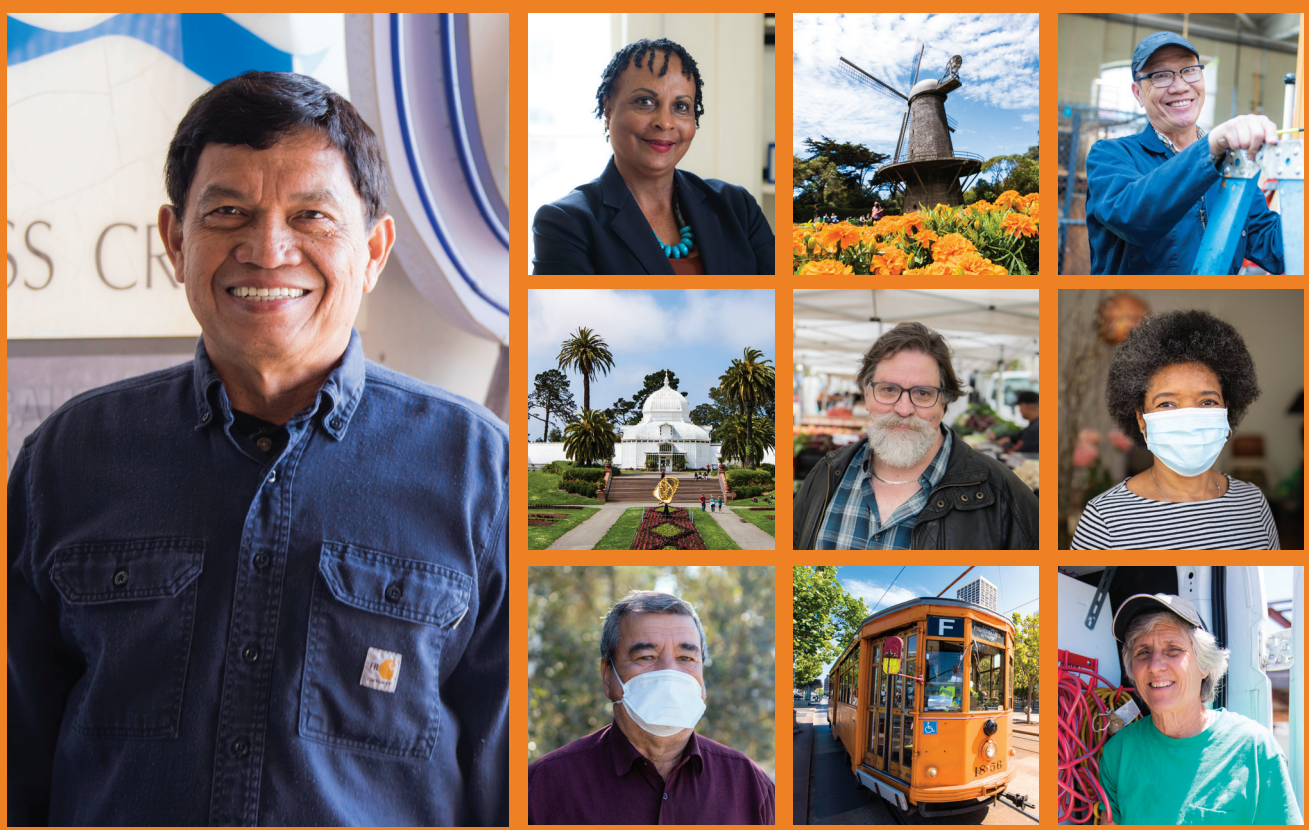
2021

Retirees

Health Benefits Guide



SAN FRANCISCO
HEALTH SERVICE SYSTEM

What's New for 2021

Medical, Vision and Dental

- Check out our new virtual health fairs at **sfhss.org/oe2021**.
- 2021 Medical, Vision and Dental contributions are on pages 18 to 21, 23 and 24.
- Starting January 1st, SFHSS Members have the option to use a VSP-assigned member ID, instead of their social security number. You will receive a welcome letter in early January 2021 with member ID card. You can also access the VSP website to obtain your member ID and print an ID card.
- Nitrous oxide gas and other non-IV sedation is now covered under the Delta Dental PPO Active and Retiree plans.
- For Kaiser California plans, starting January 1st, members with certain chronic conditions can get the following services at no cost: A1c testing for diabetes risk, low-density lipoprotein (LDL) testing for heart disease and INR (international normalized ratio) testing for liver disease or bleeding disorders.

