

San Francisco Health Service System Rules

Approved by the Health Service System Board on September 10, 2020
to be effective January 1, 2021.

Table of Contents

A.	Health Service System Member Eligibility.....	3
B.	Eligible Dependents of Health Service System Members.....	6
C.	Eligibility Documentation Required.....	12
D.	Taxation of Health Benefits for a Domestic Partner.....	13
E.	Member Responsibility to Notify Health Service System When a Dependent Becomes Ineligible.....	14
F.	Open Enrollment Period.....	14
G.	Qualifying Status Changes and Other Applicable Events for Changing Benefit Elections Outside of the Open Enrollment Period.....	15
H.	Transfer of Health Benefit Plans.....	19
I.	Continuation of Health Benefits Coverage After Retirement.....	21
J.	Required Medicare Enrollment.....	22
K.	Medicare Advantage Enrollment.....	23
L.	Dual Health Plan Coverage Restrictions.....	24
M.	Member Health Benefits Coverage Periods.....	26
N.	Dependent Health Benefits Coverage Periods.....	28
O.	Waiving Health Benefits Coverage (Voluntary).....	31
P.	Member Premium Contributions and, Employer Premium Subsidies, and Delinquencies.....	33
Q.	Termination of Benefits Coverage (Involuntary).....	37
R.	Employees on Authorized Unpaid Leave.....	38
S.	COBRA Continuation of Health Benefits Coverage.....	39
T.	Other Public Agencies Eligible to Participate in the Health Service System.....	41
U.	Member Appeals and Grievances.....	42
V.	Rules of Interpretation.....	44
	APPENDIX A: Benefits Coverage Periods January-December 2015.....	46

A. HEALTH SERVICE SYSTEM MEMBER ELIGIBILITY

In accordance with City Charter Section 12.202, and San Francisco Administrative Code Section 16.700, the following persons shall be members of the San Francisco Health Service System. A member will be the primary enrolled subscriber for benefits offered through the Health Service System (HSS). Members are eligible to choose from the benefit plans provided by the Health Service System.

1. City & County of San Francisco Employees

- (1) All permanent employees of the City & County of San Francisco whose normal work week at the time of inclusion in the Health Service System is not less than twenty (20) hours;
- (2) All regularly scheduled provisional employees of the City & County of San Francisco whose normal work week at the time of inclusion in the Health Service System is not less than twenty (20) hours;
- (3) All other employees of the City & County of San Francisco, including “as needed” employees who have worked one thousand and forty (1,040) hours in any consecutive twelve (12) month period and whose normal work week at the time of inclusion in the Health Service System is not less than twenty (20) hours.
- (4) All other employees who are deemed ‘full-time employees’ under the shared responsibility provision of the Patient Protection and Affordability Care Act (section 4980H).

2. Elected Officials

All elected officials, including but not limited to:

- (1) the Mayor
- (2) the Board of Supervisors
- (3) the Assessor-Recorder
- (4) the Treasurer
- (5) the City Attorney
- (6) the Public Defender
- (7) the Sheriff

3. All Members of the Following Boards and Commissions During Their Time in Service with the City & County of San Francisco

- (1) Access Appeals Commission
- (2) Airport Commission
- (3) Arts Commission
- (4) Asian Art Commission

- (5) Board of Education
- (6) Board of Appeals
- (7) Building Inspection Commission
- (8) Civil Service Commission
- (9) Commission on the Aging
- (10) Commission on the Environment
- (11) Commission on the Status of Women
- (12) Community College District Governing Board
- (13) Concourse Authority
- (14) Elections Commission
- (15) Ethics Commission
- (16) Entertainment Commission
- (17) Fine Arts Museums Board of Trustees
- (18) Fire Commission
- (19) Film and Video Arts Commission
- (20) First Five Commission
- (21) Health Commission
- (22) Health Service Board
- (23) Historic Preservation Commission
- (24) Human Rights Commission
- (25) Human Services Commission
- (26) Juvenile Probation Commission
- (27) Law Library Board of Trustees
- (28) Library Commission
- (29) Municipal Transportation Authority
- (30) Planning Commission
- (31) Police Commission
- (32) Port Commission
- (33) Public Utilities Commission
- (34) Recreation and Parks Commission
- (35) Residential Rent Stabilization and Arbitration Board
- (36) Retirement Board
- (37) Small Business Commission
- (38) Sunshine Ordinance Task Force

- (39) Treasure Island Development Authority Board
- (40) War Memorial and Performing Arts Center Board
- (41) Youth Commission
4. **All Officers and Employees as Determined Eligible by the Governing Board of Education of the San Francisco Unified School District**
5. **All Officers and Employees as Determined Eligible by the Governing Board of Education of the San Francisco Community College District**
6. **All Officers and Employees as Determined Eligible by the Governing Bodies of the:**
 - (1) San Francisco Transportation Authority
 - (2) San Francisco Parking Authority
 - (3) San Francisco Redevelopment Agency
 - (4) Treasure Island Development Authority
 - (5) San Francisco Superior Court
7. **Any Other Employees Not Listed in Sections A.1 –A.6, as Determined Eligible by Ordinance**
8. **Retirees**

As used in these Rules, a Retiree Member is defined as a former employee member who leaves active employment after meeting his or her employer's requirements for retirement based on duration of service, disability or vesting and retires under his or her respective retirement system (SFERS, STRS, or PARS). To be eligible for participation in the Health Service System and to be eligible for health benefits at the premium contribution rate established for retirees (Section P), a Retiree Member must have elected to receive benefits under their retirement system and must have been enrolled in a health benefit plan through the Health Service System for some period during his or her term of employment with the City and County of San Francisco, the San Francisco Unified School District (SFUSD) or the San Francisco Community College District (SFCCD). SFUSD and SFCCD may impose additional requirements for health coverage.

If hired on or after January 10, 2009, a retiree is eligible to participate in the Health Service System, with no employer contributions toward health insurance premiums, after five (5) years of service. The Health Service System calculates service based on service with the Health Service System's participating employers – the City and County of San Francisco, the SFUSD, the SFCCD and the San

Francisco Superior Court. A retiree who retires for industrial disability does not have to meet the five-year service requirement to be eligible for coverage.

9. Resigned Members

As used in these Rules, a Resigned Member is defined as an employee member who resigned and withdrew his or her funds from a retirement system within thirty (30) days immediately prior to the date on which, but for his or her resignation, he or she could have been retired for service as a member of a retirement system. Coverage of a Resigned Member is at the unsubsidized full premium rate. Coverage must be continuous and, if lapsed, may not be reinstated without Board approval. (See San Francisco City Charter Section A8.425 and Administrative Code 16.701(d).)

10. Former Elective Members of the Legislative Body

Members shall also include former elective members of the legislative body who have served in office after January 1, 1981, and whose total service at the time of termination of service on such legislative body is not less than twelve (12) years when the respective legislative body provides for the continuation of health benefits as authorized by Government Code Section 53201.

B. ELIGIBLE DEPENDENTS OF HEALTH SERVICE SYSTEM MEMBERS

If enrolled by a Health Service System member, the following dependents of a member shall be eligible for coverage subject to the following conditions and limitations:

1. A Member's Legal Spouse

- a.** A member's legal spouse may be enrolled within 30 days of marriage, during the open enrollment period or within 30 days of a qualifying event as defined in Section G. A member's legal spouse shall be eligible as a dependent of the member provided that the member files a copy of their marriage certificate, the spouse's Social Security number, and Medicare card (if applicable) with the Health Service System. Coverage shall be effective on the first day of the coverage period following the date in which HSS receives documentation.
- b.** When a member is granted a final dissolution of marriage or is legally separated, the member's former spouse shall not be eligible as a dependent as of the last day of the coverage period in which the legal separation, divorce or final dissolution has been granted. A member must immediately notify the Health Service System in writing and provide documentation when the legal separation, divorce or final dissolution of marriage has been granted. When a member has been granted a final dissolution of marriage, or is legally separated, coverage for his or her dependent children shall continue as long as they are otherwise eligible. However, coverage for stepchildren will not continue. (See Section E regarding member responsibilities for timely notification of ineligible dependents and dependent eligibility audit requirements.)

2. A Member's Legal Domestic Partner

- a. A domestic partner may be enrolled within 30 days of registration of domestic partnership, during open enrollment, or within 30 days of a qualifying event as defined in Section G. A domestic partner of a member shall be eligible as a dependent of a member if the member meets the following requirements:
- b. The member must provide to HSS a certification of domestic partnership that has been processed per the requirements of the issuing city or county:
 - (1) For members residing in San Francisco, domestic partnership must be established by filing the Declaration of Domestic Partnership with the San Francisco County Clerk. (Domestic Partnership registration completed through a notary public in San Francisco is not accepted by HSS.)
 - (2) Members residing in California (including San Francisco) may alternatively provide a California Secretary of State Certificate of Registration of Domestic Partnership. (See www.sos.ca.gov.)
 - (3) If the member resides in a city, county or state that does not issue certification of domestic partnership, then the member and his or her domestic partner must sign and submit a notarized Health Service System Declaration of Domestic Partnership form. The requirements for domestic partner eligibility in the Health Service System may be greater than what is required by a city or county for domestic partner registration.
 - (4) The member and his or her legal domestic partner must certify to the Health Service System that they are economically responsible to each other for the common necessities of life, defined as food, shelter and medical care, and that this shall remain the case for expenses incurred during the period the member's domestic partner is covered by the Health Service System.
 - (5) The domestic partner's Social Security number and Medicare card (if applicable) must also be provided to HSS. Coverage will be effective on the first day of the coverage period following the date in which HSS receives all documentation.
- c. When the member is granted dissolution of domestic partnership, is legally separated, or there is any change of circumstances as attested to in a Declaration of Domestic Partnership, the member's partner is no longer eligible as a dependent. A member must immediately notify the Health Service System in writing when the member's partner is not eligible. Failure to do so can result in termination of coverage and financial penalties. (See Section E regarding member responsibilities for timely notification of ineligible dependents and dependent eligibility audit requirements..) Once a member's partner is no longer eligible, any children of the former partner are also no longer eligible.

