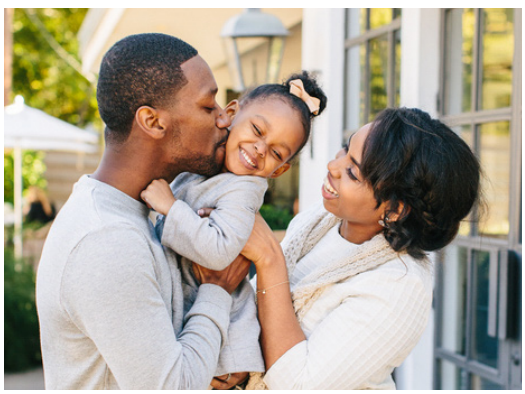

Municipal Executives

2017 HEALTH BENEFITS

Excellent benefits for our amazing city family

SAN FRANCISCO
HEALTH SERVICE SYSTEM

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 2017

New and Expanded Voluntary Benefits

MEA flex benefits help provide financial protection for you and your family. In 2017, you can enroll in Critical Illness Insurance. Expanded life insurance up to $100,000 is available without any medical exam. (Higher amounts are available with additional medical requirements.) And there are new plans for Short Term Disability, Accident and Pet Insurance.

Best Doctors

This free and confidential service is available to employees and family members who are enrolled in an HSS medical plan. It provides an expert case review whenever you and covered family members face an important medical decision. Contact Best Doctors if you have questions about a medical diagnosis or treatment. Call Best Doctors at 1-866-904-0910.

2017 Medical and Dental Plan Premium Contributions Are Changing

Before making Open Enrollment decisions, review the rates for your bargaining unit, available on myhss.org.

Kaiser Permanente Adds Coverage for Acupuncture

Acupuncture can help relieve chronic pain, like back or knee pain. It also may help with other conditions, such as migraines. In 2017 Kaiser offers coverage of a combined total of 30 chiropractic and acupuncture visits per year. Self-refer to practitioners through American Specialty Health (ASH) at a $15 co-pay per visit.

Kaiser Permanente Adds Coverage Tier for Specialty Drugs

In 2017 Kaiser will cover specialty drugs at 20% co-insurance. Kaiser enrollees pay up to a $100 co-pay for each 30-day supply. For more details speak with your Primary Care Physician or contact Kaiser at 1-800-464-4000.

Kaiser Permanente Service Area Expands to Santa Cruz County

In 2017 HSS members living in Santa Cruz county will have the Kaiser Permanente HMO as a medical plan option.

Blue Shield Offers Free Identify Theft Protection

Blue Shield medical plan members can now get identity protection services and credit monitoring for you and your covered family members – at no charge. You can access these services by calling 1-855-904-5733, 6:00AM to 6:00PM, Monday through Saturday or 24/7 at blueshieldca.allclearid.com.

VSP Vision Care Adds Hearing Aid Discount and Expands Primary Eyecare

VSP provides savings on hearing aids through TruHearing. For details about the hearing aid discount contact TruHearing at 1-877-396-7194 and identify yourself as a VSP member. With a $5 co-pay, VSP offers coverage for some urgent and acute eye conditions. Contact VSP at 1-800-877-7195.

Surrogacy and Adoption Reimbursement

If you add a child to your family through surrogacy or adoption in 2017 you can apply for a one-time reimbursement of up to $15,000. For information about qualified expenses, and how to apply for reimbursement, contact HSS at 1-415-554-1750.

UnitedHealthcare Dental Offers Implant Coverage and Reduces Orthodontia Co-pays

UnitedHealthcare Dental will cover implants starting in 2017. Co-pays apply; see Summary of Benefits at myhss.org. Orthodontia copays for this plan will decrease in 2017: $1,250 for children and $1,250 for adults.

How to Enroll in Health Benefits

- Learn about your health 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. See pages 8-9 for more information about qualifying events.
- To enroll in medical, vision and dental benefits, submit a completed enrollment application and required eligibility documentation to the Health Service System by the **30-day deadline**. Submit copies, not originals, 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 application and eligibility documentation. The fax number is 1-415-554-1721.
- Eligible Municipal Executives also receive flex credits, which can be spent on a variety of pre-tax and post-tax benefit options. If the premium contributions for your benefit choices cost more than your flex credits, you pay the balance from salary. If your benefits choices cost less than flex credits, you will receive cash back as taxable, non-pensionable earnings in your paycheck. To enroll in flex benefits contact EBS at 1-800-229-7683. Flex benefit enrollment for promotions and new hires must be completed no later than 30 **days** after your start work date.
- Employee premium contributions are deducted from paychecks bi-weekly. Review your paycheck to verify that the correct employee premium contribution is being deducted. 2017 premiums are on pages 40-41.
- October Open Enrollment is your annual opportunity to change benefit elections without any qualifying events. Changes made during October Open Enrollment are effective the following January 1.
- Questions about health benefits, premium contributions or eligibility documentation? **Call 1-415-554-1750**.

Message from the Director

Catherine Dodd RN, PhD
Director, Health Service System

I am proud to serve the members of the San Francisco Health Service System (HSS) and proud of the efforts of the Health Service Board and Health Service System staff. The HSS membership has increased to over 116,000 lives, up over 8,000 over the last five years. We remain dedicated to preserving and improving sustainable, quality health benefits and enhancing the well-being of employees, retirees, and their families.

HSS has successfully implemented all requirements of the Affordable Care Act (ACA). All members should have received 1095 forms in spring of 2016 which were also submitted to the IRS as proof of health coverage. The ACA excise tax expected to be implemented in 2018 is on hold. If the next President and Congress go forward with the excise tax, anticipate changes in Flexible Spending Accounts in 2018. For now, we are in compliance with all parts of the ACA.

Over the past five years overall premium rate increases have consistently been below five percent, far below the national average increases. We have saved tens of millions of dollars for our members and our four employers (City & County, School District, City College and Superior Court). We have done this by monitoring and working closely with the Blue Shield Accountable Care Organizations for active members: Brown & Toland, Hill Physicians and John Muir. Working together has not only reduced costs, it has improved patient care by adding urgent care coverage to avoid hospitalizations, and by coordinating discharge care to prevent long hospital stays and readmissions. We also have worked closely with Kaiser Permanente and they continue to excel at providing excellent care and coordinating care to prevent unnecessary hospitalizations.

This year we are seeing premium increases driven by three things, only one of which is unique to the San Francisco Bay Area. The first and unique cost driver is the high cost of hospitalization and outpatient medical treatments in the Bay Area driven by large hospital system consolidation. The second cost driver is the rapidly increasing cost of drugs. These include several categories of new drugs to treat cancer, drugs to treat and cure hepatitis C, other anti-retroviral drugs and drugs to treat autoimmune disorders. Most of these drugs did not exist five years ago and although we have had many drugs as generics for several years, the manufacturers are increasing the costs of generics to increase their profit margin. The last cost driver is utilization of medical services. If HSS members keep themselves healthy, our utilization will decrease. Unfortunately, as our membership ages and develops more chronic illnesses, utilization increases.

What can be done? **Take care of yourself, get preventive screenings including eye exams and dental screenings.** Take advantage of the HSS flu shot events in the fall. If you have children, keep up their routine appointments and vaccinations. Most chronic illnesses can be managed through diet, stress reduction and exercise. Decide to live longer and better.

In an effort to assist HSS members in reducing chronic illness and feeling better, the Health Service System with the support of the Mayor, the Controller and the Department of Human Resources launched a Wellness/Well-Being program which was fully staffed as of July 2016. **Health classes and programs are promoted by champions in almost every department** as well as in the School District, City College and the Superior Court. Check the well-being section of myhss.org to find out where classes and activities are. If you are in the Civic Center area, join your

colleagues for a walk every Tuesday. Look for opportunities to participate in educational and behavioral challenges that focus on better nutrition, reducing stress and increasing movement. Sign up for the HSS enews at myhss.org to get monthly information and tips. HSS is partnering with Kaiser Permanente on research to prevent diabetes. They are also conducting group health coaching at the Wellness Center.

