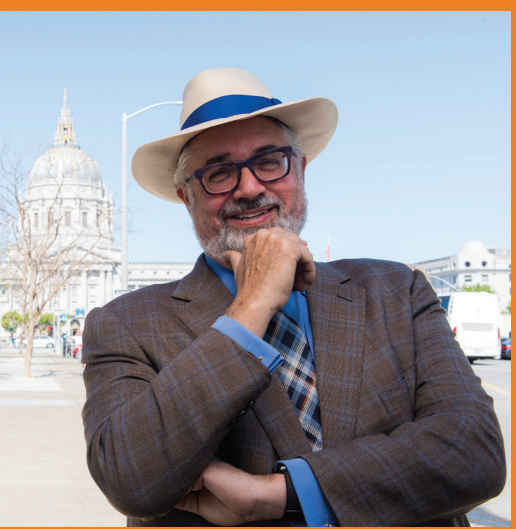
Retirees

2019
HEALTH BENEFITS



SAN FRANCISCO
HEALTH SERVICE SYSTEM

Retirees

Your Open Enrollment To-Do List:

- ☐ Review your **Open Enrollment Guide and Letter!** Visit sfhss.org.
- ☐ **Premiums are changing in 2019**. Review your medical and dental plan premiums even if you are not planning to make any changes.
- ☐ Review **What's New** so you're informed about new benefits you may want to use.
- ☐ Review your dependents listed in your **Open Enrollment letter**. This is the time to add or drop dependents.
- ☐ Make your benefits elections on your SFHSS Open Enrollment form. Be sure to:
    - ☐ Select the benefits you want
    - ☐ List all dependents you're covering
    - ☐ Sign your application
    - ☐ Have the supporting documents for new dependents
- ☐ Review your **Confirmation Statement** to make sure your benefits elections are correct. You'll receive your Confirmation Statement from SFHSS in December 2018.
- ☐ If you have questions, call **San Francisco Health Service System at (415) 554-1750**.
- ☐ Open Enrollment applications and documentation **can be delivered to SFHSS in person, by mail or fax**. The SFHSS address is 1145 Market Street, 3rd Floor, San Francisco, CA 94103. The SFHSS fax number is (415) 554-1721. Changes made during Open Enrollment take effect January 1, 2019. For more information about Open Enrollment visit sfhss.org.
- ☐ **Open Enrollment deadline is October 31, 2018, 5:00pm.**

This guide provides an overview of the San Francisco Health Service System rules approved by the San Francisco Health Service Board. The rules can be found at sfhss.org. To request a paper copy of the rules call (415) 554-1750.

What's New and Available for 2019

2019 Medical, Dental and VSP Premier Plan Premium Contributions are Changing. City Plan PPO Co-Pays for Prescription Drugs and Out-of-Network Deductibles Have Increased

Review the rates for your bargaining unit at sfhss.org before making your Open Enrollment elections. City Plan PPO co-pays for prescription drugs have increased along with deductibles for out-of-network services. See pages 19-22, 24 and 25 for more details.

Blue Shield of California's Trio HMO Plan Offers Concierge Support for Members

The Trio HMO Plan, now in its second year, provides the exact same benefits and plan design as the Access+ HMO, with lower premium contributions, and access to many of the same hospitals and physicians. If you are a current Access+ HMO enrollee, but your doctors are in the Trio Network, you may choose to select a lower premium contribution for the exact same benefits. Please call the dedicated Trio HMO Concierge line at (855) 747-5800 or visit blueshieldca.com/sfhss.

New and Existing Blue Shield Trio HMO Non-Medicare Members Eligible for Sun Basket Custom Home Meals Delivery

Starting in January, new and currently enrolled Trio HMO members will be eligible to receive a two-week complimentary subscription to Sun Basket (sunbasket.com) for custom home delivered meals. Sun Basket is a healthy meal-kit service that delivers organic, sustainable ingredients and easy recipes for cooking at home. Includes three customizable meals a week for two people, over the two-week period. To qualify, Trio HMO enrollees need complete their annual preventive care visit within the first 90 days of enrollment. Existing Trio members can provide proof of a completed annual preventive care visit within the previous nine months.

UnitedHealthcare Medicare Advantage PPO Prescription Drug Formulary Change

In support of the San Francisco Health Service System (SFHSS) mission to preserve and improve sustainable, quality health benefits for Retirees, the UnitedHealthcare Medicare Advantage PPO plan will be changing its Prescription Drug Formulary effective January 1, 2019. If you are currently enrolled in the UnitedHealthcare Medicare Advantage PPO plan, you will receive a letter notifying you that the Prescription Drug Formulary will be changing and if you are taking any prescription medications which may no longer be covered. Please take the time to review the letter, and if applicable, work with your doctor to select covered formulary medications.

Medicare Issuing New Medicare Beneficiary Identifier Numbers (MBIs)

Starting in April 2018, Medicare began issuing Medicare Beneficiary Identifier numbers to all Medicare members, to replace existing Medicare cards with Social Security numbers. All new cards should be received by April 2019. MBIs are 11-digits long and are randomly generated by Medicare. If you or your dependent are asked or required to submit proof of Medicare-coverage to SFHSS, please be sure to write your DSW number on your new Medicare card or Proof of Medicare Letter, otherwise, we will not be able to identify your corresponding record. Contact Member Services at (415) 554-1750.

Delta Dental PPO New SmileWay Program, Adult Orthodontia Lifetime Max Increase, and Dental Accident Benefits

Beginning January 1, 2019, Delta Dental PPO enrollees who have certain chronic conditions (diabetes, heart disease, HIV/AIDS, rheumatoid arthritis and/or stroke), will be able to receive an annual periodontal scaling and root planing procedure (deep cleaning of gums) as well as more frequent annual teeth cleaning or periodontal maintenance services. Dental Accident Benefits have been added to provide additional dental service coverage for conditions caused directly or independently of all other causes by external, violent, and accidental means. See pages 25-26.

VSP Vision Offers 100% Coverage for Standard Progressive Lenses

VSP Basic and Premier Plans are now offering 100% coverage (no co-pay) for standard progressive lenses. Additionally, if you are enrolled in the VSP Premier Plan, your co-pay for premium progressive lenses and custom progressive lenses will be $25. Basic Plan co-pays for premium and custom progressive lenses will not change. See pages 23-24.

eBenefits Online Open Enrollment Now Available for Employees with Employee Portal Access!

SFHSS is excited to announce that ***eBenefits*** is now available to City and County of San Francisco active employees who have access to the City's Employee Portal through their Department. Members currently eligible to participate in ***eBenefits*** will receive special instructions in their 2019 Plan Year Open Enrollment letter. SFHSS will continue to roll out ***eBenefits*** to more members in 2019!

Remember to Check that Your Dependents are Still Eligible for Benefits

As stated in the San Francisco Health Service System Rules, dependent eligibility may be audited by SFHSS and proof of dependent eligibility may be required at any time. Failure to furnish such proof within thirty (30) days after a request shall result in termination of coverage. The enrollment of a dependent who does not meet eligibility requirements, or the failure to disenroll a dependent when they become ineligible, will be treated as an intentional misrepresentation of a material fact, or fraud.

Executive Director's Message

The Greater Good is a Healthier You

Administering benefits for over 120,000 active employees, retirees and their dependents is both a privilege and an undertaking. We are currently in an environment where health care is impacted by advancing technologies that are emerging at record speeds, in the face of ever-changing political and social divisions.