3. Children

To be an eligible dependent child under these rules, a child must be one of the following and meet all other applicable criteria as stated in this Section B.3.

- (1) A natural child (up to age 26) of an enrolled member.
- (2) A legally adopted child, or child placed for adoption with, an enrolled member, (up to age 26).
- (3) A stepchild (up to age 26) who is a natural child of, a legally adopted child of, or a child placed for adoption with, a member's enrolled spouse or domestic partner.
- (4) A child (up to age 19) under the legal guardianship of a member, a member's spouse or a member's domestic partner
- (5) A member's child (up to age 19) as directed by court order.

a. Eligibility Requirements for Natural Children, Adopted Children, and Stepchildren

To be an eligible dependent child under these rules, a child must be under the age of 26 and one of the following:

- A natural child of an enrolled member.
- A legally adopted child of, or a child placed for adoption with, an enrolled member.
- A stepchild who is a natural child, legally adopted child, or child placed for adoption with, a member's enrolled spouse or domestic partner.

All of the following criteria are required:

- (1) A child may be enrolled within thirty (30) days of birth, adoption, or adoption placement date, during open enrollment, or within thirty (30) days of a qualifying event as defined in Section G;
- (2) A member must provide eligibility documentation for the child, including a birth certificate, adoption certificate or court documents, and a Social Security number;
- (3) No child of a member may remain, or be enrolled, in the Health Service System past the maximum age of 26 except a disabled child as provided in Section 3d below;
- (4) Coverage will become effective on the first day of the coverage period following the receipt of all documentation by HSS by required deadlines;
- (5) Recertification of eligibility may be required as determined by HSS.

b. Eligibility Requirements for Children Under Legal Guardianship

To be eligible, a child under legal guardianship of a member, a member's enrolled spouse, or member's enrolled domestic partner, must meet all of the following criteria.

- (1) Child must be under 19 years of age;
- (2) Child may be enrolled within 30 days of the effective date of legal guardianship, during open enrollment, or within thirty (30) days of a qualifying event as defined in Section G.
- (3) The member must provide eligibility documentation, including a copy of the legal judgment or decree assigning legal guardianship and a Social Security number;
- (4) Coverage will become effective on the first day of the coverage period following the receipt of all documentation by HSS by required deadlines;
- (5) Recertification may be required as determined by HSS.
- (6) Grandchildren, nieces and nephews, the spouse of a member's child and other relatives or children of no family relation residing with a member are not eligible to be enrolled in an HSS administered health plan unless the child meets the qualifications for a child under legal guardianship.

c. Eligibility Requirements for Children Under Court Order

For the child to be eligible, a member must be required by judgment, decree or order issued by a court to provide health coverage for the child. All of the following criteria must be met:

- (1) Child must be under 19 years of age;
- (2) The member must provide HSS with a copy of the court order and the child's Social Security number;
- (3) Recertification may be required as determined by HSS.

d. Age Exemption for Eligible 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: Disabled adult child ("Adult Child") is enrolled in a San Francisco Health Service System medical plan on the his or her 26th birthday; and

- (1) Adult Child has met the requirements of being an eligible dependent child under Section B.3 before turning 26 years old; and
- (2) 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
- (3) Adult Child is incapable of self-sustaining employment due to the physical or mental disability; and

- (4) Adult Child is dependent on HSS Member for substantially all of his or her economic support, and is declared as an exemption on the Member's federal income tax;
- (5) Member is required to comply with their enrolled medical plan's disabled dependent certification process and recertification process every year thereafter or upon request.
- (6) All enrolled dependents, including an Adult Child, who qualify for Medicare due to a disability are required to enroll in Medicare (See Section J). Members must notify HSS of any dependent's eligibility for Medicare, as well as any dependent's subsequent enrollment in Medicare.
- (7) To maintain ongoing eligibility after the Adult Child has been enrolled, the Member must continuously enroll the Adult Child in an HSS medical plan without interruption and must ensure that the Adult Child remains continuously enrolled with Medicare A/B (if eligible) without interruption.

A newly hired employee who adds an eligible dependent Adult Child, who is age 26 or older, must meet all requirements listed, except d.(1) and d.(2) above and comply with their enrolled medical plan's disabled dependent certification process specified in d. (5) within (30) days of employee's hire date

4. Eligibility Requirements for Surviving Dependents

a. Surviving Spouse or Surviving Domestic Partner of an Active Employee Hired Before January 10, 2009

The surviving spouse or surviving domestic partner of an active employee hired before January 10, 2009 is eligible to enroll, provided that the surviving spouse or surviving domestic partner and the active employee had been married or registered as domestic partners for a period of at least one (1) year prior to the death of the active employee.

b. Surviving Spouse or Surviving Domestic Partner of an Active Employee Hired On or After January 10, 2009

1. The surviving spouse or surviving domestic partner of an active employee hired on or after January 10, 2009 is eligible to enroll if the deceased employee had accrued ten (10) or more years of credited service (as determined by HSS). The surviving spouse or surviving domestic partner and the active employee must have been married or registered as domestic partners for a period of at least one (1) year prior to the death of the active employee.
2. The surviving spouse or surviving domestic partner of an active employee hired on or after January 10, 2009, who died in the line of duty is eligible to enroll if the surviving spouse or surviving domestic partner is entitled to a death allowance as a result of the death in the line of duty. The surviving spouse or surviving domestic partner and the active employee must have been

married or registered as domestic partners for a period of at least one (1) year prior to the death of the active employee.

3. The surviving spouse or surviving domestic partner of an active member hired on or after January 10, 2009, who did not accrue ten (10) years of credited service (as determined by HSS) or who did not die in the line of duty with death allowance entitlement is not eligible.
4. The surviving spouse, or surviving domestic partner, and eligible dependent children of a firefighter or peace officer who died in the line of duty, is entitled to health benefits under the same terms and conditions provided prior to the death. (see Section 4856 of the California Labor Code).

c. Surviving Spouse or Surviving Domestic Partner of a Retired Member Hired Before January 10, 2009

The surviving spouse or surviving domestic partner of a Retiree Member who was hired before January 10, 2009 is eligible to enroll provided that the surviving spouse or surviving domestic partner and the Retiree Member have been married or registered as domestic partners for a period of at least one (1) year prior to the death of the Retiree Member.

d. Surviving Spouse or Surviving Domestic Partner of a Retired Member Hired On or After January 10, 2009

1. The surviving spouse or surviving domestic partner of a Retiree Member who was hired on or after January 10, 2009 is eligible to enroll if the deceased member had accrued ten (10) or more years of credited service (as determined by HSS) and retired within 180 days of separation from employment. The surviving spouse or surviving domestic partner and the retired member must have been married or registered as domestic partners for a period of at least one (1) year prior to the death of the Retiree Member.
2. The surviving spouse or surviving domestic partner of a deceased Retiree Member who was hired on or after January 10, 2009, and who retired with a disability retirement from their retirement system, is eligible to enroll if the surviving spouse or the surviving domestic partner and the Retiree Member were married or registered as domestic partners for a period of at least one year prior to the death of the retiree member.
3. The surviving spouse or surviving domestic partner of a Retiree Member hired on or after January 10, 2009, who did not accrue ten (10) years of credited service (as determined by HSS) or did not retire within 180 days of separation from employment, is not eligible.

e. Eligibility Requirements for Surviving Dependent Children

Surviving dependent children of an active employee or Retiree Member must have been enrolled on the member's coverage at the time of the member's death, must meet eligibility requirements in B.3, and are only eligible for benefits under a surviving spouse member or a surviving domestic partner member.

f. Additional Surviving Dependent Enrollment Requirements

- (1) The surviving spouse or surviving domestic partner of a deceased Resigned Member is not eligible.
- (2) Because they are dependents themselves, surviving spouses and surviving domestic partners do not have the member privilege of enrolling any individuals as additional dependents on their coverage. A surviving dependent cannot enroll additional dependents, including children not enrolled at the time of the member's death, or a new spouse or domestic partner.
- (3) Eligible surviving dependents may continue enrollment if they complete the surviving dependent enrollment process within thirty (30) days of a member's death. They may continue to be enrolled as long as they remain eligible. An eligible surviving spouse or domestic partner not enrolled within thirty (30) days of the member's death is eligible for coverage but must wait for the next open enrollment period or other qualifying event.
- (4) Surviving dependents of a firefighter or peace officer killed in the line of duty are eligible for subsidized benefits at the active rate unless a lump sum survivor's benefit is elected (*section 4856 of the State of California Labor Code*).
- (5) See Section P for rules regarding surviving dependent premium contributions, employer subsidy and delinquency.

C. ELIGIBILITY DOCUMENTATION REQUIRED**1. Members**

All members are required to provide eligibility documentation as requested by the Health Service System and as required under federal, state or local law. Failure to provide eligibility documentation as required shall result in termination of coverage.

2. Dependents, Including Eligible Spouses, Domestic Partners, Children and Surviving Dependents

The Health Service System may require proof of dependent eligibility at any time. Failure to furnish such proof within thirty (30) days after a request by the Health

Service System shall result in termination of coverage. Re-enrollment may occur during annual open enrollment, with coverage effective the first day of the following plan year, upon submission to the Health Service System of a completed enrollment application and required eligibility documentation.