The good news is that feeling better is the outcome of improving health status and lowering health costs goes along with feeling better. Look for changes on the myhss.org website which will include links to resources on any number of health topics.

This fall HSS will be working with Kaiser and Blue Shield to educate our members on the importance of advanced care planning. Watch for mailings and talks at HSS to help you complete important paperwork so that your health provider will know your wishes should you be unable to speak for yourselves.

Read the what's new sections of this guide carefully. **The Health Service Board voted to add a new expert medical review benefit.** Many members have been frustrated by limited second opinion options in HSS health plans. Beginning in 2017, a company called Best Doctors will be available to review health records and provide opinions of diagnoses and treatment plans. This is a very valuable resource for members and covered dependents. Please take advantage of this new benefit.

Take care of your health. Keep a file on your health or try carezone.com for free (not an HSS product). Keep a chronological record of any symptoms you may have. When did they start, be specific. Instead of complaining vaguely about pain, rate it on a scale of 0 to 10 (with 10 being the worst). Describe the quality of your pain or discomfort. Is it dull and aching as with tooth pain? Or is it a painful pressure, as if an elephant were sitting on y our chest? Does the pain radiate or spread into adjacent areas? How long has it hurt, and how often does it hurt? What makes it better? Prepare for your provider visits: write down your questions in advance and tell the doctor you have questions. Tell the doctor everything, even if it seems minor. If you are having tests done, ask what this test is for and when will I get the results?

If you are having a procedure done, ask in advance of the appointment: how many times has the doctor done this procedure? If a treatment is being ordered ask: why am I getting this treatment, what can I expect? In deciding on whether to take a medication or have a procedure, use the BRAIN decision technique: What are the Benefits, Risks (including side effects), Alternatives – what Insight do you gain from knowing these, and what will happen if you do Nothing? Bring all your medications with you to appointments. Ask about the medications being ordered. Will they interact with other medications you are taking, both prescription and non-prescription (over the counter)? Write down the names of the medications and how often to take them, what to expect. Keep this information in your health file and bring it with you to your appointments.

You are in charge of your health. You can ask for time to make decisions. Use the HSS Best Doctors service. Check out consumerhealthchoices.org from Consumer Reports for information on countless topics. Take charge of your health and your health care. The benefits provided by SF HSS employers are very good, but YOU can enhance them.

Comprehensive, Affordable Benefits for Eligible Employees and their Families

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 permanent employees of the City & County of San Francisco whose normal work week is not less than 20 hours.
- All regularly scheduled provisional employees of the City & County of San Francisco whose normal work week is not less than 20 hours.
- All other employees of the City & County of San Francisco, including temporary exempt or "as needed" employees, who have worked more than 1,040 hours in any consecutive 12-month period and whose normal work week is not less than 20 hours.
- Elected Officials of the City & County of San Francisco.
- All members of designated boards and commissions during their time in service to the City & County of San Francisco as defined in San Francisco Administrative Code Section 16.700(c).
- All officers and employees as determined eligible by the governing bodies of the San Francisco Transportation Authority, San Francisco Parking Authority, Treasure Island Development Authority, San Francisco Superior Court and any other employees as determined eligible by ordinance.
- All other employees who are deemed "full-time employees" under the shared responsibility provision of the federal Patient Protection and Affordability Care Act (Section 4980H).
- Temporary exempt employees of the Superior Court appointed for a specified duration of greater than six months with a normal work week not less than 20 hours become eligible on their start date.

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 domestic partner are eligible. If a member is required by a court's judgement, decree, or order to provide health coverage for a child, that child is eligible up to age 19. Coverage terminates at the end of the coverage period in which the child turns 19. The member must provide HSS with proof of guardianship, court order, or decree by required deadlines.

Adult Disabled Children

Children who are disabled may be covered beyond the age limits stated previously, provided all of the following criteria are met. (A newly hired employee who enrolls an adult disabled child age 26 or older must meet all requirements below, except 1 and 2.)

1. Adult child was enrolled in an HSS medical plan on the child's 19th birthday and 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 in 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.

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. October Open Enrollment is the only time to drop ineligible dependents without a penalty.

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 a county issued 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. Certificates of marriage or partnership must be issued in the United States. 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.

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 U.S. 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, be enrolled at the time of the member's death and are only eligible for benefits under a surviving spouse or surviving domestic partner. Many union members also have life insurance coverage;see page 29.

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 HSS at 1-415-554-1750.

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 will 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. Like the HMO plans, the PPO has 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. 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 2017. 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	❍	■	■
Santa Cruz	■	■	■
Solano	■	■	■
Sonoma	❍	■	■
Stanislaus	■	■	■
Tuolomne			■
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.

Blue Shield of California and Kaiser Permanente: Service Area Limits

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: No Service Area Limits

City Plan, administered by UnitedHealthcare, does not have any service area requirements. If you have questions contact UnitedHealthcare at 1-866-282-0125.

Change of Address: Notify HSS

If you move out of the service area covered by your plan, you must elect an alternate medical plan that provides coverage in your area. Failure to change your health benefit elections may result in the non-payment of claims for services received. 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 Permanente 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 Permanente.	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

Nurseline, Urgent Care, Telemedicine, Online Resources

Get care how and when you need it. Medical care is getting more convenient. Save yourself time and money by using these different services.

24/7 Nurse Line

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

Urgent Care

Sometimes you need medical care quickly, but a trip to the emergency room isn't necessary. Visit an urgent care center when it is after hours for your regular provider and you need prompt attention for an illness or injury that is not life-threatening. Urgent care offers the convenience of same-day appointments and walk-in service.

Telemedicine

Kaiser Permanente and City Plan Members: A video or virtual visit is an appointment with your doctor that is done through the camera on your mobile device or computer.

Blue Shield Members: Access board-certified doctors 24/7/365 by phone or video through teladoc.com/bsc.

Go Online

Email your doctor, access your records online, or renew your prescriptions.

Blue Shield of California HMO	Kaiser Permanente HMO	City Plan PPO
24/7 Nurseline		
NurseHelp 24/7 1-877-304-0504	Nurse Advice 24/7 1-866-454-8855	Nurseline 24/7 1-800-846-4678
Urgent After Hours Care		
1-855-256-9404 blueshieldca.com	1-866-454-8855	1-866-282-0125 welcometouhc.com/sfhss
Telemedicine		
Blue Shield members can access Teladoc's U.S. board-certified doctors 24/7/365 to resolve many non-emergency medical issues through phone or video consults. Visit teladoc.com/bsc or call 1-800-835-2362.	When scheduling an appointment in person or through the Appointment and Advice line (1-800-464-4000), ask if a video visit is right for your symptoms. You may be offered a video visit.	Members can access Virtual Visits by registering on myuhc.com, tab on the right, or by accessing health4me app, under Menu – Find and Price Care. Costs are the same as an office visit.

2017 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 PERMANENTE 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	20% up to $100 co-pay 30-day supply	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 PERMANENTE 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/ chiropractic	$15 co-pay 30 visits max for each per plan year; ASH network	$15 co-pay up to a combined total of 30 chiropractic and acupuncture visits/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

Mental Health and Substance Abuse Benefits

The Affordable Care Act protects mental health coverage. All medical plans must cover behavioral health treatment, such as psychotherapy and counseling, mental health inpatient services and substance abuse treatment. Due to federal mental health parity law, there is no yearly or lifetime dollar limit for essential mental health benefits. Also, deductibles, co-payments, coinsurance, out-of-pocket limits, number of days or visits covered and any pre-authorization of treatment must be the same for mental health and medical/surgical services.

