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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.

What's New 2016

Changes to SFUSD employee health benefits as of January 1, 2016.

No Changes to Medical Plan Choices or Covered Benefits

Good news! The same medical, dental and vision plans offered in 2015 are being offered in 2016. There are no changes in covered benefits or related out-of-pocket costs such as co-pays or co-insurance.

2016 Premium Contribution Changes

Employee premium contributions will change as of January 2016. Please review premium contribution changes before making your 2016 enrollment decisions.

HSS EAP Available to SFUSD as of January 1, 2016

EAP provides confidential, voluntary, no-cost mental health services, including short-term, solution-oriented counseling for individuals, couples and families. To learn more visit myhss.org/eap.html.

How to enroll in medical and vision benefits

Don't Miss the 30-Day Deadline

- Learn about your medical and vision benefits options by reading this Guide and visiting myhss.org.
- Eligible new and rehired employees must enroll in health coverage within **30 calendar days**. If you do not enroll within this 30-day period, you can only apply for benefits during the next Open Enrollment or within 30 days of a qualifying event, such as losing other coverage.
- To enroll, submit a completed enrollment application and all required eligibility documentation to the Health Service System by the 30-day deadline. Be prepared by making copies of eligibility documentation such as a marriage certificate, domestic partner certification, and children's birth certificates. You may mail, fax or drop off your enrollment documents to the Health Service System. The fax number is 1-415-554-1721.
- Employee premium contributions are deducted from paychecks bi-weekly. Review your paycheck to verify that the correct employee premium contribution is being deducted.
- October Open Enrollment is your annual opportunity to change benefit elections without any qualifying events.
- Questions about health benefits or premium contributions? **Call Member Services at 1-415-554-1750.**

Working Together to Stay Healthy and Manage Costs

In the next year, the Health Service System will spend over \$718 million on health benefits for over 113,000 members and dependents. It is important that HSS, the health plans, and the members work together to manage costs.

Overall premiums increased by less than 4% for 2016. This includes increases in vision and dental care. In 2018, the Affordable Care Act requires a 40% excise tax be charged on every dollar above a specified amount. This will greatly increase the cost of benefits. The Health Service Board has taken actions to keep costs below the excise tax. There are ways you can help us manage everyone's costs and improve your health at the same time.

Ten Ways You Can Stay Healthy and Manage Costs

- 1. Live a healthy lifestyle.** Be physically active each day, eat nutritious foods, limit alcohol, avoid tobacco, and strive for a healthy weight. HSS offers an Employee Assistance Program (EAP), healthy challenges (Daily Challenge, Walking Challenge), the Well-being Assessment, worksite-specific programming (group exercise classes, biometric screenings, wellness coaching, flu shot clinics, Champion network) and the Wellness Center to help HSS members take small steps toward the big reward of a healthier lifestyle.
- 2. Go to regular checkups.** Take advantage of 100% covered or low co-pay regular medical, dental and vision checkups.
- 3. Talk to your doctor.** Communicate openly and regularly with your physician. Your doctor provides the best care when he or she knows what is going on.
- 4. Get vaccinated.** Prevent illness by getting vaccinations. Ask your doctor to recommend appropriate vaccinations, including seasonal flu, tetanus, adult boosters for childhood immunizations and more.
- 5. Get screened.** Detect conditions early by getting the recommended screenings (blood pressure, cholesterol, colon cancer and other cardiovascular and cancer screenings).
- 6. Don't ignore your mental health and well-being.** If you have a mental health condition, get relief by seeking care. Protect your mental and emotional well-being by learning stress management techniques and seeking help before challenges escalate.
- 7. Manage existing conditions.** If you have a condition, live a healthy lifestyle and follow treatments (including medications) as prescribed by your physician. Condition management can slow disease progression, help avoid certain complications and improve quality of life.
- 8. Call ahead.** Use your plan's nurse advice phone line service to determine the best place to seek care.
- 9. Consider urgent care after hours.** After your doctor's hours, urgent care is often the least expensive and quickest way to get the care you need. Use the emergency room for emergencies only.
- 10. Plan your end of life care.** Advance directives give you and your family peace of mind that your wishes will be respected. Ask your health plan or physician for more information.

Eligibility

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

Member Eligibility

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

- All regularly scheduled provisional or temporary exempt employees of the SFUSD whose normal scheduled work week at date of hire is not less than 20 hours.
- All other employees of the SFUSD, including “as needed” intermittent or substitute temporary/temporary exempt employees, who have worked at least 20 hours a week in a consecutive 12 month period.
- All members of the SF Board of Education boards during their time in service to the San Francisco Unified School District.
- All other employees who are deemed “full-time employees” under the shared responsibility provision of the federal Patient Protection and Affordability Care Act (Section 4980H).

Dependent Eligibility

Spouse or Domestic Partner

A member’s spouse or registered domestic partner may be eligible for HSS health coverage. Proof of legal 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 coverage 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. A spouse covered on an employee’s medical plan is not required to enroll in Medicare. A registered domestic partner who is eligible for Medicare is required to enroll in Medicare.

Natural Children, Stepchildren, Adopted Children

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

Legal Guardianships and Court-Ordered Children

Children under 19 years of age placed under the legal guardianship of an enrolled member, a member’s spouse, or registered domestic partner are eligible. If a member is required by a court’s judgment, 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 is continuously covered for at least one year prior to the child's 19th birthday.
2. Adult child was continuously enrolled in an HSS medical plan from age 19 to 26.
3. Adult child is incapable of self-sustaining employment due to the disability.
4. Adult child is unmarried.
5. Adult child permanently resides with the employee member.
6. Adult child is dependent on the member for substantially all of his or her economic support and is declared as an exemption on the member's federal income tax.
7. Member submits to HSS acceptable medical documentation—a certification that an adult child is enrolled in Medicare due to a Social Security-qualifying disability, or HSS disabled dependent forms completed and signed by a physician at least 60 days prior to child's attainment of age 26 and every year thereafter as requested.
8. All enrolled dependents who qualify for Medicare due to a disability are required to enroll in Medicare. Members must notify HSS of any dependent's eligibility for, and enrollment in, Medicare.
9. Once enrolled, the member must continuously enroll the disabled adult child in HSS coverage and Medicare (if eligible) to maintain future eligibility.

Medicare Enrollment Requirements for Dependents

HSS Rules require domestic partners, dependents with End Stage Renal Disease (ESRD) and children who have received Social Security insurance for more than 24 months to enroll in premium-free Medicare Part A and Part B. Medicare coverage begins 30 months after disability application. Note that a member or dependent with ESRD may be prohibited from changing medical plan enrollment.

Medicare Enrollment Requirements When You Retire

Retirees and dependents who are eligible for Medicare must have Medicare Part A and Part B in effect when retiring. Proof of Medicare coverage is required by HSS before any Medicare-eligible individual can be enrolled in retiree health coverage. Failure to enroll in Medicare when first eligible may also result in a late-enrollment penalty from Medicare. The Medicare application process at Social Security often takes three months so plan ahead.

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.

Eligibility Documentation

Required Eligibility Documentation

	Employment Evidence	Marriage Certificate	Domestic Partner Cert	Birth Certificate	Adoption Certificate	Proof Of Placement	Court Order Or Decree	Medical Evidence	Social Security #
Employee: Permanent/Provisional	■								■
Employee: Temporary/Exempt	■								■
Spouse		■							■
Domestic Partner			■						■
Child: Natural				■					■
Stepchild: Spouse		■		■					■
Stepchild: Domestic Partner			■	■					■
Child: Adopted					■				■
Child: Placed for Adoption						■			■
Child: Legal Guardianship							■		■
Child: Court Ordered							■		■
Adult Child: Disabled				■				■	■

Proof of Medicare enrollment is required for a legal domestic partner who is age 65 and any employee or dependent who is Medicare-eligible due to disability or End Stage renal Disease (ERSD). If you have questions about eligibility or required documentation, contact HSS Member Services at 1-415-554-1750.

Temporary Employee Eligibility

Take note of this important information for temporary teachers, speech therapists, psychologists, nurses, substitutes and other SFUSD temporary employees.

Temporary Certificated Employees

Temporary certificated employees with contracts that end June 30 are as follows:

- Emergency Teachers (ETs)
- Categorical Teachers (CTCs)
- University Interns (ITs)

If you are a Temporary Certificated employee whose contract ends on June 30, your last day of coverage will be June 30.

If you are a temporary teacher whose contract ends prior to June 30, your last day of coverage will be the last day of the month in which employment terminates.

