Retirees

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 in 2017

Retirees with Medicare have different medical plan options– Blue Shield is no longer being offered.

Retirees with Medicare Have Two Medical Plan Choices in 2017

Retirees with Medicare can enroll in Kaiser Permanente Senior Advantage or the New City Plan offered by UnitedHealthcare. The New City Plan is a UnitedHealthcare Group Medicare Advantage PPO plan.

Retirees Without Medicare Have The Same Medical Plan Options In 2017

Retirees and family members who are not yet eligible for Medicare have the same medical plan choices in 2017 as they had in 2016: Kaiser Permanente Traditional HMO, Blue Shield of California Access+ HMO and UnitedHealthcare City Plan PPO. There are no changes to plan maximums for these plans in 2017. Blue Shield members who who turn 65 will have an option to enroll in Kaiser Permanente Senior Advantage or will be enrolled in the New City Plan UHC MAPD PPO.

Retiree Medical and Dental Premium Contributions Will Change in 2017

See pages 40–43 for details about 2017 retiree monthly premium contributions.

Best Doctors

This free and confidential service provides an expert case review whenever you or an eligible family member faces an important medical decision. Contact Best Doctors if you have questions about a medical diagnosis, treatment or if you are facing a critical condition. Call Best Doctors at 1-866-904-0910.

Kaiser 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 Adds Coverage Tier for Specialty Drugs

In 2017 Kaiser will cover specialty drugs at 20% co-insurance (not to exceed $100) for up to a 30 day supply. For more details, speak with your Primary Care Physician or contact Kaiser at 1-800-464-4000.

Kaiser Expands to Santa Cruz County for Non-Medicare Retirees

In 2017 early retirees living in Santa Cruz county will have Kaiser Permanente HMO as a medical plan option.

Kaiser Senior Advantage Adds Silver&Fit for Medicare Retirees

Free access to fitness facilities, home fitness kits and online resources to help you stay healthy and thrive. For details visit silverandfit.com.

VSP Hearing Aid Discount

In 2017, VSP also provides savings on hearing aids through TruHearing. For details contact TruHearing at 1-877-396-7194 and identify yourself as a VSP member.

UnitedHealthcare Dental Adds Implant Coverage

UnitedHealthcare Dental will cover implants starting in 2017. (Co-pays apply. See the Summary of Benefits at myhss.org.)

Enrolling In Retiree Health Benefits

Learn About Retiree Health Benefits Options

Get informed about retiree plans and premium contributions by reading this Guide and visiting myhss.org. You may also visit the Health Service System office at 1145 Market Street, San Francisco and speak with a Benefits Analyst. No appointment is necessary.

Once you are enrolled, **retiree premium contributions are deducted from pension checks** monthly. Review your pension check to verify that the correct premium contribution is being deducted. If your pension check does not cover your required premiums you must contact the Health Service System for options on how to make your monthly payments. 2017 retiree premium contributions are on pages 40–43.

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

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

You may only make changes to benefit elections during the plan year if there is a qualifying event. For more information about qualifying events see pages 34–35.

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

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

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

New retirees should plan ahead. **If you are Medicare eligible, you must be enrolled in Medicare** to enroll in benefits. The Social Security Administration may take up to three months to process Medicare enrollment so apply before your 65th birthday.

To be eligible for retiree health benefits, **employees hired after January 9, 2009** must have at least five years of credited service with a City employer: City & County of San Francisco, San Francisco Unified School District, San Francisco City College or San Francisco Superior Court. Other government service is not credited. If this applies to you, make sure you understand the **City Charter rules that determine your eligibility** and retiree premium contributions before finalizing your retirement date. See page 8 of this guide.

Depending on your retirement date, there can be a gap between when active employee coverage ends and retiree coverage begins. Setting a retirement date at the end of the month will help avoid a gap in HSS coverage.

Questions About Retiree Health Benefits

Call HSS Member Services at 1-415-554-1750 or visit the HSS office at 1145 Market Street, 3rd Floor, San Francisco. No appointment is necessary.

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 and 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 your 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.

Eligibility

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

Retiree Member Eligibility

An employee must meet age and minimum service requirements and have been enrolled in HSS health benefits at some time during active employment to be eligible for retiree health coverage. HSS calculates service. Service requirements vary. If hired on or after January 9, 2009, Proposition B applies. (See page 8.) If a retiree chooses to take a lump sum pension distribution, retiree health premium contributions will be unsubsidized and paid at full cost. Other restrictions may apply. For an assessment of eligibility for retiree health benefits contact the Health Service System.

Newly eligible retirees must enroll in retiree medical and/or dental coverage **within 30 days** of their retirement effective date. To enroll you must provide HSS with a completed enrollment application and all required eligibility documentation, including retirement system paperwork. Members eligible for Medicare at the time of retirement must also provide proof of Medicare enrollment. Medicare applications take three to four months to process by Social Security, so plan ahead before your 65th birthday. If you fail to meet required deadlines, you must wait until the next Open Enrollment.

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

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

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

Dependent Eligibility

Spouse or Registered Domestic Partner

A member's spouse or registered domestic partner may be eligible for HSS healthcare coverage. Proof of marriage or domestic partnership is required, as well as the dependent's Social Security number. Enrollment in HSS benefits must be completed within 30 days of the date of marriage or partnership. In that case, coverage begins on the first day of the 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. Proof of Medicare enrollment must be provided for a spouse or registered domestic partner who is Medicare-eligible due to age or disability. Medicare applications take three to four months to process by Social Security, so plan ahead.

Natural Children, Stepchildren, Adopted Children

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

Legal Guardianship and Court-Ordered Children

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

Eligibility

Adult Disabled Children

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

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

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

COBRA Continuation Coverage

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

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

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

Medicare Enrollment is Required

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

Financial Penalties for Failing to Disenroll Ineligible Dependents

Members must notify HSS within 30 days and cancel coverage for a dependent who becomes ineligible. If a member fails to notify HSS, the member may be held responsible for the costs of ineligible dependents' health premiums and any medical services provided.