Blue Shield of California HMO	Kaiser Permanente HMO	City Plan PPO
Mental Health and Substance Abuse Services		
Call 1-877-263-9952 to find a provider and schedule an appointment.	Call 1-800-464-4000 to make an appointment or contact your Primary Care Physician. Or contact California Behavioral Healthcare Helpline, available 24/7 at 1-800-900-3277–can help you access care.	Call 1-866-282-0125 to find a provider and schedule an appointment. Telemental Health services are available with participating providers. To find providers online, go to welcometouhc.com/sfhss.
Mental Well Being Services		
Counseling: LifeReferrals is available with no co-payment. Topics include relationship problems, stress, grief, and community referrals. Legal and identify thief consultations are available. Call 1-800-985-2405, 24/7. Online Coaching: Take well-being one day at a time with the DailyChallenge: wellvolution.com Tobacco Cessation: Visit QuitNet at mywellvolution.com.	Classes, Support Groups: Contact your local Kaiser facility for a calendar, or visit kp.org/mentalhealth. Telephone/Online Coaching: Call 1-866-251-4514 or visit kp.org and search for HealthMedia Relax. Tobacco Cessation: Contact your local Kaiser facility for classes. Call 1-866-251-4514 for a telephonic coach. For HealthMedia Breathe and other resources visit kp.org/quitsmoking.	Online Coaching: Visit welcometouhc.com/sfhss for the online stress management program. Tobacco Cessation: Visit welcometouhc.com/sfhss for the online smoking cessation program.
For urgent mental health issues, members should call 911, go to the nearest emergency department.		

Free, Confidential Counseling and More through the HSS Employee Assistance Program

EAP provides confidential, voluntary, free mental health services to employees, and their family members. EAP is staffed by licensed therapists. Our services include:

- Short-term, solution-focused counseling for individual, couples and families
- Seminars and workshops
- Critical incident debriefing and trauma response
- Mediation and conflict resolution
- Resources and referrals

EAP services are confidential, in accordance with state and federal law. Employees may use sick or personal time for EAP counseling. Appointments are available 9:00AM-5:00PM Monday through Friday. Call 1-800-795-2351.

Acupuncture and Chiropractic Benefits

HSS medical plans offer coverage for medically necessary acupuncture and chiropractic services.

These services may help in the treatment of back and neck pain, joint pain, muscle pain, sports pain and recovery from accidents. Coverage is limited, per your plan contract.

Blue Shield of California HMO	Kaiser Permanente HMO	City Plan PPO
Acupuncture and Chiropractic Services		
Self-refer up to 30 visits for chiropractic and 30 visits for acupuncture per year. Services are provided through the American Specialty Health network at $15 co-pay per visit. Find a practitioner at ashlink.com/ash or call 1-800-678-9133. If you need to book additional visits beyond the 30 visits covered by this plan, contact Blue Shield at 1-855-256-9404 to request a pre-authorization. Blue Shield also offers additional discounted acupuncture and chiropractic services through the ChooseHealthy discount program. Visit choosehealthy.com/Default.aspx?hp=BSCA or call 1-888-999-9452. Note: Acupuncture and chiropractic services must be medically necessary. Call Blue Shield or read your EOC for details on what is covered.	Self-refer up to 30 total visits (combined for chiropractic and acupuncture) per year. Services are provided through the American Specialty Health network at $15 co-pay per visit. Find a practitioner at ashlink.com/ash/kp or call 1-800-678-9133. After the 30 visits covered by this plan, you can book additional discounted visits using the ChooseHealthy discount program. Visit kp.org/choosehealthy or call 1-877-335-2746 weekdays from 5:00AM to 6:00PM. The Kaiser acupuncture benefit is new in 2017. Note: Acupuncture and chiropractic services must be medically necessary. Call Kaiser or read your EOC for details on what is covered.	Self-refer to a licensed practitioner at 50% reasonable and customary co-insurance, up to $1,000 maximum per year, after paying your deductible. Find a practitioner at welcometouhc.com/sfhss. If you exhaust your benefits, you can find discounted practitioners at unitedhealthallies.com so you can continue care. Note: Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Chiropractic/Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Chiropractic/Manipulative Treatment.
If you have questions about acupuncture or chiropractic coverage call your medical plan for more information.		

Best Doctors: Expert Medical Case Review

Expert physicians provide free and confidential case review when you or a family member faces any important medical decision.

New in 2017! Get an in-depth medical review by a world-renowned expert when concerned about a medical service or treatment plan. Consider using Best Doctors if you or a family member needs to:

- Confirm a diagnosis
- Decide if a recommended surgery is necessary
- Review a recommended treatment plan for a life-threatening illness like cancer or heart disease
- Learn more about a prescribed medication or medication interactions
- Evaluate options for treating chronic joint pain or back pain
- Manage a complex chronic condition, or multiple conditions

The Best Doctors benefit includes:

In-Depth Medical Case Review

At your request, Best Doctors collects and reviews your medical records, including images and tests. Expert physicians review your information and you receive a detailed report and a confidential recommendation about your diagnosis and treatment plan. Best Doctors will discuss this report with you and with your treating physician if you request it. This service helps you make the treatment decisions that are right for you.

Ask the Expert

If you have a basic question about a diagnosis or treatment options, you can obtain personalized guidance from a physician with specific expertise.

Critical Care

If you or your dependent family member is admitted to an emergency room with a traumatic injury requiring critical care or neonatal unit for an acute medical event, Best Doctors' emergency medical experts can provide early intervention along with your treating medical team. A nurse will be sent within two hours to review your care and coordinate with the Best Doctors' expert if needed to help make critical decisions.

Find a Doctor

Best Doctors can locate an in-network physician using their network of medical experts.

Medical Records eSummary

Best Doctors can collect and organize all your medical records along with a personal health summary from a Best Doctor and provide them to you on an easy-to-access USB drive.

Contact Best Doctors

To get started, call Best Doctors at 1-866-904-0910 or visit members.bestdoctors.com. You will be assigned a Best Doctors clinician to help you through the process and to select the best option for you. With your permission Best Doctors will gather and review your medical records, including images, lab results and pathology slides to make their recommendations.

Healthy Family Benefits

HSS provides benefits to support healthy families.

Affordable Care Act Mandated Services

The Affordable Care Act requires coverage of the following services with no cost-sharing: To access these services consult with your doctor.

- Well-woman visits
- Well-baby visits
- Screening for gestational diabetes
- Breastfeeding pumps
- Contraceptives
- Domestic violence screening

Pregnancy Support

Blue Shield of California	Kaiser Permanente	City Plan	DeltaDental
Visit blueshieldca.com/prenatal to enroll online or call 1-877-371-1511.	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/mydoctor/pregnancy.	Call 1-888-246-7389 for the Healthy Pregnancy Program.	Pregnant women are covered for 3 dental cleanings each plan year.

Infertility

All medical plans offered by HSS offer limited coverage for infertility services. For details contact your medical plan or read your Evidence of Coverage, available online at myhss.org.

Dependent Care Flexible Spending Account for Childcare.

A Dependent Care FSA can pay for certified day care, pre-school, day camp, and before or after school programs for children under age 13. Set aside between $250 and $5,000 pre-tax per household for the plan year. See pages 26-27 for more information.

Surrogacy and Adoption

Effective January 1, 2017, employees eligible for HSS benefits can apply for a one-time reimbursement of up to $15,000 for qualified expenses resulting from adoption or surrogacy. For information about how to apply for surrogacy or adoption reimbursement, contact HSS at 1-415-554-1750 or go to myhss.org.

Vision Plan 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 dependents enrolled in a medical plan adminstered by HSS have vision coverage through VSP Vision Care. You may use a VSP Vision Care network doctor or a non-VSP doctor. To locate a VSP network doctor visit vsp.com or contact Member Services at 1-800-877-7195.

Accessing Your Vision Benefits

No ID cards are issued for the vision plan. To receive service from a VSP Vision Care network doctor, contact the doctor, identify yourself as a VSP Vision Care member and make an appointment. VSP Vision Care 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 Vision Care network doctor without prior authorization, or obtain services from a vision care service provider outside of the VSP Vision Care network (including Kaiser Permanente), you are responsible for payment in full to the provider. You may then submit an itemized bill directly to VSP Vision Care for partial reimbursement. Compare the costs of out-of-network vision services to VSP Vision Care 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 Vision Care doctor.