3. Social Security Numbers Required

All members are required to provide the Health Service System with Social Security numbers for themselves and all enrolled dependents. The failure to provide Social Security numbers will result in the termination of health coverage administered by the Health Service System. Exceptions can be made on a case-by-case basis for members and dependents who do not qualify for Social Security numbers upon approval of the Health Service System Director.

4. Member Addresses Required

All members are required to keep a current residential and mailing address on file with the Health Service System. Members must report address changes to the Health Service System within thirty (30) days. Members are responsible for promptly responding to notices mailed by the Health Service System to the address on file with HSS. Health care coverage may be terminated for members who do not keep their address and contact information updated at HSS. The Health Service System will document a minimum of five attempts over a period of two years to contact a member whose address and contact information on file with the Health Service System is incorrect. After five attempts, the member's health benefits will be terminated. A member terminated for failure to keep current his or her address and contact information may seek reinstatement during the next open enrollment period.

D. TAXATION OF HEALTH BENEFITS OF A DOMESTIC PARTNER

Premium contributions for the domestic partner's health coverage may or may not be eligible for pre-tax treatment contingent on applicable federal and state income tax law. Thus, coverage of the domestic partner dependent could result in additional imputed income to the member, with possible withholding for payroll taxes, including income and Social Security taxes, on such amounts.

Members who file a *Declaration That Enrolled Dependent Meets IRS Standard For Pre-Tax Health Premium Deduction* form with HSS will pay member health premium contributions for the domestic partner and/or the partner's children on a pre-tax basis effective the first day of the coverage period following the date in which HSS receives the form. Imputed income will not accrue for the employer's portion of premium contributions for qualifying dependents.

Changes in a dependents tax status cannot be made retroactively. An Annual declaration must be filed for each qualifying dependent.

E. MEMBER RESPONSIBILITY TO NOTIFY HEALTH SERVICE SYSTEM WHEN A DEPENDENT BECOMES INELIGIBLE

It is the responsibility of the member to provide immediate written notification to the Health Service System when canceling coverage for any dependent who no longer meets the conditions for eligibility. There shall be no obligation on the part of the Health Service System to provide health coverage to, or refund contributions made on account of, an ineligible dependent. If a member fails to notify the Health Service System when an enrolled dependent becomes ineligible the member may be held responsible for payment of all health premium costs, including but not limited to any employer premium costs and costs for medical services provided, dating back to the date of the dependent's ineligibility.

Dependent eligibility may be audited by HSS at any time. Audits may require submission of documentation that substantiates and confirms that the dependent's relationship with the employee or retiree is current. Acceptable documentation may include, but is not limited to, current federal tax returns and other documentation that demonstrates cohabitation or financial interdependency.

Enrollment of a dependent who does not meet the plan's eligibility requirements as stated in Health Service System Rules and enrollment materials, or failure to disenroll when a dependent becomes ineligible, will be treated as an intentional misrepresentation of a material fact, or fraud.

F. OPEN ENROLLMENT PERIOD

The Health Service System shall conduct an annual open enrollment for a period of three to four weeks as approved by the Health Service Board.

1. A member may change benefit plan elections and add or cancel dependents during open enrollment.
2. A member must submit all required enrollment applications and eligibility documentation by the open enrollment due date established by the Health Service System.
3. A retiree may waive medical coverage at any time. A retiree may only waive dental coverage for themselves and enrolled dependents during open enrollment, unless there is a qualifying event. (See Section G.)
4. Dependents that are deleted from coverage during open enrollment are not eligible for COBRA continuation coverage.
5. All changes made during the annual open enrollment period shall be effective on the first day of the following plan year.
6. If no changes are elected during open enrollment, current medical, dental and vision plan elections and enrolled dependents will remain the same.

Flexible Spending Accounts (FSAs) require annual enrollment. HSS administers a Child Care Dependent Care FSA and a Healthcare FSA with Carryover. Carryover allows unused health FSA balance of a \$10 minimum up to a \$550 maximum to be carried forward for one plan year after which any remaining carryover funds will be forfeited. The health FSA carryover option (from \$10 to \$550) is independent of the annual FSA election requirement. Child Care Dependent Care FSA
SFHSS Rules for Plan Year 2021.

does not have a Carryover provision.

G. QUALIFYING STATUS CHANGES AND OTHER APPLICABLE EVENTS FOR CHANGING BENEFIT ELECTIONS OUTSIDE OF THE OPEN ENROLLMENT PERIOD

For enrollments due to a qualifying change in status, or other qualifying applicable event, the member must notify the Health Service System and complete the enrollment process, including the submission of all required eligibility documentation, no later than thirty (30) calendar days after the qualifying event.

A member may make a benefit election change, healthcare and/or dependent care Flexible Spending Account (FSA) change due to a qualifying status change a maximum of twice per plan year.

The following qualifying status changes, or other applicable events, allow a member to make benefit election changes, healthcare and/or dependent care Flexible Spending Account (FSA) changes outside of open enrollment so long as the election change is a result of and consistent with, the change in status.

1. Change in Legal Marital or Partnership Status

a. Marriage

A member's marriage allows the member to add his or her new spouse and eligible stepchildren, as defined in Section B.3., to his or her existing HSS coverage or, in the alternative, drop his or her existing HSS coverage by joining the spouse's employer coverage and providing Proof of Coverage on spouse's coverage within 30 days of the coverage's effective date.

b. Domestic Partnership

A member's domestic partnership allows the member to add his or her new partner and eligible stepchildren, as defined in Section B.3., to his or her existing coverage or, in the alternative, drop his or her HSS coverage by joining the domestic partner's employer coverage and providing Proof of Coverage on domestic partner's coverage within 30 days of the coverage's effective date.

c. Divorce, Legal Separation, Annulment or Dissolution of Partnership

In the event of divorce, legal separation, annulment or dissolution of domestic partnership, a member must immediately terminate health coverage for the ex-spouse or domestic partner and any accompanying covered stepchildren. A member will be responsible for the full cost of all health premiums back to the date of the dependent's ineligibility for failure to terminate health coverage within 30 days for the ex-spouse, domestic partner or any accompanying covered stepchildren. (See Section E regarding member responsibilities for timely notification of ineligible dependents and dependent eligibility audit requirements.)

2. Change in Number of Dependents

a. Birth

b. The birth of a child allows the member to add the child to his or her existing coverage. Adoption and Placement for Adoption

The adoption and placement for adoption of a child allows the member to add the child to his or her existing coverage.

c. Legal Guardianship

If an enrolled member, or the member's spouse or domestic partner, assumes legal guardianship of a child, the member may add the child to his or her existing coverage outside of open enrollment.

d. Court Order

If a court orders an enrolled member to provide health coverage for a child, the member may add the child to his or her existing coverage outside of open enrollment. The member may also cancel health coverage if the court orders coverage to be provided by someone else. Dependent care Flexible Spending Account contributions cannot be modified due to this status change.

3. Change in the Employment Status of Spouse, Domestic Partner, or Other Dependent

a. Loss of Other Coverage

Members and eligible dependents that lose other coverage may be enrolled in Health Service System coverage. Proof of loss of coverage must be provided by the HSS member.

(1) Termination of Employment

If a member or eligible dependent loses other coverage due to employment termination, the member may enroll his or herself, and/or the member's spouse, domestic partner, and any affected eligible children, in HSS health coverage within thirty (30) days of the loss of coverage. Proof of loss of coverage is required. The member also has the option of initiating or modifying healthcare and dependent care Flexible Spending Account contributions.

(2) Change from Full-Time to Part-Time Employment

If a member or enrolled dependent loses other coverage, or cannot afford other coverage, due to a change from full-time to part-time employment, the member may enroll his or her self, and the member's spouse, domestic partner and any affected eligible children, within thirty (30) days of the change in employment status. Proof of loss of coverage is required. The member also has the option of initiating or modifying healthcare and dependent care Flexible Spending Account contributions.

(3) Open Enrollment Under Dependent's Employer

If a dependent drops coverage during his or her employer's open enrollment period, the member may add his or her self, spouse, domestic partner and any affected eligible children, to HSS health coverage within thirty (30) days of the loss of coverage. Proof of loss of coverage is required. The member also has the option of initiating or modifying dependent care Flexible Spending Account contributions. Healthcare Flexible Spending Account contributions cannot be modified.

(4) Commencement of an Unpaid Leave of Absence

If a dependent loses other coverage due to an unpaid leave of absence, the member may enroll the spouse, domestic partner and any affected eligible children, on HSS health coverage within thirty (30) days of the loss of coverage. Proof of loss of coverage is required. The member also has the option of initiating or modifying healthcare and dependent care Flexible Spending Account contributions.

(5) Loss of Medicare or Medicaid

If a member or eligible dependent loses other coverage due to ineligibility for Medicare or Medicaid, that individual may be enrolled on HSS health coverage within thirty (30) days of the loss of coverage. Proof of loss of coverage is required. The member also has the option of initiating or modifying healthcare Flexible Spending account contributions. Dependent care Flexible Spending Account contributions cannot be modified due to this status change.

b. Gain of Other Coverage

Members and eligible dependents that gain other coverage may be disenrolled from Health Service System coverage. Proof of gain of other coverage must be provided by the HSS member.

(1) Commencement of Employment

If an enrolled dependent gains other coverage due to new employment, the member may waive HSS coverage for his or her self, and/or drop dependent(s) from HSS coverage within thirty (30) days of the date the other coverage begins. (If member waives coverage, dependent coverage must also be dropped.) Proof of gain of other coverage is required. The member also has the option of modifying healthcare and dependent care Flexible Spending Account contributions.