Eligibility

City Charter Amendments and Retiree Benefits

2008 Proposition B: Employees Hired After January 9, 2009

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

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

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

If eligible, different premium contribution rates apply for employees hired after January 9, 2009, based on years of credited service with the City employers. See pages 40–43 for retiree premium contributions based on Proposition B.

With at least five years but less than 10 years of credited service, the retiree member must pay the full premium rate and does not receive any employer premium contribution.

- With at least 10 years but less than 15 years of credited service, the retiree will receive 50% of the employer premium contribution for themselves and eligible dependents.
- With at least 15 years but less than 20 years of credited service, the retiree will receive 75% of the employer premium contribution for themselves and eligible dependents.
- With 20 or more years of credited service or disability retirement, the retiree will receive 100% of the employer premium contribution for themselves and eligible dependents.

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

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

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

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

- The retiree member receives 100% of the employer premium contribution defined by the City Charter.
- The retiree pays the full premium for any other enrolled dependents. There is no employer premium contribution.

Getting Ready to Retire?

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

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

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

Ten Things Retirees Should Know

1. **The Health Service System is Your Trusted Resource for Health Benefits Information**
   If you have questions about your benefits contact the Health Service System at 1-415-554-1750 or 1-800-541-2266. Visit our website at myhss.org.

2. **Retiree Health Benefits Eligibility Is Determined by the San Francisco City Charter**
   Eligibility for retiree health benefits and retiree premium contributions vary depending upon an individual's hire date, years of credited service, time of retirement and other factors.

3. **Retiree Health Benefits Are Different Than Employee Health Benefits**
   Review retiree benefits options carefully. Retiree medical and dental plans are not the same as active employee plans. Premium contributions are also different.

4. **New Retirees: There Is A 30 Day Deadline to Enroll In Retiree Health Benefits**
   You must complete enrollment in retiree benefits within 30 days of your retirement date. If you miss the 30 day deadline, you must wait until Open Enrollment to enroll in retiree health benefits.

5. **Retirees and Dependents Must Enroll In Medicare Part A and Part B As Soon As Eligible**
   Retirees and dependents who are Medicare-eligible due to age or disability must enroll in premium-free Medicare Part A hospital insurance and Medicare Part B medical insurance.

6. **Do Not Enroll In Any Individual Medicare Part D Prescription Drug Plan**
   All Health Service System retiree medical plans include enhanced group Medicare Part D coverage. You must not enroll in an individual Part D plan offered through pharmacy, organization or insurer.

7. **Medicare-eligible Retirees Must Pay Premiums to the Federal Government**
   You must pay Medicare premiums to maintain continuous enrollment in Medicare. There is a premium for Medicare Part B. You may also be required to pay a premium for your group Medicare Part D.

8. **Health Service Premium Contributions Must Also Be Paid**
   Any premium contributions due to the Health Service System must be paid to maintain your enrollment in health coverage provided through the Health Service System.

9. **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.

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

Medical Plans: Retirees Without Medicare

HMO

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

Kaiser Permanente HMO

Traditional Plan
(No Medicare HMO)

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

Your Medicare dependents will be in Kaiser Permanente Senior Advantage.

Blue Shield of California HMO

Access+
(No Medicare HMO)

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

Your Medicare dependents will be enrolled in New City Plan PPO UHC MAPD.

PPO

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

City Plan PPO

UnitedHealthcare
(No Medicare PPO)

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

Your Medicare dependents will be enrolled in New City Plan PPO UHC MAPD.

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

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

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2017. If any discrepancy exists between this guide and the EOC, the EOC will prevail. EOCs are available on myhss.org.

Medical Plans: Retirees With Medicare

HMO

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

Kaiser Permanente HMO	
Senior Advantage (Medicare Advantage HMO)	• Must be eligible for Medicare Part B • Must live in Kaiser service area • In-network service only • Out-of-pocket, fixed co-pays • No deductible • One ID card for all your covered services and prescription drugs.
Your Medicare dependents will be enrolled in Kaiser Permanente Senior Advantage.	

PPO

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

New City Plan PPO	
UnitedHealthcare (Group Medicare Advantage PPO)	• Must be eligible for Medicare • Live anywhere in the USA • One ID card for all your covered services and prescription drugs from a network of 67,000 pharmacies nationwide • Out-of-pocket; fixed co-pay • No deductible • Obtain service from any willing Medicare provider in the USA
Your non-Medicare dependents may be enrolled in City Plan or Blue Shield HMO.	

Plan Features	Kaiser Permanente HMO	New City Plan PPO
	Senior Advantage MEDICARE ADVANTAGE HMO	**UnitedHealthcare Medicare Advantage** NATIONAL PPO
Kaiser only integrated care delivery system	■	
Bay area network of doctors and hospitals	■	■
National network of doctors and hospitals		■
Primary Care Physician required	■	
Medicare Advantage	■	■
Excercise and Fitness Programs	Silver&Fit	Silver Sneakers
Enhanced coverage for diabetic supplies		■
No annual deductible and fixed co-pays	■	■

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2017. If any discrepancy exists between this guide and the EOC, the EOC will prevail. EOCs are available on myhss.org.