Online payments

For your convenience, you can now pay your premiums through the **SF Payment Portal**, see **sfhss.org/how-make-payment** website for details.

Well-Being

- There are several **virtual offerings** to support your well-being such as group exercise classes, educational workshops, healthy weight programs, diabetes prevention programs and more. To learn more about dates and times, visit **sfhss.org/events**.
- **Get Your Flu Shot**: It's more important now more than ever to get your flu shot. SFHSS is sponsoring flu shot clinics throughout the City. You can also obtain your shot through your health plan. For more information on flu go to **sfhss.org/well-being/flu-prevention**.

This Guide includes an overview of the San Francisco Health Service System Rules, as approved by the Health Service Board. Rules can be found at **sfhss.org** or request a copy by calling **(628) 652-4700.**

Executive Director's Message

Back in late March, I became part of the sourdough baking movement. Like everyone else, I struggled to find whole wheat and bread flours. My son from the East Coast coached me through video chat on how to make sourdough bread, and before I knew it, baking sourdough, pancakes and muffins became my obsession. As I reflect on that time, I realize it was a distraction from all things PANDEMIC, and having my life suddenly upended along with a significant loss of my normal routine. If my anxiety was manifesting in sourdough obsession when I had limited exposure and am able to telecommute, then what was happening to others?

Prior to SFHSS, I spent more than 20 years comparing and analyzing the community health needs of San Francisco residents. While progress is significant in some matters such as the management and treatment of HIV. Other health conditions that are driven by social determinants such as race, gender, income, housing, food access and occupation still affect the health of our City's population and of our work force.

The pandemic has brought this to light once again as we look at the disproportionate share of disease burden that persons of color in our community has from COVID-19. As employees and retirees of the city of San Francisco, we are privileged to have access to health care, and yet, our overall disease prevalence mirrors that of the community at large. Within our workforce, we see disparities in rates of diabetes amongst members of different race and ethnicity groups. People of color are less likely to have continuation of care for their mental health needs.

In the coming year, SFHSS is focusing on three areas to address these discrepancies as we work to improve your health outcome.

Mental Health

Right now, one in three Americans are experiencing anxiety and that's not reflected in our benefits utilization. Don't wait to seek help.

If you're feeling stressed, anxious or depressed, we have many ways for you to reach out for help from anywhere. See page 35 for your mental health benefits that include everything from well-being apps like Calm, Talk Space or Sanvello to tele-behavioral health counselors who are ready to listen and address your needs.

For active employees, we have expanded EAP services where counselors are available 24/7 to guide you.

Preventive Care Services

If you haven't already done so this year, I urge you to make those preventive care appointments for well check-ups or dental cleanings. We have a Preventive Care Scheduler on page 34 to help you track and use the benefits you've earned as the medical and dental offices safely reopen and telehealth services are readily available.

Abbie's Sourdough Bread

Well-Being Support

Your health and well-being is the foundation from which you are able to better serve your family, friends and community. SFHSS has well-being programs to help you on your journey, so you don't have to do it alone. You will find a variety of programs at **sfhss.org/events** from virtual fitness classes to diabetes prevention programs to help you stay healthy and live vibrant lives.

I am fortunate to have a strong social support circle. When I was gifted some sourdough starter, I was able to escape and make my world right again through the comfort and joy of sourdough bread.

So as we abide by the social distancing and masking rules and learn to live in this pandemic environment, I hope you're able to do what brings you comfort and take care of your health.

Be well,

Abbie Yant, *RN, MA*
Executive Director

Step-by-Step Enrollment Guide

STEP 1: Are you a new retiree or do you have a Qualifying Life Event where you need to enroll or update your benefits?

STEP 2: Do you need to drop a dependent? Please review your current dependents and follow the steps below.

- Review dependent eligibility rules on page 29 or on our website at **sfhss.org/eligibility-rules**.
- Complete the Review Dependents page in ***eBenefits*** to add dependents or edit existing dependents. Or you can complete box 5 or box 6 on your Enrollment Application form.
- Submit copies of supporting documents for a Qualifying Life Event. New dependents must have supporting documentation submitted with their elections in order to be enrolled (e.g. birth certificate, certified marriage certificate).