Primary Eyecare

With a $5 co-pay, VSP Vision Care offers limited coverage for eye conditions such as pink eye, sudden flashers and floaters, eye pain or sudden vision changes. VSP primary eyecare does not cover treatment of chronic conditions like diabetes-related eye disease or glaucoma. These types of conditions may be covered by your medical plan.

Computer Vision Care Benefit (VDT)

Some union contracts provide employer-paid computer vision (VDT) benefits. Coverage includes an annual computer vision exam, $75 in-network retail frame allowance every 24 months and single vision, lined bifocal, lined trifocal lenses.

VSP Vision Care Member Extras

VSP Vision Care offers exclusive special offers and discounts, including an extra $20 on featured frame brands, and rebates on popular contact lenses. VSP also provides savings on hearing aids through TruHearing® for you, covered dependents and extended family including parents and grandparents.

No Medical Plan, No Vision Benefits

If you do not enroll in a medical plan, you and your dependents cannot access VSP Vision Care benefits.

Municipal Executives

2017 Vision Plan Benefits-at-a-Glance

2017 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 enhancements	Not applicable
Laser Vision Correction	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities	Not applicable

*Based on your last date of service.

Take Care of Your Teeth: Take Advantage of Dental Coverage

PPO-Style Dental Plans

A PPO-style dental plan allows you to visit any in-network or out-of-network dentist. The plan pays higher benefits (and you pay less) when you visit an in-network PPO dentist. There is a maximum benefit of $2,500 per year per enrollee.

HSS offers the following PPO-style dental plan:

- Delta Dental

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

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

With Delta Dental PPO dentists, you pay lower out-of-pocket costs. Most preventive services are covered at 100%; many other services are covered at 90%.

Delta Dental Premier dentists charge higher out-of-pocket fees. Covered charges are based on pre-arranged charges with each contracted dentist. Most preventive services are covered at 100%; many other services are covered at 80%.

You can also choose any dentist outside of the PPO and Premier networks. When you receive service from an out-of-network dentist, many services are covered at a lower percentage, so you pay more. Also, payment is based on reasonable and customary fees for the geographic area. Your out-of-pocket costs will be higher if your out-of-network dentist charges more than reasonable and customary fees.

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

HMO-Style Dental Plans (DMOs)

Similar to medical HMOs, a Dental Maintenance Organization (DMO) plans require that you receive all of your dental care from within a network of participating dental offices. DMOs charge a flat rate for all services. These networks are generally smaller than a dental PPO network. There is no monthly premium for DMOs. Before you elect a DMO plan, make sure that the plan's network includes the dentist of your choice.

HSS offers the following DMO plans:

- DeltaCare USA
- UnitedHealthcare Dental
  (formerly Pacific Union Dental)

Can you enroll in only a dental plan?

Yes, you can elect to enroll yourself and eligible dependents in an HSS dental plan even if you elect not to enroll in an HSS medical plan.

Municipal Executives

2017 Dental Plan Benefits-at-a-Glance

	Delta Dental			DeltaCare USA	UnitedHealthcare
Choice of dentist	You may choose any licensed dentist. You will receive a higher level of benefit and lower out-of-pocket costs when using a Delta Dental PPO dentist.			DeltaCare dental network only	UnitedHealthcare dental network only
Deductible	None			None	None
Plan year maximum	$2,500 per person Per year, excluding orthodontia benefits			None	None
Covered Services	**PPO Dentists**	**Premier Dentists**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
Cleanings and exams	100% covered 2x/year; pregnant women 3x/year	100% covered 2x/year; pregnant women 3x/year	80% covered 2x/year; pregnant women 3x/year	100% covered 1 every 6 months	100% covered 1 every 6 months
X-rays	100% covered full mouth 1x/5 years bitewing 2x/year to age 18; 1x/year over age 18	100% covered full mouth 1x/5 years bitewing 2x/year to age 18; 1x/year over age 18	80% covered full mouth 1x/5 years bitewing 2x/year to age 18; 1x/year over age 18	100% covered	100% covered
Extractions	90% covered	80% covered	60% covered	100% covered	100% covered
Fillings	90% covered	80% covered	60% covered	100% covered Limitations apply to resin materials	100% covered Limitations apply
Crowns	90% covered	80% covered	50% covered	100% covered Limitations apply to resin materials	100% covered Limitations apply
Dentures, pontics and bridges	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	100% covered Full and partial dentures 1x/5 years; fixed bridgework, limitations apply	100% covered Full and partial dentures 1x/5 years; fixed bridgework, limitations apply
Endodontic/ Root Canals	90% covered	80% covered	60% covered	100% covered Excluding the final restoration	100% covered
Oral surgery	90% covered	80% covered	60% covered	100% covered	100% covered
Implants	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	Not covered	Covered, Refer to co-pay schedule
Orthodontia	50% covered 6-month wait; child $2,500 lifetime max; adult $1,500 lifetime max	50% covered 6-month wait; child $2,000 lifetime max; adult $1,000 lifetime max	50% covered 6-month wait; child $1,500 lifetime max; adult $500 lifetime max	Employee pays: $1,600/child $1,800/adult $350 startup fee; limitations apply	Employee pays: $1,250/child $1,250/adult $350 startup fee; limitations apply

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

Flex Benefits

2017 Dollar Value Of Flex Credits Bi-Weekly					
	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE +2 OR MORE		
			Blue Shield of California	Kaiser Permanente	City Plan
CITY & COUNTY OF SAN FRANCISCO					
Municipal Executives MEA Unrepresented Managers MTA MEA Fire and Police MEA	**$317.41**	**$366.24**	**$812.41**	**$628.47**	**$812.41**
SUPERIOR COURT					
Municipal Executives MEA Unrepresented Managers Court Duty Officer Courts Commissioners' Association	**$989.00**	**$989.00**	**$989.00**	**$989.00**	**$989.00**

How Flex Benefits Work

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

$50,000 Group Life Insurance

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

New Hires

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

Open Enrollment

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

Flex Credit Benefit Options (Except FSAs) Will Roll Forward in 2017

If you are not making any changes to benefit selections, and you do not wish to fund an FSA (Flexible Spending Account), you do not need to meet with EBS during Open Enrollment. Your current benefit elections (except FSAs) will roll forward in 2017. To continue making FSA contributions, or to change your benefit choices, you must contact EBS during Open Enrollment. Without re-enrollment, all FSA contributions will cease December 31, 2016.

Qualifying Event Changes

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

Leaves of Absence

If you are going on an unpaid leave of absence, you may be responsible for making premium payments for selected benefits while no payroll deductions are taken. Contact HSS at 1-415-554-1750 for more information.

Flex Benefits

Maximize Your Benefits

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

Pre-Tax Flex Benefit Options

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

	Tax Status	EOI Required
Medical and Dental Premium Contributions	Pre-Tax	No
Healthcare Flexible Spending Account P & A Group	Pre-Tax	No
Dependent Care Flexible Spending Account P & A Group	Pre-Tax	No
Cancer Insurance Allstate Benefits	Pre-Tax	Yes
Heart and Stroke Insurance Allstate Benefits	Pre-Tax	Yes
Long-Term Disability Insurance (Employee Only and Employee + 1) Aetna	Pre-Tax	Yes

Taxable Flex Benefit Options

	Tax Status	EOI Required
Accident Insurance Voya	Post-Tax	Yes
Critical Illness Voya Financial	Post-Tax	During Open Enrollment in October 2016, you may enroll with no EOI
Universal Life Insurance Voya	Post-Tax	Yes
Short-Term Disability Insurance Abacus	Post-Tax	Yes
Long-Term Care Insurance John Hancock, MetLife, Mass Mutual	Post-Tax	Yes
Pet Insurance PetsBest	Post-Tax	No
Group Legal Plan Pre-Paid Legal	Post-Tax	No
Supplemental Group Term Life Insurance Aetna	Post-Tax	During Open Enrollment in October 2016, you may enroll in up to $100,000 additional life insurance with no EOI
LifeLock Identity Theft Protection LifeLock Benefit Solutions	Post-Tax	No

Evidence of Insurability (EOI)

Some benefits require additional information before enrollment is completed. This can include medical evidence. The insurer will contact you if specific records are required. It is your responsibility to provide all requested documentation. Enrollment may be denied by the insurer. In 2017, no payroll deductions will be taken until enrollment is approved by each insurer. If approved, there may be a catch-up payroll deduction retroactive to the effective date of your policy. If denied coverage, no premiums for that benefit will be deducted from your paycheck.