Service Areas: Retirees Without Medicare

County	Blue Shield of California	Kaiser Permanente	United Healthcare	County	Blue Shield of California	Kaiser Permanente	United Healthcare
	Access+ NO MEDICARE HMO	**Traditional** NO MEDICARE HMO	**City Plan** CHOICE PLUS NO MEDICARE PPO		**Access+** NO MEDICARE HMO	**Traditional** NO MEDICARE HMO	**City Plan** CHOICE PLUS NO MEDICARE PPO
Alameda	■	■	■	Orange	■	■	■
Alpine	❍	❍	■	Placer	❍	❍	■
Amador			■	Plumas			■
Butte	■	❍	■	Riverside	■	❍	■
Calaveras	■	■	■	Sacramento	■	■	■
Colusa			■	San Benito			■
Contra Costa	❍	❍	■	San Bernardino	❍	❍	■
Del Norte	❍	❍	■	San Diego	❍	❍	■
El Dorado	■	■	■	San Francisco	■	■	■
Fresno	■	■	■	San Joaquin	■	■	■
Glenn	■		■	San Luis Obispo	■		■
Humboldt	■	■	■	San Mateo	■	■	■
Imperial	■		■	Santa Barbara	■		■
Inyo	■	■	■	Santa Clara	■	■	■
Kern	■		■	Santa Cruz	■	■	■
Kings			■	Shasta			■
Lake			■	Sierra			■
Lassen			■	Siskiyou			■
Los Angeles	■	■	■	Solano	■	■	■
Madera	■	❍	■	Sonoma	■	❍	■
Marin	■	■	■	Stanislaus	■	■	■
Mariposa		❍	■	Sutter		❍	■
Mendocino			■	Tehama			■
Merced			■	Trinity			■
Modoc	■	❍	■	Tulare	■	❍	■
Mono			■	Tuolumne			■
Monterey	■	❍	■	Ventura	■	❍	■
Napa	■	❍	■	Yolp	■	❍	■
Nevada		❍	■	Yuba		❍	■
				Outside CA			■

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

If you move out of the service area covered by your medical 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.

Service Areas: Retirees With Medicare

County	Kaiser Permanente	United Healthcare	County	Kaiser Permanente	United Healthcare
	Senior Advantage MEDICARE ADVANTAGE HMO	**Medicare Advantage** NATIONAL PPO		**Senior Advantage** MEDICARE ADVANTAGE HMO	**Medicare Advantage** NATIONALPPO
Alameda	■	■	Orange	■	■
Alpine		■	Placer	❍	■
Amador	❍	■	Plumas		■
Butte		■	Riverside	❍	■
Calaveras		■	Sacramento	■	■
Colusa		■	San Benito		■
Contra Costa	■	■	San Bernardino	❍	■
Del Norte		■	San Diego	❍	■
El Dorado	❍	■	San Francisco	■	■
Fresno	❍	■	San Joaquin	■	■
Glenn		■	San Luis Obispo		■
Humboldt		■	San Mateo	■	■
Imperial	❍	■	Santa Barbara		■
Inyo		■	Santa Clara	■	■
Kern	❍	■	Santa Cruz		■
Kings	❍	■	Shasta		■
Lake		■	Sierra		■
Lassen		■	Siskiyou		■
Los Angeles	❍	■	Solano	■	■
Madera	❍	■	Sonoma	❍	■
Marin	■	■	Stanislaus	■	■
Mariposa	❍	■	Sutter	❍	■
Mendocino		■	Tehama		■
Merced		■	Trinity		■
Modoc		■	Tulare	❍	■
Mono		■	Tuolumne		■
Monterey		■	Ventura	❍	■
Napa	❍	■	Yolp	❍	■
Nevada		■	Yuba	❍	■
			Outside CA		■

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

If you move out of the service area covered by your medical 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.

2017 Medical Plan Benefits-at-a-Glance

	BLUE SHIELD OF CALIFORNIA Access+ HMO	KAISER PERMANENTE Traditional HMO
DEDUCTIBLES		
Deductible and out-of-pocket maximum (medical)	No deductible Annual out-of-pocket maximum $2,000/individual; $4,000 family	No deductible Annual out-of-pocket maximum $1,500/person; $3,000 family
PREVENTIVE CARE		
Routine physical	No charge	No charge
Immunizations and inoculations	No charge	No charge
Well woman exam and family planning	No charge	No charge
Routine pre/post-partum care	No charge visits limited; see EOC	No charge visits limited; see EOC
PHYSICIAN and OTHER PROVIDER CARE		
Office and home visits	$25 co-pay	$20 co-pay
Inpatient hospital visits	No charge	No charge
PRESCRIPTION DRUGS		
Pharmacy: generic drugs	$10 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: brand-name drugs	$25 co-pay 30-day supply	$15 co-pay 30-day supply
Pharmacy: non-formulary drugs	$50 co-pay 30-day supply	Physician authorized only
Mail order: generic drugs	$20 co-pay 90-day supply	$10 co-pay 100-day supply
Mail order: brand-name drugs	$50 co-pay 90-day supply	$30 co-pay 100-day supply
Mail order: non-formulary drugs	$100 co-pay 90-day supply	Physician authorized only
Specialty drugs	20% coinsurance up to $100 per prescription, 30 day supply	20% coinsurance up to $100 per prescription, 30 day supply
OUTPATIENT SERVICES		
Diagnostic X-ray and laboratory	No charge	No charge
EMERGENCY		
Hospital emergency room	$100 co-pay waived if hospitalized	$100 co-pay waived if hospitalized
Urgent care facility	$25 co-pay within CA service area	$20 co-pay
HOSPITAL/SURGERY		
Inpatient	$200 co-pay per admission	$100 co-pay per admission
Outpatient	$100 co-pay per surgery	$35 co-pay

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2017. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Find EOCs on myhss.org.

Retirees Without Medicare

UNITEDHEALTHCARE

City Plan Choice Plus PPO

In-Network or Out-of Area*	Out-of-Network*
$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $3,750/person	$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $7,500/person
100% covered no deductible	50% covered after deductible
100% covered no deductible	50% covered after deductible
100% covered no deductible	50% covered after deductible
85% covered after deductible	50% covered after deductible
85% covered after deductible	50% covered after deductible
85% covered after deductible	50% covered after deductible
$5 co-pay 30-day supply	50% covered after $5 co-pay; 30-day supply
$20 co-pay 30-day supply	50% covered after $20 co-pay; 30-day supply
$45 co-pay 30-day supply	50% covered after $45 co-pay; 30-day supply
$10 co-pay 90-day supply	Not covered
$40 co-pay 90-day supply	Not covered
$90 co-pay 90-day supply	Not covered
Same as 30-day supply above limitations apply; see EOC	Same as 30-day supply above limitations apply; see EOC
85% covered after deductible	50% covered after deductible; prior notification
85% covered after deductible; if non-emergency 50% after deductible	85% covered after deductible; if non-emergency 50% after deductible
85% covered after deductible	50% covered after deductible
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible	50% covered after deductible