Our job is to navigate these waters on your behalf, while ensuring you receive comprehensive, quality benefits at the most competitive rates. Our approach to providing benefits is holistic, inclusive and aimed at offering cost-effective options that meet all your needs throughout your life.

For these reasons, we are committed to focusing on preventive health benefits and measures that empower each of you to take action and do your part to maintain your good health and well-being.

As you make your benefit selections this year, please consider taking advantage of all the preventive and annual care benefits available under your selected plans. Don't wait to use your benefits until you are ill.

We personally collaborate with health care providers, through our contracted health plans, to ensure that you are provided with benefits that support preventive health care. When you do your part, your provider can help you catch issues early and help you manage health concerns before they become serious. Schedule your annual check-ups, dental cleanings and exams in a timely manner.

Each medical and dental plan features its own annual check-up benefits, of which you should take advantage. In addition to maintaining your good health, you are supporting us in our mission to maintain quality-affordable health care by managing your own health. We all have a role to play. The choices you make today have a direct impact on the health care costs that you and your fellow employees will pay down the road.

We are steadfastly committed to providing benefits and programs that support your total health and well-being. We do this on several fronts: Supporting your physical health by providing you with a variety of health plan options to meet your needs as well as well-being services that promote healthy lifestyles. Supporting your mental health through our mental health benefits with our health plans, and our Employee Assistance Program (EAP), which offers counseling and coaching services to all active members and their immediate family members, allowing them to meet confidentially with licensed therapists about personal or professional matters.

With affordable comprehensive and quality benefits in mind for 2019, I am happy to announce that Delta Dental PPO will be increasing their dental coverage for members with SmileWay, a new plan that expands dental cleaning coverage for members with chronic conditions like diabetes, heart disease, HIV/AIDS, rheumatoid arthritis, and stroke. VSP continues to augment benefits by including 100% coverage for standard progressive lenses.

I invite you to make 2019 the year that you engage in your lifelong journey of preventive health practices. Please explore our 2019 Benefits Guide to learn about all the ways you can maintain a healthier you in 2019 and the years to come!

Abbie Yant, RN, MA
Executive Director

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 sfhss.org. You may also visit the San Francisco Health Service System office at 1145 Market Street, 3rd floor, 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 San Francisco Health Service System for options on how to make your monthly payments. 2019 retiree premium contributions are listed beginning on page 19.

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 January 1, 2019.

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 page 7-8.

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

Contact SFHSS 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 SFHSS 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. I**f 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 at least three months 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 and 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 6 of this Guide for more information.

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 SFHSS coverage.

Questions About Retiree Health Benefits

Call SFHSS Member Services at (415) 554-1750 or visit the SFHSS office at 1145 Market Street, 3rd Floor, San Francisco. We are open Monday to Friday, 8:00am to 5:00pm (except every other Thursday, when we open at 9:30am). No appointment is necessary.

Eligibility

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

Retiree Member Eligibility

An employee must meet age and minimum service requirements and have been enrolled in SFHSS health benefits at some time during active employment to be eligible for retiree health coverage. SFHSS calculates service. Service requirements vary. If hired on or after January 9, 2009, Proposition B applies (see page 6). 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 San Francisco 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 SFHSS 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 SFHSS Member Services at (415) 554-1750 three months before your retirement date to prepare for enrollment in retiree benefits. You must notify SFHSS of retirement even if you are not planning to elect SFHSS coverage on your retirement date.

For more information, visit: sfhss.org.

Dependent Eligibility

Spouse or Registered Domestic Partner

A member's spouse or registered domestic partner may be eligible for SFHSS healthcare coverage. Proof of marriage or domestic partnership is required, as well as the dependent's Social Security number. Enrollment in SFHSS 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 SFHSS. 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 SFHSS with proof of guardianship, court order, or decree by required deadlines.

Eligibility

Adult Disabled Children

To qualify a dependent disabled adult child, the adult child must be incapable of self-support because of a mental or physical condition that existed prior to age 26, continuously live with disability after turning 26, and meet each of the following criteria:

1. Disabled adult child ("Adult Child") is enrolled in a San Francisco Health Service System (SFHSS) medical plan on his or her 26th birthday; and
2. Adult Child has met the requirements of being an eligible dependent child under SFHSS Member Rules Section B.3 before turning 26 years old; and
3. Adult Child must have been physically or mentally disabled on the date coverage would have otherwise terminated due to age, i.e. turning 26 years old, and continue to be disabled from age 26 on; and
4. Adult Child is incapable of self-sustaining employment due to the physical or mental disability; and
5. Adult Child is dependent on Member for substantially all of his or her economic support, and is declared as an exemption on the Member's federal income tax;
6. Member is required to comply with their enrolled medical plan's disabled dependent certification process and recertification process every year thereafter or upon request.
7. An Adult Child, who qualify for Medicare due to a disability are required to enroll in Medicare (see SFHSS Member Rules Section J). Members must notify SFHSS of the Adult Child's eligibility for Medicare, as well as the Adult Child's subsequent enrollment in Medicare.
8. To maintain ongoing eligibility after the Adult Child has been enrolled, the Member must re-enroll the Adult Child with SFHSS each year and must ensure that he or she remains continuously enrolled Medicare (if eligible) without interruption.
9. A newly hired employee who adds an eligible dependent Adult Child, who is age 26 or older, must meet all requirements listed, except (1) and (2) above and comply with their enrolled medical plan's disabled dependent certification process specified in (6) within (30) days of employee hire date.

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 SFHSS coverage
- Retiree's spouse, domestic partner, or stepchildren who are losing SFHSS coverage due to legal separation, divorce, or dissolution of partnership
- Covered dependents who are not eligible for survivor benefits and are losing SFHSS coverage due to the death of an SFHSS 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 sfhss.org/benefits/cobra.html or call SFHSS at (415) 554-1750.

Medicare Enrollment is Required

Retiree members and dependents covered on a San Francisco 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 SFHSS within 30 days and cancel coverage for a dependent who becomes ineligible. If a member fails to notify SFHSS, 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 and 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 19-22 for retiree premium contributions based on Proposition B.

With at least 5 years, but less than 10 years of credited service, the retiree member must pay the full premium rate and does not receive any employer premium contribution.

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

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: sfhss.org/benefits/retirees.html.

If enrolled in retiree health benefits administered by the San Francisco 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. First, 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 San Francisco 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.

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/domestic partner and eligible children of a spouse/partner in San Francisco Health Service System (SFHSS) healthcare coverage, submit a completed SFHSS enrollment application, a copy of a certified marriage certificate or certificate of domestic partnership, and a birth certificate for each child to SFHSS **within 30 days** of the legal date of the marriage or partnership. Certificates of marriage or domestic 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 their 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 SFHSS enrollment application and a copy of the birth certificate, letter from hospital 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 SFHSS 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 SFHSS 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 SFHSS 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

SFHSS 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, SFHSS 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 SFHSS coverage begins.

Waiving Health Coverage

You may waive SFHSS 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 SFHSS enrollment form **within 30 days**. After enrollment form is submitted, SFHSS coverage will terminate on the last day of the coverage period. There may be an overlap of coverage between the date the other coverage begins and the date SFHSS coverage terminates. You must pay premium contributions up to the termination date of SFHSS 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 SFHSS plan that offers service based on your new address. Complete an SFHSS 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 SFHSS receives your enrollment application and any required documentation.