Temporary School-Term Biweekly Employees

Temporary School-Term Biweekly employees include but are not limited to:

- Clerical Workers
- Paraprofessionals
- Security Aides

If you are a Temporary School-Term Biweekly employee coverage will end on the last day of the pay period in which your employment is concluded.

Eligible Temporary Exempt Employees

As needed intermittent or substitute temporary/temporary exempt employees who have worked at least 20 hours a week in a consecutive 12-month period typically become eligible to enroll in med-

ical and dental benefits. The determination of eligibility is made by the SFUSD Benefits Office. Documentation is required.

Options for Maintaining Coverage

Covered California: The state health insurance exchange, created under the federal Patient Protection and Affordable Care Act, allows you to compare and shop for health insurance. In some cases, you may qualify for Medi-Cal, tax credits and other assistance to make health insurance more affordable. Call 1-888-975-1142 or visit coveredca.com.

COBRA: The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted in 1986 allows employees and their covered dependents to elect temporary extension of healthcare coverage in certain instances where coverage would end. The COBRA administrator will notify you of the opportunity to elect COBRA coverage. You have 60 days from the notification date to complete COBRA enrollment. With COBRA you pay the full cost of premiums.

Individual Coverage: You may be able to purchase individual health coverage from your healthcare plan or other insurers. Contact plans directly for details and costs. All employees and dependents who were covered under an HSS-administered medical plan are entitled to a certificate showing evidence of prior health coverage.

Rehired in the Fall?

If you are rehired in the fall with an eligible SFUSD assignment, you must re-enroll for healthcare benefits through HSS and SFUSD within 30 calendar days of your rehire date.

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. Note: an individual with End Stage Renal Disease may be prohibited from changing medical plans.

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 domestic partnership and a birth certificate for each child 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 coverage 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 penalties equal to the total cost of benefits and services provided for any ineligible dependents.

Loss of Other Health Coverage

HSS members and eligible dependents who lose other coverage may enroll by submitting a completed application and proof of loss of coverage **within 30 days** of the date other coverage terminates. Coverage can be lost due to termination of employment, change from full-time to part-time work, dropping other employer coverage during Open Enrollment, ineligibility for Medicare or Medicaid, unpaid leave of absence or return from military service. Documentation of lost coverage must state the date other coverage ends and the names of individuals losing coverage. If 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 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.

Death of a Member

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

spouse or domestic partner of an employee member hired after January 9, 2009, may not be eligible for HSS benefits. Other restrictions apply.

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

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

A surviving spouse or partner who is not enrolled on the deceased member's health plan at the time of the member's death may be eligible for coverage, but must wait until Open Enrollment to enroll. Surviving dependent children of a member must meet eligibility requirements for dependent children and be enrolled at the time of the member's death and are only eligible for benefits under a surviving spouse or surviving domestic partner.

Changing FSA Contributions

Per IRS regulations, some qualifying events may allow you to initiate or modify Flexible Spending Account (FSA) contributions. For questions about qualifying events and authorized FSA contribution changes contact SFUSD at 1-415-241-6101.

Responsibility for Premium Contributions

Change in coverage due to a qualifying event may change premium contributions. Review your paycheck or 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 coverage.

The Health Service System Provides You With Medical Plan Options

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

Health Maintenance Organization (HMO)

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

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

Preferred Provider Organization (PPO)

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

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

How To Enroll In Medical Benefits

Eligible full-time employees must enroll in an HSS medical plan **within 30 calendar days** of their start work date. (Part-time or temporary employees see page 7.) Submit a completed enrollment application and eligibility documentation to HSS. If you do not enroll by required deadlines, you can only apply during Open Enrollment or due to a qualifying event. Coverage will start the first day of the coverage period after eligibility has been approved by HSS. Verify the date coverage will start with HSS when you enroll. Once enrolled, you must pay all required employee premium contributions. Review your paycheck to make sure correct deductions are being taken.

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

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

The Evidence of Coverage (EOC) contains a complete list of benefits and exclusions in effect for each plan from January to December 2016. Review your EOC for plan details. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Download plan EOCs at myhss.org.

Medical Plan Service Areas

County	Kaiser Permanente HMO	Blue Shield of California HMO	City Plan PPO
Alameda	■	■	■
Contra Costa	■	■	■
Marin	■	■	■
Napa	○		■
Sacramento	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Clara	○	■	■
Solano	■	■	■
Sonoma	○	■	■
Stanislaus	■	■	■
Tuolumne			■
Outside of California	Urgent/ER Care Only	Urgent/ER Care Only	No service area limits

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

To enroll in a Blue Shield or Kaiser Permanente HMO, you must reside in a zip code serviced by the plan. If you do not see your county listed above, contact the medical plan to see if service is available to you. For Blue Shield of California call 1-855-256-9404. For Kaiser Permanente call 1-800-464-4000.

City Plan PPO does not have any service area requirements.

Change of Address?

If you move out of the service area covered by your plan, you must elect an alternate medical plan that provides coverage in your area. Failure to change your health benefit elections may result in the non-payment of claims for services received. Contact the Health Service System at 1-415-554-1750 to update your information and review plan options if you are changing your address.

Choosing Your Medical Plan

	Blue Shield of California HMO	Kaiser Permanente HMO	City Plan PPO
Must I select a PCP (Primary Care Physician)?	You can choose your PCP after you enroll, or Blue Shield will assign.	You can choose your PCP after you enroll, or Kaiser will assign.	No PCP– you have more responsibility for coordinating care.
Can I change my PCP during the plan year?	Yes, monthly.	Yes, anytime.	
Am I required to use the plan's contracted network of service providers?	Yes. Services must be received from the contracted network.	Yes. Services must be received from Kaiser.	No, but out-of-network providers will cost you more.
Is access to hospitals and specialists determined by medical group assignment?	Yes. PCP referrals to specialists and hospitals will be determined by medical group affiliation.	Yes. All services must be received from a Kaiser facility.	No
Do I have to pay an annual deductible?	No	No	Yes
Do I have to file claim forms?	No	No	Only if you use an out-of-network provider.
How do I get more information about the plan?	1-855-256-9404 blueshieldca.com	1-800-464-4000 kp.org	1-866-282-0125 welcometouhc.com/sfhss

Blue Shield of California: Your Medical Group Determines Your Provider and Hospital Network

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

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

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 care.

Visit an urgent care center when your physician is not available, after hours or 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	City Plan PPO
NurseHelp 24/7	Nurse Advice 24/7	Nurseline 24/7
1-877-304-0504	1-866-454-8855	1-800-846-4678
Urgent After Hours Care	Urgent After Hours Care	Urgent After Hours Care
For the urgent after hours care nearest you contact Blue Shield: 1-855-256-9404 blueshieldca.com	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 1-650-299-2015 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.	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 This is a partial list. For more current and additional urgent care facilities call 1-866-282-0125 or visit welcometouhc.com/sfhss .

2016 Medical Plan Benefits At-a-Glance

This chart provides a summary of benefits. It is not a contract. In some cases, billed amounts for out-of-network and out-of-area services provided through the City Plan PPO may exceed reasonable and customary fees, resulting in higher out-of-pocket costs.

For a detailed description of benefits and exclusions for each plan, please review your plan's Evidence of Coverage, available on myhss.org.