STEP 3: Are you or your dependent approaching age 65 and about to become Medicare-eligible?

- If **YES,** and you are not yet enrolled in Medicare, you must enroll through the Social Security Administration online at **ssa.gov** or by calling **(800) 772-1213**.
- If **NO,** be sure to apply for Medicare at least three months before your 65th birthdate.
- Proof of enrollment in Medicare Part A & B are required to maintain your SFHSS benefits. Review Medicare Basics and FAQs on page 4.
- Submit proof of Medicare enrollment by mailing a copy of your Medicare card or letter to SFHSS.

STEP 4: Are you making changes to your health plan benefits?

- If yes, review the Service Areas of the medical plans available to you. Non-Medicare retirees, go to page 8. Retirees with Medicare, go to page 9.
- Review the rates for available plans in your area. Non-Medicare retirees go to page 18 (within CA) or page 19 (outside CA). Retirees with Medicare go to page 20 (within CA) or page 21 (outside CA).
- Choose a Medical Plan page in ***eBenefits*** or select your plan by checking the health plan in box 2 or box 3 on the Enrollment Application form.

STEP 5: Are you making changes to your vision benefits?

- Review the Vision benefit options on pages 22 and 23.
- You must be enrolled in a medical plan to receive Vision benefits.
- Enrollment in the VSP Premier Plan requires that all dependents enrolled in medical coverage also be enrolled in the VSP Premier Plan.
- Complete the Enroll in a Vision Premier Plan page in ***eBenefits*** or complete box 4 or box 5 on the Enrollment Application form.

STEP 6: Are you making changes to your dental benefits?

- Review your Dental benefit options and associated costs on pages 24 to 25.
- Complete the Enroll in a Dental Plan page in ***eBenefits***. On your Enrollment Application form, complete Box 3 or Box 4.

STEP 7: If you have a Qualifying Life Event or are retiring, go online to ***eBenefits*** to complete and submit your elections.

To create an ***eBenefits*** account, go to **sfhss.org/enroll-online**. You can also fax or mail your completed Enrollment Application form and documentation to SFHSS (see below).

Our address is **1145 Market Street, 3rd Floor, San Francisco, CA 94103** and our fax number is **(628) 652-4701**.

To download an Enrollment Application form, visit **sfhss.org/benefits/retirees-with-medicare** or **sfhss.org/benefits/retirees-without-medicare**.

For **HELP**, call San Francisco Health Service System (SFHSS) Member Services at **(628) 652-4700** or visit **sfhss.org**.

Our telephone hours are Monday, Tuesday, Wednesday and Friday from 9am to 12pm and 1pm to 5pm and Thursday from 10am to 12pm and 1pm to 5pm PST.

Our offices are currently closed to the public.

Medicare Basics

SFHSS requires all retirees and dependents to enroll in Medicare Part A and Part B at least three months before turning 65.

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

Medicare Basics

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

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

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

If you are not currently receiving Social Security, it is your responsibility to contact the Social Security Administration to apply for Medicare *at least three months* prior to your 65th birthday or if you become disabled. **Failure to do so could result in penalties being assessed by the Social Security Administration and the San Francisco Health Service System.**

If you have a Social Security-qualified disability or End Stage Renal Disease, you should contact the Social Security Administration immediately to apply for Medicare.

In the case where an SFHSS member and their covered dependent(s) are enrolled in a Blue Shield of California HMO plan (Access+ or Trio HMO), when either member or dependent(s) become eligible for Medicare, they must enroll in the UnitedHealthcare Medicare Advantage PPO plan.

Medicare Part A: Hospital Insurance

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

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

You are eligible for premium-free Medicare Part A if you are age 65 or older and have worked and contributed to Social Security for at least 10 years (40 quarters). You may also qualify for Medicare Part A through a current, former, or deceased spouse. If you are under age 65 and have End Stage Renal Disease or a Social Security-qualified disability, you may also qualify for Medicare Part A.

If you are under age 65 with a qualifying disability, Medicare coverage generally starts 24 to 30 months following eligibility. If you have questions about your eligibility for premium-free Medicare Part A, contact the **Social Security Administration** at **(800) 772-1213**.