Death of a Dependent

If an enrolled dependent dies, notify SFHSS 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 SFHSS 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 SFHSS benefits. Other restrictions apply.

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

- Completed surviving dependent enrollment form
- Copy of member's death certificate
- Copy of certified U.S. certificate of marriage or partnership (if not already on file at SFHSS)
- 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 SFHSS. You must pay any premiums that are owed. Unpaid premium contributions will result in termination of coverage.

Medical Plans: Retirees Without Medicare

HMO

An HMO (Health Maintenance 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
(Non-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

Trio HMO
(Non-Medicare HMO)

Access+ HMO
(Non-Medicare HMO)

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

Your Medicare dependents will be enrolled in United Healthcare MAPD PPO.

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
(Non-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 coinsurance %
- Lower rate of employer coinsurance for out-of-network providers
- Reasonable and customary fee reimbursement limits

Your Medicare dependents will be enrolled in United Healthcare MAPD PPO.

Plan Features	Kaiser Permanente HMO	Blue Shield of California HMO	City Plan PPO
	Traditional NON-MEDICARE HMO	**Trio HMO and Access+ HMO** NON-MEDICARE HMO	**UnitedHealthcare** NON-MEDICARE CHOICE PLUS PPO
Kaiser only integrated care delivery system	■		
Bay area network of doctors and hospitals	■	■	■
National network of doctors and hospitals	Some areas in WA, OR, and HI		■
Primary Care Physician required	■	■	
No annual deductible and fixed co-pays	■	■	
Annual deductible and coinsurance			■

Note: City Plan PPO 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 coinsurance. Your out-of-area status may change as doctors join or leave the City Plan PPO network.

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2019. If any discrepancy exists between this guide and the EOC, the EOC will prevail. EOCs are available on sfhss.org.

Medical Plans: Retirees With Medicare

HMO

An HMO (Health Maintenance 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.

Your non-Medicare dependents will be enrolled in Kaiser Permanente's Traditional HMO Plan.

PPO

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

UnitedHealthcare PPO

UnitedHealthcare
(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 68,000 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 PPO, Blue Shield Trio HMO, or Access+ HMO.

Plan Features	Kaiser Permanente HMO	UnitedHealthcare PPO
	Senior Advantage Medicare Advantage HMO	**UnitedHealthcare** Medicare Advantage 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	■	■
Exercise and fitness programs	Silver & Fit	Silver Sneakers
Enhanced coverage for diabetic supplies		■
No annual deductible and fixed co-pays	■	■
Annual deductible and coinsurance		

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2019. If any discrepancy exists between this guide and the EOC, the EOC shall prevail. EOCs are available on sfhss.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+ HMO NON-MEDICARE HMO	Trio+ HMO NON-MEDICARE HMO	Traditional NON- MEDICARE HMO	City Plan PPO NON-MEDICARE PPO		Access+ HMO NON-MEDICARE HMO	Trio+ HMO NON-MEDICARE HMO	Traditional NON-MEDICARE HMO	City Plan PPO NON-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			❍	■	Yolo	■	❍	❍	■
Nevada	❍	❍		■	Yuba			❍	■
					Outside CA			❍ OR, WA, HI	■

■ = Available in this county

❍ = Available in some zip codes

City Plan PPO: (HMO Choice Not Available)

Non-Medicare Members and non-Medicare dependents who lack geographic access to other plans offered by SFHSS (Blue Shield of California's Trio HMO, Access+ HMO or Kaiser Permanente) are eligible to enroll in City Plan–Choice Not Available with lower premiums.

Service Areas: Retirees With Medicare

County	Kaiser Permanente	United Healthcare	County	Kaiser Permanente	United Healthcare
	Senior Advantage MEDICARE ADVANTAGE HMO	**Medicare Advantage** PPO		**Senior Advantage** MEDICARE ADVANTAGE HMO	**Medicare Advantage** 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	■	■	Yolo	❍	■
Nevada		■	Yuba	❍	■
			Outside CA	❍ OR, WA, HI	▲

■ = Available in this county

❍ = Available in some zip codes

▲ = Service area includes all 50 states, District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Moving?

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 San Francisco Health Service System at (415) 554-1750 to update your information and review plan options if you are changing your address.

2019 Medical Plan Benefits-at-a-Glance

	BLUE SHIELD OF CALIFORNIA Trio HMO and 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
Most 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 in-network	$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

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	$500 Deductible retiree only $1,000 Deductible + 1 $1,500 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
$10 co-pay 30-day supply	50% covered after $5 co-pay; 30-day supply
$25 co-pay 30-day supply	50% covered after $20 co-pay; 30-day supply
$50 co-pay 30-day supply	50% covered after $45 co-pay; 30-day supply
$20 co-pay 90-day supply	Not covered
$50 co-pay 90-day supply	Not covered
$100 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

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2019. If any discrepancy exists between the information provided in this guide and the EOC, the EOC shall prevail. Find EOCs at sfhss.org.

2019 Medical Plan Benefits-at-a-Glance

	BLUE SHIELD OF CALIFORNIA Trio HMO and 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
GENDER DYSPHORIA		
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 2019. If any discrepancy exists between the information provided in this guide and the EOC, the EOC shall prevail. Find EOCs at sfhss.org.

2019 Medical Plan Benefits-at-a-Glance

	KAISER PERMANENTE **Senior Advantage** Medicare Advantage HMO	UnitedHealthcare Medicare Advantage 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 (Tier 1)	$5 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: Brand-Name Drugs (Tier 2)	$15 co-pay 30-day supply	$20 co-pay 30-day supply
Pharmacy: Non-Preferred Brand Drugs (Tier 3)	Physician authorized only	$45 co-pay 30-day supply
Mail Order: Generic Drugs (Tier 1)	$10 co-pay 100-day supply	$10 co-pay 90-day supply
Mail Order: Brand-Name Drugs (Tier 2)	$30 co-pay 100-day supply	$40 co-pay 90-day supply
Mail Order: Non-Preferred Brand Drugs (Tier 3)	Physician authorized only	$90 co-pay 90-day supply
Specialty Drugs (Tier 4)	20% coinsurance up to $100 per prescription, 30 day supply	$20 co-pay retail pharmacy up to 30-day supply $40 co-pay mail order pharmacy up to 90-day supply
OUTPATIENT SERVICES		
Diagnostic X-ray and Laboratory	No charge	$0 co-pay
EMERGENCY		
Hospital Emergency Room	$50 co-pay waived if hospitalized	$65 co-pay
Urgent Care Facility	$20 co-pay	$20 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	UnitedHealthcare Medicare Advantage PPO
REHABILITATIVE		
Physical/Occupational Therapy	$20 co-pay authorization required	$20 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
GENDER DYSPHORIA		
Office Visits and Outpatient Surgery	Co-pays apply authorization required	Co-pays apply authorization required
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 and 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	Covered by Original Medicare
OUTSIDE SERVICE AREA		
Care Access and Limitations	Only emergency services before condition permits transfer to Kaiser facility. Co-pays apply.	Nationwide coverage provided. Services obtained outside of the United States and UnitedHealthcare covered United States territories will only be authorized in the case of urgently needed services or in the case of emergency.

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2019. If any discrepancy exists between the information provided in this guide and the EOC, the EOC shall prevail. Find EOCs at sfhss.org.