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

2017 Medical Plan Benefits-at-a-Glance

	BLUE SHIELD OF CALIFORNIA Access+ HMO	KAISER PERMANENTE Traditional HMO
REHABILITATIVE		
Physical/occupational therapy	$25 co-pay per visit	$20 co-pay authorization req.
Acupuncture/chiropractic	$15 co-pay 30 visits of each max per plan year; ASH network	$15 co-pay 30 visits combined acupuncture or chiro max per plan year; ASH network; for 25% discount see kp.org/choosehealthy
TRANSGENDER		
Office visits and outpatient surgery	Co-pays apply authorization required	Co-pays apply authorization required
DURABLE MEDICAL EQUIPMENT		
Home medical equipment	No charge	No charge as authorized by PCP according to formulary
Diabetic monitoring supplies	No charge based upon allowed charges	No charge see EOC
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary
Hearing aids	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each
MENTAL HEALTH		
Inpatient hospitalization	$200 co-pay per admission	$100 co-pay per admission
Outpatient treatment	$25 co-pay non-severe and severe	$10 co-pay group $20 co-pay individual
Inpatient detox	$200 co-pay per admission	$100 co-pay per admission
Residential rehabilitation	$200 co-pay per admission	$100 co-pay per admission; physician approval required
EXTENDED & END-OF-LIFE CARE		
Skilled nursing facility	No charge up to 100 days/year	No charge up to 100 days/year
Hospice	No charge authorization required	No charge when medically necessary
OUTSIDE SERVICE AREA		
Care access and limitations	Urgent care $50 co-pay; guest membership benefits for college students in some areas.	Only emergency services before condition permits transfer to Kaiser facility. Co-pays apply.

Retirees Without Medicare

UNITEDHEALTHCARE City Plan Choice Plus PPO	
In-Network or Out-of Area*	Out-of-Network*
85% covered after deductible; 60 visits/year	50% covered after deductible; 60 visits/year
50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible; notification required	50% covered after deductible; notification required
Co-pays apply see pharmacy benefits	Co-pays apply see pharmacy benefits
85% covered after deductible; when medically necessary; notification required	50% covered after deductible; when medically necessary; notification required
85% covered after deductible; 1 aid per ear, every 36 months, up to $2,500 each	50% covered after deductible; 1 aid per ear, every 36 months, up to $2,500 each
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible; authorization required	50% covered after deductible; authorization required
85% covered after deductible; up to 120 days/year; notification required; custodial care not covered	50% covered after deductible; up to 120 days/year; notification required; custodial care not covered
85% covered after deductible; authorization required	50% covered after deductible; authorization required
Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. In-network and out-of-network percentages and co-pays apply.

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2017. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Find EOCs on myhss.org.

2017 Medical Plan Benefits-at-a-Glance

	KAISER PERMANENTE **Senior Advantage** Medicare Advantage HMO	NEW CITY PLAN **UnitedHealthcare** Medicare Advantage National PPO
DEDUCTIBLES		
Deductible and out-of-pocket maximum	No deductible Annual out-of-pocket maximum $1,500/individual; $3,000/family	No deductible Annual out-of-pocket maximum $3,750/individual
PREVENTIVE CARE		
Routine physical	No charge	$0 co-pay
Immunizations and inoculations	No charge	$0 co-pay
Well woman exam and family planning	No charge	$0 co-pay
Routine pre/post-partum care	No charge visits limited; see EOC	Cost share per type and location of service
PHYSICIAN AND PROVIDER CARE		
Office and home visits	$20 co-pay	$5 co-pay PCP; $15 co-pay specialist
Hospital visits	No charge	$150 co-pay per admission
PRESCRIPTION DRUGS		
Pharmacy: generic drugs	$5 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: brand-name drugs	$15 co-pay 30-day supply	$20 co-pay 30-day supply
Pharmacy: non-formulary drugs non-preferred brands	Physician authorized only	$45 co-pay 30-day supply
Mail order: generic drugs	$10 co-pay 100-day supply	$10 co-pay 90-day supply
Mail order: brand-name drugs	$30 co-pay 100-day supply	$40 co-pay 90-day supply
Mail order: non-formulary drugs non-preferred brands	Physician authorized only	$90 co-pay 90-day supply
Specialty drugs	20% coinsurance up to $100 per prescription, 30 day supply	Same as all above limitations apply; see EOC
OUTPATIENT SERVICES		
Diagnostic X-ray and laboratory	No charge	$0 co-pay
EMERGENCY		
Hospital emergency room	$50 co-pay waive if hospitalized	$65 co-pay
Urgent care facility	$20 co-pay	$35 co-pay
HOSPITAL/SURGERY		
Inpatient	$100 co-pay per admission	$150 co-pay per admission
Outpatient	$35 co-pay	$100 co-pay