	BLUE SHIELD HMO ACCESS+ IN-NETWORK ONLY	KAISER HMO TRADITIONAL PLAN IN-NETWORK ONLY	CITY PLAN PPO UNITEDHEALTHCARE CHOICE PLUS IN-NETWORK AND OUT-OF-AREA OUT-OF-NETWORK	
Choice of physician	Access+ plan network only. Primary Care Physician assignment required.	Kaiser network only. Primary Care Physician assignment required.	You may use any licensed provider. You receive a higher level of benefit and pay lower out-of-pocket costs when choosing in-network providers.	
Deductible	No deductible	No deductible	\$250 employee only \$500 + 1 \$750 + 2 or more	\$250 employee only \$500 + 1 \$750 + 2 or more
Out-of-pocket maximum does not include premium contributions	\$2,000 per individual \$4,000 per family	\$1,500 per individual \$3,000 per family	\$3,750 per individual \$12,700 per family	\$7,500 per individual
General Care and Urgent Care				
Routine physical; well woman exam	No charge	No charge	100% covered no deductible	50% covered after deductible
Doctor's office visit	\$25 co-pay	\$20 co-pay	85% covered after deductible	50% covered after deductible
Urgent care visit	\$25 co-pay in-network	\$20 co-pay	85% covered after deductible	50% covered after deductible
Family planning	No charge	No charge	100% covered no deductible	50% covered after deductible
Immunizations	No charge	No charge	100% covered no deductible	50% covered after deductible
Lab and x-ray	No charge	No charge	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Doctor's hospital visit	No charge	No charge	85% covered after deductible	50% covered after deductible
Prescription Drugs				
Pharmacy: generic	\$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	\$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	\$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	\$20 co-pay 90-day supply	\$10 co-pay 100-day supply	\$10 co-pay 90-day supply	Not covered
Mail order: brand-name	\$50 co-pay 90-day supply	\$30 co-pay 100-day supply	\$40 co-pay 90-day supply	Not covered
Mail order: non-formulary	\$100 co-pay 90-day supply	Physician authorized only	\$90 co-pay 90-day supply	Not covered
Specialty	20% up to \$100 co-pay; 30-day supply	Same as all above limitations apply; see EOC	Same as 30-day above limitations apply; see EOC	Same as 30-day above limitations apply; see EOC

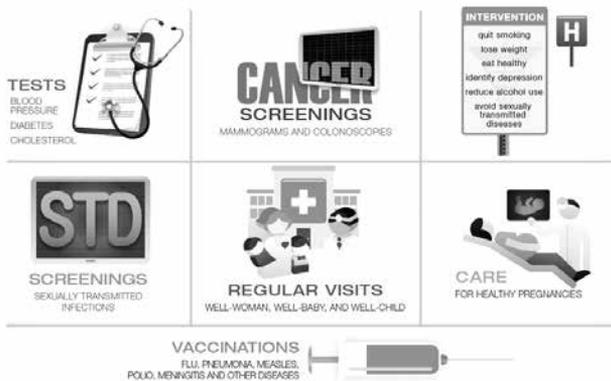
	BLUE SHIELD HMO ACCESS+ IN-NETWORK ONLY	KAISER HMO TRADITIONAL PLAN IN-NETWORK ONLY	CITY PLAN PPO UNITEDHEALTHCARE CHOICE PLUS IN-NETWORK AND OUT-OF-AREA : OUT-OF-NETWORK	
Hospital Outpatient and Inpatient				
Hospital outpatient	\$100 co-pay per surgery	\$35 co-pay	85% covered after deductible	50% covered after deductible
Hospital inpatient	\$200 co-pay per admission	\$100 co-pay per admission	85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification
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
Skilled nursing facility	No charge 100 days per plan year	No charge 100 days per benefit period	85% covered after deductible; 120 days per plan year; limits apply	50% covered after deductible; 120 days per plan year; limits apply
Hospice	No charge authorization required	No charge when medically necessary	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Maternity and Infertility				
Hospital or birthing center	\$200 co-pay per admission	\$100 co-pay per admission	85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification
Pre-/post-partum care	No charge	No charge	85% covered after deductible	50% covered after deductible
Well child care	No charge must enroll newborn within 30 days of birth; see EOC	No charge must enroll newborn within 30 days of birth; see EOC	100% covered no deductible	100% covered no deductible
IVF, GIFT, ZIFT and artificial insemination	50% covered limitations apply; see EOC	50% covered limitations apply; see EOC	50% covered after deductible; limitations apply; prior notification	50% covered after deductible; limitations apply; prior notification
Mental Health and Substance Abuse				
Outpatient treatment	\$25 co-pay non-severe and severe	\$10 co-pay group \$20 co-pay individual	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Inpatient facility including detox and residential rehab	\$200 co-pay per admission	\$100 co-pay per admission	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Other				
Hearing aids 1 aid per ear every 36 months, evaluation no charge	Up to \$2,500 each	Up to \$2,500 each	85% covered after deductible; up to \$2,500 each	50% covered after deductible; up to \$2,500 each
Medical equipment, prosthetics and orthotics	No charge as authorized by PCP	No charge as authorized by PCP	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Physical and occupational therapy	\$25 co-pay	\$20 co-pay authorization required	85% covered after deductible; 60 visits max per plan year	50% covered after deductible; 60 visits max per plan year
Acupuncture	\$15 co-pay 30 visits max per plan year; ASH network	Not covered 25% discount at kp.org/choosehealthy	50% covered after deductible; \$1,000 max per plan year	50% covered after deductible; \$1,000 max per plan year
Chiropractic	\$15 co-pay 30 visits max per plan year; ASH network	\$15 co-pay 30 visits max per plan year; ASH network; 25% discount at kp.org/choosehealthy	50% covered after deductible; \$1,000 max per plan year	50% covered after deductible; \$1,000 max per plan year
Transgender office visits and outpatient surgery	Co-pays apply authorization required	Co-pays apply authorization required	85% covered after deductible; prior notification	50% covered after deductible; prior notification

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	City Plan PPO
<p>Acupuncture and Chiropractic Self-refer up to 30 visits per year through the American Specialty Health network at a \$15 co-pay per visit. Find a practitioner at: ashcompanies.com or call 1-800-678-9133.</p> <p>After the 30 visits covered by your plan, you can book additional visits using the discount program below.</p> <p>Acupuncture, Chiropractic, Massage and Wellness Discounts 25% off usual and customary fees for acupuncture, chiropractic and massage booked through the ChooseHealthy program. Visit choosehealthy.com/Default.aspx?hp=BSCA or call 1-888-999-9452.</p> <p>For additional discounts visit: blueshieldca.com/wellnessdiscounts.</p>	<p>Chiropractic Self-refer up to 30 visits per year through the American Specialty Health network at a \$15 co-pay per visit. Find a practitioner at: ashcompanies.com/kp or call 1-800-678-9133.</p> <p>After the 30 visits covered by your plan, you can book additional visits using the discount program below.</p> <p>Acupuncture, Chiropractic, Massage and Wellness Discounts 25% off usual and customary fees for acupuncture, chiropractic and massage booked through the ChooseHealthy program. Visit kp.org/choosehealthy or call 1-877-335-2746.</p> <p>For additional discounts visit: kp.org/choosehealthy.</p>	<p>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.</p> <p>Acupuncture, Chiropractic, Massage and Wellness Discounts Up to 50% off fees for acupuncture, chiropractic, massage and other wellness resources. Visit unitedhealthallies.com.</p>

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. The HSS EAP (Employee Assistance Program) can help you assess a mental health condition and assist you in accessing treatment. For EAP call 1-800-795-2351. For more information about mental health services visit myhss.org/well-being/eap.

	Blue Shield of California HMO	Kaiser Permanente HMO	City Plan PPO
Mental Health Condition Services	Inpatient/outpatient mental health, professional services.	Inpatient/outpatient mental health, professional services.	Outpatient counseling, immediate care and intensive case management.
Substance Abuse Services	Inpatient/outpatient including detox and residential rehabilitation.	Inpatient/outpatient including detox and residential rehabilitation.	Inpatient/outpatient including detox and residential rehabilitation.
How to Access	Call 1-877-263-9952.	Call 1-800-464-4000 to make an appointment for therapy and other counseling services, or contact your Primary Care Physician.	Call 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	City Plan PPO	HSS EAP
<p>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.</p> <p>Online Coaching Take well-being one day at a time with the Daily Challenge: myhss.org/well-being/dailychallenge.</p> <p>Tobacco Cessation Visit QuitNet at mywellvolution.com.</p>	<p>Classes, Support Groups Contact your local Kaiser facility for a comprehensive list, or visit kp.org/mentalhealth.</p> <p>Telephone/Online Coaching Call 1-866-251-4514 or visit kp.org and search for HealthMedia Relax.</p> <p>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</p>	<p>Online Coaching Visit welcometouhc.com/sfhss for the online stress management program.</p> <p>Tobacco Cessation Visit welcometouhc.com/sfhss for the online smoking cessation program.</p>	<p>Counseling EAP (Employee Assistance Program) offers up to six confidential and free counseling appointments for individuals, couples and families. Call 1-800-795-2351</p> <p>In-Person Coaching Work one-on-one with a coach to reach your goals. Schedule an appointment by calling 1-415-554-0643.</p>

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	City Plan PPO
<p>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.</p> <p>Your physician’s medical group may also have condition management programs—ask your PCP.</p> <p>Receive support during your pregnancy. Visit blueshieldca.com/prenatal to enroll online or call 1-877-371-1511.</p>	<p>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. Your Primary Care Physician will coordinate your care.</p> <p>For pregnancy support, call the nurse advice line at 1-866-454-8855 or email your doctor. Free educational classes and support groups are also available. Visit kp.org/pregnancy.</p>	<p>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.</p> <p>Call 1-888-246-7389 for the Healthy Pregnancy Program.</p>

Live a Healthy Lifestyle: Small Steps, Big Rewards

Based on the the most recent Well-being Assessment, employees would like to be more active, eat better, manage stress, quit tobacco and lose weight. Commit to taking small steps to achieve the big reward of a healthier lifestyle.