2019 Medical Premiums: Retiree or Survivor of Retiree Without Medicare Residing in California

RETIREES OR SURVIVORS OF RETIREES HIRED BEFORE JANUARY 9, 2009

2019 Monthly Medical Premiums	Blue Shield of California				Kaiser Permanente HMO		UHC City Plan PPO		UHC City Plan (Choice Not Available)	
	Trio HMO		Access+ HMO							
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$1,684.49	$37.78	$1,911.82	$100.26	$1,225.27	$0	$1,085.27	$202.61	$1,187.62	$100.26
Retiree/Survivor +1 Dependent with no Medicare	$2,070.89	$424.18	$2,363.20	$551.65	$1,528.94	$303.66	$1,590.07	$707.41	$1,692.42	$605.06
Retiree/Survivor +2 or More Dependents with no Medicare	$2,070.89	$1,041.07	$2,363.20	$1,272.27	$1,528.94	$807.74	$1,590.07	$1,470.21	$1,692.42	$1,367.86
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$1,872.32	$225.60	$2,099.65	$288.08	$1,390.20	$164.93	$1,273.10	$390.43	$1,375.45	$288.08
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$1,872.32	$842.49	$2,099.65	$1,008.70	$1,390.20	$669.01	$1,273.10	$1,153.23	$1,375.45	$1,050.88

RETIREES OR SURVIVORS OF RETIREES HIRED AFTER JANUARY 9, 2009[1] WITH 10 AND LESS THAN 15 YEARS OF SERVICE

2019 Monthly Medical Premiums	Blue Shield of California				Kaiser Permanente HMO		UHC City Plan PPO		UHC City Plan (Choice Not Available)	
	Trio HMO		Access+ HMO							
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$842.25	$880.02	$955.91	$1,056.17	$612.64	$612.63	$542.64	$745.24	$593.81	$694.07
Retiree/Survivor +1 Dependent with no Medicare	$1,035.45	$1,459.62	$1,181.60	$1,733.25	$764.47	$1,068.13	$795.04	$1,502.44	$846.21	$1,451.27
Retiree/Survivor +2 or More Dependents with no Medicare	$1,035.45	$2,076.51	$1,181.60	$2,453.87	$764.47	$1,572.21	$795.04	$2,265.24	$846.21	$2,214.07
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$936.16	$1,161.76	$1,049.83	$1,337.90	$695.10	$860.03	$636.55	$1,026.98	$687.73	$975.80
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$936.16	$1,778.65	$1,049.83	$2,058.52	$695.10	$1,364.11	$636.55	$1,789.78	$687.73	$1,738.60

[1] ***Retirees or survivors of retirees with at least 5 years of service but less than 10 years of service have no city contribution and must pay the full premium rate.***

Required Retiree/Survivor 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 SFHSS to make payment arrangements.

2019 Medical Premiums: Retiree or Survivor of Retiree With Medicare Part A and Part B Residing in California

RETIREES HIRED BEFORE JANUARY 9, 2009

2019 Monthly Medical Premiums	Kaiser Permanente HMO		UHC Medicare Advantage PPO		UHC Medicare Advantage PPO with Non-Medicare Dependents in Blue Shield of CA Trio HMO		UHC Medicare Advantage PPO with Non-Medicare Dependents in Blue Shield of CA Access+ HMO	
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$333.99	$0	$379.78	$0	$379.78	$0	$379.78	$0
Retiree/Survivor +1 Dependent with no Medicare	$637.66	$303.66	$884.58	$504.80	$766.18	$386.40	$831.16	$451.39
Retiree/Survivor +2 or More Dependents with no Medicare	$637.66	$807.74	$884.58	$1,267.60	$766.18	$1,003.29	$831.16	$1,172.01
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$498.92	$164.93	$567.61	$187.82	$567.61	$187.82	$567.61	$187.82
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$498.92	$669.01	$567.61	$950.62	$567.61	$804.71	$567.61	$908.44

RETIREES HIRED AFTER JANUARY 9, 2009[1] WITH 10 AND LESS THAN 15 YEARS OF SERVICE

2019 Monthly Medical Premiums	Kaiser Permanente HMO		UHC Medicare Advantage PPO		UHC Medicare Advantage PPO with Non-Medicare Dependents in Blue Shield of CA Trio HMO		UHC Medicare Advantage PPO with Non-Medicare Dependents in Blue Shield of CA Access+ HMO	
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$167.00	$166.99	$189.89	$189.88	$189.89	$189.89	$189.89	$189.89
Retiree/Survivor +1 Dependent with no Medicare	$318.83	$622.49	$442.29	$947.09	$383.09	$769.49	$415.58	$866.97
Retiree/Survivor +2 or More Dependents with no Medicare	$318.83	$1,126.57	$442.29	$1,709.89	$383.09	$1,386.38	$415.58	$1,587.59
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$249.46	$414.39	$283.81	$471.62	$283.81	$471.62	$283.81	$471.62
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$249.46	$918.47	$283.81	$1,234.42	$283.81	$1,088.51	$283.81	$1,192.24

[1] ***Retirees or survivors of retirees with at least 5 years of service but less than 10 years of service have no city contribution and must pay the full premium rate.***

2019 Medical Premiums: Retiree or Survivor of Retiree Without Medicare Residing Outside of California

RETIREES OR SURVIVORS OF RETIREES HIRED BEFORE JANUARY 9, 2009

2019 Monthly Medical Premiums	Kaiser Permanente HMO						City Plan PPO Choice Not Available	
	Northwest		Washington		Hawaii			
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$1,335.93	$0	$1,330.59	$0	$969.81	$0	$1,187.62	$100.26
Retiree/Survivor +1 Dependent with no Medicare	$2,001.83	$665.89	$1,993.83	$663.23	$1,452.65	$482.83	$1,692.42	$605.06
Retiree/Survivor +2 or More Dependents with no Medicare	$2,001.83	$1,771.27	$1,993.83	$1,764.19	$1,452.65	$1,284.33	$1,692.42	$1,367.86
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$1,535.64	$199.71	$1,490.54	$159.94	$1,155.80	$185.99	$1,375.45	$288.08
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$1,535.64	$1,305.09	$1,490.54	$1,260.90	$1,155.80	$987.49	$1,375.45	$1,050.88

RETIREES OR SURVIVORS OF RETIREES HIRED AFTER JANUARY 9, 2009[1] WITH 10 AND LESS THAN 15 YEARS OF SERVICE

2019 Monthly Medical Premiums	Kaiser Permanente HMO						City Plan PPO Choice Not Available	
	Northwest		Washington		Hawaii			
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$667.97	$667.96	$665.30	$665.29	$484.91	$484.90	$593.81	$694.07
Retiree/Survivor +1 Dependent with no Medicare	$1,000.92	$1,666.80	$996.92	$1,660.14	$726.33	$1,209.15	$846.21	$1,451.27
Retiree/Survivor +2 or More Dependents with no Medicare	$1,000.92	$2,772.18	$996.92	$2,761.10	$726.33	$2,010.65	$846.21	$2,214.07
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$767.82	$967.53	$745.27	$905.21	$577.90	$763.89	$687.73	$975.80
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$767.82	$2,072.91	$745.27	$2,006.17	$577.90	$1,565.39	$687.73	$1,738.60

[1]Retirees or survivors of retirees with at least 5 years of service but less than 10 years of service have no city contribution and must pay the full premium rate.

