. Proof of Medicare enrollment is also required for a domestic partner who is Medicare-eligible due to age or disability. Coverage for your spouse or domestic partner and his or her eligible children will be effective the first day of the coverag period following the submission of the required application and documentation.

Birth or Adoption

To enroll your newborn or newly adopted child, you must submit a completed HSS enrollment application and a copy of the birth certificate or adoption documentation **within 30 days** from the date of birth or placement for adoption. Coverage for an enrolled newborn child will be effective on the child's date of birth. Coverage for an enrolled adopted child will be effective on the date the child is placed. A Social Security number must be provided within six months of the date of birth or adoption or your child's coverage may be terminated.

Legal Guardianship or Court Order

Coverage for a child under legal guardianship is effective the date guardianship takes effect, if all documentation is submitted by the **30-day deadline**. Coverage for a dependent per a court order will be effective the date of court order, if all documentation is submitted to HSS by the **30-day deadline**.

Divorce, Separation, Dissolution, Annulment

By law, you must disenroll ineligible dependents **within 30 days** from the date of a divorce, legal separation, annulment or dissolution of partnership. Submit a completed HSS application with a copy of the legal documentation of your family status change. Coverage for an ex-spouse, domestic partner and stepchildren will terminate on the last day of the coverage period in which the divorce, legal separation, annulment or dissolution of domestic partnership occurred, provided you complete disenrollment **within 30 days**. Failure to notify HSS can result in significant financial penalti equal to the total cost of benefits and services pr - vided for any ineligible dependents.

Loss of Other Health Coverage

Health Service System members and eligible dependents who lose other coverage may enroll by submitting a completed application and proof of the loss of coverage **within 30 days** of the date other coverage terminates. Coverage can be lost due to a termination of employment, a change from full-time to part-time work, dropping other employer coverage during Open Enrollment, ineligibility for Medicare or Medicaid or an unpaid leave of absence. Documentation of lost coverage must state the date other coverage ends and the names of the individuals losing coverage. If all required documentation is submitted, HSS coverage will be effective on the first day of the next coverage period. There may be a break in coverage between the date other coverage terminates and the date HSS coverage begins.

Changing Benefit Elections: Qualifying Events

Obtaining Other Health Coverage

You may waive HSS coverage for yourself or a dependent who enrolls in other health coverage. (If you waive coverage for yourself, coverage for all your enrolled dependents must also be waived.) Submit a completed HSS application and proof of enrollment **within 30 days** of the date of enrollment in the other health plan. Proof of coverage must indicate the effective date of coverage and the names of enrolled individuals. After all required documentation is submitted, HSS coverage will terminate on the last day of the coverage period. There may be an overlap of coverage between the date other coverage begins and the date HSS coverage terminates. You must pay premium contributions up to the termination date of HSS coverage.

Moving Out of Your Plan's Service Area

If you move your primary residence to a location outside your health plan's service area, you cannot obtain services through that plan. Don't risk termination of coverage. You must enroll in a different HSS plan that offers service based on your new address. 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 enrollment application and any required documentation.

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. o be eligible for health benefits, the surviving spouse or domestic partner of a retiree must have been married to the member or registered as the member's domestic partner, for at least one year prior to the death of the member. The surviving spouse or domestic partner of a retiree member hired after January 9, 2009, may not be eligible for HSS benefits. Other restrictions apply.

After being notified of a membe '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 membe '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 certificat
- Copy of certificate of marriage or partnershi (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.

Death of a Dependent

If an enrolled dependent dies, notify HSS as soon as possible and submit a copy of the death certificate **within 30 days** of the date of death. Coverage terminates the day after the dependent's death.

Responsibility for Premium Contributions

Change in coverage due to a qualifying event may change premium contributions. Review your pension check to make sure premium deductions are correct. If the premium deduction is incorrect, contact HSS. You must pay any premiums that are owed. Unpaid premium contributions can result in termination of health coverage.