Flexible Spending Accounts (FSAs)

Pay for everyday expenses, such as healthcare, child daycare and elder daycare, with tax-free dollars.

Flexible Spending Accounts (FSAs) let you set aside money pre-tax to pay for eligible healthcare and/or dependent care expenses. For every $100 you set aside you save approximately $30 in taxes. An FSA account can pay qualifying expenses incurred by you, your spouse, or qualifying child or relative (as defined in Internal Revenue Code Section 152). You can enroll in either a Healthcare FSA, a Dependent Care FSA, or both.

Before enrolling in your FSA, calculate a detailed estimate of the eligible expenses you are likely to incur in 2017. Budget conservatively. You are allowed to carry over between a minimum of $10 and a maximum of $500 of your healthcare FSA each plan year for one year, if you do not use your funds during 2017. Unreimbursed funds under $10 and beyond $500 are forfeited and cannot be returned to you. Submit claims incurred during the plan year for up to 90 days after the plan year ends. FSA expenses must meet Internal Revenue Service (IRS) eligibility criteria. Learn more online: irs.gov/pub/irs-pdf/p15b.pdf.

FSA Rules

- FSA enrollment is required each year. You must re-enroll in Flexible Spending Account(s) every Open Enrollment if you want to continue this benefit.
- Expenses for your 2017 FSA must be incurred during calendar year 2017. Carryover funds (up to $500) from 2016 must also be incurred during calendar year 2017.
- You cannot transfer money between Healthcare and Dependent Care Flexible Spending Accounts.
- You cannot change FSA contributions during the January to December plan year unless you have a qualifying event. For details, visit myhss.org/benefits/fsa.html.
- If your employment ends, in some cases you have the option of continuing your FSA with COBRA. (See page 35). Without COBRA, you can only file claims for eligible FSA expenses that were incurred while you were actively employed.

If you miss two payroll deductions during an unpaid leave, your FSA will be terminated. You may reinstate your FSA if you contact HSS within 30 days of your return to work. See page 31 for more information.

New FSA Administrator: P&A Group

- FSA benefits are administered by P&A Group.
- For a complete list of FSA eligible healthcare and dependent care expenses, visit padmin.com.
- For FSA account information, visit padmin.com or call 1-800-688-2611. Monday to Friday, 5:30AM–7:00PM Pacific Time.
- P&A will issue a debit card for you to use to make spending your FSA easier.

Avoid Forfeiting FSA Contributions

FSA expenses for the 2017 plan year must be incurred in 2017 and received by P&A no later than March 31, 2018. Per IRS rules, you forfeit all funds remaining in an FSA by the end of the claim filing period unless they are covered by the Healthcare FSA Carryover provision. There are no exceptions.

Flexible Spending Accounts (FSAs)

Learn about the two different types of FSAs you are eligible to participate in.

Healthcare FSA with Carryover

A Healthcare FSA can pay for medical expenses such as medical, pharmacy, dental and vision co-payments, other dental and vision care expenses, acupuncture and chiropractic care, weight loss programs and more. For a complete list of eligible healthcare expenses, visit padmin.com.

- Set aside between $250 and $2,500 pre-tax per employee for the plan year. Depending on the amount you elect, deductions between $10 and $100 be taken bi-weekly from your paycheck January–December 2017.
- Submit reimbursement documentation by mail, online, or by smartphone app for eligible out-of-pocket medical expenses to P&A Group.
- P&A will issue a debit card for you to use to make spending your FSA easier.
- When you elect a Healthcare FSA, the total annual amount you designate becomes available for eligible healthcare expenses as of January 1, 2017. You do not have to wait for your contributions to accumulate in your account.
- HSS administers a carryover minimum of $10. At the end of the plan year claim filing period, unreimbursed healthcare FSA funds below $10 and over $500 will be forfeited.
- Carryover fund amounts between $10 and $500 are determined after the end of the claim filing period and are then available for any claims incurred as of the first day of the new plan year.
- A domestic partner's medical expenses cannot be reimbursed under an FSA unless the domestic partner is a "qualifying relative."
- Carryover funds can be accessed for one plan year. Any remaining carryover funds will be forfeited.

Childcare/Eldercare Dependent Care FSA

A Dependent Care FSA can pay for certified day care, pre-school, day camp, and before or after school programs for children under age 13. The Dependent Care FSA can also pay for adult day care for an aging parent or adult disabled child. These expenses must allow you (and, if married, your spouse) to continue working. For a complete list of eligible dependent care expenses, visit padmin.com.

- Set aside between $250 and $5,000 pre-tax per household for the plan year. ($2,500 each if you are married filing separate federal tax returns.) Depending on the amount you elect, deductions between $10 and $200 will be taken biweekly from your paycheck in 2017.
- Funds for a Dependent Care FSA cannot be used for dependent medical expenses. The Dependent Care FSA is for qualified child care and elder care expenses only.
- If you have a stay-at-home spouse, you may not enroll in the Dependent Care FSA.
- Submit reimbursement documentation to P&A Group by mail, online, or by smartphone app for eligible out-of-pocket expenses.
- Funds for a Dependent Care FSA are available after being deducted from your paycheck and received by the plan administrator. Unlike a Healthcare FSA, the entire annual amount for a Dependent Care FSA is not available January 1, 2017.
- Funds for a Dependent Care FSA must be used for incurred qualifying expenses during the plan year or be forfeited. Unlike a Healthcare FSA, there is no carryover option.

Long Term Disability Insurance (LTD)

LTD can replace lost income if you are injured or ill.

Long Term Disability Insurance

Employees represented by the Municipal Executives Association (MEA) who have families enrolled in medical coverage receive employer-sponsored LTD. Other MEA employees may apply to purchase LTD with flex credits through EBS.

A long-term disability is an illness or injury that prevents you from working for an extended period of time. If you submit a claim and it is approved, the LTD plan may replace part of your lost income by paying you monthly. (LTD payments will be reduced if you qualify for other sources of income, such as workers' compensation or state disability benefits.)

Generally plan benefits include:

- 66.667% of monthly base earnings (as defined by Aetna)
- $7,500 monthly maximum
- 90-day monthly elimination period
- There may be a waiting period based on your start work date.

If You Become Disabled

Notify Aetna of your disability as soon as possible by calling 1-866-326-1380. Within 30 days after the date of your disability you should begin filing a long-term disability insurance claim with Aetna. Aetna will work with your doctor to certify that your illness or injury will prevent you from working.

Aetna may request authorization to obtain additional medical information from your healthcare providers. You may also be asked to provide non-medical information to support your claim.

For more information about LTD Insurance visit myhss.org/benefits/ccsf_other_benefits.html.

Leave of Absence and LTD Coverage

If you are not actively at work due to illness or injury, LTD coverage will continue for 12 months from the start of your approved medical leave. If your coverage terminates during a period of disability which began while you had coverage, benefits will be available as long as your period of disability continues. Make sure your portion of health premiums are paid.

If you are not actively at work due to non-medical reasons, including temporary lay-off, personal leave, family care leave, or administrative leave, LTD coverage will terminate at the end of the month following the month your absence began. Call HSS at 1-415-554-1750 for more information about leave of absence and long-term disability coverage.

Returning To Work

LTD programs can help you get back on the job when it's medically safe for you to do so. You may be able to return to work part-time, or work at a different type of job. If you qualify, LTD can continue paying a portion of your benefits.

Bargaining Units Covered by LTD

90-day elimination period; up to 66.6667% of monthly base earnings; $7500 monthly maximum:

You will be eligible for employer-sponsored LTD if you are represented in collective bargaining by the Municipal Executives Association (MEA), you have at least two dependents enrolled on your medical coverage, and you are actively at work more than 20 hours per week at the time of your disability. Other individuals represented by MEA may apply to purchase LTD with flex credits. See pages 24-25.