2019 Medical Premiums: Retiree or Survivor of Retiree With Medicare Part A and Part B Residing Outside of California

RETIREES OR SURVIVORS OF RETIREES HIRED BEFORE JANUARY 9, 2009

2019 Monthly Medical Premiums	Kaiser Permanente Senior Advantage HMO						UHC Medicare Advantage PPO	
	Northwest		Washington		Hawaii			
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$403.55	$0	$324.02	$0	$376.11	$0	$379.78	$0
Retiree/Survivor +1 Dependent with no Medicare	$1,069.45	$665.89	$987.26	$663.23	$858.95	$482.83	$884.58	$504.80
Retiree/Survivor +2 or More Dependents with no Medicare	$1,069.45	$1,771.27	$987.26	$1,764.19	$858.95	$1,284.33	$884.58	$1,267.60
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$603.26	$199.71	$483.97	$159.94	$562.10	$185.99	$567.61	$187.82
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$603.26	$1,305.09	$483.97	$1,260.90	$562.10	$987.49	$567.61	$950.62

RETIREES OR SURVIVORS OF RETIREES HIRED AFTER JANUARY 9, 2009[1] WITH 10 AND LESS THAN 15 YEARS OF SERVICE

2019 Monthly Medical Premiums	Kaiser Permanente Senior Advantage						UHC Medicare Advantage PPO	
	Northwest		Washington		Hawaii			
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$201.78	$201.77	$162.01	$162.01	$188.06	$188.05	$189.89	$189.89
Retiree/Survivor +1 Dependent with no Medicare	$534.73	$1,200.61	$493.63	$1,156.86	$429.48	$912.30	$442.29	$947.09
Retiree/Survivor +2 or More Dependents with no Medicare	$534.73	$2,305.99	$493.63	$2,257.82	$429.48	$1,713.80	$442.29	$1,709.89
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$301.63	$501.34	$241.99	$401.92	$281.05	$467.04	$283.81	$471.62
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$301.63	$1,606.72	$241.99	$1,502.88	$281.05	$1,268.54	$283.81	$1,234.42

[1] ***Retirees or survivors of retirees with at least 5 years of service but less than 10 years of service have no city contribution and must pay the full premium rate.***

2019 Vision Plan Benefits

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

Vision Plan Benefits

SFHSS members and dependents enrolled in a medical plan administered by SFHSS 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 (800) 877-7195.

Accessing Your Vision Benefits

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

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

Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every other calendar year unless enrolled in the Premier Plan. 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.

VSP Basic and Premier Vision Plans

You now have choices—as a new hire or during open enrollment you can stay enrolled in the Basic Plan or choose the Premier Plan for enhanced benefits, such as a $300 allowance on frames or a $250 allowance on contacts lenses every calendar year. Anti-reflective are covered in full with a $25 co-pay for each. Starting on July 1, 2018, standard progressive lenses will be covered at 100%, with co-pays for premium and custom progressive lenses. See page 24 for details.

VSP Vision Care Member Extras

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

No Medical Plan, No Vision Benefits

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

2019 Vision Plan Benefits-at-a-Glance

New Premier Plan Choice

You now have choice—stay enrolled in the Basic Plan or choose the Premier Plan for enhanced benefits. Members and dependents enrolled in medical coverage are automatically enrolled in VSP Vision Care Basic benefits. Once enrolled, you have the choice of using a VSP in-network provider or a licensed, out-of-network provider. Locate a VSP in-network provider by visiting vsp.com. No ID cards are issued for vision benefits. If you receive service from a provider outside of the VSP network (including Kaiser Permanente), you must pay in full and submit a bill to VSP for reimbursement. Visit *vsp.com/optical-discounts.html* for a detailed list of VSP Vision Care discounts, including hearing aid reimbursement.

Covered Services	Basic	Premier
Well Vision Exam	$10 co-pay every calendar year	$10 co-pay every calendar year
Single Vision Lenses Lined Bifocal Lenses Lined Trifocal Lenses	$25 co-pay every other calendar year $25 co-pay every other calendar year $25 co-pay every other calendar year	$0 every calendar year $0 every calendar year $0 every calendar year
Standard Progressive Lenses Premium Progressive Lenses Custom Progressive Lenses	$100% coverage every other calendar year $95–$105 co-pay every other calendar year $150–$175 co-pay every other calendar year	$100% coverage every calendar year $25 co-pay every calendar year $25 co-pay every calendar year
Standard Anti-Reflective Coating Premium Anti-Reflective Coating Custom Anti-Reflective Coating	$41 co-pay every other calendar year $58-$69 co-pay every other calendar year $85 co-pay every other calendar year	$25 co-pay every calendar year
Scratch-Resistant Coating	Fully covered every other calendar year[1]	Fully covered every calendar year
Frames	$150 allowance for a wide selection of frames $170 allowance for featured frames $80 allowance at Costco $25 co-pay applies; 20% savings on amount over the allowance; every other calendar year	$300 allowance for a wide selection of frames $320 allowance for featured frames $165 allowance at Costco no additional co-pay, 20% savings on amount over your allowance every calendar year
Contacts (instead of glasses)	$150 allowance every other calendar year	$250 allowance every calendar year
Contact Lens Exam	Up to $60 co-pay every other calendar year	Up to $60 co-pay every calendar year
Primary Eye Care	$5 co-pay	$5 co-pay
Vision Care Discounts		
Laser Vision Correction	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities
	Retiree/Survivor Monthly Contribution	**Retiree/Survivor Monthly Contribution**
	Included in medical premium	Retiree/Survivor Only $9.36 Retiree/Survivor + 1 Dependent $14.04 Retiree/Survivor + 2 or More Dependents $29.32

Your Coverage with Out-of-Network Providers

Visit vsp.com for details if you plan to see a provider other than a VSP network provider.

Exam Up to $50 Frame Up to $70	Single Vision Lenses Up to $45 Lined Bifocal Lenses Up to $65	Lined Trifocal Lenses Up to $85 Progressive Lenses Up to $85	Contacts Up to $105

[1] With the Basic Plan, new eyeglass lenses may be covered the next year if Rx change is more than .50 diopters. Based on your last date of service. In the instance where information in this chart conflicts with the plan's Evidence of Coverage, the plan's Evidence of Coverage shall prevail.

2019 Dental Plan Benefits

Delta Dental PPO's *SmileWay* program features 100% coverage for one annual periodontal scaling and root planing procedure and an increased number of teeth cleaning or periodontal maintenance services for members with specific chronic conditions. Additionally, adult orthodontic lifetime maximums have increased and Dental Accident Benefits have been added to provide additional coverage for dental services for conditions caused directly or independently of all other causes by external, violent, and accidental means.

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.

SFHSS offers the following PPO-style dental plan:

- Delta Dental PPO

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

The Delta Dental plan has two different networks. Ask your dentist if they are a Delta Dental PPO network or Premier network dentist. Both networks are held to the same quality standards. But choosing a PPO dentist will save you money. You can also choose any dentist outside of the PPO and Premier networks. However, many services may be covered at a lower percentage, so you pay more. Also, payment is based on reasonable and customary fees for the geographic area. Diagnostic and preventative do not count 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 (888) 335-8227.

DHMO-Style Dental Plans

Similar to medical HMOs, Dental Health Maintenance Organization-style (DHMO-style) 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 DHMO-style 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 dental plan.