Glossary of Healthcare Terms

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

Ambulatory Care
Care provided in outpatient setting.

Benefits Coverage Period
Dates when your health insurance coverage begins and ends.

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

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

Co-Insurance
Co-insurance refers to the amount of money that a member is required to pay for healthcare services, after any required deductible has been paid. Co-insurance is specified by a percentage. For example, the enrollee 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.

Covered California
California state health insurance exchange where people can purchase affordable insurance if they lose coverage. coveredca.com

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

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

Dental Maintenance Organization (DMO)
Entity that provides dental services through a limited 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.

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 fo , 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.

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 specific groups of providers. HMO participants typically need pre-approval from a primary care provider before seeing a specialist

Glossary of Healthcare Terms

Imputed Income
IRS regulations require that the value of non-cash compensation, such as the employer's contribution toward health premiums for a retiree's registered 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.

In-Patient
Services that are provided in a hospital and require admission and an overnight stay.

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

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.

Out-Patient
Services that are provided in a clinic or doctor's office. It does not require overnight admission to the hospital.

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

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

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

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

Same Day Surgery
Surgery procedures performed at an ambulatory care center or inpatient hospital without an admission or over night stay..

Specialty Drug
New types of drugs to treat specific illnesses.

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

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

Legal Notices About Health Benefits

Notice of Medicare Part D Creditable Coverage

If you are Medicare-eligible and enrolled in a medical plan through the Health Service System, your prescription drug coverage is better than the standard level of coverage set by the federal government under Medicare Part D. This qualifies as creditable coverage under Medicare Part D.

You only need to worry about this if, in the future, you or a Medicare-eligible dependent terminates or loses medical coverage administered through the Health Service System. At that point, this evidence of creditable coverage will prevent you from incurring penalties charged by the federal government for late enrollment in Medicare Part D. You must enroll in Medicare Part D no more than 62 days after your coverage through the Health Service System terminates. Anyone who fails to act within that time period will incur a late enrollment penalty of at least 1% per month for each month after May 15, 2006 that the person did not have creditable coverage or enrollment in Part D.

For example, if 19 months passed between the time a person terminated creditable coverage with the Health Service System and that person's enrollment in Medicare Part D, that person's Medicare Part D premium would always be at least 19% higher than what most other people pay. That person might also be required to wait until the following November, when the federal government conducts Open Enrollment for Medicare, in order to sign up for Medicare Part D prescription coverage.

If a person loses creditable prescription drug coverage through no fault of his or her own, that person may also be eligible for a Special Enrollment Period (SEP) to join a Medicare drug plan.

Women's Health and Cancer Rights Notice

The Women's Health and Cancer Rights Act of 1998 requires that your medical plan provide benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between breasts, prostheses and complications resulting from a mastectomy, including lymphedema. Contact your medical plan for details.

Use and Disclosure of Your Personal Health Information

The Health Service System maintains policies to protect your personal health information, in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA). Other than the uses listed below, the Health Service System will not disclose your health information without your written authorization:

- To make or obtain payments from plan vendors contracted with the Health Service System.
- To facilitate administration of health insurance coverage and services for Health Service System members.
- To assist actuaries in making projections and soliciting premium bids from health plans.
- To provide you with information about health benefits and services.
- When legally required to disclose information by federal, state or local law (including Worker's Compensation regulations), law enforcement investigating a crime and court order or subpoena.
- To prevent a serious or imminent threat to individual or public health and safety.

If you authorize the Health Service System to disclose your health information, you may revoke that authorization in writing at any time.

You have the right to express complaints to the Health Service System and the Federal Health and Human Services Agency if you feel your privacy rights have been violated. Any privacy complaints made to the Health Service System should be made in writing.

This is a summary of a legal notice that details Health Service System privacy policy. The full legal notice is available at: myhss.org/health_service_board/privacy_policy.html.

You may also contact the Health Service System to request a written copy of the full legal notice.