All SFHSS members are required to enroll in Medicare as soon as they become eligible or face penalties.

Medicare FAQs

Medicare Part B: Medical Insurance

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

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

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

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

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

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

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

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

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

When an SFHSS member does not enroll in Medicare when eligible or who loses Medicare coverage due to non-payment of Medicare premiums, they will lose their existing SFHSS medical coverage and automatically be enrolled in City Plan 20.

City Plan 20 significantly increases premium and out-of-pocket costs. Under City Plan 20, you will be responsible for paying the 80% that Medicare would have paid for a covered service, plus any amounts above usual and customary fees.

In addition, under City Plan 20, yearly out-of-pocket limits increase to $10,950. For information on City Plan 20, visit **sfhss.org/city-plan-20**.

Medicare FAQs

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

Medicare Part D: Prescription Drug Insurance

There are two types of Medicare Part D prescription plans: *individual* and *group*. Individual Part D prescription drug coverage is purchased directly by an individual from an insurer or pharmacy.

SFHSS members should not enroll in any individual Medicare Part D plan. SFHSS members are automatically enrolled in group prescription drug coverage under Medicare Part D when they enroll in any medical plan offered through SFHSS. SFHSS medical plans offer enhanced group Medicare Part D prescription drug coverage.

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

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

A Do not enroll in an individual Medicare Part D prescription drug plan.

If you are Medicare-eligible, enhanced group Medicare Part D drug coverage is included with your SFHSS medical plan.

Private insurance companies, pharmacies, and other entities may try to sell you an individual Medicare Part D prescription drug plan.

If you enroll in any private, individual Medicare Part D prescription drug plan, your Medicare coverage will be assigned to that plan and **your SFHSS group medical coverage will be terminated.**

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

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

If you are charged a Part D premium, but your income changes and falls below the threshold, contact Social Security to request an adjustment.

Medicare enrollees with income exceeding certain thresholds are charged a quarterly Part D premium also known as the Income Related Monthly Adjusted Amount (IRMAA). In most cases, this Part D premium will be deducted from your Social Security check.

For information on Medicare Part D premiums, visit **medicare.gov/part-d/costs/premiums/drug-plan-premiums.html** or call Social Security at **(800) 772-1213**.

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

A Retirees and dependents who fail to pay a required Part D premium will result in Part D coverage being terminated by the Social Security Administration. Consequently, SFHSS medical coverage will also be terminated. SFHSS members who have lost Part D eligibility due to lack of payment will be enrolled in City Plan 20 (see page 5) member only coverage and their dependent coverage will be terminated. Full SFHSS medical coverage for a member or dependent may be reinstated at the beginning of the next available coverage period after SFHSS receives proof of Medicare Part D reinstatement.

If you are enrolled in Medicare, do not enroll in any outside Part D plans. Prescription benefits are already covered in your SFHSS medical plan. Doing so will terminate your coverage.

Enrolling in Retiree Health Benefits

NEW Retirees: Don't Miss the 30-Day Deadline. The transition of health benefits from active employee to retiree status does not happen automatically.

You must enroll to continue retiree health coverage by submitting a retiree Enrollment Application form and supporting documents by fax to **(628) 652-4701** or mail to SFHSS by the required deadlines. You can enroll by submitting a **Retiree Enrollment Application form** and supporting documents to SFHSS by fax or mail. Get started by visiting **sfhss.org/benefits/getting-ready-to-retire**.

New retirees must complete enrollment in retiree health coverage within 30 calendar days of their retirement date. If you do not enroll within 30 days, you will only be able to enroll in benefits during the next Open Enrollment period (unless you have a Qualifying Life Event, see pages 29 and 30).

New retirees should plan ahead. If you are Medicare eligible, you must be enrolled in Medicare to keep SFHSS benefits. See pages 5 and 6 for Medicare FAQs.

Your retiree premium contributions will be deducted from your monthly pension check. Be sure to review your monthly check to verify that the correct premium contribution is being deducted. If your pension check does not cover your required premium payment, you must make payments directly through the **City of San Francisco Payment Portal**.

To create an account to make online payments, visit **sfhss.org/how-make-payment**. You can schedule recurring payments through the portal. **There are no service fees for payment by electronic check.**

For instructions on how to make online payments, go to **sfhss.org/how-make-payment**. You can find premium contribution rates on pages 18 to 21.