(2) Change from Part-Time to Full-Time Employment

If an enrolled member or dependent gains other coverage due to the dependent's change from part-time to full-time employment, the member may waive coverage for his or her self, and/or drop dependent(s) from HSS coverage, within thirty (30) days of the date other coverage begins. Proof of gain of other coverage is required. The member also has the option of modifying healthcare and dependent care Flexible Spending Account contributions.

(3) Open Enrollment Under Dependent's Employer

If an enrolled member or dependent gains other coverage during the open enrollment period of the dependent's employer, the member may drop waiver coverage for his or her self, and/or drop dependent(s) from HSS coverage within thirty (30) days of the date other coverage begins. (If member waives coverage, dependent coverage must also be dropped.) Proof of gain of coverage is required. The member also has the option of modifying dependent care Flexible Spending Account contributions. Healthcare Flexible Spending Account contributions cannot be changed due to this status change.

(4) Return From an Unpaid Leave of Absence

If an enrolled member or dependent gains other coverage upon the dependent's return from an unpaid leave-of-absence, the member may waive coverage for his or her self, and or drop dependent(s) from coverage within thirty (30) days of the date other coverage begins. Proof of gain of other coverage is required. The member also has the option of modifying healthcare and dependent care Flexible Spending Account contributions.

(5) Entitlement to Medicare or Medicaid

If the member or dependent gains other coverage due to eligibility for Medicare or Medicaid, the member may waive coverage for his or her self, and drop dependents from HSS coverage, consistent with the entitlement change. Proof of gain of Medicare or Medicaid coverage is required. The member also has the option of modifying healthcare Flexible Spending Account contributions. Dependent care Flexible Spending Account contributions cannot be changed due to this status change.

4. An Active Employee Member May Drop Coverage for Self or Dependents Outside of Open Enrollment Only with Proof of Other Coverage that was effective within the last 30 days

5. A Retiree Member May Waive Medical Coverage for Self or Dependents at Any Time Outside of Open Enrollment by Submitting Required Forms to HSS

If a Retiree Member waives coverage, he or she may not re-enroll self or dependents until the next open enrollment or outside of open enrollment if there is a qualifying event as defined in Section G. (Retirees may not waive dental coverage outside of open enrollment unless there is a qualifying event as defined in Section G.)

6. A Surviving Dependent May Waive Medical Coverage for Self or Dependents at Any Time Outside of Open Enrollment by Submitting Required Forms to HSS

If surviving spouse or domestic partner waives coverage, he or she may not re-enroll until the next open enrollment, or if there is a qualifying event as defined in Section G. If coverage is waived for surviving eligible children those children cannot be re-enrolled.

7. Significant Change in Health Coverage During a Plan Year

If there is a mid-year change in coverage such as a substantial decrease in medical providers under a plan, or a significant increase in deductible, copayment or out-of-pocket limits, the Health Service Board may direct HSS to allow mid-year plan changes due to this applicable event. When so directed, a member may elect to drop HSS coverage or change HSS coverage options. Healthcare Flexible Spending Account contributions cannot be changed due to this status change.

8. Dependent Care Flexible Spending Accounts: Significant Change in Dependent Care Costs

If there is a significant increase or decrease in the cost for dependent care, the member may increase or decrease dependent care flexible spending contributions. This is allowed only if the cost change is required by a dependent care provider who is not a relative of the member. Proof of cost change is required.

H. TRANSFER OF HEALTH BENEFIT PLANS

The application to change from one health benefit plan to another may be made only during the annual open enrollment period each year with coverage to become effective the first day of the following plan year, unless otherwise provided for by these Rules.

1. Members Moving Primary Residence Outside a Health Benefit Plan Service Area

Members who move their primary residence to a location outside their health plan's service area will no longer be able to obtain services through that plan. Members will need to enroll in a different HSS plan that offers services based on the new primary address. A member must complete an HSS application to elect a new plan within thirty (30) days of his or her move. Coverage in the new plan will be effective the first day of the coverage period following the date HSS receives the completed enrollment application. Coverage will be terminated for active employee members who move their primary residence outside their health plans service area and do not enroll in a new plan within thirty (30) days of their move. Retiree Members who move their primary residence outside the service area of their health plan service area and do not enroll in a new plan in thirty (30) days will automatically be moved to City Health Plan.

2. Members Residing Temporarily Outside a Health Benefit Plan Service Area for Six or More Months

A member who is leaving the area of service of a health benefit plan temporarily for a period in excess of six (6) months may apply for a transfer to a health benefit plan servicing the area of residence. Application must be submitted to the Health Service System in writing at least thirty (30) days prior to the member's leaving the service area of the current plan. Transfer into the new health benefit plan shall become effective on the first day of the coverage period after such application is received by Health Service System. A member may return to the original health benefit plan, if written application to the Health

**Service System is made within thirty (30) days of return to the area of service.
Retirees Establishing Permanent Residence Outside of the United States**

- a. Retiree Members and dependents, regardless of health benefit plan, who reside outside of the United States are required to enroll in the City Health Plan or temporarily waive coverage.
- b. Medicare enrollment is not required for members residing outside the United States; however, services within the United States will not be covered if Medicare enrollment is waived or discontinued. Members will be required to complete an HSS form certifying that they are waiving Medicare enrollment. and waiving health coverage within the United States.
- c. For retired members and dependents who reside outside the United States and continue their Medicare enrollment, services within the United States will be covered. Services outside the United States will be paid at the out-of-area reimbursement rate.
- d. Applications must be made thirty (30) days in advance of leaving the United States. Members who establish permanent residency outside the United States may retain coverage and must make the required premium payments directly to the Health Service System by the applicable due dates.

3. Members Enrolled in a Discontinued Health Benefit Plan

Members of a health benefit plan discontinued during the benefit year will be provided a special enrollment period to select an alternative health benefit plan. A member who does not enroll in an alternate health benefit plan during the special enrollment period will automatically be enrolled in the City Health Plan.

4. School Term Employees

School term employees of the San Francisco Unified School District or San Francisco Community College District may not transfer plans, or add dependents to their existing plans, during the open enrollment period unless they continue group coverage for the summer months.

5. Entitlement to Medicare

If a retired member or their dependent becomes entitled to Medicare, the member or dependent will need to transfer to a Medicare Advantage Plan in order to maintain HSS coverage if no Medicare Advantage and Medicare Prescription Drug Plan is available in their pre-Medicare plan. (See Section J & K)

I. CONTINUATION OF HEALTH BENEFITS COVERAGE AFTER RETIREMENT

1. Service, Disability or Vesting Retirement for Members Who Have Been Enrolled in Health Service System Health Benefit Plans While Actively Employed

A member who retires for service, disability or vesting may continue coverage through the Health Service System at the rate established for retired employees, provided he or she applies for continuation of coverage within thirty (30) days after such retirement is approved by his or her retirement system. Thereafter, application for enrollment may be made only during open enrollment, with coverage to become effective the first day of the following plan year. In addition to Health Service System requirements, San Francisco Unified School District and San Francisco Community College District employees must meet their employer's respective eligibility requirements. To be eligible for health benefits at the premium contribution rate established for retirees, a member must have been enrolled in a health benefit plan through the Health Service System for some period during his or her term of employment with the City & County of San Francisco, the San Francisco Unified School District or the San Francisco Community College District.

2. Service, Disability or Vesting Retirement for Members Who Have Not Been Enrolled in Health Service System Health Benefit Plans While Actively Employed

Per City Charter Section A8.428, an individual who would qualify for coverage under Section I.1. above, but for the fact that he or she has never been enrolled in a health benefit plan through the Health Service System for some period during his or her term of employment with the City & County of San Francisco, San Francisco Unified School District or San Francisco Community College District, may enroll in a health benefit plan as described in Section I.1., except that he or she shall pay the full, unsubsidized rate. The full, unsubsidized rate is the total premium paid to the health plan consisting of both the retiree contribution and the employer contribution.

3. Resigned Retiree Members

A member who resigned, and withdrew his or her funds from a retirement system within thirty (30) days immediately prior to the date on which, but for his or her resignation, he or she could have been retired for service as a member of a retirement system, may continue coverage at the full unsubsidized rate for resigned employees as established by the Health Service Board under the provisions of Charter Section A8.425. A Resigned Member also includes teachers who moved funds from the San Francisco Employees Retirement System (SFERS) to the State Teachers Retirement System (STRS). Such Resigned Members must apply for

continuation of coverage within thirty (30) days after resignation. Such Resigned Members (including surviving spouse dependents) must make arrangements to pay contributions monthly in advance to the Health Service System by the applicable due dates. Coverage of a Resigned Member must be continuous and, if lapsed, cannot be reinstated without Health Service Board approval.

4. Retiree Premium Contribution Payments Required

If sufficient funds are available, the Health Service System requires all premium payments to be deducted from the retiree member's pension check. If sufficient funds are not available, the retiree must make required premium contributions directly to the Health Service System by applicable due dates. Failure to make premium contributions by the applicable due dates may result in termination of coverage.

5. Retiree Must Notify the Health Service System of Current Primary Address

A retiree member who is enrolled in a Health Service System administered health benefit plan must maintain his or her correct primary residential address on file with the Health Service System and notify the Health Service System within thirty (30) days of any primary address change. Change in primary residence may require a change in health plan. A retiree who becomes ineligible for coverage because he or she moves outside of the plan's service area may be required by the plan to pay for all services received while ineligible.

Health care coverage may be terminated for members who do not keep their address and contact information updated at HSS. The Health Service System will document a minimum of five attempts over a period of two years to contact a member whose address and contact information on file with the Health Service System is incorrect. After five attempts, the members' health benefits will be terminated. A member terminated for failure to keep current his or her address and contact information may seek reinstatement during the next open enrollment period.