Health Service Board

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Appointee
President

Wilfredo Lim
Elected Employee
Vice President

Karen Breslin
Elected Retiree

Mark Farrell
Appointee

Sharon Ferrigno
Elected Retiree

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Gregg Sass
Appointee

The Health Service Board conducts an annual review of health benefit costs, ensures benefits are applied without favor or privileg and administers the business of the Health Service System. Visit myhss.org/health_service_board.

Health Service Board Achievements

Well-being Program: Approved the City's wellness plan.

Steps to Avoid the 2018 Excise Tax: Allocated $5.4M from the City Plan Stabilization Reserve to reduce 2016 City Plan premiums for employees and early retirees. This allocation, along with the Blue Shield of California 2015 rate stabilization, will reduce the base rate used to calculate the 40% federal excise tax in 2018.

Competition Between Plans: Funded a stabilization reserve from excess 2013 underwriting gains and stabilized Blue Shield of California 2015 premiums. This helped balance the risk between the Blue Shield of California and Kaiser Permanente plans, keeping employee premium contributions affordable and competitive.

ACOs: Approved establishing two of the first Accountable Care Organizations (ACOs) in California. Through these ACOs, the Health Service System, Blue Shield of California, Brown & Toland Physicians, Hill Physicians and John Muir Medical Group are working together to improve patient care and reduce costs.

Flex Funding: Approved flex-funding of the Blue Shield of California plan, allowing the Health Service System to reduce insurance costs by paying hospital, pharmacy and physician costs directly.

Performance Guarantees: Approved plan vendor performance guarantees with financial penalties. The guarantees are based on unique criteria that align with providing quality care and service to Health Service System members.

All Payer Claims Database: Approved funding and implementation of a database that will power data-driven analysis focused on improving care and decreasing costs.

Flat Contribution Model: Supported an initiative by the City & County and the unions which changed the employee premium contribution methodology to a flat percentage of plan premium. This helped maintain competition and balance risk between plans, ensuring a choice of plans for Health Service System members.

HSS members may submit comments to the Board. Email: health.service.board@sfgov.org. Mail: Board Secretary, Health Service System, 1145 Market Street, 3rd Floor, San Francisco, CA 94103. Phone: 1-415-554-0662.

Retiree Not Yet Eligible For Medicare: Medical Premiums

RETIREES HIRED BEFORE JANUARY 9, 2009

2016 Monthly Medical Premiums	Blue Shield HMO		Kaiser Permanente HMO		City Plan PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	$1,593.25	$71.14	$1,112.19	0	$845.74	$88.71
Retiree +1 Dependent with no Medicare	$1,967.11	$445.00	$1,388.19	$275.99	$1,297.90	$540.88
Retiree +2 or More Dependents with no Medicare	$1,967.11	$1,042.17	$1,388.19	$734.14	$1,297.90	$1,161.83
Retiree +1 Dependent with Medicare Part B Only	$1,967.11	$445.00	$1,271.67	$159.48	$938.02	$180.98
Retiree +1 Dependent with Medicare Part A and Part B	$1,779.49	$257.37	$1,271.67	$159.48	$972.78	$215.75
Retiree +1 Dependent with Medicare Part B Only +1 or more Deps	$1,967.11	$1,042.17	$1,271.67	$617.63	$938.02	$801.93
Retiree +1 Dependent with Medicare Part A and B +1 or more Dependents	$1,779.49	$854.54	$1,271.67	$617.63	$972.78	$836.70

RETIREES HIRED AFTER JANUARY 9, 2009 WITH MORE THAN 5 AND LESS THAN 10 YEARS OF SERVICE

2016 Monthly Medical Premiums	Blue Shield HMO		Kaiser Permanente HMO		City Plan PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	$1,664.39	0	$1,112.19	0	$934.45
Retiree +1 Dependent with no Medicare	0	$2,412.11	0	$1,664.18	0	$1,838.78
Retiree +2 or More Dependents with no Medicare	0	$3,009.28	0	$2,122.33	0	$2,459.73
Retiree +1 Dependent with Medicare Part B Only	0	$2,412.11	0	$1,431.15	0	$1,119.00
Retiree +1 Dependent with Medicare Part A and Part B	0	$2,036.86	0	$1,431.15	0	$1,188.53
Retiree +1 Dependent with Medicare Part B Only +1 or more Deps	0	$3,009.28	0	$1,889.30	0	$1,739.95
Retiree +1 Dependent with Medicare Part A and B +1 or more Dependents	0	$2,634.03	0	$1,889.30	0	$1,809.48