Retirees With Medicare

	KAISER PERMANENTE **Senior Advantage** Medicare Advantage HMO	NEW CITY PLAN **UnitedHealthcare** Medicare Advantage National PPO
REHABILITATIVE		
Physical/Occupational therapy	$20 co-pay authorization req.	$25 co-pay
Acupuncture/chiropractic	$15 co-pay 30 visits combined acupuncture or chiro max per plan year; ASH network; for 25% discount see kp.org/choosehealthy	$15 co-pay 24 visits of each max per plan year
TRANSGENDER		
Office visits and outpatient surgery	Co-pays apply authorization req.	Co-pays apply authorization req. $75,000 lifetime max for surgery
DURABLE MEDICAL EQUIPMENT		
Home medical equipment	No charge as authorized by PCP according to formulary	$15 co-pay
Prosthetics/orthotics	No charge when medically necessary	$15 co-pay
Diabetic monitoring supplies	No charge see EOC	$0 co-pay
Hearing aids	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each
MENTAL HEALTH		
Inpatient hospitalization	$100 co-pay per admission	$150 co-pay per admission
Outpatient treatment	$10 co-pay group $20 co-pay individual	$5 co-pay group $15 co-pay individual
Inpatient detox	$100 co-pay per admission	$150 co-pay per admission
Residential rehabilitation	$100 co-pay per admission; physician approval required	$150 co-pay per admission
EXTENDED & END-OF-LIFE CARE		
Skilled nursing facility	No charge up to 100 days per year	No charge up to 100 days/benefit period; no custodial care
Hospice	No charge when medically necessary	No charge when medically necessary
OUTSIDE SERVICE AREA		
Care access and limitations	Only emergency services before condition permits transfer to Kaiser facility. Co-pays apply.	Nationwide coverage. In-Network and Out-of-Network benefits are the same.

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2017. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Find EOCs on myhss.org.

Medicare and Health Service System Benefits

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

The Social Security Administration is the federal agency responsible for Medicare eligibility, enrollment and premiums. Download the *Medicare and You* handbook at: medicare.gov.

Medicare Basics

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

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

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

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

An HSS member and his or her covered dependents may not all be eligible for Medicare. In that case, whoever is eligible for Medicare will be covered under either the Kaiser Permanente Senior Advantage Plan (if the member under 65 is in the Kaiser Permanente HMO) or under the New City Plan PPO UnitedHealthcare Medicare Advantage Plan (if the member under 65 is in either Blue Shield or City Plan).

Medicare Part A: Hospital Insurance

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

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

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

Medicare and Health Service System Benefits

Medicare Part B: Medical Insurance

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

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

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

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

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

Q What happens if I enroll after age 65 or change HSS plans during Open Enrollment?

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

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

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

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

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

Medicare and Health Service System Benefits

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

Medicare Part D: Prescription Drug Insurance

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

The New City Plan PPO UHC Medicare Advantage members will receive only one card that covers medical and pharmacy services.

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

A Do not enroll in an individual Medicare Part D prescription drug plan. If you are Medicare-eligible, enhanced group Medicare Part D drug coverage is included with your HSS medical plan. Private insurance companies, pharmacies and other entities may try to sell you an individual Medicare Part D prescription drug plan. If you enroll in any private, individual Medicare Part D prescription drug plan, your Medicare coverage will be assigned to that plan and your HSS group medical coverage will be terminated.

Q **Am I required to pay a premium for Medicare Part D?**

A Most people are not required to pay a Medicare Part D premium. However, if your income exceeds a certain threshold, you may be required to pay a Part D premium to the Social Security Administration. (See medicare.gov.)

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

Q **What is the HSS penalty if I or my dependent fail to pay a Part D premium to Social Security?**

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

Medicare and Health Service System Benefits

Medicare Eligibility

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

Medicare Part A

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

Medicare Part B

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

Group Medicare Part D

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

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

Avoid Termination of Medical Coverage: Notify HSS of a Change of Address

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

How Medicare Works With Your Medical Plan

Medicare Assignment

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

Payments

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

Accessing Health Care

The New City Plan National Medicare Advantage PPO:

A Health Service System member may enroll with UnitedHealthcare as a new retiree or during annual Open Enrollment. UnitedHealthcare provides one plan choice for Medicare-eligible enrollees. This plan does not have any service area requirements. With UnitedHealthcare Group Medicare Advantage (PPO) plan you can receive service nationwide from any willing Medicare provider, hospital or pharmacy. To locate providers, simply call UnitedHealthcare tollfree at 1-877-259-0493, TTY 711, 8:00AM– 8:00PM local time, 7 days a week or go online to welcometouhc.com/sfhss. For additional choices, you can also go to medicare.gov/physicancompare.

Kaiser Permanente Senior Advantage

A Health Service System member may enroll with Kaiser Permanente as a new retiree or during annual Open Enrollment. You must live in a Kaiser service area in Northern or Southern California. If you are eligible for Medicare, you will be enrolled in Kaiser Senior Advantage. If you or a dependent becomes eligible for Medicare during the plan year while enrolled with Kaiser, the Health Service System must automatically enroll you in Senior Advantage. **Even if you or your dependent are not eligible for premium-free Part A, you are still eligible for Senior Advantage when enrolled in Part B.** With Kaiser Senior Advantage you receive service from the same network of Kaiser Permanente doctors, hospitals and pharmacies. If you are already a Kaiser Permanente member you do not have to change providers when moving into the Senior Advantage plan. If you are new to Kaiser Permanente Senior Advantage, you can find a primary care provider at kp.org.

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

For Medicare and Non-Medicare Members

Traveling Outside the Service Area of Your Health Plan

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

- Blue Shield of California HMO for retirees without Medicare only covers emergency services outside of California service areas.
- Kaiser Permanente HMOplans only cover emergency services outside of their California service areas.
- The New City Plan PPO covers emergency services outside the United States.
- Pre-Medicare retirees in the UnitedHealthcare City Plan Choice Plus PPO are covered outside the United States. If you obtain service outside the United States, you will pay out-of-area co-insurance.

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

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

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

Retirees Residing Permanently Outside the U.S.

Non-Medicare Retiree (under 65) members who reside permanently outside the United States must either enroll in UnitedHealthcare City Plan Choice Plus PPO or waive Health Service System coverage.

Medicare enrollment is not required for retired members over 65 residing outside the United States (foreign residents). However, healthcare services within the United States will not be covered for foreign residents who are not enrolled in Medicare. Members who choose to not enroll in Medicare must complete an HSS form certifying that they are waiving Medicare enrollment and waiving health coverage within the United States.

If you are a foreign resident, please contact the Social Security Administration for more information before choosing to disenroll from Medicare. The federal government may charge you significant penalties if you disenroll from Medicare now but decide to re-enroll in the future.