This is a general summary. For LTD coverage details, see plan documents on myhss.org or call Aetna at 1-866-326-1380.

Group Life Insurance

MEA union contract provides for employer-paid life insurance.

Employer-Paid Group Life Insurance

Life insurance offers your loved ones basic financial protection if you die. It can help pay your final expenses or help those you leave behind pay bills, like a mortgage or college tuition.

You are eligible for employer-paid life insurance if you:

- Have a union contract that provides for employer-paid life insurance coverage.
- Are actively at work.

Coverage begins the first day of the month following your date of hire.

Life Insurance Beneficiaries

A beneficiary is the person or entity who receives the life insurance payment when the insured person dies. You may designate multiple beneficiaries. It is your responsibility to keep your beneficiary designations current. To update beneficiary designations, complete the Change Beneficiary Form and return to HSS: myhss.org/benefits/ccsf_other_benefits.html.

Leaves of Absence

If you are not actively at work due to a temporary lay-off, personal leave, family care leave, or administrative leave (non-medical reasons), your coverage will terminate at the end of the month following the month your absence started.

If you are not actively at work due to illness or injury, your life insurance coverage will continue for 18 months from the start of your absence for medical reasons. After six months, you may qualify for a further extension of your life insurance benefits (Permanent and Total Disability Benefit); however, you must provide Aetna with a written notice of claim for this extended benefits within the 18-month coverage period. Call HSS at 1-415-554-1750 for information about how a leave of absence can impact your life insurance coverage.

Outline of Life Insurance Plan Basics

Bargaining Unit	Coverage
Municipal Executives (except Fire and Police)	$50,000

Fire and police employees represented by MEA have other life insurance benefits.

Life Insurance Benefits Change Over Time

When you reach age 65, your benefits will drop to 65% of the original coverage amount. At age 70, your benefits will drop to 50%. At age 75, your benefits will drop to 30%.

Facing a Terminal Illness

If you are diagnosed with a terminal illness, you may request an Accelerated Death Benefit payment which pays you up to 75% of your life insurance coverage if you have 24 months or less to live. Also, Aetna Life Essentials offers no cost legal assistance for preparation of a living will or power of attorney, funeral planning and phone counseling by a licensed social worker. Visit aetna.com/aetnalifeessentials or contact Aetna Care Advocacy at 1-800-276-5120.

Portability

If you leave your job or otherwise lose eligibility you can convert your group life coverage to an individual policy, but you must pay life insurance premiums.

This is a general summary. For Life Insurance details, see plan documents on myhss.org or call Aetna at 1-800-523-5065.

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

Type of Leave	Health Benefits Eligibility
Family and Medical Leave (FMLA) Workers' Compensation Leave Family Care Leave Military Leave	Notify the Health Service System (HSS) as soon as your leave begins–within 30 days. You may elect to continue or waive coverage for the duration of your approved leave of absence. Notify HSS immediately upon return to work to avoid a break in coverage.
Personal Leave Following Family Care Leave	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. Notify the HSS immediately upon return to work to avoid a break in coverage.
Educational Leave Personal Leave Leave for Employment as an Employee Organization Officer or Representative	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. Notify the HSS immediately upon return to work to avoid a break in coverage. 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 premium contribution plus your employer's premium contribution. Contact HSS for details.

Your Responsibilities

Notify your supervisor and your department's Human Resources Professional (HRP) prior to your leave. (If your leave is due to an unexpected emergency contact your HRP as soon as possible.) Your HRP will help you understand the process and documentation required for an approved leave. Your HRP 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 immediately and **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.

Health Benefits During a Paid or Unpaid Leave of Absence

Medical, Dental and Vision

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.

Healthcare FSA

During an unpaid leave, no FSA payroll deductions can be taken. To maintain your FSA, you must pay FSA contributions directly to HSS. Contact HSS **within 30 days** of when leave begins to arrange for payment of FSA contributions. You may suspend your Healthcare FSA if you notify HSS at the beginning of your leave. Accounts that remain unpaid for three consecutive pay periods will be suspended retroactively to the first missed pay period. Your Healthcare FSA will be reinstated once you return to work. If you want to maintain your annual election amount for expenses incurred before and after your leave, you must notify HSS **within 30 days** of your return to work. Your payroll deductions will be increased and spread proportionally over the remaining pay periods in the Plan Year. If you do not contact HSS, your annual election amount will be reduced by the amount of contributions missed (if any) during your leave of absence.

Dependent Care FSA

A Dependent Care FSA must be suspended while you are on leave. Claims incurred during leave are not reimbursable. To reinstate, you must notify HSS **within 30 days** of your return to work. Reinstatement of a Dependent Care FSA is only allowed on a go-forward basis. You may reinstate at the original bi-weekly FSA deduction amount, or you can increase bi-weekly deductions for the plan year. If you increase deductions, total FSA contributions for the year must equal and cannot exceed, the amount designated during Open Enrollment. If you do not notify HSS **within 30 days** of your return to work and request reinstatement of your FSA payroll deduction, FSA(s) will be canceled for the remainder of the plan year. There are no exceptions. If you return to work after December 2017, a suspended Healthcare or Dependent Care FSA initiated during the 2017 plan year cannot be reinstated. There are no exceptions.

Group Life Insurance

If you go on an approved leave due to illness or injury, employer-paid group life coverage continues for up to 18 months. For other types of leave, group life coverage ends the last day of the month after the month in which your leave begins. Group life insurance resumes the first day of the coverage period after you officially return to work.

Long Term Disability (LTD) Insurance

If you go on an approved leave due to illness or injury, employer-paid long term disability coverage continues for up to 12 months. Health premiums are not deducted from LTD payments. Call HSS to arrange to pay your premiums. For other types of leave, LTD coverage ends the last day of the month after the month in which your leave begins. LTD coverage resumes the first day of the coverage period after you officially return to work.

Domestic Partner Imputed Income

If you have a 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 About Health Benefits During a Leave

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

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.

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.

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. Health premium contributions will be taken from your pension check. If monthly premium contributions are greater than your pension check, you must contact HSS to make payment arrangements. Premium 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 registered domestic partner of an employee who is eligible for Medicare must be enrolled in Medicare to qualify for HSS medical coverage. The federal government charges a premium for Medicare Part B and in some cases, for Part D. All Medicare premium payments must be paid to maintain continuous Medicare enrollment. A domestic partner who fails to enroll in Medicare Part B when first eligible may be charged Medicare late enrollment penalties.

Contact the Employee Assistance Program

Contact EAP at 1-800-795-2351 before your retirement date to plan for a meaningful retirement. Address any emotional or psychological changes and make your retirement years be the best they can be.

It's Important to Plan as You Approach Retirement

City Charter provisions regarding retiree health benefits for employees hired after January 9, 2009.

Proposition B, approved by San Francisco voters in 2008, amended City Charter provisions relating to retiree health benefits.

To be eligible for retiree health benefits, employees hired after January 9, 2009 must have at least 5 years of credited service with a City employer: City & County of San Francisco, San Francisco Unified School District, San Francisco City College or San Francisco Superior Court. Other government employment is not credited.

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

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

If eligible, different premium contribution rates apply for employees hired after January 9, 2009, based on years of credited service with the City employers.

- **With at least 5 years but less than 10 years of credited service,** the retiree member must pay the full premium rate and does not receive any employer premium contribution.
- **With at least 10 years but less than 15 years of credited service,** the retiree will receive 50% of the employer premium contribution for themselves and eligible dependents.
- **With at least 15 years but less than 20 years of credited service,** the retiree will receive 75% of the employer premium contribution for themselves and eligible dependents.
- **With 20 or more years of credited service,** or disability retirement, the retiree will receive 100% of the employer premium contribution for themselves and eligible dependents.

Thinking About Retiring?

Make an informed decision. Confirm years of credited service with your retirement system: SFERS, CalPERS, CalSTRS or PARS. (There is no reciprocity with other government employment under Proposition B for health benefits.) Then contact the Health Service System. A benefits analyst will review your service credits, health benefits eligibility, retiree health plan options and premium contributions.