- 78% of employees want to get more exercise, but only 30% are meeting minimum daily physical activity requirements.
- 73% want to eat more fruits and vegetables, but only 17% are meeting the recommended intake of five servings daily.
- 65% want to improve their stress management skills. 37% of employees report feeling very stressed every day.

Discover free, low cost and discounted services available through the Health Service System and health plans by visiting:



myhss.org/well-being/movement



myhss.org/well-being/nutrition



myhss.org/well-being/prevention



myhss.org/well-being/peaceofmind

Well-being at Work

We spend over 50% of our time at work. Our work environment can make a big difference in our health. Let's create a culture of well-being that supports making healthy choices.

Last year the Health Service System launched a well-being program. The goal is to enhance employees' quality of life, improve morale, reduce injuries and contain healthcare costs. A key component of this program is bringing well-being to the workplace. Learn more at myhss.org/well-being.

Worksite Well-being Programs

- Walking Challenge
- Nutrition Challenge
- Daily Challenge

Onsite Well-being Services

- Group Exercise Classes
- Wellness Coaching
- Well-being Seminars
- EAP Trainings and Seminars
- Flu Shot Clinics
- Biometric Screenings

The Health Service System Administers Your Vision Benefits

All HSS members and dependents who are enrolled in an HSS medical plan are automatically enrolled in vision benefits.

Vision Plan Benefits

HSS members and eligible dependents who enroll in the Kaiser HMO, Blue Shield HMO or City Plan PPO can access vision coverage administered by Vision Service Plan (VSP). You may use a VSP network doctor or a non-VSP doctor. Locate a VSP network doctor in your area by visiting vsp.com or contacting VSP Member Services at 1-800-877-7195.

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

Accessing Your Vision Benefits

No ID cards are issued for the vision plan. To receive service from a VSP network doctor, contact the doctor, identify yourself as a VSP member and make an appointment. VSP will provide benefit authorization to the doctor. Services must be received prior to the benefit authorization expiration date.

If you receive services from a VSP network doctor without prior authorization, or obtain services from a vision care service provider outside of the VSP network (including Kaiser), you are responsible for payment in full to the provider. You may then submit an itemized bill directly to VSP for partial reimbursement. Compare the costs of out-of-network vision services to VSP in-network costs before choosing. Download claim forms at vsp.com.

Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every 24 months, per last date of service. If examination reveals prescription change of 0.50 diopter or more after 12 months, replacement lenses covered.
- Eligible dependent children are covered in full for polycarbonate prescription lenses.
- Cosmetic extras, including progressive, tinted or oversize lenses, will cost you more.

Vision Plan Expenses Not Covered

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

Acute and Urgent Eye Care

With a \$5 co-pay, VSP offers limited coverage for urgent and acute eye conditions, including pink eye, sudden onset of flashers and floaters and diagnosis of eye pain or sudden changes in vision. Contact a VSP network doctor or call the customer service number for the closest location. 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 a medical plan, you and your dependents cannot access VSP vision benefits.

Vision Service Plan Benefits At-a-Glance

2016 Covered Services	In-Network	Out-of-Network
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 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	In-Network	Out-of-Network
Non-covered lens options (anti-reflective coating, photochromic, polycarbonate)	Average 20%–25% savings after co-pay; available on most enhance- ments	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.

SFUSD Provides Your Dental Benefits

Contact SFUSD for information about enrolling in dental benefits for eligible employees and family members.

SFUSD Dental Plan Eligibility Guidelines

Enrollment in dental benefits is administered by SFUSD Benefits Office. To download an enrollment application visit Salary and Benefits at sfusd.edu. SFUSD pays 100% of the dental plan premium contribution. SFUSD dental eligibility guidelines:

- Active or permanent SFUSD employees whose normal workweek at enrollment is at least 20 hours;
- Active SFUSD employees appointed to full-time permanent exempt positions;
- Provisional (temporary) SFUSD employees after 1040 hours of continuous service whose normal workweek at enrollment is at least 20 hours;
- Spouse, registered domestic partner, and unmarried children up to age 26 who meet SFUSD eligibility requirements.

Delta Dental PPO: Principal Benefits And Covered Services

Most SFUSD dental benefits are covered at 70% the first year of qualifying employment, 80% the second, 90% the third and 100% the fourth year, provided the employee and each covered dependent uses the dental coverage at least once a year and remains enrolled with no break in coverage.

	In-Network PPO Dentist	Premier Dentist	Non-Network Dentist
	Lowest cost; fixed fees for all dentists in-network	Contracted fees vary for each dentist	Uncontracted; fees vary for each dentist
Diagnostic and Preventive Care oral examinations, cleanings, x-rays, examinations of tissue biopsy, fluoride treatment, space maintainers, specialist consultation	In-network dentist's contracted fee is covered at: <ul style="list-style-type: none"> • 70% the first year • 80% the second year • 90% the third year • 100% the fourth year 	Premier dentist's contracted fee is covered at: <ul style="list-style-type: none"> • 70% the first year • 80% the second year • 90% the third year • 100% the fourth year 	Reasonable and customary fee only is covered at: <ul style="list-style-type: none"> • 70% the first year • 80% the second year • 90% the third year • 100% the fourth year In addition to %, you pay out-of-pocket for any fees above reasonable and customary.
Basic Benefits oral surgery (extractions), fillings, root canals, periodontic (gum) treatment, tissue removal (biopsy), sealants			
Crowns and Cast Restorations			
Prosthodontic Benefits bridges, partial dentures, full dentures, implants	50%–70% based on employee classification and labor affiliation	50%–70% based on employee classification and labor affiliation	
Orthodontic Benefits dependent children to age 25 only	In-network dentist's contracted fee is covered at:	Premier dentist's contracted fee is covered at:	Reasonable and customary fee only is covered at:
Dental Accident Benefits	<ul style="list-style-type: none"> • 50% (\$750 lifetime maximum per person) 	<ul style="list-style-type: none"> • 50% (\$750 lifetime maximum per person) 	<ul style="list-style-type: none"> • 50% (\$750 lifetime maximum per person)

Maximum benefit payable in a calendar year for in-Network PPO is \$2,000.00 (Local 1021 and Classified Managers) or \$1,500 for Premier (Local 21 and monthly and paraprofessional employees).

This is a general summary only. Contact the SFUSD Benefits Office for more information.

You should also refer to your plan contract for details about covered services, limitations and exclusions.

Other Benefits Administered by SFUSD

Flexible Spending Accounts

Flexible Spending Account enrollment is handled by the SFUSD Benefits Office. FSAs can save you money by reducing your taxable income. You can enroll in a Healthcare FSA, a Dependent Care FSA, or both. Once enrolled, you set aside money pre-tax via payroll deduction to fund your FSA account/s. To receive FSA reimbursements you must submit documentation to plan administrator WageWorks by required deadlines. For more information visit wageworks.com.

A Healthcare FSA allows each employee to pay for up to \$2,550 per year in qualifying medical expenses pre-tax. Qualifying expenses include medical, pharmacy, dental and vision co-pays and deductibles for the enrolled employee and eligible dependents.

A Dependent Care FSA can help pay pre-tax for qualifying dependent care expenses up to \$5,000 per household per year. Qualifying expenses include certified day care, pre-school and elder care. Children in day care must be under age 13.

Before enrolling in your FSA, you should work out a detailed estimate of the eligible expenses you are likely to incur in 2015. Budget conservatively. Based on new federal law, you may roll forward up to \$500 in unused funds in your Healthcare FSA year over year. But any unreimbursed funds in excess of \$500 are forfeited at the end of the plan year and cannot be returned to you. Dependent Care FSA does not qualify for rollover. FSA expenses must meet Internal Revenue Service criteria:

- irs.gov/pub/irs-pdf/p502.pdf
- irs.gov/pub/irs-pdf/p503.pdf

Note: with a FSA your taxable income will be reduced for Social Security purposes so there may be a corresponding reduction in Social Security benefits.

Additional Voluntary Supplemental Benefits

Refer to the SFUSD website at sfusd.edu or call SFUSD at 1-415-241-6101 for a list of additional voluntary supplemental benefit programs available through SFUSD.