J. REQUIRED MEDICARE ENROLLMENT

Medicare is a federal health insurance program for people age 65 years or older, under age 65 with a Social Security-qualified disability, and people of any age with End-Stage Renal Disease. The different parts of Medicare help cover specific services: Part A covers hospital insurance; Part B covers medical insurance; and Part D covers prescription drug insurance. (See medicare.gov.)

1. Active Employee Members Age 65 and Over

All active employees over the age of 65 have the option, but are not required, to enroll in non-contributory Medicare Part A and contributory Medicare Part B as soon as they are eligible.

2. Dependents of Active Employee Members

Subject to CMS rules, all married spouses, natural children, step children, adopted children or children under legal guardianship of an active member who are Medicare-eligible due to either age or disability, have the option, but are not required, to enroll in non-contributory Medicare Part A and contributory Medicare Part B as soon as they are eligible.

Subject to CMS Rules, all domestic partner dependents of active employee members who are Medicare-eligible must enroll in both non-contributory Medicare Part A and contributory Medicare Part B as soon as they become eligible. (Some dependents will only qualify for Medicare Part B.) If an active employee member's domestic partner is Medicare-eligible but fails to enroll in either non-contributory Medicare Part A or contributory Medicare Part B that dependent's HSS medical coverage will be terminated.

3. Retiree Members

Retiree Members who are Medicare-eligible due to either age or disability must enroll in both non-contributory Medicare Part A and contributory Medicare Part B. (Some retired members will only qualify for Medicare Part B.) It is the responsibility of the member to notify the Health Service System of Medicare eligibility and enrollment. A Retiree Member who is eligible but fails to enroll in both non-contributory Part A and in contributory Part B of Medicare, will be automatically transferred to the City Health Plan 20 until proof of Medicare enrollment is provided. City Plan 20 provides coverage at a higher out-of-pocket cost to the Retiree Member.

4. Dependents of Retiree Members

All dependents of Retiree Members who are eligible due to either age or disability must enroll in both non-contributory Medicare Part A and contributory Medicare Part B. If a dependent is eligible but fails to enroll in either non-contributory Part A or contributory Part B of Medicare that dependent's coverage will be terminated. (Some dependents will only be eligible for Medicare Part B.)

K. MEDICARE ADVANTAGE ENROLLMENT

Medicare Advantage and Medicare Prescription Drug program (MAPD) participation is required for all Medicare-eligible Retiree Members and dependents who are enrolled in a plan administered by HSS. Retiree Members who fail to maintain enrollment in non-contributory Medicare Part A, Medicare Part B or Medicare Part D will need to waive their coverage or will be automatically transferred to the City Health Plan 20. City Plan 20 provides coverage at a higher out-of-pocket cost to the Retiree Member. (See Section J.)

L. DUAL HEALTH PLAN COVERAGE RESTRICTIONS

1. No Dual Health Service System Coverage

Health Service System members and their dependents cannot be enrolled in two administered medical or dental plans at the same time. In other words, members may not be enrolled in an HSS-administered plan or plans both as a member and as a dependent of another member. If dual enrollment elections are submitted, HSS will automatically eliminate dual coverage as follows:

- a. For any member who is covered both as a member and as a dependent of another member, coverage as a dependent will be terminated.
- b. For dependents who are covered by two different HSS members, the dependent(s) will be covered by the member who covered the dependent(s) first based on date of enrollment.

2. No Dual Medicare Coverage

3. **For the HSS Medicare Advantage or Medicare-sponsored plans, members and their dependents enrolled in these plans cannot be simultaneously enrolled in a non-HSS administered Medicare plan. Medicare will allow only the most recent enrollment to apply and will require disenrollment from the prior plan. Other non-Medicare Dual Coverage Must Be Disclosed to the Health Service System.**

Health Service System members are required to disclose to HSS dual health plan coverage for the member and any enrolled dependents. Other medical or dental coverage through a spouse or domestic partner's employer, the Veterans Administration, Tricare or other government health program, a retirement benefit from a previous employer, or a second employer must be disclosed to HSS during open enrollment and with any mid-year status changes.

M. MEMBER HEALTH BENEFITS COVERAGE PERIODS

1. Coverage Effective Date

Coverage shall be effective as set forth below. See Appendix A for coverage period schedules for the current plan year.

a. Eligible Permanent, Provisional and Temporary Exempt Employees of the City & County of San Francisco and Other Designated Employers

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
1 st thru 31 st	1 st day of the following coverage period
Health and Dependent Care Flexible Spending Accounts	1 st day of the following coverage period

b. Eligible Commissioners of the City & County of San Francisco

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
1 st thru 31 st	1 st day of the following coverage period

c. Eligible Employees of the San Francisco Unified School District

(i) Monthly

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
1 st thru 31 st	1 st day of the following coverage period

(ii) Bi-Weekly

COVERAGE EFFECTIVE DATE
First day of the pay period following the Eligibility Event Date

d. Eligible Employees of the San Francisco Community College District

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
1 st thru 15 th	16 th of that month
16 th thru 31 st	1 st day of the following coverage period

2. Coverage Termination Date

Coverage shall terminate as set forth below:

a. Eligible Permanent, Provisional and Temporary Exempt Employees of the City & County of San Francisco and Other Designated Employers

ELIGIBILITY EVENT DATE	COVERAGE TERMINATION DATE
1 st thru 31 st	Last day of the coverage period for which the employee premium contributions have been made in full
Health and Dependent Care Flexible Spending Accounts	Last day of the coverage period for which the employee premium contributions have been made in full

b. Eligible Commissioners of the City & County of San Francisco

ELIGIBILITY EVENT DATE	COVERAGE TERMINATION DATE
1 st thru 31 st	Last day of the coverage period for which the employee premium contributions have been made in full

c. Eligible Employees of the San Francisco Unified School District

(i) Monthly

ELIGIBILITY EVENT DATE	COVERAGE TERMINATION DATE
1 st thru 31 st	Last day of the coverage period for which the employee premium contributions have been made in full

(ii) Bi-Weekly

COVERAGE TERMINATION DATE
Last day of the pay period following the eligibility event date

d. Eligible Employees of the San Francisco Community College District

ELIGIBILITY EVENT DATE	COVERAGE TERMINATION DATE
1 st thru 15 th	15 th of that month
16 th thru 31 st	Last day of the coverage period for which the employee premium contributions have been made in full

e. Termination Date for Deceased Eligible Members

COVERAGE TERMINATION DATE
Coverage terminated as of the day after death

N. DEPENDENT HEALTH BENEFITS COVERAGE PERIODS

1. Coverage Effective Dates

Eligibility qualification requires submission of completed application form and other required documentation to the Health Service System within thirty (30) days of a qualifying event. Coverage shall be effective as set forth below. See Appendix A for coverage period schedules for the current plan year.

a. Eligible Dependents

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
At the time of member's original enrollment	1 st day of the coverage period after a completed application is filed with the Health Service System

A member may enroll his eligible dependents at the time of original enrollment. Coverage for eligible dependents becomes effective on the same day as the member. However, a dependent that is hospital-confined at the time of the member's original eligibility shall be added effective on the date he or she is no longer hospital confined. Eligibility documentation is required.

b. Eligible Spouses, or Domestic Partners, and Other Eligible Dependents Acquired By Marriage or Domestic Partnership

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days after the date of marriage or domestic partnership	1 st day of the coverage period after a completed application is filed with the Health Service System

An active employee or Retiree Member, who marries or enters into a domestic partnership after becoming a member, may enroll his or her spouse or domestic partner and other eligible dependents acquired by marriage or domestic partnership. Enrollment is to be made within thirty (30) days after the date of marriage or domestic partnership, and coverage for eligible dependents so enrolled shall become effective as of the 1st day of the coverage period after a completed application is filed with Health Service System. However, a hospital-confined dependent shall be added effective the date he or she is no longer hospital confined. Documentation of marriage or domestic partnership is required.

c. Eligible Newborns

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days after birth or commencement of legal custody	The date of birth as long as a completed application is filed with the Health Service System within thirty (30) days of the date of birth

A member's newborn child must be enrolled in the Health Service System to have coverage, provided such enrollment is made within thirty (30) days after birth. Such enrollment shall be made by application to the Health Service System and shall be effective from the date of birth. Documentation of birth is required.

d. Eligible Adopted Children and Children Placed for Adoption

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of the commencement of legal custody or placement	The commencement of legal custody as long as a completed application is filed with the Health Service System within thirty (30) days of the date of adoption

An adopted child of a member (or member's spouse or domestic partner) may be enrolled, provided such enrollment is made within thirty (30) days of commencement of legal custody. Such enrollment shall be made by application to the Health Service System and shall be effective from the date on which such legal custody commenced. Documentation of adoption is required.

e. Limited Exceptions for Newborn and Adopted Child Enrollments

Notwithstanding the foregoing, after the expiration of the applicable period of thirty (30) days set forth in Sections N.1.c. and N.1.d. above, the Health Service System Director may permit the enrollment of a newborn child or a newly adopted child into a medical benefit plan offered by the Health Service System upon satisfaction of each of the following conditions:

- (1) The Director has found that the member has acted in good faith and not in willful violation of the rules contained in Sections N.1.c. and N.1.d. above;
- (2) The child's membership will be effective on the date of birth or the date of commencement of legal custody, as the case may be;

- (3) The Health Service System receives full payment of all premiums (both employer-paid and member-paid portions) required to enroll the child for the period from such effective date through the end of the current coverage period;
- (4) To comply with agreements established with the health benefit plan vendors, newborns must be enrolled within six (6) months of the date of birth to be eligible for coverage.

f. Eligible Dependent Children for Whom the Member (or Member’s Spouse or Domestic Partner) Has Assumed Legal Guardianship

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of commencement of legal guardianship	1 st day of the coverage period after a completed application is filed with the Health Service System

An eligible dependent child of whom the member (or member’s spouse or domestic partner) has assumed legal custody may be enrolled provided such enrollment is made within thirty (30) days of commencement of legal custody. Such enrollment shall be made by application to the Health Service System and shall be effective the first day of the coverage period after a completed application is filed with the Health Service System. Documentation of eligibility is required.

g. Other Eligible Dependents Who Have Entered the United States or Have Moved Into the Service Area of the Member’s Health Benefit Plan

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of the date the dependent changes his or her primary residence	1 st day of the coverage period after a completed application is filed with the Health Service System.