Mental Health and Well-being Benefits

Mental Health Condition Management

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

City Plan PPO	Blue Shield of California HMO	Kaiser Permanente HMO	New City Plan PPO
Non-Medicare Only	**Non-Medicare Only**	**Medicare and Non-Medicare**	**Medicare Only**
Mental Health Outpatient counseling, immediate care and intensive case management. **Substance Abuse** Inpatient/outpatient including detox and residential rehabilitation. **How to Access** 1-866-282-0125	**Mental Health** Inpatient/outpatient mental health, professional services. **Substance Abuse** Inpatient/outpatient including detox and residential rehabilitation. **How to Access** 1-877-263-9952	**Mental Health** Inpatient/outpatient mental health, professional services. **Substance Abuse** Inpatient/outpatient including detox and residential rehabilitation. **How to Access** Call 1-800-464-4000 or speak with your PCP.	**Mental Health** Inpatient/outpatient, partial hospitalization and professional services. **Substance Abuse** Inpatient/outpatient including detox and residential rehabilitation. **How to Access** Call 1-877-259-0493.

Mental Well-being Services

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

City Plan PPO	Blue Shield of California HMO	Kaiser Permanente HMO	New City Plan PPO
Non-Medicare Only	**Non-Medicare Only**	**Medicare and Non-Medicare**	**Medicare Only**
Online Coaching Visit welcometouhc.com/sfhss for the online stress management program. **Tobacco Cessation** Visit welcometouhc.com/sfhss for the online smoking cessation program.	**Counseling** LifeReferrals is available 24/7 for mental health, marriage, family and relationship services. Also find resources to help you manage the impact of home, health and career. Call 1-800-985-2405. **Online Coaching** Take well-being one day at a time with the Daily Challenge: myhss.org/well-being/dailychallenge. **Tobacco Cessation** Visit QuitNet at mywellvolution.com for the online smoking cessation program.	**Counseling** Call 1-800-464-4000. **Classes, Support Groups** Contact your local Kaiser facility for a comprehensive list or visit kp.org/mentalhealth. **Telephone/Online Coaching** Call 1-866-251-4514 or visit kp.org and search for HealthMedia Relax. **Tobacco Cessation** Contact your local Kaiser facility for classes. Call 1-866-251-4514 for a telephonic coach. For HealthMedia Breathe and other resources visit kp.org/quitsmoking.	**Counseling/Therapy** Individual and group therapy, screenings and education. Call 1-877-259-0493.

Nurseline and Urgent Care

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

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

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

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

City Plan PPO	Blue Shield of California HMO	Kaiser Permanente HMO	New City Plan PPO
Non-Medicare Only	**Non-Medicare Only**	**Medicare and Non-Medicare**	**Medicare Only**
Nurseline 24/7 1-800-846-4678 **Urgent After Hours Care** San Francisco Golden Gate Urgent Care 1-415-746-1812 Hayward St. Francis Urgent Care 1-510-780-9400 Rohnert Park Concentra 1-866-944-6046 For more current and additional urgent care facilities call 1-866-282-0125 or visit welcometouhc.com/sfhss.	**NurseHelp 24/7** 1-877-304-0504 **Urgent After Hours Care** For the urgent after hours care nearest you contact Blue Shield: 1-855-256-9404 blueshieldca.com	**Nurse Advice 24/7** 1-866-454-8855 **Urgent After Hours Care** San Francisco 1-415-833-2200 Adult and Pediatric Oakland 1-510-752-1190 Adult 1-510-752-1200 Pediatric Redwood City 1-650-299-2015 Adult and Pediatric Walnut Creek 1-925-295-4070 Adult 1-925-295-4200 Pediatric San Rafael 1-415-444-2940 Adult 1-415-444-4460 Pediatric This is a partial list. For additional Kaiser urgent care facilities call 1-866-454-8855.	**Nurseline** 1-877-365-7949 **Urgent After Hours Care** For urgent care facilities call UnitedHealthcare at 1-877-259-0493 welcometouhc.com/sfhss

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. If you have questions about acupuncture or chiropractic coverage call your medical plan for more information.

City Plan PPO	Blue Shield of California HMO	Kaiser Permanente HMO	New City Plan PPO
Non-Medicare Only	**Non-Medicare Only**	**Medicare and Non-Medicare**	**Medicare Only**
Acupuncture and Chiropractic Self-refer to a licensed practitioner at 50% reasonable and customary co-insurance, up to $1,000 maximum per year, after paying your deductible. 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.	**Acupuncture and Chiropractic** 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.	**Acupuncture and Chiropractic** 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. Services cannot be for prevention or maintenance. Call Kaiser or read your EOC for details on what is covered.	**Acupuncture** $15 co-pay per visit, 24 visit maximum per year. **Chiropractic** $15 co-pay; Medicare-covered care is unlimited; 24 visits per year maximum for routine care.

Best Doctors: Expert Medical Review

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

New in 2017! In-depth medical review by a world-renowned expert is available for medical services or treatments plans that concern you: Consider using Best Doctors if you or an eligible 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.

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), 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.

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. Discounts are also available 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.

2017 Vision Plan Benefits-at-a-Glance

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.

Dental Plan Options

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

PPO-Style Dental Plans

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

HSS offers the following PPO-style dental plan:

- **Delta Dental**

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

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

You can also choose any dentist outside of the PPO and Premier networks. However, many services may be covered at a lower percentage, so you pay more. Also, payment is based on reasonable and customary fees for the geographic area. Diagnostic and preventive are not counted towards the annual maximum.