Retiree Eligible For Medicare Part A and Part B: Medical Premiums

RETIREES HIRED BEFORE JANUARY 9, 2009

2016 Monthly Medical Premiums	Blue Shield HMO		Kaiser Permanente HMO		City Plan PPO		UnitedHealthcare NPPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	$374.50	0	$320.99	0	$280.66	0	$311.20	0
Retiree +1 Dependent with no Medicare	$748.36	$373.86	$596.99	$275.99	$732.82	$452.17	$763.36	$452.17
Retiree +2 or More Dependents with no Medicare	$748.36	$971.03	$596.99	$734.14	$732.82	$1,073.12	$763.36	$1,073.12
Retiree +1 Dependent with Medicare Part B Only	$748.36	$373.86	$480.47	$159.48	$372.94	$92.27	$403.48	$92.27
Retiree +1 Dependent with Medicare Part A and Part B	$560.74	$186.23	$480.47	$159.48	$407.70	$127.04	$465.79	$154.58
Retiree +1 Dependent with Medicare Part B Only +1 or more Deps	$748.36	$971.03	$480.47	$617.63	$372.94	$713.22	$403.48	$713.22
Retiree +1 Dependent with Medicare Part A and B +1 or more Dependents	$560.74	$783.40	$480.47	$617.63	$407.70	$747.99	$465.79	$775.53

RETIREES HIRED AFTER JANUARY 9, 2009 WITH MORE THAN 5 AND LESS THAN 10 YEARS OF SERVICE

2016 Monthly Medical Premiums	Blue Shield HMO		Kaiser Permanente HMO		City Plan PPO		UnitedHealthcare NPPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	$374.50	0	$320.99	0	$280.66	0	$311.20
Retiree +1 Dependent with no Medicare	0	$1,122.22	0	$872.98	0	$1,184.99	0	$1,215.53
Retiree +2 or More Dependents with no Medicare	0	$1,719.39	0	$1,331.13	0	$1,805.94	0	$1,836.48
Retiree +1 Dependent with Medicare Part B Only	0	$1,122.22	0	$639.95	0	$465.21	0	$495.75
Retiree +1 Dependent with Medicare Part A and Part B	0	$746.97	0	$639.95	0	$534.74	0	$620.37
Retiree +1 Dependent with Medicare Part B Only +1 or more Deps	0	$1,719.39	0	$1,098.10	0	$1,086.16	0	$1,116.70
Retiree +1 Dependent with Medicare Part A and B +1 or more Dependents	0	$1,344.14	0	$1,098.10	0	$1,155.69	0	$1,241.32

Retiree Eligible For Medicare Part B Only: Medical Premiums

RETIREES HIRED BEFORE JANUARY 9, 2009

2016 Monthly Medical Premiums	Blue Shield HMO		Kaiser Permanente HMO		City Plan PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	$1,664.39	0	$320.99	0	$222.53	0
Retiree +1 Dependent with no Medicare	$2,038.25	$373.86	$596.99	$275.99	$674.69	$452.17
Retiree +2 or More Dependents with no Medicare	$2,038.25	$971.03	$596.99	$734.14	$674.69	$1,073.12
Retiree +1 Dependent with Medicare Part B Only	$2,038.25	$373.86	$480.47	$159.48	$314.81	$92.27
Retiree +1 Dependent with Medicare Part A and Part B	$1,850.63	$186.23	$480.47	$159.48	$349.57	$127.04
Retiree +1 Dependent with Medicare Part B Only +1 or more Deps	$2,038.25	$971.03	$480.47	$617.63	$314.81	$713.22
Retiree +1 Dependent with Medicare Part A and B +1 or more Dependents	$1,850.63	$783.40	$480.47	$617.63	$349.57	$747.99