Other eligible dependents who have either entered the United States or have moved into the service area of the member’s health benefit plan may be enrolled provided such enrollment is made within thirty (30) days of the date the dependent changes his or her primary residence. Coverage will be effective on the first day of the coverage period after a completed application is filed with the Health Service System. Documentation is required.

h. Eligible Dependents Who Lose Group Health Insurance Coverage Through Job Displacement

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of the last date of group coverage under another employer.	1 st day of the coverage period after a completed application is filed with the Health Service System

Eligible dependents who lose group health insurance coverage through job displacement may apply for coverage through the Health Service System within thirty (30) days of the last date of group coverage under another employer. Such application for coverage requires a letter from the former employer or former health benefit plan vendor stating the reason for lost coverage and the last date of coverage. The approval or rejection of the application and effective date of any coverage other than listed above is subject to the discretion of the Health Service System.

i. Open Enrollment Coverage Effective Date

Dependents not enrolled by the member at the time of the member's enrollment, or within the applicable periods of eligibility as described in this Section M. may thereafter be enrolled only during open enrollment with coverage to be effective the first day of the following plan year. Documentation of eligibility is required.

O. WAIVING HEALTH BENEFITS COVERAGE (VOLUNTARY)

A member may waive coverage by submitting a completed HSS application form and requesting that coverage be waived. It shall be the sole responsibility of the member to apply for a coverage waiver in accordance with these Rules. Unless otherwise noted in the subsections below, if an enrolled member waives coverage for himself, herself or any enrolled dependents, the termination date of coverage will vary depending on the member's premium contribution dates and corresponding coverage periods.

1. Voluntary Waiver of Health Benefits Coverage

- a.** A member may elect to waive coverage when he or she first qualifies for Health Service System eligibility per Section A.
- b.** A member may elect to waive coverage during open enrollment by submitting all required forms and documentation to the Health Service System no later than the required deadlines. Disenrollment from benefit plans takes effect the first day of the following plan year.

- c. Based on the rules governing qualifying events set forth in Section G, a member may waive coverage outside of open enrollment by submitting required forms and documentation by the deadlines prescribed by the Health Service System.
- d. A retiree member may waive medical coverage for himself or herself or a dependent at any time by completing the Retiree Enrollment form and submitting to HSS for processing. Retiree dental coverage can only be waived during open enrollment, unless there is a qualifying event. (Section G.)
- e. A member may elect to waive enrollment in a health benefit plan for himself or herself, and any enrolled dependents, for the duration of an unpaid leave if appropriate notice and documentation is given to the Health Service System in advance or immediately upon the commencement of the unpaid leave. (See Section R.)

2. Duration of Voluntary Waived Health Benefits Coverage

- a. Waiver of coverage will remain in effect until lifted by the member, which shall only take place during the open enrollment or if there is a qualifying event. To enroll in coverage a member must complete the required enrollment application and submit required documentation to the Health Service System by applicable due dates.
- b. A member who has waived coverage and who loses group coverage through job displacement of a spouse or domestic partner may apply for coverage through the Health Service System within thirty (30) days of the last date of group coverage under the same provisions as provided for dependents in Section N.1.h.
- c. A member may waive coverage if other medical or dental coverage has been obtained. An application form and required documentation must be submitted to HSS within 30 days of the date other coverage begins. The waiver will be effective the first day of the coverage period following receipt of application. Exceptions to this rule may be made at the discretion of the Operations Manager.

3. Potential Impact of Waiving Employee Health Benefits on Eligibility For Retiree Health Benefits

Under City Charter Section A8.428, an active employee must participate in a Health Service System health plan while an active employee to qualify for participation in the Health Service System as a "Retired Person" at the rate established for retired employees after service, disability or vesting retirement. Charter Sections A8.428(a)(1) and (a)(4) require that "Retired Person(s)" be a "former member(s) of the Health Service System."

P. MEMBER PREMIUM CONTRIBUTIONS, EMPLOYER PREMIUM SUBSIDIES, AND DELINQUENCIES**1. Employer Premium Subsidy for Active Employee Members**

An active employee is eligible for the full employer contribution for their employer-subsided premium rate.

2. Employer Premium Subsidy for Retiree Members

- a) A Retiree Member hired before January 10, 2009 is eligible for the full employer contribution for his or her employer-subsidized premium rate with the following exception:
 - (1) A Retiree Member who retires after January 6, 2012, and who left employment before June 30, 2001, is not eligible for the Proposition E 50% reduction toward his or her premium (Charter Section A8.428(b)(3)(iii)) or the employer contribution of 50% of healthcare premiums for the first dependent (Charter Section A8.428(c)).
- b) A Retiree Member hired on or after January 10, 2009, who retired with a disability retirement, is eligible for the full employer contribution for his or her employer-subsidized premium rate.
- c) A Retiree Member hired on or after January 10, 2009, with ten (10) or more years of credited service (as determined by HSS), and who retires within 180 days of separation from employment, is eligible for the pro-rated employer contribution for his or her employer-subsidized premium rate based on the member's years of credited service:
 - (1) With twenty (20) or more years of credited service, the Retiree Member is eligible for the full employer contribution for his or her employer-subsided premium rate.
 - (2) With at least fifteen (15) years but less than twenty (20) years of credited service, the Retiree Member is eligible for the 75% employer contribution for his or her employer-subsided premium rate.
 - (3) With at least ten (10) years but less than fifteen (15) years of credited service, the Retiree Member is eligible for the 50% employer contribution for his or her employer-subsided premium rate.
 - (4) With at least five (5) years but less than ten (10) years of credited service, the Retiree Member must pay the full premium rate and is not eligible for any employer-subsided premiums.

3. Employer Premium Subsidy for Eligible Surviving Dependents of an Active Employee Member

- a) If the deceased active employee member was hired before January 10, 2009, the member's enrolled surviving spouse or surviving domestic partner is eligible for the full employer contribution for his or her employer-subsidized premium rate.
- b) If the deceased active member was hired on or after January 10, 2009 and had at least ten (10) years of credited service (as determined by HSS), the member's enrolled surviving spouse or surviving domestic partner is eligible for a pro-rated employer contribution rate, with an employer-subsidized premium rate based on the deceased member's years of credited service.
 - (1) The surviving spouse or surviving domestic partner of a deceased active member with twenty (20) or more years of credited service (as determined by HSS) will receive the full employer contribution to his or her employer-subsidized premium rate.
 - (2) The surviving spouse or surviving domestic partner of a deceased active member with more than fifteen (15) but less than twenty (20) years of credited service (as determined by HSS) will receive 75% of the employer contribution to his or her employer-subsidized premium rates.
 - (3) The surviving spouse or surviving domestic partner of a deceased active member with more than ten (10) but less than fifteen (15) years of credited service (as determined by HSS) will receive 50% of the employer contribution to his or her employer-subsidized premium rate.
 - (4) A surviving spouse or surviving domestic partner of a deceased active member who died in the line of duty, where the surviving spouse or surviving domestic partner is entitled to a death allowance, will receive the full employer contribution to his or her employer-subsidized premium rate.
 - (5) Surviving dependent children are charged the full premium and are not eligible for the employer-subsidized premium.

4. Employer Premium Subsidy for Eligible Surviving Dependents of a Retiree Member Hired Before January 10, 2009

A surviving spouse or surviving domestic partner of a deceased Retiree Member (as defined in Section A.8) hired before January 10, 2009, is eligible for the full employer contribution to his or her employer-subsidized premium rate.

5. Employer Premium Subsidy for Eligible Surviving Dependents of a Retiree Member Hired On or After January 10, 2009

- a. The surviving spouse or surviving domestic partner of a deceased Retiree Member who retired with a disability retirement under his or her retirement system is eligible for full employer contribution to his or her employer-subsidized premium rate.
- b. An enrolled surviving spouse or surviving domestic partner of a deceased Retiree Member who was hired on or after January 10, 2009, with at least ten (10) years of credited service (as determined by HSS), and retired within 180 days of separation from employment, is eligible for the pro-rated employer contribution rate for his or her employer-subsidized premium rate, based on the member's years of credited service:
 - (1) The surviving spouse or surviving domestic partner of a deceased Retiree Member with twenty (20) or more years of credited service (as determined by HSS) will receive the full employer contribution to their employer-subsidized premium rate.
 - (2) The surviving spouse or surviving domestic partner of a deceased Retiree Member with more than fifteen (15) but less than twenty (20) years of credited service (as determined by HSS) will receive 75% of the employer contribution to his or her employer-subsidized premium rate.
 - (3) The surviving spouse or surviving domestic partner of a deceased Retiree Member with more than ten (10) but less than fifteen (15) years of credited service (as determined by HSS) will receive 50% of the employer contribution to his or her employer-subsidized premium rate.