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

HMO-Style Dental Plans

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

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

HSS offers the following DMO plans:

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

Dental Plan Quick Comparison

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

Retirees

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
Annual deductible	$50 per person; $150 for family for Premier and Out-of-Network services, excluding diagnostic and preventive care			None	None
Plan year maximum	$1,000 per person per year, excluding preventive cleanings and exams			None	None
Covered Services	**PPO Dentists**	**Premier Dentists**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
Cleanings and exams	100% covered 1 every 6 months;	80% 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 1x year over age 18; not subject to annual maximum	80% covered full mouth 1x/5 years; bitewing 1x year over age 18; not subject to annual maximum	80% covered full mouth 1x/5 years; bitewing 1x year over age 18; not subject to annual maximum	100% covered some limitations apply	100% covered some limitations apply
Extractions	80% covered	80% covered	80% covered	100% covered	$5-$25 co-pay
Fillings	80% covered	80% covered	80% covered	100% covered Limitations apply to resin materials	$5-$95 co-pay
Crowns	50% covered	50% covered	50% covered	100% covered Limitations apply to resin materials	$20-$100 co-pay
Dentures, pontics and bridges	50% covered	50% covered	50% covered	100% covered Full and partial dentures 1x/5 years; fixed bridgework, limitations apply	$90-$100 co-pay
Endodontic/ Root Canals	50% covered	50% covered	50% covered	100% covered Excluding the final restoration	$15-$60 co-pay
Oral surgery	80% covered	80% covered	80% covered	100% covered	Co-pays vary
Implants	50% covered	50% covered	50% covered	Not covered	Covered Refer to co-pay schedule
Orthodontia	Not Covered	Not Covered	Not Covered	Member pays: $1,600/child $1,800/adult $350 startup fee; limits apply	Member pays: $2,000/child $2,000/adult $350 startup fee; limits apply

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

After being notified of a 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.

Responsibility for Premium Contributions

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

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.

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 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.

Legal Notices About Health Benefits

Notice of Medicare Part D Creditable Coverage

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

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

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

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

Women's Health and Cancer Rights Notice

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

Use and Disclosure of Your Personal Health Information

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

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

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

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

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

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

Health Service Board 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 an expert medical review benefit through Best Doctors. All members will be able to contact Best Doctors for an in-depth review of diagnoses and treatment plans and to to get personalized answers to medical questions.
- Approved addition of acupuncture and specialty drug tier to Kaiser Permanente and Silver&Fit to Kaiser 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.

2017 Medical Premiums: Retiree Without Medicare

RETIREES HIRED BEFORE JANUARY 9, 2009

2017 Monthly Medical Premiums	Kaiser Permanente HMO		Blue Shield HMO		City Plan PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	$1,167.51	0	$1,659.72	$73.70	$1,043.70	$98.78
Retiree +1 Dependent with no Medicare	$1,456.59	$289.08	$2,048.51	$462.50	$1,593.07	$648.15
Retiree +2 or More Dependents with no Medicare	$1,456.59	$768.95	$2,048.51	$1,083.17	$1,593.07	$1,426.75
Retiree +1 Dependent with Medicare Part B Only	$1,339.88	$172.36	$1,983.43	$397.42	$1,367.41	$422.50
Retiree +1 Dependent with Medicare Part A and Part B	$1,339.88	$172.36	$1,822.12	$236.10	$1,206.10	$261.18
Retiree +1 Dependent with Medicare Part B Only +1 or more Deps	$1,339.88	$652.23	$1,983.43	$1,018.09	$1,367.41	$1,201.10
Retiree +1 Dependent with Medicare Part A and B +1 or more Dependents	$1,339.88	$652.23	$1,822.12	$856.77	$1,206.10	$1,039.78

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

2017 Monthly Medical Premiums	Kaiser Permanente HMO		Blue Shield HMO		City Plan PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	$1,167.51	0	$1,733.42	0	$1,142.48
Retiree +1 Dependent with no Medicare	0	$1,745.67	0	$2,511.01	0	$2,241.22
Retiree +2 or More Dependents with no Medicare	0	$2,225.54	0	$3,131.68	0	$3,019.82
Retiree +1 Dependent with Medicare Part B Only	0	$1,512.24	0	$2,380.85	0	$1,789.91
Retiree +1 Dependent with Medicare Part A and Part B	0	$1,512.24	0	$2,058.22	0	$1,467.28
Retiree +1 Dependent with Medicare Part B Only +1 or more Deps	0	$1,992.11	0	$3,001.52	0	$2,568.51
Retiree +1 Dependent with Medicare Part A and B +1 or more Dependents	0	$1,992.11	0	$2,678.89	0	$2,245.88

2017 Medical Premiums: Retiree With Medicare Part A and Part B

RETIREES HIRED BEFORE JANUARY 9, 2009

2017 Monthly Medical Premiums	Kaiser Permanente HMO		New City Plan PPO		New City Plan with Non Medicare Dependants in Blue Shield *	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	$349.11	0	$329.18	0		
Retiree +1 Dependent with no Medicare	$638.19	$289.08	$878.55	$549.37	717.97	388.80
Retiree +2 or More Dependents with no Medicare	$638.19	$768.95	$878.55	$1,327.97	717.97	1,009.47
Retiree +1 Dependent with Medicare Part B Only	$521.48	$172.36	$652.89	$323.72		
Retiree +1 Dependent with Medicare Part A and Part B	$521.48	$172.36	$491.58	$162.40		
Retiree +1 Dependent with Medicare Part B Only +1 or more Deps	$521.48	$652.23	$652.89	$1,102.32	652.89	944.39
Retiree +1 Dependent with Medicare Part A and B +1 or more Dependents	$521.48	$652.23	$491.58	$941.00	491.58	783.07

2017 Medical Premiums: Retiree With Medicare Part B Only

RETIREES HIRED BEFORE JANUARY 9, 2009

2017 Monthly Medical Premiums	Kaiser Permanente HMO		New City Plan PPO		New City Plan with Non Medicare Dependants in Blue Shield *	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	$349.11	0	628.33	23.48		
Retiree +1 Dependent with no Medicare	$638.19	$289.08	1,177.70	572.85	1,017.12	412.28
Retiree +2 or More Dependents with no Medicare	$638.19	$768.95	1,177.70	1,351.45	1,017.12	1,032.95
Retiree +1 Dependent with Medicare Part B Only	$521.48	$172.36	952.04	347.20		
Retiree +1 Dependent with Medicare Part A and Part B	$521.48	$172.36	790.73	185.88		
Retiree +1 Dependent with Medicare Part B Only +1 or more Deps	$521.48	$652.23	952.04	1,125.80	952.04	967.87
Retiree +1 Dependent with Medicare Part A and B +1 or more Dependents	$521.48	$652.23	790.73	964.48	790.73	806.55

* These are the rates for Retirees with Medicare who are transferring to the New City Plan from Blue Shield 65+ and have dependents not yet eligible for Medicare.