COBRA, Covered California and Holdover

COBRA

Under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), employees without holdover rights, or whose holdover rights have ended, may be eligible to continue medical, dental and vision coverage for themselves and eligible dependents at the employee's expense. Current year FSAs (Flexible Spending Accounts) may also be COBRA-eligible.

For Cobra information, visit padmin.com or call 1-800-688-2611

Employees may elect to continue healthcare coverage through COBRA if coverage is lost due to:

- Voluntary or involuntary termination of employment (except for gross misconduct).
- Hours of employment reduced, making the employee ineligible for employer health coverage.

Covered spouses or domestic partners may also elect to be covered under COBRA if coverage is lost due to:

- Voluntary or involuntary termination of the employee's employment (except for misconduct).
- Divorce, legal separation, or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

Covered dependent children may elect COBRA coverage if healthcare coverage is lost due to:

- Loss of dependent child status under the plan rules.
- Voluntary or involuntary termination of the employee employment (except for misconduct).
- Hours of employment reduced, making the employee ineligible for employer health coverage.
- Parent's divorce, legal separation, or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

COBRA Notification and Election Time Limits

If an employee and any enrolled dependents lose HSS coverage due to separation from employment, P&A Group will notify the employee of the opportunity to elect COBRA coverage. The employee or dependent has 60 days from the COBRA notification date to complete enrollment and continue coverage. Coverage will be retroactive to the date of the COBRA-qualifying event, so there is no break in coverage. Employee coverage ends on the last day of the coverage period in which employment terminates. However, if the termination date falls on the first day of the coverage period, coverage ends that same day. If an enrolled dependent of an employee loses coverage due to divorce, dissolution of partnership, or aging out, the employee or the dependent must notify P&A Group within 30 days of the qualifying event and request COBRA enrollment information.

Paying for COBRA

It is the responsibility of covered individuals enrolled in COBRA to pay required healthcare premium payments directly to P&A Group. COBRA premiums are not subsidized by the employer.

Dependents dropped from coverage during Open Enrollment are not eligible for COBRA.

Duration of COBRA Continuation Coverage

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. Employees and dependents who are eligible for less than 36 months of federal COBRA may also be eligible for Cal-COBRA. Continuation coverage under both federal and California state COBRA will not exceed 36 months.

Employees who are disabled on the date of their qualifying event, or 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% of group rate.

2017 Monthly COBRA Premium Rates

Blue Shield of California HMO	
Employee Only	$767.30
Employee +1	$1,530.09
Employee +2 or More	$2,163.18
Kaiser Permanente HMO	
Employee Only	$594.19
Employee +1	$1,183.91
Employee +2 or More	$1,673.38
City Plan (United Healthcare) PPO	
Employee Only	$818.45
Employee +1	$1,592.31
Employee +2 or More	$2,234.38
Delta Dental PPO	
Employee Only	$65.80
Employee +1	$138.19
Employee +2 or More	$197.41
DeltaCare USA DMO	
Employee Only	$27.49
Employee +1	$45.35
Employee +2 or More	$67.08
UnitedHealthcare Dental DMO	
Employee Only	$28.36
Employee +1	$46.82
Employee +2 or More	$69.22

Flexible Spending Accounts and COBRA

To continue FSA benefits under COBRA, year-to-date FSA contributions must exceed year-to-date claims as of your employment termination date. To keep your FSA open, apply under COBRA and continue making the bi-weekly contribution plus a 2% administrative charge. COBRA Flexible Spending Account contributions are made post-tax.

Termination of COBRA Continuation Coverage

COBRA coverage will end if:

- You obtain coverage under another group plan.
- You fail to pay the premium required under the plan within the grace period.
- The applicable COBRA period ends.

Covered California: Alternative to COBRA

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.

Holdover Rights

Employees who are placed on a holdover roster may be eligible to continue HSS medical, dental and vision coverage for themselves and covered dependents. Eligibility requirements include:

Employees must certify annually that they are unable to obtain other health coverage.

Holdover premium contributions must be paid by the due date listed on the 2017 Health Coverage Calendar. (See page 36.) Rates may increase each plan year.

Health Coverage Calendar

Work Dates	Pay Date	Benefits Coverage Period
December 31, 2016–January 13, 2017	January 24, 2017	December 31, 2016–January 13, 2017
January 14, 2017–January 27, 2017	February 7, 2017	January 14, 2017–January 27, 2017
January 28, 2017–February 10, 2017	February 21, 2017	January 28, 2017–February 10, 2017
February 11, 2017–February 24, 2017	March 7, 2017	February 11, 2017–February 24, 2017
February 25, 2017–March 10, 2017	March 21, 2017	February 25, 2017–March 10, 2017
March 11, 2017–March 24, 2017	April 4, 2017	March 11, 2017–March 24, 2017
March 25, 2017–April 7, 2017	April 18, 2017	March 25, 2017–April 7, 2017
April 8, 2017–April 21, 2017	May 2, 2017	April 8, 2017–April 21, 2017
April 22, 2017–May 5, 2017	May 16, 2017	April 22, 2017–May 5, 2017
May 6, 2017–May 19, 2017	May 30, 2017	May 6, 2017–May 19, 2017
May 20, 2017–June 2, 2017	June 13, 2017	May 20, 2017–June 2, 2017
June 3, 2017–June 16, 2017	June 27, 2017	June 3, 2017–June 16, 2017
June 17, 2017–June 30, 2017	July 11, 2017	June 17, 2017–June 30, 2017
July 1, 2017–July 14, 2017	July 25, 2017	July 1, 2017–July 14, 2017
July 15, 2017–July 28, 2017	August 8, 2017	July 15, 2017–July 28, 2017
July 29, 2017–August 11, 2017	August 22, 2017	July 29, 2017–August 11, 2017
August 12, 2017–August 25, 2017	September 5, 2017	August 12, 2017–August 25, 2017
August 26, 2017–September 8, 2017	September 19, 2017	August 26, 2017–September 8, 2017
September 9, 2017–September 22, 2017	October 3, 2017	September 9, 2017–September 22, 2017
September 23, 2017–October 6, 2017	October 17, 2017	September 23, 2017–October 6, 2017
October 7, 2017–October 20, 2017	October 31, 2017	October 7, 2017–October 20, 2017
October 21, 2017–November 3, 2017	November 14, 2017	October 21, 2017–November 3, 2017
November 4, 2017–November 17, 2017	November 28, 2017	November 4, 2017–November 17, 2017
November 18, 2017–December 1, 2017	December 12, 2017	November 18, 2017–December 1, 2017
December 2, 2017–December 15, 2017	December 26, 2017	December 2, 2017–December 15, 2017
December 16, 2017–December 29, 2017	January 9, 2018	December 16, 2017–December 29, 2017

New Hires: Health Coverage Does Not Begin on Your Start Work Date

You have 30 days from your start work date to enroll in health benefits. If you enroll by the 30-day deadline, health coverage will begin on the first day of the coverage period following your start work date.

Employee premium contributions are deducted from paychecks bi-weekly. Employee premium contributions for benefits coverage period are paid concurrent with the coverage period.

Flexible Spending Account (FSA) deductions will only occur on pay dates during the 2017 tax 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 30-31 for more information about maintaining health coverage during a leave.

Health Service Board Achievements

Randy Scott
Appointee
President

Wilfredo Lim
Elected
Employee
Vice President

Karen Breslin
Elected
Retiree

Mark Farrell
Appointee
Board of
Supervisors

Sharon Ferrigno
Elected
Retiree

Stephen
Follansbee, MD
Appointee

Gregg Sass
Appointee

Well-being Program: Approved the City's wellness plan with expansion to all four employers and retirees.