SFHSS offers the following DHMO-style plans:

- DeltaCare USA
- UnitedHealthcare Dental

2019 Dental Premiums: All Retirees / Survivors

2019 Monthly Dental Premiums	Delta Dental PPO		DeltaCare USA DHMO-style		UnitedHealthcare Dental DHMO	
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$0	$45.77	$0	$32.85	$0	$16.47
Retiree/Survivor +1 Dependent	$0	$91.04	$0	$54.21	$0	$27.20
Retiree/Survivor +2 or More Dependents	$0	$135.88	$0	$80.19	$0	$40.22

2019 Dental Plan Benefits-at-a-Glance

	Delta Dental PPO			DeltaCare USA DHMO-style	United Healthcare Dental DHMO
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 network 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	$1,250 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 2x/yr; pregnancy 3x/yr; chronic condition 4x/yr[1] (new)	80% covered 2x/yr; pregnancy 3x/yr; chronic condition 4x/yr[1] (new)	80% covered 2x/yr; pregnancy 3x/yr; chronic condition 4x/yr[1] (new)	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 urgery	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
Night Guards	80% covered (1x3yr)	80% covered (1x3yr)	80% covered (1x3yr)	$100 co-payment	100% covered

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

[1] Chronic Conditions are diabetes, heart disease, HIV/AIDS, rheumatoid arthritis and/or stroke.

Best Doctors: Expert Medical Case Review

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

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

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

The Best Doctors benefit includes:

In-Depth Medical Case Review

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

Ask the Expert

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

Critical Care

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

Find a Doctor

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

Medical Records eSummary

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

Contact Best Doctors: To get started, call Best Doctors at (866) 904-0910, M-F, 5am-6pm PST, 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.

Medicare and San Francisco Health Service System Benefits

The San Francisco 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 and Medicaid Services (cms.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 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 San Francisco Health Service System. If you have a Social Security-qualified disability or End Stage Renal Disease, you should contact the Social Security Administration immediately to apply for Medicare.

A SFHSS 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 UnitedHealthcare Medicare Advantage PPO Plan (if the member under 65 is in either the Blue Shield of California's Trio HMO, Access+ HMO or City Plan PPO).

Medicare Part A: Hospital Insurance

SFHSS 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 (800) 772-1213.

Medicare and San Francisco Health Service System Benefits

Medicare Part B: Medical Insurance

SFHSS 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 SFHSS from the Social Security Administration verifying that you are not eligible for premium-free Medicare Part A. SFHSS 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. SFHSS members and dependents are required to enroll in Medicare in accordance with SFHSS rules, even if they are paying a federal penalty for late Medicare enrollment.

Q **What happens if I enroll after age 65 or change SFHSS 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 SFHSS if you have questions.

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

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

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

A An SFHSS member who does not enroll in Medicare when eligible or who loses Medicare coverage due to non-payment of Medicare premiums, will lose existing SFHSS 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 San Francisco Health Service System Benefits

Do not enroll in any individual Medicare Part D plan. Doing so will result in the termination of your SFHSS 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. SFHSS members should not enroll in any individual Medicare Part D plan. SFHSS members are automatically enrolled in group prescription drug coverage under Medicare Part D when they enroll in any medical plan offered through SFHSS. SFHSS medical plans offer enhanced group Medicare Part D prescription drug coverage.

UHC Medicare Advantage PPO 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 SFHSS 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 SFHSS 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.

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/part-d/costs/premiums/drug-plan-premiums.html or call Social Security at (800) 772-1213.

Q **What is the SFHSS 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, SFHSS medical coverage will also be terminated. SFHSS 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 SFHSS medical coverage for a member or dependent may be reinstated at the beginning of the next available coverage period after SFHSS receives proof of Medicare Part D reinstatement.

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

For Medicare and Non-Medicare Members

Traveling Outside of 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 of the United States. In general, if you are travelling outside of the United States:

- Blue Shield of California's Trio HMO and Access+ HMO for retirees without Medicare only covers emergency services outside of California service areas.
- Kaiser Permanente HMO plans only cover emergency services outside of their service areas.
- The UnitedHealthcare Medicare Advantage PPO covers urgently needed or emergency services outside of the United States.
- Pre-Medicare retirees in the UnitedHealthcare City Plan Choice Plus PPO are covered outside of the United States. If you obtain service outside of the United States, you will pay out-of-area coinsurance.

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 SFHSS.

Retirees Residing Permanently Outside of the United States

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

Medicare enrollment is not required for retired members over 65 residing outside of 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 SFHSS 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.

If you are currently enrolled in a Medicare plan offered through SFHSS, and you are planning to move outside of the continental United States, you must contact SFHSS Member Services at (415) 554-1750 for information on other health plan options that may be available to you.

Health Service Board Achievements

Karen Breslin
President
Elected

Stephen Follansbee, MD
Vice President
Appointee

Sharon Ferrigno
Elected
Retiree

Wilfredo Lim
Elected
Employee

Rafael Mandelman
Board of
Supervisors

Randy Scott
Appointee
Commissioner

Steps to Improve and Maintain Affordable Benefits:

1. Through the Health Service Board Education Policy, the Board continues to be fully committed to being knowledgeable and apply understanding to business principles and practices of the San Francisco Health Service System and the Health System Trust.
2. Recruit and hire a new Executive Director for San Francisco Health Service System.

Benefit Additions:

The Health Service Board approved the following plan enhancements and benefits for 2019:

Flexible Spending Accounts (FSAs)

- Approved an increase to Health Flexible Spending Account (FSA) maximum from $2,500 to $2,650 for 2019.

VSP Basic and Premier Vision Plans

- Approved 100% coverage for standard progressive lenses for both Basic and Premier Vision Plan members.

Delta Dental PPO

- Approved SmileWay program allowing members diagnosed with chronic health conditions (diabetes, heart disease, HIV/AIDS, rheumatoid arthritis and/or stroke) 100% coverage for one annual periodontal scaling and root planing procedure and up to four (any combination) teeth cleaning or periodontal maintenance services per year.
- Approved Adult orthodontic lifetime maximum increase by $1,000 in each provider tier category (to match child orthodontia maximum levels).
- Approved removal of six-month waiting period for prosthodontic and orthodontic coverage.
- Approved Cost Estimator Tool providing members the ability to model the estimated cost of specific dental services in advance and will suggest as an option, alternative, less-costly providers.
- Approved Accident Benefit Rider or additional coverage for dental services for conditions caused directly or independently of all other causes by external, violent, and accidental means.

City Plan PPO

- Approved new “City Plan PPO—HMO Choices Not Available” option providing lower member contributions for those who lack geographic access to other medical plans offered by SFHSS.
- Approved a provider re-contracting initiative increasing average discounts for provider services, without any change in provider composition of the PPO network.

UnitedHealthcare Medicare Advantage PPO

- Approved preferred diabetic supplies program.
- Approved reduction to member co-payments for kidney dialysis, urgent care and certain therapy services.
- Approved change to prescription drug formulary to better align with Medicare standards.
- Approved the Select Plus network for all California membership allowing for increased average network discounts for provider services allowing for greater discounts with no network disruption to the PPO network.
- Approved post-discharge meal delivery, care-related transportation (post-discharge and routine transportation), and nutritional counseling benefits.