You Must Notify the Health Service System About a Leave of Absence

Type of Leave	Health Benefits Eligibility
<p>Family and Medical Leave (FMLA) Workers' Compensation Leave Family Care Leave Military Leave</p>	<p>After confirming your leave with the SFUSD leave specialist, notify the Health Service System (HSS) as soon as your leave begins—within 30 days. You may elect to continue or waive health coverage for the duration of your approved leave of absence.</p>
<p>Personal Leave Following Family Care Leave</p>	<p>If you have been on an approved Family Care Leave and are approved to extend this as a Personal Leave, you may elect to continue or waive health coverage for the duration of your approved Personal Leave. Contact the Health Service System.</p>
<p>Educational Leave Personal Leave Leave for Employment as an Employee Organization Officer or Representative</p>	<p>After confirming your leave with the SFUSD leave specialist, Notify the Health Service System as soon as your leave begins—within 30 days. You may elect to continue or waive health coverage for the duration of your approved leave of absence.</p> <p>If your leave lasts beyond 12 weeks, you must pay the total cost of health coverage for yourself and any enrolled dependents. This includes your employee premium contribution plus your employer's premium contribution. Contact HSS for details.</p>

You Must Pay Premiums to Maintain Medical Coverage While on Leave

While you are on an unpaid leave, premiums for health coverage cannot be deducted from your paycheck. To maintain coverage, you must pay premium contributions directly to HSS. Contact HSS **within 30 days** of when leave begins to either waive coverage or arrange for payment of premiums. Failure to do so can result in the termination of your health benefits, which may not be reinstated until you return to work or during Open Enrollment. When you return to work, contact HSS immediately (**within 30 days**) to request that health premium payroll deductions be returned to active status.

Domestic Partner Imputed Income

If you have a registered domestic partner enrolled on your health coverage while you are on unpaid leave, you will have a catch-up payroll deduction for taxation related to imputed income when you return from leave.

Questions?

Call HSS at 1-415-554-1750 if you have questions about health benefits during a leave of absence.

Health Benefits During a Paid or Unpaid Leave of Absence

Your Responsibilities

Notify your supervisor and the SFUSD leave specialist prior to your leave.

(If your leave is due to an unexpected emergency contact the SFUSD leave specialist as soon as possible.)
The leave specialist will help you understand the process and documentation required for an approved leave.
The leave specialist will also provide the Health Service System with important information about your leave.

Contact the Health Service System as soon as your leave begins—within 30 days. You may choose to continue or waive health coverage while on leave. If you continue coverage, you must pay employee premium contributions while you are on leave. If premium payments are not deducted from your paycheck while you are on leave you must pay the Health Service System directly. Failure to do so will result in termination of your health benefits.

When leave ends, contact the Health Service System to reinstate your benefits within 30 days of return to work. If you continued your health coverage while on an unpaid leave, you must request that HSS resume health premium payroll deductions. If coverage was waived or terminated while you were on leave, you must request that the Health Service System reinstate your benefits and resume your payroll deductions.

Contact SFUSD for Information About Other Benefits While You Are on Leave

A leave of absence may also affect your dental coverage, Flexible Spending Accounts, LTD insurance and other employer-provided health benefits. Contact SFUSD at 1-415-241-6101 for information to get more information about these benefits while you are on an unpaid leave of absence.

Transition to Retirement

Enrollment in Retiree Benefits Does Not Happen Automatically

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

Depending on your retirement date, there can be a gap between when active employee coverage ends and retiree coverage begins. Setting a retirement date at the end of the month will help avoid a gap in HSS coverage. Call HSS at 1-415-554-1750 to review your options before deciding on your retirement date.

Medicare Enrollment Required for Medicare-eligible Retirees and Dependents

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

Retiree Premium Contributions

If you choose to continue medical and/or dental coverage through HSS after you retire, your retiree premium contribution may be higher than your active employee contributions. As a retired member, you will also be required to pay for dental coverage. Costs will depend on your plan choices, number of dependents covered and your Medicare status. A retiree must have been a member of HSS at some time during his or her active employment in order to be eligible for retiree health benefits. Other restrictions may apply. Health premium contributions will be taken from your pension check. If required monthly premium contributions are greater than the total amount of

your pension check, you must contact HSS to make payment arrangements. Premium contribution rates are subject to change every plan year.

Lump-Sum Pension Distribution Will Affect Retiree Premium Contributions

If you choose to take a lump-sum pension distribution, your retiree healthcare premium contributions will be unsubsidized and you will pay the full cost.

Active Employee Medicare Enrollment

If you are working and eligible for HSS health coverage at age 65 or older, you are not required to enroll in Medicare. Even though it is not required, you are eligible for Medicare at age 65 and can enroll if you choose. Some employees over age 65 choose to enroll in premium-free Medicare Part A while they are still working. If you enroll in Part A, you must contact the Social Security Administration and enroll in Medicare Part B **three months before you retire** or otherwise leave City employment. If you are over age 65 and not enrolled in both Medicare Part A and Part B upon retirement, you may be charged penalties by the federal government and you will be enrolled in City Plan 20.

Married Spouse Medicare Enrollment

A spouse covered on an active employee's HSS plan is not required to enroll in Medicare until you retire. A Medicare-eligible spouse must have enrolled in Medicare to be covered on a retiree's health plan.

Domestic Partner Medicare Enrollment

A domestic partner of an active employee who is eligible for Medicare must be enrolled in Medicare to qualify for HSS medical coverage. If enrolled in HSS medical coverage without Medicare, domestic partner benefits will be terminated. The federal government charges a premium for Medicare Part B and in some cases, for group employer Part D. All Medicare premium payments must be paid to maintain continuous Medicare enrollment. Be aware that domestic partners who fail to enroll in Medicare Part B when first eligible may later be charged significant late enrollment penalties by the federal government.

Domestic Partner Health Benefits Taxation

Health coverage for a 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 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, employee or retiree premium contributions for domestic partner health benefits are paid post-tax. Employee or 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 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 form can be downloaded here: myhss.org/downloads/forms_guides/dp.pdf

If the dependent of an employee or 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, employee or retiree premium contributions will be paid post-tax.

Equitable California State Tax Treatment

The health benefits of a domestic partner age 62 or older, and children of a 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. An employee can then deduct the value of employer paid health insurance premiums for a domestic partner and his or her children, when filing a California state income tax return. An employee 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 defined by the IRS.

Consult with Your Tax Advisor

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

COBRA and Covered California

COBRA Continuation Coverage

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

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

Time Limits for COBRA Elections

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

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

Duration of COBRA Continuation Coverage

Group COBRA coverage is generally available for a maximum of 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a coverage extension for up to 36 months.

COBRA enrollees who are disabled on the date of their qualifying event, or at any time during the first 60 days of COBRA coverage, are eligible for 29 months of coverage. Beginning the 19th month of coverage, the cost will rise to 150 percent of the group rate. Retirees and dependents who are eligible for less than 36 months of federal COBRA may be eligible for Cal-COBRA. Continuation coverage under both federal and California state COBRA will not exceed 36 months.

Termination of COBRA Continuation Coverage

COBRA coverage will end if:

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

Paying for COBRA

Once COBRA continuation coverage is elected, it is the responsibility of the covered individuals to remit the required healthcare premium payments directly to the COBRA administrator. For COBRA rate information, visit myhss.org or contact HSS.

COBRA Continuation Coverage Alternatives

Individuals who are not eligible for HSS coverage should consider obtaining health insurance through the state insurance exchange, Covered California. In some cases, you may qualify for tax credits and other assistance to make health insurance more affordable. For information about Covered California health plans, call 1-888-975-1142 or visit coveredca.com.

As an alternative to COBRA continuation coverage, you may be able to purchase individual health coverage from your healthcare plan or other insurers. Contact plans directly for details and costs.

Employees and dependents who were covered under an HSS-administered health plan are entitled to a certificate showing evidence of prior coverage.