6. Additional Rules for Employer Premium Subsidy for Eligible Surviving Dependents

- a. A surviving spouse or surviving domestic partner of a retiree member may elect a lump-sum settlement without affecting eligibility (Section B.5) or the employer contribution to the employer-subsidized premium rate.
- b. The surviving spouse or surviving domestic partner who remarries, or enters into a new domestic partnership, does not lose his or her current coverage including current employer-subsidized premium rate. However, no new dependents can be added. (See section B.5.)
- c. Eligible surviving dependent children, designated as the first dependent, will receive the 50% employer Charter contribution toward the healthcare premiums of the retired Health Service System member's first dependent. Other eligible surviving dependent children are charged the full premium and are not eligible for the employer-subsidized premium rate.

7. Members and Surviving Dependents Not Subject to Payroll or Pension Deductions

- a.** It is the responsibility of the member, or surviving dependent, to make payments directly to the Health Service System for employee and retiree premium contributions which are not, or cannot be, made by payroll or pension deductions.
- b.** Members not subject to payroll, or retirement pension, deductions must pay the Health Service System directly by applicable due dates.
- c.** Premium contributions are due by the last day of the effective coverage period. See Appendix A.

8. Delinquent Payments

- a.** Any member premium contributions not paid when due shall constitute delinquent payments. After any payment becomes delinquent, the Health Service System shall provide to each affected member a notice of delinquency. Such notice shall be addressed to the current address on file with HSS and shall be sent by U.S. mail. Such delinquency notice shall indicate that, unless all premium contributions are paid by the due date specified, coverage shall be terminated on the last day of the coverage period in which full payment was made.
- b.** If member fails to pay all delinquent premium contributions not made by the due date specified in the notice, coverage shall be terminated as of the last day of the coverage period in which full payment was made. HSS shall provide each affected member, or surviving dependent, a notice of termination of coverage. If payment is made within 14 calendar days of notice of termination, HSS will reinstate coverage with a \$50 reinstatement charge.
- c.** Members, and surviving dependents, will be allowed one period of delinquent payment per benefit year. Repeated payment delinquency periods will result in termination of coverage.
- d.** Partial payment of delinquent premium contributions shall not be sufficient to avoid or delay termination. Any such partial payment received by the Health Service System shall be applied to the most delinquent full coverage period. Premium contributions insufficient for a full coverage period will be returned or refunded.
- e.** An employee member who does not make required premium contributions while on authorized leave will have his or her health plan benefits terminated. The health plan benefits in which he or she was enrolled prior to going on leave will resume on the first day of the coverage period following his or her return to active employee status, provided the employee notifies the Health Service System in writing within thirty (30) days of the date he or she returns to work.

- f. Notwithstanding anything to the contrary contained herein, if any applicable memorandum of understanding should require that the Health Service System continue coverage for any insured whose employee premium contributions are delinquent hereunder, then the Health Service System shall not terminate such insured so long as the insured's employer has provided written notice to the Health Service System of the memorandum of understanding, and all employee premium contributions are paid to the Health Service System by such employer when due.

Q. TERMINATION OF HEALTH BENEFITS COVERAGE (INVOLUNTARY)

1. Unless noted in the subsections below, termination date of coverage will vary depending on the member's premium contribution dates and corresponding coverage periods.
2. When a member is delinquent in the payment of employee or retiree premium contributions, benefits coverage for the member and any enrolled dependents will be terminated. (See Section P.8.)
3. If a member does not supply the Health Service System with all required eligibility documentation by required deadlines, including a Social Security number for himself or herself and/or any enrolled dependents, benefits coverage will be terminated. (See Section C: Eligibility Documentation Required.)
4. If a member does not maintain correct address and contact information on file with the Health Service System and cannot be contacted after a minimum of five attempts over two years to contact the member, benefits coverage will be terminated. **A member terminated for failure to keep current his or her address and contact information may seek reinstatement during the next open enrollment period.** (see Section C.4.)
5. Benefits of a member or dependent who becomes ineligible for any reason shall terminate on the last day of the coverage period for which full premium payments have been received. In the event that the date of ineligibility cannot be determined, termination shall be effective on the last day of the coverage period in which discovery of ineligibility occurs. (See Section E for member penalties that

will be incurred when a member fails to notify the Health Service System when a member's dependent becomes ineligible.)

6. Failure to comply with the conditions and requirements set forth in these Rules may result in retroactive termination of coverage.
7. Upon termination of a member's coverage, dependent coverage shall also be terminated.
8. An eligible member who has had benefits terminated may re-enroll himself or herself and his or her eligible dependents during annual open enrollment, with benefits coverage to commence the first day of the following plan year.

R. EMPLOYEES ON AUTHORIZED UNPAID LEAVE

Eligibility for membership in the Health Service System continues for the duration of all approved unpaid leaves. If an employee does not notify the Health Service System regarding his or her preference for either continuing or waiving coverage prior to going on authorized unpaid leave, existing health coverage will continue, and the employee will be responsible for making all required health premium payments to the Health Service System by applicable due dates. Employees must notify HSS in advance or immediately upon their leave to either waive coverage or arrange for payment of employee premium contributions while on leave.

1. Continuing Coverage While on Authorized Unpaid Leave

While on authorized leave, an employee can continue existing coverage for himself or herself and enrolled dependents. Employees may not make changes to medical or dental coverage after unpaid leave has begun. If an employee chooses to continue coverage while on authorized unpaid leave, he or she must make all required health premium payments directly to the Health Service System by applicable due dates. To return premium contributions to active status, employees must immediately notify the Health Service System—no later than thirty (30) days of returning to work.

2. Waiving Coverage While on Authorized Unpaid Leave

At any time during an authorized leave, an employee may waive his or her existing coverage. To waive coverage, an employee must notify the Health Service System and submit all required forms and documentation prior to the start of leave. Employee must immediately notify the Health Service System—no later than thirty (30) days of returning to work in order to resume coverage and return premium contributions to active status. Coverage will resume the first day of the next coverage period following HSS notification of return to work.

3. Educational Leave and Personal Leave

Membership in the Health Service System continues for the duration of the approved leave. For the first twelve (12) weeks, the City subsidy continues, and the member is only responsible for employee premium contribution amounts. If the approved leave continues beyond twelve (12) weeks, and the City subsidy ends, the member is responsible for paying the entire premium amount, which is the

combined total of the employee's and employer's premium contributions. Payments must be made directly to the Health Service System by the applicable due dates.

4. Leave for Employment as an Employee Organization Officer or Representative

Membership in the Health Service System continues for the duration of the approved leave. For the first twelve (12) weeks, the City subsidy continues, and the member is only responsible for employee premium contribution amounts. If the approved leave continues beyond twelve (12) weeks, and the City subsidy is discontinued, the member is responsible for paying entire premium contribution amount directly to the Health Service System by the applicable due dates. In certain cases, the union in which the member is serving will pay the cost of the member's health and/or dental insurance. In these cases, it is still the member's responsibility to make sure the premiums are paid. The Health Service System will not seek payment directly from the member's union.

5. Family Care Leave

While a member is on family care leave, Health Service System coverage continues as long as the member continues to pay any premium portion that was deducted from his or her paycheck. The City subsidy continues for the duration of the family care leave. The member is responsible for ensuring that the required health coverage payments are paid directly to the Health Service System by the applicable due dates.

6. Personal Leave Following Family Care Leave

If a member has been on family care leave, has maintained his or her health coverage, and continues his/her leave by personal leave for the same reason, then the City subsidy continues for the duration of the leave. The member is responsible for ensuring that the required health coverage payments are paid directly to the Health Service System by the applicable due dates.

S. COBRA CONTINUATION OF HEALTH BENEFITS COVERAGE

1. Pursuant to the federally mandated Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), and any subsequent federal legislation regarding COBRA, members and dependents who have lost coverage for the following reasons shall be entitled to elect COBRA continuation coverage under the Health Service System.

a. COBRA Qualifying Events for Employees

- (1) The employee’s employment is terminated (voluntarily or involuntarily) for reasons other than gross misconduct.
- (2) The employee’s regular work hours are reduced, resulting in loss of coverage.

b. COBRA Qualifying Events for an Employee’s Spouse or Legal Domestic Partner Who is Covered on the Employee’s Health Benefit Plan

- (1) Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- (2) Reduction in the hours worked by the covered employee
- (3) Covered employee's becoming entitled to Medicare
- (4) Divorce or legal separation of the covered employee
- (5) Death of the covered employee

c. COBRA Qualifying Events for Dependent Children Covered on an Employee’s Health Benefit Plan

- (1) Loss of dependent child status under either Health Service System or health benefit plan vendor rules
- (2) Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- (3) Reduction in the hours worked by the covered employee
- (4) Covered employee's becoming entitled to Medicare
- (5) Divorce or legal separation of the covered employee
- (6) Death of the covered employee

2. Duration of COBRA Coverage

The duration of COBRA coverage listed below may be extended (or shortened) in accordance with provisions in the original federal Act as well as subsequent federal and state legislation relating to COBRA.