Mental Health and Substance Abuse Benefits

As a result of federal mental health parity law, there is no yearly or lifetime dollar limit for essential mental health benefits. Additionally, deductibles, co-payments, coinsurance, out-of-pocket limits, number of days or visits covered and any pre-authorization of treatment must be the same for mental health and medical/surgical services. For urgent mental health issues, members should call 911, or go to the nearest emergency department.

Kaiser Permanente HMO	UnitedHealthcare City Plan PPO	UHC Medicare Advantage PPO Plan
Medicare and Non-Medicare	**Non-Medicare**	**Medicare Only**
Call (800) 464-4000 to make an appointment or contact your Primary Care Physician or call (415) 833-2292. You don't need a referral to see a therapist. Make an appointment to see a therapist, without referral, through your Primary Care Physician.	Call (866) 282-0125 to make an appointment. Telemental Health: Services are available with participating providers. To find providers online, go to liveandworkwell.com or welcometouhc.com/sfhss.	Call (877) 259-0493 to make an appointment or contact your Primary Care Physician. Telemental Health services are available with participating providers. To learn more or find a list of participating virtual medical doctors online sign into your member account at UHCRetiree.com.

Mental Well-being Services

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

Kaiser Permanente HMO	UnitedHealthcare City Plan PPO	UHC Medicare Advantage PPO Plan
Medicare and Non-Medicare	**Non-Medicare**	**Medicare Only**
Counseling: Call (800) 464-4000 **Classes, Support Groups:** Contact your local Kaiser facility for a calendar or visit kp.org/mentalhealth. **Telephone/Online Coaching:** Call (866) 862-4295 for a telephonic coach or go to kp.org for more details. **Tobacco Cessation:** Contact your local Kaiser facility for classes. Call (866) 862-4295 for a telephonic coach. For HealthMedia Breathe and other resources, visit kp.org/quitsmoking. **Home Health Care:** Caregivers have one thing in common: They make time in their lives to provide social, financial, emotional, and physical support to someone who needs their help. There are many excellent resources to assist you in your caregiving role. Ask your doctor about Kaiser Permanente resources for caregivers, or visit kp.org for resources and classes.	Call the *Confidential Help* line 24/7 at (866) 282-0125. **Telemental Health:** Services are available with participating providers. To find providers online, go to liveandworkwell.com or welcometouhc.com/sfhss. **Tobacco Cessation:** Visit welcometouhc.com/sfhss or liveandworkwell.com for the online smoking cessation information. **Mental Health Providers and Online Resources** can be found at liveandworkwell.com. Members can also link to this directly from their myuhc.com profile.	**Solutions for Caregivers:** The Solutions for Caregivers case managers can help with making difficult decisions about various topics including living arrangements and care needs. Services include: • In-person assessment • Telephone consultation • Toll-free access to caregiver coaches with a list of local resources • Personalized care plan • Caregiver coaches act as an advocate • Coordination of services Services are available for members and those who care for members. A *Medicare Advantage Member number* is needed to obtain services. Call (866) 896-1895, 24 hours a day, seven days a week. **Counseling/Therapy:** Individual and group therapy, screenings, and education. Call (877) 259-0493.

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 San Francisco Health Service System (SFHSS), 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 SFHSS. 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 SFHSS 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 SFHSS and 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

SFHSS 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, SFHSS will not disclose your health information without your written authorization:

- To make or obtain payments from plan vendors contracted with SFHSS
- To facilitate administration of health insurance coverage and services for SFHSS 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 a court order or subpoena.
- To prevent a serious or imminent threat to individual or public health and safety.

If you authorize SFHSS to disclose your health information, you may revoke that authorization in writing at any time.

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

This is a summary of a legal notice that details SFHSS privacy policy. The full legal notice is available at sfhss.org.

You may also contact SFHSS to request a written copy of the full legal notice.

Nurseline and Urgent Care

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

24/7 Nurse Line - Call a free nurse advice line and speak to a registered nurse. Get answers to your questions about health problems, illness or injury. The nurse can also help you decide if you need routine, urgent or emergency service.

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

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

Go Online - email your doctor, access your lab results, refill your prescriptions, schedule and cancel appointments, print vaccination records and access online tools and educational materials.

Kaiser Permanente HMO	City Plan PPO (UnitedhealthCare)	UHC Medicare Advantage PPO
Non-Medicare Only	**Medicare and Non-Medicare**	**Medicare Only**
Nurseline 24/7: (866) 454-8855 **Urgent Care:** (866) 454-8855 **Urgent After Hours Care:** **San Francisco** (415) 833-2200 **Oakland** (510) 752-1190 **Redwood City** (650) 299-2015 **Walnut Creek** (925) 295-4070 **San Rafael** (415) 444-2940 This is a partial list. For additional Kaiser urgent care facilities call (866) 454-8855. When scheduling an appointment in person or through the *Appointment and Advice line* at (800) 464-4000, ask if a video visit is right for your symptoms. You may be offered a video visit. To register online, visit kp.org/registernow from a computer (have your medical record number ready). Online services include: • Instant access to lab result • Ability to refill most prescriptions • Schedule/cancel most appointments • email your doctor and much more	**Nurseline 24/7:** (800) 846-4678 **Urgent After Hours Care:** **San Francisco Golden Gate Urgent Care** (415) 746-1812 **Hayward St. Francis Urgent Care** (510) 780-9400 **Rohnert Park Concentra** (866) 944-6046 For more current and additional urgent care facilities call (866) 282-0125 or visit welcometouhc.com/sfhss. Members can access *Virtual Visits* by registering on myuhc.com, tab on the right, or by accessing **health4me app**, under *Menu – Find and Price Care*. Costs are the same as an office visit. Myuhc.com gives members the ability to: • Review eligibility and look up benefits • Check current and past claim status • Find a doctor or hospital • "Chat" with a nurse in real-time • Take a health assessment and participate in Health Coaching programs and much more	**Nurseline 24/7:** (877) 365-7949 **Urgent After Hours Care:** For urgent care facilities call UnitedHealthcare at (877) 259-0493 welcometouhc.com/sfhss **HouseCalls** is a special program designed to help you stay on top of your health by providing an in-home health and wellness visit by an advanced practice clinician. This annual visit is provided at no additional cost to you. HouseCalls is for everyone, even if you are healthy and regularly see your doctor. There are many advantages of a HouseCalls visit including: • 45–60 minutes of one-on-one attention with your clinician • No travel for the appointment • No waiting in the doctor's office • An evaluation of any safety risks in the home • Eligibility to receive gift cards. In addition to a health evaluation and important screenings, during your in-home visit, you'll make a plan with the clinician and discuss health concerns.