2017 Medical Premiums: Retirees With Medicare Part B Only

RETIREES HIRED BEFORE JANUARY 9, 2009

2017 Monthly Medical Premiums	Kaiser Permanente HMO		New City Plan PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	$349.11	0	$628.33	$23.48
Retiree +1 Dependent with no Medicare	$638.19	$289.08	$1,177.70	$572.85
Retiree +2 or More Dependents with no Medicare	$638.19	$768.95	$1,177.70	$1,351.45
Retiree +1 Dependent with Medicare Part B Only	$521.48	$172.36	$952.04	$347.20
Retiree +1 Dependent with Medicare Part A and Part B	$521.48	$172.36	$790.73	$185.88
Retiree +1 Dependent with Medicare Part B Only +1 or more Deps	$521.48	$652.23	$952.04	$1,125.80
Retiree +1 Dependent with Medicare Part A and B +1 or more Dependents	$521.48	$652.23	$790.73	$964.48

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

2017 Monthly Medical Premiums	Kaiser Permanente HMO		New City Plan PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	$349.11	0	$651.81
Retiree +1 Dependent with no Medicare	0	$927.27	0	$1,750.55
Retiree +2 or More Dependents with no Medicare	0	$1,407.14	0	$2,529.15
Retiree +1 Dependent with Medicare Part B Only	0	$693.84	0	$1,299.24
Retiree +1 Dependent with Medicare Part A and Part B	0	$693.84	0	$976.61
Retiree +1 Dependent with Medicare Part B Only +1 or more Deps	0	$1,173.71	0	$2,077.84
Retiree +1 Dependent with Medicare Part A and B +1 or more Dependents	0	$1,173.71	0	$1,755.21

2017 Medical Premiums: Surviving Spouse or Domestic Partner

NON-MEDICARE SURVIVORS OF RETIREES HIRED BEFORE JANUARY 9, 2009

2017 Monthly Medical Premiums	Kaiser Permanente HMO		Blue Shield HMO		City Plan PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Survivor Only	$1,167.51	0	$1,659.72	$73.70	$1,043.70	$98.78
Survivor +1 Dependent with no Medicare	$1,456.59	$289.08	$2,048.51	$462.50	$1,593.07	$648.15
Survivor +2 or More Dependents with no Medicare	$1,456.59	$768.95	$2,048.51	$1,083.17	$1,593.07	$1,426.75

MEDICARE SURVIVORS OF RETIREES HIRED BEFORE JANUARY 9, 2009

2017 Monthly Medical Premiums	Kaiser Permanente HMO		New City Plan PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays
Survivor Only	$349.11	0	$329.18	0
Survivor +1 Dependent with no Medicare	$638.19	$289.08	$878.55	$549.37
Survivor +2 or More Dependents with no Medicare	$638.19	$768.95	$878.55	$1,327.97

2017 Dental Premiums: All Retirees

2017 Monthly Medical Premiums	Delta Dental PPO		DeltaCare USA DMO		UnitedHealthcare Dental DMO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree	0	$42.94	0	$32.85	0	$16.47
Retiree +1 Dependent	0	$85.42	0	$54.21	0	$27.20
Retiree +2 or More Dependents	0	$127.49	0	$80.19	0	$40.22

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

Key Contacts

HEALTH SERVICE SYSTEM

Member Services

1145 Market Street, 3rd Floor
San Francisco, CA 94103

Tel: 1-415-554-1750
1-800-541-2266
Fax: 1-415-554-1721
myhss.org

Well-being Program

1145 Market Street, 1st Floor
San Francisco, CA 94103

Tel: 1-415-554-0643
wellness@sfgov.org

Health Service Board

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

MEDICAL PLANS			
Blue Shield of California Access+ No Medicare	1-855-256-9404	blueshieldca.com	Group W0051448
Kaiser Permanente Senior Advantage and Traditional	1-800-443-0815	kp.org	Group 888 Northern California Group 231003 Southern California
City Plan UnitedHealthcare No Medicare	1-866-282-0125	welcometouhc.com/sfhss	Group 752103
New City Plan UnitedHealthcare Medicare Advantage PPO	1-877-259-0493	welcometouhc.com/sfhss	Group 13694 Group 12786 Part B Only
DENTAL and VISION PLANS			
Delta Dental	1-888-335-8227	deltadentalins.com	Group 1673-0001
DeltaCare USA	1-800-422-4234	deltadentalins.com	Group 71797-0003
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
COBRA			
P&A Group	1-800-688-2611	padmin.com	
MEDICAL CASE REVIEW			
Best Doctors	1-866-904-0910	members.bestdoctors.com	
OTHER AGENCIES			
SFERS	1-415-487-7000	mysfers.org	Pension benefits
CalPERS	1-888-225-7377	calpers.ca.gov	
CalSTRS	1-800-228-5453	calstrs.org	
PARS	1-800-540-6369	parsinfo.org	
Social Security	1-800-772-1213 TTY 1-800-325-0778	ssa.gov	Medicare enrollment
Medicare	1-800-633-4227 TTY 1-877-486-2048	medicare.gov	Medicare administration
Covered California	1-888-975-1142	coveredca.com	State insurance exchange

10 Things Retirees Should Know...

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

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

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

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

Retiree Health Benefits Are Different Than Employee Health Benefits

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

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

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

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

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

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

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

Medicare-eligible Retirees Must Pay Premiums to the Federal Government

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

Health Service Premium Contributions Must Also Be Paid

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

You Must Disenroll Ineligible Family Members Within 30 Days

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

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

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