COBRA QUALIFYING EVENT	INDIVIDUALS ELIGIBLE	DURATION OF COBRA COVERAGE
<ul style="list-style-type: none"> • Employee’s termination • Employee’s reduction in working hours 	<ul style="list-style-type: none"> • Employee • Spouse • Dependent child 	<p>18 months from date active employee coverage ends</p>

COBRA QUALIFYING EVENT	INDIVIDUALS ELIGIBLE	DURATION OF COBRA COVERAGE
<ul style="list-style-type: none"> • Covered employee’s death • Covered employee’s divorce or legal separation 	<ul style="list-style-type: none"> • Spouse • Dependent child 	<p>36 months from date active employee coverage ends</p>
<ul style="list-style-type: none"> • Loss of dependent child status 	<ul style="list-style-type: none"> • Child 	<p>36 months from date active employee coverage ends</p>

3. A COBRA-eligible individual who elects COBRA coverage will have a contribution rate which shall not exceed 102 percent of the applicable contract rate.
4. The deadlines for notices and payments shall be the same with respect to dependents as the deadlines applicable to employee members with COBRA coverage.
5. Dependents may elect continuation coverage for themselves as individuals, or in combination with each other and/or the eligible member, consistent with COBRA.
6. Employees and dependents who have exhausted continuation coverage under federal COBRA, may be eligible for Cal-COBRA if they are entitled to less than 36 months of federal COBRA. (Continuation coverage under both federal and state coverage will not exceed 36 months.) Self-funded plans, including UHC (City Plan), are not eligible for Cal-COBRA.

T. OTHER PUBLIC AGENCIES ELIGIBLE TO PARTICIPATE IN THE HEALTH SERVICE SYSTEM

1. Election to Participate

San Francisco Administrative Code Section 16.700 authorizes specified public agencies other than the City & County of San Francisco to participate in the Health Service System, and to determine, by resolution of the appropriate governing body, the officers and employees who are eligible to enroll in the System. If a resolution electing to participate in the Health Service System is filed with the System on or before April 1st, then the participating agency and its employees, retirees, and dependents shall be eligible to enroll the following January 1st. These time requirements may be modified only with the approval of the Health Service Board.

2. Reports and Payments

A participating agency shall perform the functions necessary to enroll its employees and to submit timely and accurate reports and payments as may be

required by the Director of the Health Service System; provided, however, that the Director may not impose any reporting or payment requirements that differ from those applicable to the City & County of San Francisco, without approval of the Health Service Board.

3. Terminating Participation

A participating agency may end its participation in the Health Service System by filing a resolution of its governing body with the Health Service Board. The resolution must be filed with the Health Service Board no later than April 1st to be effective the following January 1st. Coverage of all agency employees, retirees and dependents will terminate on December 31st, the end of the plan year. The resolution electing to end participation in the Health Service System is irrevocable after it is filed with the Health Service Board. An agency may not file a resolution electing to resume participation in the Health Service System for five (5) years after the effective date of its exit from the Health Service System.

4. Exclusive Plans

A participating agency may not maintain for its employees any medical plan or program offering hospital and medical care, other than the plans offered by the Health Service System, except as expressly agreed to by the Health Service Board.

U. MEMBER APPEALS AND GRIEVANCES

1. Members who have a grievance with the HSS determination of credited service or their eligibility for retiree health benefits and employer-sponsored premium subsidies must submit their grievance and supporting documents in writing to:

San Francisco Health Service System
Attention: Member Appeals
1145 Market Street, Suite 300
San Francisco, CA 94103

2. Members who have a grievance with a specific benefit plan must first try and resolve their grievance through the plan's member assistance process. Grievances will not be considered by the Health Service System until this action is taken and documentation is submitted to HSS.
3. Members are advised that grievances relating to medical service received (or not received) from a Health Maintenance Organization (HMO) plan must be filed with the California Department of Managed Healthcare (DMHC). Grievances relating to Preferred Provider Organization (PPO) medical services must be filed with the

California Department of Insurance (DOI). Grievances related to a self-insured plan are filed with Health Service System.

4. Members having grievances that cannot be resolved to the satisfaction of the member may submit the facts in writing to:
San Francisco Health Service System
Attention: Member Appeals
1145 Market Street, Suite 300
San Francisco, CA 94103
5. Member grievances must be submitted within sixty (60) days of the event giving rise to the grievance or the denial of the grievance by the member's specific benefit plan under Section U.2. above.
6. The Health Service System shall consider each appeal or grievance and shall notify the member of its decision within sixty (60) days of receiving a member grievance
7. Any member dissatisfied with the Health Service System's decision shall retain the right to appeal the decision in writing to the Health Service Board. Such appeal must be made within fifteen (15) business days after the date the Health Service System mails its decision to the member at the member's last known address on file with the Health Service System. The Health Service Board may grant an extension of time upon the showing of good cause
8. City Charter Section 12.200(5) requires the Health Service Board receive, consider and, within sixty (60) days after receipt, act upon any matter pertaining to the policies of, or appeals from, the Health Service System submitted to it in writing by any member or any person who has contracted to render medical care to the members.
9. The appeal to the Health Service System Board shall specifically identify the basis of the member's disagreement with the Health Service System decision in writing.
10. Prior to the Health Service System Board hearing, the Health Service System shall serve a written response to the member's grievance upon the member and the Board.
11. The Health Service System Board shall grant, deny or otherwise respond to all written appeals submitted consistent with City Charter Section 12.200(5).
12. All actions taken by the Health Service Board shall be final.
13. All appeals to the Health Service System Board shall be heard in closed session, unless the member requests that it be held in open session. The Health Service Board minutes shall not reflect any member-identifiable information relating to appeals.
14. Members shall be allowed to bring a personal representative of their choosing to the Health Service Board hearing, along with any other witnesses the member

believes may have direct knowledge of the facts underlying the member's claim. The Health Service System shall also be allowed to bring any witnesses it believes will help the Board in its decision-making process. The Health Service System Board may exclude any witness upon a finding that their testimony would be duplicative, without foundation and/or not relevant to the member's claim.

V. RULES OF INTERPRETATION

The Health Service System has absolute discretionary authority to control and manage the operation and administration of the Health Service System, to correct errors, and to construe and interpret the Health Service System Rules including, but not limited to, determinations regarding benefits, eligibility and qualifying status change events. All decisions and interpretations of the Health Service System and the Health Service Board shall be conclusive and binding upon all persons and shall be given the greatest deference permitted by law.

Any activity or transaction between members, dependents and the Health Service System not explicitly determined by these Rules remains under the discretion of the Health Service System and/or the Health Service Board. To the extent these Rules conflict with the City Charter, the express language of the Charter, and not these Rules, shall apply.

APPENDIX A: BENEFITS COVERAGE PERIODS

For January 1, 2020 through December 31, 2020, benefit coverage periods for members on a bi-weekly premium payment schedule of twenty-six (26) premium payments per year:

Benefits Coverage Period
December 26, 2020 – January 8, 2021
January 9, 2021 – January 22, 2021
January 23, 2021 – February 5, 2021
February 6, 2021 – February 19, 2021
February 20, 2021 – March 5, 2021
March 6, 2021 – March 19, 2021
March 20, 2021 – April 2, 2021
April 3, 2021 – April 16, 2021
April 17, 2021 – April 30, 2021
May 1, 2021 – May 14, 2021
May 15, 2021 – May 28, 2021
May 29, 2021 - June 11, 2021
June 12, 2021– June 25, 2021
June 26, 2021 – July 9, 2021
July 10, 2021 – July 23, 2021
July 24, 2021 – August 6, 2021
August 7, 2021 – August 20, 2021
August 21, 2021 – September 3, 2021
September 4, 2021 – September 17, 2021
September 18, 2021– October 1, 2021
October 2, 2021 – October 15, 2021
October 16, 2021 – October 29, 2021
October 30, 2021 - November 12, 2021
November 13, 2021– November 26, 2021
November 27, 2021 – December 10, 2021
December 11, 2021 – December 24, 2021

APPENDIX A: BENEFITS COVERAGE PERIODS *(continued)*

For January 1, 2020 – December 31, 2020, benefit coverage periods for members on a twice-monthly premium payment schedule of twenty-four (24) premium payments:

Benefits Coverage Period	
1	December 23, 2020–January 5, 2021
2	January 6, 2021–January 19, 2021
3	January 20, 2021–February 2, 2021
4	February 3, 2021–February 16, 2021
5	February 17, 2021–March 2, 2021
6	March 3, 2021–March 16, 2021
7	March 17, 2021–March 30, 2021
8	March 31, 2021–April 13, 2021
9	April 14, 2021–April 27, 2021
10	April 28, 2021–May 11, 2021
11	May 12, 2021–May 25, 2021
12	May 26, 2021–June 8, 2021
13	June 9, 2021–June 30, 2021
14	July 1, 2020–July 6, 2021
	<i>Summer Coverage Period extra payroll deductions taken January to June pre-pay this summer coverage period</i>
15	August 4, 2021–August 17, 2021
16	August 18, 2021–August 31, 2021
17	September 1, 2021–September 14, 2021
18	September 15, 2021–September 28, 2021
19	September 29, 2021–October 12, 2021
20	October 13, 2021–October 26, 2021
21	October 27, 2021–November 9, 2021
22	November 10, 2021–November 23, 2021
23	November 24, 2021–December 7, 2021
24	December 8, 2021–December 21, 2021

APPENDIX A: BENEFITS COVERAGE PERIODS *(continued)*

For January 1, 2019 – December 31, 2019, benefit coverage periods for members on a monthly premium payment schedule of twelve (12) premium payments:

1	-	January 1, 2021	-	January 31, 2021
2	-	February 1, 2021	-	February 29, 2021
3	-	March 1, 2021	-	March 31, 2021
4	-	April 1, 2021	-	April 30, 2021
5	-	May 1, 2021	-	May 31, 2021
6	-	June 1, 2021	-	June 30, 2021
7	-	July 1, 2021	-	July 31, 2021
8	-	August 1, 2021	-	August 31, 2021
9	-	September 1, 2021	-	September 30, 2021
10	-	October 1, 2021	-	October 31, 2021
11	-	November 1, 2021	-	November 30, 2021
12	-	December 1, 2021	-	December 31, 2021