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

Open Enrollment is your annual opportunity to change your benefit elections for you and your eligible dependents without a qualifying event. Changes made during the October Open Enrollment period become effective January 1, 2021.

Outside of Open Enrollment, **you can only make changes to benefit elections during the plan year if there is a Qualifying Life Event.** See pages 29 and 30 for information about Qualifying Life Events.

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

Make sure you understand the **City Charter rules determining your eligibility** and premium contributions *before* finalizing your retirement date. See page 28 for more information.

And remember...

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

Questions about health benefits, premium contributions or eligibility documentation? Call (628) 652-4700.

Service Areas for Retirees *without* Medicare

County	Blue Shield of California		Kaiser Permanente	United Healthcare	County	Blue Shield of California		Kaiser Permanente	United Healthcare
	Access+ HMO NON-MEDICARE HMO	Trio+ HMO NON-MEDICARE HMO	Traditional NON-MEDICARE HMO	PPO (City Plan) NON-MEDICARE PPO		Access+ HMO NON-MEDICARE HMO	Trio+ HMO NON-MEDICARE HMO	Traditional NON-MEDICARE HMO	PPO (City Plan) NON-MEDICARE PPO
Alameda	■	■	■	■	Orange	■	■	■	■
Alpine				■	Placer	○	○	○	■
Amador			○	■	Plumas				■
Butte	■			■	Riverside	■	○	○	■
Calaveras				■	Sacramento	■	○	■	■
Colusa				■	San Benito				■
Contra Costa	■	■	■	■	San Bernardino	○	○	○	■
Del Norte				■	San Diego	○	○	○	■
El Dorado	○	○	○	■	San Francisco	■	■	■	■
Fresno	■		○	■	San Joaquin	■	■	■	■
Glenn				■	San Luis Obispo	■	○		■
Humboldt				■	San Mateo	■	■	■	■
Imperial	■		○	■	Santa Barbara	■			■
Inyo				■	Santa Clara	■	■	○	■
Kern	○	○	○	■	Santa Cruz	■	■	○	■
Kings	■		○	■	Shasta				■
Lake				■	Sierra				■
Lassen				■	Siskiyou				■
Los Angeles	■	○	○	■	Solano	■	○	■	■
Madera	■		○	■	Sonoma	■		○	■
Marin	■	○	■	■	Stanislaus	■	○	■	■
Mariposa			○	■	Sutter			○	■
Mendocino				■	Tehama				■
Merced	■			■	Trinity				■
Modoc				■	Tulare	■	○	○	■
Mono				■	Tuolumne				■
Monterey				■	Ventura	■	○	○	■
Napa			○	■	Yolo	■	○	○	■
Nevada	○	○		■	Yuba			○	■
					Outside CA			◆	■

■ Available in this county
○ Available in some zip codes
◆ OR, WA, HI

UnitedHealthcare PPO

Non-Medicare members and their non-Medicare dependents who lack geographic access to Trio HMO or Access+ HMO, both offered by Blue Shield of California, or Kaiser Permanente HMO, are eligible to enroll in **UnitedHealthcare PPO** with lower premiums.

Service Areas for Retirees *with* Medicare

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

■ Available in this county
○ Available in some zip codes
◆ OR, WA, HI
▲ Service area includes all 50 states, District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands

Moving? Change of Address? Contact SFHSS (628) 652-4700 or visit sfhss.org/change-address.
If you move out of the service area covered by your plan, you must elect an alternate medical plan that provides coverage in your area. Failure to change your elections may result in non-payment of claims for services rendered.