Health Coverage Calendars

SFUSD BI-WEEKLY EMPLOYEES

Work Dates	Pay Date	Benefits Coverage Period
December 30, 2015–January 12, 2016	January 20, 2016	January 1, 2016–January 12, 2016
January 13, 2016–January 26, 2016	February 3, 2016	January 13, 2016–January 26, 2016
January 27, 2016–February 9, 2016	February 17, 2016	January 27, 2016–February 9, 2016
February 10, 2016–February 23, 2016	March 2, 2016	February 10, 2016–February 23, 2016
February 24, 2016–March 8, 2016	March 16, 2016	February 24, 2016–March 8, 2016
March 9, 2016–March 22, 2016	March 30, 2016	March 9, 2016–March 22, 2016
March 23, 2016–April 5, 2016	April 13, 2016	March 23, 2016–April 5, 2016
April 6, 2016–April 19, 2016	April 27, 2016	April 6, 2016–April 19, 2016
April 20, 2016–May 3, 2016	May 11, 2016	April 20, 2016–May 3, 2016
May 4, 2016–May 17, 2016	May 25, 2016	May 4, 2016–May 17, 2016
May 18, 2016–May 31, 2016	June 8, 2016	May 18, 2016–May 31, 2016
June 1, 2016–June 14, 2016	June 22, 2016	June 1, 2016–June 14, 2016
June 15, 2016–June 28, 2016	July 6, 2016	June 15, 2016–June 28, 2016
June 29, 2016–July 12, 2016	July 20, 2016	June 29, 2016–July 12, 2016
July 13, 2016–July 26, 2016	August 3, 2016	July 13, 2016–July 26, 2016
July 27, 2016–August 9, 2016	August 17, 2016	July 27, 2016–August 9, 2016
August 10, 2016–August 23, 2016	August 31, 2016	August 10, 2016–August 23, 2016
August 24, 2016–September 6, 2016	September 14, 2016	August 24, 2016–September 6, 2016
September 7, 2016–September 20, 2016	September 28, 2016	September 7, 2016–September 20, 2016
September 21, 2016–October 4, 2016	October 12, 2016	September 21, 2016–October 4, 2016
October 5, 2016–October 18, 2016	October 26, 2016	October 5, 2016–October 18, 2016
October 19, 2016–November 1, 2016	November 9, 2016	October 19, 2016–November 1, 2016
November 2, 2016–November 15, 2016	November 23, 2016	November 2, 2016–November 15, 2016
November 16, 2016–November 29, 2016	December 7, 2016	November 16, 2016–November 29, 2016
November 30, 2016–December 13, 2016	December 21, 2016	November 30, 2016–December 13, 2016
December 14, 2016–December 27, 2016	January 4, 2017	December 14, 2016–December 31, 2016

Employee premium contributions are deducted from paychecks bi-weekly, for a total of 26 payroll deductions for the 2016 plan year.

If you take an approved unpaid leave of absence, you must pay HSS directly for the premium contributions that were being deducted from your paycheck. Employee premium contributions are due no later than the pay date of the benefits coverage periods above. See pages 24–25 for more information about maintaining health coverage during a leave.

Health Coverage Calendars

UESF K-12 PARAPROFESSIONAL SCHOOL TERM EMPLOYEES

Work Dates	Pay Date	Benefits Coverage Period
December 30, 2015–January 12, 2016	January 20, 2016	December 30, 2015–January 12, 2016
January 13, 2016–January 26, 2016	February 3, 2016	January 13, 2016–January 26, 2016
January 27, 2016–February 9, 2016	February 17, 2016	January 27, 2016–February 9, 2016
February 10, 2016–February 23, 2016	March 2, 2016	February 10, 2016–February 23, 2016
February 24, 2016–March 8, 2016	March 16, 2016	February 24, 2016–March 8, 2016
March 9, 2016–March 22, 2016	March 30, 2016	March 9, 2016–March 22, 2016
March 23, 2016–April 5, 2016	April 13, 2016	March 23, 2016–April 5, 2016
April 6, 2016–April 19, 2016	April 27, 2016	April 6, 2016–April 19, 2016
April 20, 2016–May 3, 2016	May 11, 2016	April 20, 2016–May 3, 2016
May 4, 2016–May 17, 2016	May 25, 2016	May 4, 2016–May 17, 2016
May 18, 2016–May 31, 2016	June 8, 2016	May 18, 2016–May 31, 2016
<i>Summer Break off from regular work</i>	June 22, 2016	<i>Summer Coverage Period extra payroll deductions taken January to June pre-pay this summer coverage period</i>
	July 6, 2016	
	July 20, 2016	
	August 3, 2016	
	August 17, 2016	
August 10, 2016–August 23, 2016	August 31, 2016	August 10, 2016–August 23, 2016
August 24, 2016–September 6, 2016	September 14, 2016	August 24, 2016–September 6, 2016
September 7, 2016–September 20, 2016	September 28, 2016	September 7, 2016–September 20, 2016
September 21, 2016–October 4, 2016	October 12, 2016	September 21, 2016–October 4, 2016
October 5, 2016–October 18, 2016	October 26, 2016	October 5, 2016–October 18, 2016
October 19, 2016–November 1, 2016	November 9, 2016	October 19, 2016–November 1, 2016
November 2, 2016–November 15, 2016	November 23, 2016	November 2, 2016–November 15, 2016
November 16, 2016–November 29, 2016	December 7, 2016	November 16, 2016–November 29, 2016
November 30, 2016–December 13, 2016	December 21, 2016	November 30, 2016–December 13, 2016
December 14, 2016–December 27, 2016	January 4, 2017	December 14, 2016–December 31, 2016

Employee premium contributions are deducted from paychecks bi-weekly, for a total of 21 payroll deductions for the 2016 plan year. Employee premium deductions from January to June include an additional premium amount to fund benefits coverage during the summer months. During summer months with no paycheck, benefits coverage will continue as long as all summer premium contributions have been funded.

If you take an approved unpaid leave of absence, you must pay HSS directly for the premium contributions that were being deducted from your paycheck. Employee premium contributions are due no later than the pay date of the benefits coverage periods above. See pages 24–25 for more information about maintaining health coverage during a leave.

Health Coverage Calendars

SEIU LOCAL 1021 SCHOOL TERM EMPLOYEES

Work Dates	Pay Date	Benefits Coverage Period
December 30, 2015–January 12, 2016	January 20, 2016	January 1, 2015–January 12, 2016
January 13, 2016–January 26, 2016	February 3, 2016	January 13, 2016–January 26, 2016
January 27, 2016–February 9, 2016	February 17, 2016	January 27, 2016–February 9, 2016
February 10, 2016–February 23, 2016	March 2, 2016	February 10, 2016–February 23, 2016
February 24, 2016–March 8, 2016	March 16, 2016	February 24, 2016–March 8, 2016
March 9, 2016–March 22, 2016	March 30, 2016	March 9, 2016–March 22, 2016
March 23, 2016–April 5, 2016	April 13, 2016	March 23, 2016–April 5, 2016
April 6, 2016–April 19, 2016	April 27, 2016	April 6, 2016–April 19, 2016
April 20, 2016–May 3, 2016	May 11, 2016	April 20, 2016–May 3, 2016
May 4, 2016–May 17, 2016	May 25, 2016	May 4, 2016–May 17, 2016
May 18, 2016–May 31, 2016	June 8, 2016	
<i>Summer Break off from regular work</i>	June 22, 2016	<i>Summer Coverage Period extra payroll deductions taken January to June pre-pay this summer coverage period</i>
	July 6, 2016	
	July 20, 2016	
	August 3, 2016	
July 27, 2016–August 9, 2016	August 17, 2016	July 27, 2016–August 9, 2016
August 10, 2016–August 23, 2016	August 31, 2016	August 10, 2016–August 23, 2016
August 24, 2016–September 6, 2016	September 14, 2016	August 24, 2016–September 6, 2016
September 7, 2016–September 20, 2016	September 28, 2016	September 7, 2016–September 20, 2016
September 21, 2016–October 4, 2016	October 12, 2016	September 21, 2016–October 4, 2016
October 5, 2016–October 18, 2016	October 26, 2016	October 5, 2016–October 18, 2016
October 19, 2016–November 1, 2016	November 9, 2016	October 19, 2016–November 1, 2016
November 2, 2016–November 15, 2016	November 23, 2016	November 2, 2016–November 15, 2016
November 16, 2016–November 29, 2016	December 7, 2016	November 16, 2016–November 29, 2016
November 30, 2016–December 13, 2016	December 21, 2016	November 30, 2016–December 13, 2016
December 14, 2016–December 27, 2016	January 4, 2017	December 14, 2016–December 31, 2016

Employee premium contributions are deducted from paychecks bi-weekly, for a total of 22 payroll deductions for the 2016 plan year. Employee premium deductions from January to June include an additional premium amount to fund benefits coverage during the summer months. During summer months with no paycheck, benefits coverage will continue as long as all summer premium contributions have been funded.

If you take an approved unpaid leave of absence, you must pay HSS directly for the premium contributions that were being deducted from your paycheck. Employee premium contributions are due no later than the pay date of the benefits coverage periods above. See pages 24–25 for more information about maintaining health coverage during a leave.