Key Contact Information

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

Well-Being
1145 Market Street, 1st Floor
San Francisco, CA 94103
Tel: (415) 554-0643
email: wellbeing@sfgov.org

Employee Assistance Program
Tel: (415) 554-0610

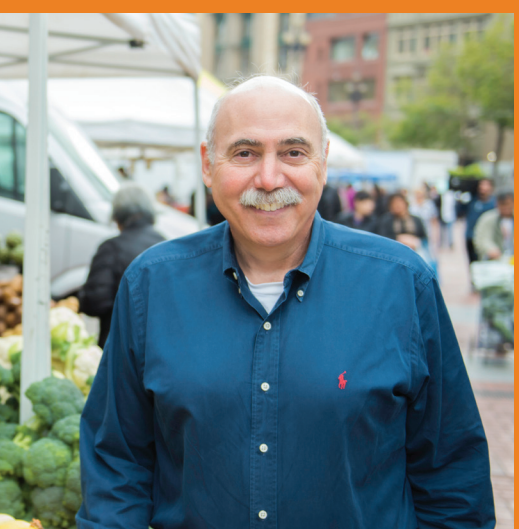
Health Service Board
Tel: (415) 554-0662
email: health.service.board@sfgov.org

MEDICAL PLANS			
Blue Shield of California Trio HMO Non-Medicare Access+ HMO Non-Medicare	Trio HMO: (855) 747-5800 Access+ HMO: (855) 256-9404	Trio HMO: blueshieldca.com/sites/imce/trio.sp Access+HMO: blueshieldca.com/ccsf	Group W0051448 (Trio HMO and Access+ HMO)
Kaiser Permanente Traditional and Early Retiree/Medicare	CA: (800) 464-4000 / (800) 443-0815 NW: (800) 813-2000 / (877) 852-5081 WA: (206) 630-4636 / (206) 630-4600 HI: (800) 966-5955 / (877) 852-5081	my.kp.org/ccsf	Group 888 Northern California Group 231003 Southern California Group 21227 Northwest Group 25512 Washington Group 10119 Hawaii
City Plan PPO UnitedHealthcare Non-Medicare	(866) 282-0125	welcometouhc.com/sfhss	Group 752103
UnitedHealthcare Medicare Advantage PPO	(877) 259-0493	welcometouhc.com/sfhss	Group 13694 Group 12786 Part B Only
DENTAL and VISION PLANS			
Delta Dental PPO	(888) 335-8227	deltadentalins.com/ccsf	Group 01673
DeltaCare USA DHMO-style	(800) 422-4234	deltadentalins.com/ccsf	Group 71797
UnitedHealthcare Dental DHMO *formerly Pacific Union Dental*	(800) 999-3367	welcometouhc.com/sfhss	Group 275550
VSP Vision Care	(800) 877-7195	vsp.com	Group 12145878
COBRA			
P&A Group	(800) 688-2611	padmin.com	
MEDICAL CASE REVIEW			
Best Doctors	(866) 904-0910	members.bestdoctors.com	
OTHER AGENCIES			
SFERS	(415) 487-7000	mysfers.org	Pension Benefits
CalPERS	(888) 225-7377	calpers.ca.gov	
CalSTRS	(800) 228-5453	calstrs.org	
PARS	(800) 540-6369	parsinfo.org	
Social Security	(800) 772-1213 TTY 1-800-325-0778	ssa.gov	Medicare Enrollment
Medicare	(800) 633-4227 TTY 1-877-486-2048	medicare.gov	Medicare Administration
Covered California	(888) 975-1142	coveredca.com	State Insurance Exchange

OCT. 1 - NOV. 2, 2018 Benefit Fairs, Flu Clinics, and OE Events

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
1 **DEM 1011 TURK ST. ▲** Flu Shot Clinics 5am-9am & 11am-5pm 1st Floor Lunchroom	**2** **SFFD HQ** Open Enrollment & Flu Shot Clinic 8am-12pm 698 2nd St. SFFD Lobby	**3** **SFPW** **CESAR CHAVEZ YARD ▲** Health Fair 9am-1pm 2323 Caesar Chavez St.	**4** **SFPD HQ** Open Enrollment & Flu Shot Clinic 9am-4:30pm 1245 3rd St. Room 1025	**5** **HSA 1235 MISSION ST.** Flu Shot Clinic 9am-1pm Bob Becker Room 3rd Floor
8 Columbus Day **SFHSS CLOSED** **Health/Benefits Fair**–Meet with vendors and benefits analysts, drop off OE forms **OE Events**–Talk to a benefits analyst and drop off your enrollment form **Flu Shot Clinic**–Get a free flu shot **▲Employees with site access only.** **●Retirees only.**	**9** **1650 MISSION ST.** Open Enrollment & Flu Shot Clinic 9am-4pm 5th Floor Atrium	**10** **RECCSF ●** Benefits Fair & Flu Shot Clinic 10am-12pm Scottish Rite Masonic Ctr. 2850 19th Ave. **SFMTA PRESIDIO ▲** Flu Shot Clinic 10am-3pm 2610 Geary Blvd.	**11** **SFO** Health Fair 11:30am-3:30pm Open Enrollment 9am-4pm Aviation Museum International Terminal	**12** **SFUSD ▲** Benefits Fair & Flu Shot Clinic 4pm-8pm James Lick Middle School Gymnaisum 1220 Noe St.
15 **HALL OF JUSTICE** Open Enrollment & Flu Shot Clinic 9am-4:30pm 850 Bryant St. Room 551	**16** **PUC HQ** Open Enrollment & Flu Shot Clinic 8am-3pm 525 Golden Gate O'Shaughnessy Room **PUC Hetch Hetchy** Open Enrollment & Flu Shot Clinic 7:30am-12pm 1 Lakeshore, Moccasin Admininstration Great Room	**17** **ONE SOUTH VAN NESS** Benefits Fair & Flu Shot Clinic 9am-4pm 2nd Floor Atrium	**18** **SFMTA-MME ▲** Flu Shot Clinic 11am-4pm 601 25th St.	**19** **SF MAIN PUBLIC LIBRARY** Open Enrollment & Flu Shot Clinic 9am-12pm 100 Larkin St. Latino Hispanic Room **LAGUNA HONDA HOSPITAL** Open Enrollment 9am-4pm 375 Laguna Honda Blvd. Conf. Room 2, P1191
22 **ZSFG** Open Enrollment 9am-4pm 1001 Potrero Ave., Cafeteria **PUC MILLBRAE** Flu Shot Clinic 7am-12pm 1000 El Camino Real San Mateo Conference Room	**23** **REC & PARKS** Health Fair & Flu Shot Clinic 10am-2pm 1199 9th Ave. Golden Gate Park County Fair Building	**24** **CITY HALL** Benefits Fair & Flu Shot Clinic 9am-3:30pm 1 Dr. Carlton B. Goodlett Pl. South Light Court	**25** **SFHSS Wellness Center** Benefits Fair & Flu Shot Clinic 8am-5pm 1145 Market St. 1st Floor	**26** **SFHSS Wellness Center** Benefits Fair 8am-5pm 1145 Market St. 1st Floor
29 **SFHSS Wellness Center** Benefits Fair 8am-5pm 1145 Market St., 1st Floor **30 VAN NESS** Flu Shot Clinic 10am-3pm 3rd Floor	**30** **SFHSS Wellness Center** Benefits Fair 8am-5pm 1145 Market St., 1st Floor **PUC PHELPS** Flu Shot Clinic 8am-12pm 750 Phelps St. 931 Administration Annex	**31** **SFMTA FLYNN ▲** Flu Shot Clinic 10am-3pm 1940 Harrison St. **Open Enrollment applications are due today by 5:00pm.**	**Nov. 1** **WAR MEMORIAL** Flu Shot Clinic 10am-2pm 401 Van Ness, Room 302 **PORT** Flu Shot Clinic 7am-2pm Pier 1 Embarcadero Bayside 3	**2** **PUC NEWCOMB** Flu Shot Clinic 7am-11am 1990 Newcomb Ave. Building 1 CCD Training Room

Free flu shot events are for adults only, first come, first served. Supplies are limited.



For more information, visit sfhss.org or call SFHSS Member Services at (415) 554-1750.

SFHSS.ORG