Steps to Maintain Affordable Benefits and to Avoid the 2020 Federal Excise Tax:

1. Approved active and early retiree rates below 5% for 2017. This required allocation of $7.6M from the City Plan Stabilization Reserve to reduce 2017 City Plan premiums for employees and early retirees. This allocation reduced premium rates and will reduce the base rate used to calculate the 40% federal excise tax in 2020.
2. Mitigated excessive Medicare retiree rate increases by changing the financing of City Plan/UHC for Medicare retirees from self-funding to fully-funding through UHC and eliminated Blue Shield Medicare retiree plan.
3. Continued 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.
4. Continued to monitor Blue Shield's ACOs, improving care and lowering costs by coordinating care.
5. Maintained competition between Blue Shield of California flex funded plan and Kaiser Permanente plan, keeping employee premium contributions affordable and competitive.

Transparency: Per Board of Supervisors' resolution convened experts to discuss transparency in cost and quality.

Remained on Top of industry trends: Convened board educational session and contrasted benefits and costs in nine Bay Area counties, statewide and nationally. Reviewed increases to costs related to consolidation.

Benefit Additions:

- Approved addition of a medical case review benefit through Best Doctors. All members will be able to contact Best Doctors for case review regarding diagnoses, treatment plans and medical questions.
- Approved addition of acupuncture and Specialty Drug Tier to Kaiser Permanente and Silver&Fit to retiree coverage
- Approved expansion of coverage nationally for Medicare-eligible retirees through New City Plan (UHC MAPD) which has lower premiums and co-pays and Solutions for Caregivers service provided by geriatric case managers, among other benefits.
- Approved addition of Blue Shield TeleDocs so members can call to ask questions of a Board Certified physician 24/7 for non-emergency issues.
- Added a one time adoption and surrogacy benefit.

Voluntary Benefits: Approved establishing voluntary benefits for all City & County employees, paid by employees. This includes guaranteed issue (no medical screen required) life insurance, short term disability insurance, accident and critical illness insurance, identity theft protection, legal insurance, and pet insurance.

Established Mechanism for Members to Comment on Issues the Board is Considering:
Email health.service.board@sfgov.org or send letters to Board Secretary, Health Service System, 1145 Market Street, 3rd Floor, San Francisco, CA 94103.

Glossary of Healthcare Terms

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

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.

Guaranteed Issue
There are insurance policies that are guaranteed to be issued. That means regardless of your health, you cannot be declined or turned down for coverage.

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.

2017 Bi-Weekly Medical Premium Contributions

EMPLOYEE ONLY	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY PLAN PPO	
CITY & COUNTY OF SAN FRANCISCO	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives MEA Miscellaneous Unrepresented Managers Unrepresented Employees Elected Officials Municipal Executives MEA – Fire Municipal Executives MEA – Police	**$279.16**	**$68.03**	**$268.86**	**0**	**$279.16**	**$91.18**
MTA – MUNICIPAL TRANSPORATION AGENCY	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives MEA MTA Unrepresented Managers	**$279.16**	**$68.03**	**$268.86**	**0**	**$279.16**	**$91.18**
SUPERIOR COURT	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives MEA Unrepresented Managers Court Duty Officer Courts Commissioners' Association	**0**	**$347.19**	**0**	**$268.86**	**0**	**$370.34**

EMPLOYEE +1	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY PLAN PPO	
CITY & COUNTY OF SAN FRANCISCO	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives MEA Miscellaneous Unrepresented Managers Unrepresented Employees Elected Officials Municipal Executives MEA – Fire Municipal Executives MEA – Police	**$279.16**	**$413.19**	**$268.86**	**$266.85**	**$279.16**	**$441.34**
MTA – MUNICIPAL TRANSPORATION AGENCY	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives MEA MTA Unrepresented Managers	**$279.16**	**$413.19**	**$268.86**	**$266.85**	**$279.16**	**$441.34**
SUPERIOR COURT	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives MEA Unrepresented Managers Court Duty Officer Courts Commissioners' Association	**0**	**$692.35**	**0**	**$535.71**	**0**	**$720.50**

EMPLOYEE +2 or More	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY PLAN PPO	
CITY & COUNTY OF SAN FRANCISCO	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives MEA Miscellaneous Unrepresented Managers Unrepresented Employees Elected Officials Municipal Executives MEA – Fire Municipal Executives MEA – Police	**0**	**$978.81**	**0**	**$757.19**	**0**	**$1,011.03**
MTA – MUNICIPAL TRANSPORATION AGENCY	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives MEA MTA Unrepresented Managers	**0**	**$978.81**	**0**	**$757.19**	**0**	**$1,011.03**
SUPERIOR COURT	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives MEA Unrepresented Managers Court Duty Officer Courts Commissioners' Association	**0**	**$978.81**	**0**	**$757.19**	**0**	**$1,011.03**

2017 Bi-Weekly Dental Premium Contributions

CITY & COUNTY OF SAN FRANCISCO and MTA

EMPLOYEE ONLY	DELTA DENTAL		DELTACARE USA		UNITEDHEALTHCARE DENTAL	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Employee Only	$27.46	$2.31	$12.44	0	$12.83	0
Employee +1	$57.91	$4.62	$20.52	0	$21.18	0
Employee +2 or more	$82.41	$6.92	$30.35	0	$31.32	0

SUPERIOR COURT

EMPLOYEE ONLY	DELTA DENTAL		DELTACARE USA		UNITEDHEALTHCARE DENTAL	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Employee Only	$29.77	0	$12.44	0	$12.83	0
Employee +1	$62.53	0	$20.52	0	$21.18	0
Employee +2 or more	$89.33	0	$30.35	0	$31.32	0

2017 Bi-Weekly Flex Credit Dollars

	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE +2 OR MORE		
			Blue Shield of California	Kaiser Permanente	City Plan
CITY & COUNTY OF SAN FRANCISCO					
Municipal Executives MEA Miscellaneous Unrepresented Managers Unrepresented Employees MEA Fire and Police	$317.41	$366.24	$812.41	$628.47	$812.41
MTA – MUNICIPAL TRANSPORATION AGENCY					
Municipal Executives MEA MTA Unrepresented Managers	$317.41	$366.24	$812.41	$628.17	$812.41
SUPERIOR COURT					
Municipal Executives MEA	$989.00	$989.00	$989.00	$989.00	$989.00

Eligible employees of the City & County of San Francisco and Superior Court may apply these flex credit dollars to a variety of benefit options, including payment of employee medical and dental premium contributions. The amount of flex credits for employees +2 or more has been increased to reflect the City's commitment to ensuring affordable health coverage for families. For more information about flex credits see pages 24-25.

Key Contact Information

Health Service System
1145 Market Street, 3rd Floor
San Francisco, CA 94103
Tel: 1-415-554-1750
Toll Free: 1-800-541-2266
Fax: 1-415-554-1721
Web: myhss.org

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

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

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

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	welcometouhc.com/sfhss	Group 752103
DENTAL and VISION PLANS			
Delta Dental	1-888-335-8227	deltadentalins.com	Group 9502-0003
DeltaCare USA	1-800-422-4234	deltadentalins.com	Group 71797-0001
UnitedHealthcare Dental formerly Pacific Union Dental	1-800-999-3367	welcometouhc.com/sfhss	Group 275550
VSP Vision Care	1-800-877-7195	vsp.com	Group 12145878
FSAs and COBRA			
P&A Group FSA	1-800-688-2611	padmin.com	
P&A Group COBRA	1-800-688-2611	padmin.com	
FLEX BENEFITS			
EBS	1-800-229-7683	ebsbenefits.com	
SECOND MEDICAL OPINION			
Best Doctors	1-866-904-0910	members.bestdoctors.com	
LONG TERM DISABILITY (LTD) and GROUP LIFE			
Aetna LTD Long Term Disability	1-866-326-1380	aetnadisability.com/login.aspx	Group 839201
Aetna Group Life	1-800-523-5065	aetna.com/group/aetna_life_essentials	To initiate a claim, contact HSS at 1-800-541-2266
OTHER AGENCIES			
SFERS Employees' Retirement System	1-415-487-7000	mysfers.org	pension benefits
Dept of the Environment	1-415-355-3700	sfenvironment.org	commuter benefits
Covered California	1-888-975-1142	coveredca.com	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. When 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.