Health Coverage Calendars

UESF PRE-K PARAPROFESSIONAL SCHOOL TERM EMPLOYEES

Work Dates	Pay Date	Benefits Coverage Period
December 30, 2015–January 12, 2016	January 20, 2016	January 1, 2015–January 12, 2016
January 13, 2016–January 26, 2016	February 3, 2016	January 13, 2016–January 26, 2016
January 27, 2016–February 9, 2016	February 17, 2016	January 27, 2016–February 9, 2016
February 10, 2016–February 23, 2016	March 2, 2016	February 10, 2016–February 23, 2016
February 24, 2016–March 8, 2016	March 16, 2016	February 24, 2016–March 8, 2016
March 9, 2016–March 22, 2016	March 30, 2016	March 9, 2016–March 22, 2016
March 23, 2016–April 5, 2016	April 13, 2016	March 23, 2016–April 5, 2016
April 6, 2016–April 19, 2016	April 27, 2016	April 6, 2016–April 19, 2016
April 20, 2016–May 3, 2016	May 11, 2016	April 20, 2016–May 3, 2016
May 4, 2016–May 17, 2016	May 25, 2016	May 4, 2016–May 17, 2016
May 18, 2016–May 31, 2016	June 8, 2016	May 18, 2016–May 31, 2016
June 1, 2016–June 14, 2016	June 22, 2016	June 1, 2016–June 14, 2016
June 15, 2016–June 28, 2016	July 6, 2016	June 15, 2016–June 28, 2016
<i>Summer Break off from regular work</i>	July 20, 2016 August 3, 2016 August 17, 2016	<i>Summer Coverage Period extra payroll deductions taken January to June pre-pay this summer coverage period</i>
August 10, 2016–August 23, 2016	August 31, 2016	August 10, 2016–August 23, 2016
August 24, 2016–September 6, 2016	September 14, 2016	August 24, 2016–September 6, 2016
September 7, 2016–September 20, 2016	September 28, 2016	September 7, 2016–September 20, 2016
September 21, 2016–October 4, 2016	October 12, 2016	September 21, 2016–October 4, 2016
October 5, 2016–October 18, 2016	October 26, 2016	October 5, 2016–October 18, 2016
October 19, 2016–November 1, 2016	November 9, 2016	October 19, 2016–November 1, 2016
November 2, 2016–November 15, 2016	November 23, 2016	November 2, 2016–November 15, 2016
November 16, 2016–November 29, 2016	December 7, 2016	November 16, 2016–November 29, 2016
November 30, 2016–December 13, 2016	December 21, 2016	November 30, 2016–December 13, 2016
December 14, 2016–December 27, 2016	January 4, 2017	December 14, 2016–December 31, 2016

Employee premium contributions are deducted from paychecks bi-weekly, for a total of 23 payroll deductions for the 2016 plan year. Employee premium deductions from January to June include an additional premium amount to fund benefits coverage during the summer months. During summer months with no paycheck, benefits coverage will continue as long as all summer premium contributions have been funded.

If you take an approved unpaid leave of absence, you must pay HSS directly for the premium contributions that were being deducted from your paycheck. Employee premium contributions are due no later than the pay date of the benefits coverage periods above. See pages 24–25 for more information about maintaining health coverage during a leave.

Health Coverage Calendars

SFUSD MONTHLY EMPLOYEES

Work Dates	Pay Date	Benefits Coverage Period
December 21, 2015–January 20, 2016	January 29, 2016	January 1, 2016–January 31, 2016
January 21, 2016–February 20, 2016	February 29, 2016	February 1, 2016–February 29, 2016
February 21, 2016–March 20, 2016	March 31, 2016	March 1, 2016–March 31, 2016
March 21, 2016–April 20, 2016	April 29, 2016	April 1, 2016–April 30, 2016
April 21, 2016–May 20, 2016	May 31, 2016	May 1, 2016–May 31, 2016
May 21, 2016–June 20, 2016	June 30, 2016	June 1, 2016–June 30, 2016
June 21, 2016–July 20, 2016	July 28, 2016	July 1, 2016–July 31, 2016
July 21, 2016–August 20, 2016	August 31, 2016	August 1, 2016–August 31, 2016
August 21, 2016–September 20, 2016	September 29, 2016	September 1, 2016–September 30, 2016
September 21, 2016–October 20, 2016	October 30, 2016	October 1, 2016–October 31, 2016
October 21, 2016–November 20, 2016	November 30, 2016	November 1, 2016–November 30, 2016
November 21, 2016–December 20, 2016	January 2, 2017	December 1, 2016–December 31, 2016

Employee premium contributions are deducted from paychecks bi-weekly, for a total of 12 payroll deductions for the 2016 plan year.

If you take an approved unpaid leave of absence, you must pay HSS directly for the premium contributions that were being deducted from your paycheck. Employee premium contributions are due no later than the pay date of the benefits coverage periods above. See pages 24–25 for more information about maintaining health coverage during a leave.

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

Co-Insurance

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

Co-Pay

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

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.

Employee Premium Contribution

The amount you must pay toward health plan premiums.

Employer Premium Contribution

The amount your employer pays toward health plan premiums.

Employer-Subsidized Benefits

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

Enrollee

Individual enrolled in a health plan.

Explanation of Benefits (EOB)

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

Evidence of Coverage (EOC)

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

Exclusions

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

Flexible Spending Account (FSA)

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

Formulary

A comprehensive list of prescription drugs that are covered by a medical plan. The formulary is designed to assist physicians in prescribing drugs that are medically necessary and cost-effective. The formulary is updated periodically.

Generic Drug

FDA-approved therapeutic equivalent to a brand-name prescription drug, containing the same active ingredient and costing less than the brand-name drug.

Glossary of Healthcare Terms

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.

Imputed Income

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

In-Network

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

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. 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 and do 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 employee.

Primary Care Physician (PCP)

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

Privacy

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

Qualifying Event

A life event that allows you to make a change in your benefit elections outside Open Enrollment. Includes marriage, domestic partnership, separation, divorce or dissolution of partnership, birth or adoption of a child, death of a dependent, obtaining or losing other health 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.

Same Day Surgery

Surgery procedures performed at an ambulatory care center or in-patient hospital without an admission or over night stay.

Specialty Drug

New types of drugs to treat specific illnesses.

Health Service Board



Randy Scott
Appointee
President



Wilfredo Lim
Elected Employee
Vice President



Karen Breslin
Elected Retiree



Mark Farrell
Appointee



Sharon Ferrigno
Elected Retiree



Stephen Follansbee, MD
Appointee



Gregg Sass
Appointee

The Health Service Board conducts an annual review of health benefit costs, ensures benefits are applied without favor or privilege and administers the business of the Health Service System. 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.

2016 Medical Premium Contributions: Employee Only

CLASSIFIED YEAR ROUND EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Bi-weekly, 26 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Consolidated Crafts ¹						
Electric Workers Local 6	267.34	65.67	255.70	0	267.34	81.89
Stationary Engineers Local 39						
Laborers, Local 261						
SEIU Local 1021	267.34	65.67	255.70	0	297.43	51.80
Board Designated Confidential or Unrepresented						
IFPTE Local 21	267.34	65.67	255.70	0	267.34	81.89
Board Designated Managerial						
UESF Paraprofessionals						
UESF 15–19 hours Paraprofessionals			191.78	63.92		
SEIU Local 1021 PEX less than 20 hours a week			191.78	63.92		
SEIU Local 1021 Student Nutrition less than 20 hours a week			255.70	0		

K-12 SCHOOL TERM EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Bi-Weekly - 21 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
UESF and USP K-12 Paraprofessionals August–December	267.34	65.67	255.70	0	267.34	81.89
UESF and USP K-12 Paraprofessionals January–June ²	388.86	95.52	371.93	0	388.86	119.11

K-12 SCHOOL TERM EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Bi-Weekly - 22 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
SEIU Local 1021 K-12 Classified August–December	267.34	65.67	255.70	0	297.43	51.80
SEIU Local 1021 K-12 Classified January–June ²	364.55	89.55	348.68	0	405.59	70.64

PRE-K SCHOOL TERM EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Bi-weekly, 23 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
UESF and USP Paraprofessionals August–December	267.34	65.67	255.70	0	267.34	81.89
UESF and USP Paraprofessionals January–June ²	329.03	80.82	314.71	0	329.03	100.79

CERTIFICATED EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Monthly, 12 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
UASF Local 3 Administrators						
UESF Certificated Personnel						
UESF Substitute Teachers (Prop A)	579.24	142.29	554.02	0	579.24	177.43
Board of Educators (BOE)						
Superintendent's Cabinet						

¹ Consolidated Crafts includes: Machinists Local 1414, Carpenters Local 22, Glaziers Local 718, Ironworkers Local 377, Painters Local 1176, Plasterers Local 66, Plumbers & Pipefitters Local 38, Roofers Local 40, Sheet Metal Workers Local 104, Teamsters Local 853

² Rates are higher from January through June to fund coverage during the summer months. See pages 30-32 for calendars.