RETIREES HIRED AFTER JANUARY 9, 2009 WITH MORE THAN 5 AND LESS THAN 10 YEARS OF SERVICE

2016 Monthly Medical Premiums	Blue Shield HMO		Kaiser Permanente HMO		City Plan PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	$1,664.39	0	$320.99	0	$222.53
Retiree +1 Dependent with no Medicare	0	$2,412.11	0	$872.98	0	$1,126.86
Retiree +2 or More Dependents with no Medicare	0	$3,009.28	0	$1,331.13	0	$1,747.81
Retiree +1 Dependent with Medicare Part B Only	0	$2,412.11	0	$639.95	0	$407.08
Retiree +1 Dependent with Medicare Part A and Part B	0	$2,036.86	0	$639.95	0	$476.61
Retiree +1 Dependent with Medicare Part B Only +1 or more Deps	0	$3,009.28	0	$1,098.10	0	$1,028.03
Retiree +1 Dependent with Medicare Part A and B +1 or more Dependents	0	$2,634.03	0	$1,098.10	0	$1,097.56

Surviving Spouse or Domestic Partner: Medical Premiums

SURVIVOR NOT ELIGIBLE FOR MEDICARE

2016 Monthly Medical Premiums	Blue Shield HMO		Kaiser Permanente HMO		City Plan PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Survivor Only	$1,593.25	$71.14	$1,112.19	0	$845.74	$88.71
Survivor +1 Dependent with no Medicare	$1,967.11	$445.00	$1,388.19	$275.99	$1,297.90	$540.88
Retiree +2 or More Dependents with no Medicare	$1,967.11	$1,042.17	$1,388.19	$734.14	$1,297.90	$1,161.83

SURVIVOR ELIGIBLE FOR MEDICARE PART A and PART B

2016 Monthly Medical Premiums	Blue Shield HMO		Kaiser Permanente HMO		City Plan PPO		UnitedHealthcare NPPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Survivor Only	$374.50	0	$320.99	0	$280.66	0	$311.20	0
Retiree +1 Dependent with no Medicare	$748.36	$373.86	$821.37	$275.99	$732.82	$452.17	$763.36	$452.17
Retiree +2 or More Dependents with no Medicare	$748.36	$971.03	$821.37	$734.14	$732.82	$1,073.12	$763.36	$1,073.12

All Retirees: Dental Premiums

2016 Monthly Dental Premiums	Delta Dental PPO		DeltaCare USA DMO		UnitedHealthcare Dental DMO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	$42.94	0	$32.85	0	$16.47
Retiree +1 Dependent	0	$85.42	0	$54.21	0	$27.20
Retiree +2 or More Dependents	0	$127.49	0	$80.19	0	$40.22

Required retiree premium contributions, if any, will be deducted from the member's monthly pension check. If the pension check does not fully cover premium payments, the member must contact HSS to make payment arrangements.

Key Contact Information

HEALTH SERVICE SYSTEM

Member Services
1145 Market Street, 3rd Floor
San Francisco, CA 94103
Tel: 1-415-554-1750
1-800-541-2266
Fax: 1-415-554-1721
Web: myhss.org

Well-being Program
1145 Market Street, 1st Floor
San Francisco, CA 94103
Tel: 1-415-554-0643
Email: wellness@sfgov.org