2021 Medical Plans

	BLUE SHIELD OF CALIFORNIA Trio HMO and Access+ HMO	KAISER PERMANENTE Traditional HMO
DEDUCTIBLES		
Deductible and Out-of-Pocket Maximum (Medical)	No Deductible Annual out-of-pocket maximum $2,000/individual; $4,000/family	No Deductible Annual out-of-pocket maximum $1,500/person; $3,000/family
PREVENTIVE CARE		
Routine Physical	No charge	No charge
Most Immunizations and Inoculations	No charge	No charge
Well Woman Exam and Family Planning	No charge	No charge
Routine Pre/Post-Partum Care	No charge visits limited; see EOC	No charge visits limited; see EOC
PHYSICIAN AND OTHER PROVIDER CARE		
Office and Home Visits	$25 co-pay	$20 co-pay
Inpatient Hospital Visits	No charge	No charge
PRESCRIPTION DRUGS		
Pharmacy: Generic Drugs	$10 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: Brand-Name Drugs	$25 co-pay 30-day supply	$15 co-pay 30-day supply
Pharmacy: Non-Formulary Drugs	$50 co-pay 30-day supply	Physician authorized only
Mail Order: Generic Drugs	$20 co-pay 90-day supply	$10 co-pay 100-day supply
Mail Order: Brand-Name Drugs	$50 co-pay 90-day supply	$30 co-pay 100-day supply
Mail Order: Non-Formulary Drugs	$100 co-pay 90-day supply	Physician authorized only
Specialty Drugs	20% coinsurance up to $100 per prescription, 30-day supply	20% coinsurance up to $100 per prescription, 30-day supply
OUTPATIENT SERVICES		
Diagnostic X-ray and Laboratory	No charge	No charge
EMERGENCY		
Hospital Emergency Room	$100 co-pay waived if hospitalized	$100 co-pay waived if hospitalized
Urgent Care Facility	$25 co-pay in-network	$20 co-pay
HOSPITAL/SURGERY		
Inpatient	$200 co-pay per admission	$100 co-pay per admission
Outpatient	$100 co-pay per surgery	$35 co-pay

Retirees *without* Medicare

UNITEDHEALTHCARE PPO
(City Plan)

In-Network or Out-of-Area	Out-of-Network
$250 Deductible Retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $3,750/person; $7,500/Family	$500 Deductible Retiree only $1,000 Deductible + 1 $1,500 Deductible + 2 or more Annual out-of-pocket maximum $7,500/person
100% covered no deductible	50% covered after deductible
100% covered no deductible	50% covered after deductible
100% covered no deductible	50% covered after deductible
85% covered after deductible	50% covered after deductible
85% covered after deductible	50% covered after deductible
85% covered after deductible	50% covered after deductible
$10 co-pay 30-day supply	50% covered after $5 co-pay; 30-day supply
$25 co-pay 30-day supply	50% covered after $20 co-pay; 30-day supply
$50 co-pay 30-day supply	50% covered after $45 co-pay; 30-day supply
$20 co-pay 90-day supply	Not covered
$50 co-pay 90-day supply	Not covered
$100 co-pay 90-day supply	Not covered
Same as 30-day supply above limitations apply; see EOC	Same as 30-day supply above limitations apply; see EOC
85% covered after deductible	50% covered after deductible; prior notification
85% covered after deductible; if non-emergency 50% after deductible	85% covered after deductible; if non-emergency 50% after deductible
85% covered after deductible	50% covered after deductible
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible	50% covered after deductible

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2021. If any discrepancy exists between the information provided in this Guide and the EOC, the EOC shall prevail. Download EOCs at **sfhss.org**.

2021 Medical Plans

	BLUE SHIELD OF CALIFORNIA Trio HMO and Access+ HMO	KAISER PERMANENTE Traditional HMO
REHABILITATIVE		
Physical/Occupational Therapy	$25 co-pay per visit	$20 co-pay authorization required
Acupuncture/Chiropractic	$15 co-pay 30 visits of each max per plan year; ASH network	$15 co-pay 30 visits combined acupuncture or chiro max per plan year; ASH network; for 25% discount see **kp.org/choosehealthy**
GENDER DYSPHORIA		
Office Visits and Outpatient Surgery	Co-pays apply authorization required	Co-pays apply authorization required
DURABLE MEDICAL EQUIPMENT		
Home Medical Equipment	No charge	No charge as authorized by PCP according to formulary
Diabetic Monitoring Supplies	No charge based upon allowed charges	No charge see EOC
Prosthetics/Orthotics	No charge when medically necessary	No charge when medically necessary
Hearing Aids	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each
MENTAL HEALTH		
Inpatient Hospitalization	$200 co-pay per admission	$100 co-pay per admission
Outpatient Treatment	$25 co-pay non-severe and severe	$10 co-pay group $20 co-pay individual
Inpatient Detox	$200 co-pay per admission	$100 co-pay per admission
Residential Rehabilitation	$200 co-pay per admission	$100 co-pay per admission; physician approval required
EXTENDED & END-OF-LIFE CARE		
Skilled Nursing Facility	No charge up to 100 days/year	No charge up to 100 days/year
Hospice	No charge authorization required	No charge when medically necessary
OUTSIDE SERVICE AREA		
Care Access and Limitations	Urgent care $50 co-pay guest membership benefits for college students in some areas	Only emergency services before condition permits transfer to Kaiser facility; co-pays apply