Please note that access to plan options for some employees may be limited based on SFUSD's implementation of the Affordable Care Act in 2016. If you are impacted, you will receive separate communication in advance of Open Enrollment.

2016 Medical Premium Contributions: Employee Plus One

CLASSIFIED YEAR ROUND EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Bi-weekly, 26 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Consolidated Crafts ¹						
Electric Workers Local 6	599.44	65.67	510.47	0	603.46	81.89
Stationary Engineers Local 39						
Laborers, Local 261						
SEIU Local 1021						
Board Designated Confidential or Unrepresented						
IFPTE Local 21	371.19	293.92	359.55	150.92	371.19	314.16
Board Designated Managerial						
UESF Paraprofessionals	370.60	294.51	358.96	151.51	370.60	314.75
UESF 15–19 hours Paraprofessionals						
SEIU Local 1021 PEX less than 20 hours a week						
SEIU Local 1021 Student Nutrition less than 20 hours a week						

K-12 SCHOOL TERM EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Bi-Weekly - 21 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
UESF and USP K-12 Paraprofessionals August–December	370.60	294.51	358.96	151.51	370.60	314.75
UESF and USP K-12 Paraprofessionals January–June ²	539.05	428.38	522.12	220.38	539.05	454.82

K-12 SCHOOL TERM EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Bi-Weekly - 22 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
SEIU Local 1021 K-12 Classified August–December	599.44	65.67	510.47	0	603.46	81.89
SEIU Local 1021 K-12 Classified January–June ²	817.42	89.55	696.10	0	822.90	111.67

PRE-K SCHOOL TERM EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Bi-weekly, 23 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
UESF and USP Paraprofessionals August–December	370.60	294.51	358.96	151.51	370.60	314.75
UESF and USP Paraprofessionals January–June ²	456.12	362.47	441.80	186.47	456.12	387.38

CERTIFICATED EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Monthly, 12 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
UASF Local 3 Administrators						
UESF Certificated Personnel Board of Educators (BOE) Superintendent's Cabinet	802.96	638.11	777.74	328.27	802.96	681.96
UESF Substitute Teachers (Prop A)						

¹ Consolidated Crafts includes: Machinists Local 1414, Carpenters Local 22, Glaziers Local 718, Ironworkers Local 377, Painters Local 1176, Plasterers Local 66, Plumbers & Pipefitters Local 38, Roofers Local 40, Sheet Metal Workers Local 104, Teamsters Local 853

² Rates are higher from January through June to fund coverage during the summer months. See pages 30-32 for calendars.

Please note that access to plan options for some employees may be limited based on SFUSD's implementation of the Affordable Care Act in 2016. If you are impacted, you will receive separate communication in advance of Open Enrollment.

2016 Medical Premium Contributions: Employee Plus Two or More

CLASSIFIED YEAR ROUND EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Bi-weekly, 26 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Consolidated Crafts ¹						
Electric Workers Local 6	617.01	323.71	605.37	116.55	617.01	354.93
Stationary Engineers Local 39						
Laborers, Local 261						
SEIU Local 1021						
Board Designated Confidential or Unrepresented						
IFPTE Local 21	426.11	514.61	414.47	307.45	426.11	545.83
Board Designated Managerial						
UESF Paraprofessionals	393.67	547.05	382.03	339.89	393.67	578.27
UESF 15–19 hours Paraprofessionals						
SEIU Local 1021 PEX less than 20 hours a week						
SEIU Local 1021 Student Nutrition less than 20 hours a week						

K-12 SCHOOL TERM EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Bi-Weekly - 21 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
UESF and USP K-12 Paraprofessionals August–December	393.67	547.05	382.03	339.89	393.67	578.27
UESF and USP K-12 Paraprofessionals January–June ²	572.61	795.71	555.68	494.39	572.61	841.12

K-12 SCHOOL TERM EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Bi-Weekly - 22 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
SEIU Local 1021 K-12 Classified August–December	617.01	323.71	605.37	116.55	617.01	354.93
SEIU Local 1021 K-12 Classified January–June ²	841.38	441.42	825.50	158.93	841.38	484.00

PRE-K SCHOOL TERM EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Bi-weekly, 23 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
UESF and USP Paraprofessionals August–December	393.67	547.05	382.03	339.89	393.67	578.27
UESF and USP Paraprofessionals January–June ²	484.52	673.29	470.19	418.33	484.52	711.72

CERTIFICATED EMPLOYEES	BLUE SHIELD OF CALIFORNIA		KAISER PERMANENTE		CITY PLAN	
Monthly, 12 Pay Period Deductions	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
UASF Local 3 Administrators						
UESF Certificated Personnel	852.96	1,185.28	827.74	736.42	852.96	1,252.91
Board of Educators (BOE)						
Superintendent's Cabinet						
UESF Substitute Teachers (Prop A)						

¹ Consolidated Crafts includes: Machinists Local 1414, Carpenters Local 22, Glaziers Local 718, Ironworkers Local 377, Painters Local 1176, Plasterers Local 66, Plumbers & Pipefitters Local 38, Roofers Local 40, Sheet Metal Workers Local 104, Teamsters Local 853

² Rates are higher from January through June to fund coverage during the summer months. See pages 30-32 for calendars.

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Key Contact Information

HEALTH SERVICE SYSTEM

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

SFUSD BENEFITS

555 Franklin Street, 2nd Floor
San Francisco, CA 94102
Tel: 1-415-241-6101
Fax: 1-415-241-6155
Web: sfusd.edu

MEDICAL PLANS

Blue Shield of California	1-855-256-9404	blueshieldca.com	Group W0051448
Kaiser Permanente	1-800-464-4000	kp.org	Group 888 (North CA) Group 231003 (South CA)
City Plan UnitedHealthcare	1-866-282-0125	welcometomyuhc.com/sfss	Group 752103

DENTAL and VISION PLANS

Delta Dental PPO dental enrollment is administered through the SFUSD benefits office	1-888-335-8227	deltadentalins.com	Group 652-0011 (monthly) Group 652-0016 (biweekly) Group 652-0012 (paraprofessionals)
VSP Vision	1-800-877-7195	vsp.com	Group 12145878

FLEXIBLE SPENDING ACCOUNTS (FSAs)

WageWorks FSA enrollment is administered through the SFUSD benefits office	1-877-924-3967	wageworks.com	
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LONG TERM DISABILITY (LTD) and GROUP LIFE INSURANCE

LTD and Group Life Insurance are administered through the SFUSD benefits office. Please refer to the SFUSD website for more information.

OTHER AGENCIES

CalSTRS	1-800-228-5453	calstrs.com	pension benefits
SFERS	1-415-487-7000	mysfers.org	pension benefits
CalPERS	1-888-225-7377	calpers.ca.gov	pension benefits
Covered California	1-888-975-1142	coveredca.com	state health insurance exchange

6 THINGS ALL EMPLOYEES SHOULD KNOW...

There is a 30-day Deadline to Enroll in Health Benefits for You and Your Family

New hire? New spouse, new partner, new child? Adding a family member who lost other coverage? If you miss the 30-day deadline you must wait until the next Open Enrollment.

To Enroll You Must Provide Eligibility Documentation

Be prepared to provide a copy of a marriage certificate, certification of partnership, children's birth certificates or proof of adoption as well as Social Security numbers for new enrollees.

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.

Contact the Health Service System if You Go on a Leave of Absence

You must contact the Health Service System at the start and end of any approved leave of absence. Health benefits premiums must be paid while you are on leave. Don't risk termination of coverage.

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

Depending on the service areas covered by your plan, you may need to enroll in a different plan based on your new address. Don't risk termination of health benefits because of a move.

Retiree Health Benefits Are Different From Employee Benefits

You are not automatically enrolled in retiree benefits. Before you retire you must visit the Health Service System to learn about, and enroll in, retiree health benefits.

For more information visit myhss.org or call Member Services at 1-415-554-1750.