Health Service Board
Tel: 1-415-554-0662
Email:
health.service.board@sfgov.org

MEDICAL PLANS			
Blue Shield of California 65 Plus Medicare Advantage	1-800-776-4466 TTY 1-800-794-1099	blueshieldca.com	Group W0051448
Blue Shield of California Access+ Medicare Coordinated	1-855-256-9404	blueshieldca.com	Group W0051448
Blue Shield of California Access+ No Medicare	1-855-256-9404	blueshieldca.com	Group W0051448
Kaiser Permanente Senior Advantage and Traditional	1-800-443-0815	my.kp.org/ccsf	Group 888 Northern California Group 231003 Southern California
United Healthcare Medicare Advantage National PPO	1-877-714-0178 TTY 711	welcometouhc.com/sfhss	Group 13694 fully subsidized Group 13693 partially subsidized
UnitedHealthcare City Plan Choice Plus Medicare Rx	1-866-282-0125 1-877-259-0493	welcometouhc.com/sfhss	Group 752103
DENTAL and VISION PLANS			
Delta Dental	1-888-335-8227	deltadentalins.com	Group 1673-0001
DeltaCare USA	1-800-422-4234	deltadentalins.com	Group 01797-0003
UnitedHealthcare Dental formerly Pacific Union Dental	1-800-999-3367	welcometouhc.com/sfhss	Group 705287-0046
VSP Vision	1-800-877-7195	vsp.com	Group 12145878
COBRA			
P&A Group	1-800-688-2611	padmin.com	
OTHER AGENCIES			
SFERS	1-415-487-7000	mysfers.org	pension benefit
CalPERS	1-888-225-7377	calpers.ca.org	
CalSTRS	1-800-228-5453	calstrs.org	
PARS	1-800-540-6369	parsinfo.org	
Social Security	1-800-772-1213 TTY 1-800-325-0778	ssa.gov	Medicare enrollment
Medicare	1-800-633-4227 TTY 1-877-486-2048	medicare.gov	Medicare administration
Covered California	1-888-975-1142	coveredca.com	state health insurance exchange

10 THINGS RETIREES SHOULD KNOW...

The Health Service System is Your Trusted Resource for Health Benefits Information

If you have questions about your benefits contact the Health Service System at 1-415-554-1750 or 1-800-541-2266. Visit our website at myhss.org.

Retiree Health Benefits Eligibility Is Determined by the San Francisco City Charter

Eligibility for retiree health benefits and retiree premium contributions vary depending upon an individual's hire date, years of credited service, time of retirement and other factors.

Retiree Health Benefits Are Different Than Employee Health Benefits

Review retiree benefits options carefully. Retiree medical and dental plans are not the same as active employee plans. Premium contributions are also different.

New Retirees: There Is A 30 Day Deadline to Enroll In Retiree Health Benefits

You must complete enrollment in retiree benefits within 30 days of your retirement date. If you miss the 30 day deadline, you must wait until Open Enrollment to enroll in retiree health benefits.

Retirees and Dependents Must Enroll In Medicare Part A and Part B As Soon As Eligible

Retirees and dependents who are Medicare-eligible due to age or disability must enroll in premium-free Medicare Part A hospital insurance and Medicare Part B medical insurance.

Do Not Enroll In Any Individual Medicare Part D Prescription Drug Plan

All Health Service System retiree medical plans include enhanced group Medicare Part D coverage. You must not enroll in an individual Part D plan offered through pharmacy, organization or insurer.

Medicare-eligible Retirees Must Pay Premiums to the Federal Government

You must pay Medicare premiums to maintain continuous enrollment in Medicare. There is a premium for Medicare Part B. You may also be required to pay a premium for your group Medicare Part D.

Health Service Premium Contributions Must Also Be Paid

Any premium contributions due to the Health Service System must be paid to maintain your enrollment in health coverage provided through the Health Service System.

You Must Disenroll Ineligible Family Members Within 30 Days

Divorce or dissolution of partnership? Your ex-spouse, partner or stepchild is no longer eligible for health coverage. Don't risk paying significant penalties. Contact HSS and drop ineligible dependents.

If You Change Your Home Address, Contact the Health Service System

Your retirement system does not update your address with the Health Service System. If you move, make sure to notify HSS about your change of address, so we can keep you informed about your benefits.