Retirees *without* Medicare

UNITEDHEALTHCARE PPO
(City Plan)

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

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2021. If any discrepancy exists between the information provided in this Guide and the EOC, the EOC shall prevail. Download EOCs at **sfhss.org**.

2021 Medical Plans

	KAISER PERMANENTE **Senior Advantage** Medicare Advantage HMO	UNITEDHEALTHCARE Medicare Advantage PPO
DEDUCTIBLES		
Deductible and Out-of-Pocket Maximum	No Deductible Annual out-of-pocket maximum $1,500/individual; $3,000/family	No Deductible Annual out-of-pocket maximum $3,750/individual
PREVENTIVE CARE		
Routine Physical	No charge	$0 co-pay
Immunizations and Inoculations	No charge	$0 co-pay if covered under Part B
Well Woman Exam and Family Planning	No charge	$0 co-pay
Routine Pre/Post-Partum Care	No charge visits limited; see EOC	Cost share per type and location of service
PHYSICIAN AND PROVIDER CARE		
Office and Home Visits	$20 co-pay	$5 co-pay PCP; $15 co-pay specialist
Hospital Visits	No charge	$150 co-pay per admission
PRESCRIPTION DRUGS		
Pharmacy: Generic Drugs (Tier 1)	$5 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: Brand-Name Drugs (Tier 2)	$15 co-pay 30-day supply	$20 co-pay 30-day supply
Pharmacy: Non-Preferred Brand Drugs (Tier 3)	Physician authorized only	$45 co-pay 30-day supply
Mail Order: Generic Drugs (Tier 1)	$10 co-pay 100-day supply	$10 co-pay 90-day supply
Mail Order: Brand-Name Drugs (Tier 2)	$30 co-pay 100-day supply	$40 co-pay 90-day supply
Mail Order: Non-Preferred Brand Drugs (Tier 3)	Physician authorized only	$90 co-pay 90-day supply
Specialty Drugs (Tier 4)	20% coinsurance up to $100 per prescription, 30-day supply	$20 co-pay retail pharmacy up to 30-day supply $40 co-pay mail order pharmacy up to 90-day supply
OUTPATIENT SERVICES		
X-ray and Laboratory	No charge	$0 co-pay
EMERGENCY		
Hospital Emergency Room	$50 co-pay waived if hospitalized	$65 co-pay waived if admitted to the hospital within 24 hours
Urgent Care Facility	$20 co-pay	$20 co-pay waived if admitted to the hospital within 24 hours
HOSPITAL/SURGERY		
Inpatient	$100 co-pay per admission	$150 co-pay per admission
Outpatient	$35 co-pay	$100 co-pay

Retirees *with* Medicare

	KAISER PERMANENTE **Senior Advantage** Medicare Advantage HMO	UNITEDHEALTHCARE Medicare Advantage PPO
REHABILITATIVE		
Physical/Occupational Therapy	$20 co-pay authorization required	$20 co-pay
Acupuncture/Chiropractic	$15 co-pay 30 visits combined acupuncture or chiro max per plan year; ASH network; for 25% discount see **kp.org/choosehealthy**	$15 co-pay 24 visits of each max per plan year
GENDER DYSPHORIA		
Office Visits and Outpatient Surgery	Co-pays apply authorization required	Co-pays apply authorization required
DURABLE MEDICAL EQUIPMENT		
Home Medical Equipment	No charge as authorized by PCP according to formulary	$15 co-pay
Prosthetics/Orthotics	No charge when medically necessary	$15 co-pay
Diabetic Monitoring Supplies	No charge see EOC	$0 co-pay limited to certain brands
Hearing Aids	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each	Evaluation no charge $5,000 allowance for hearing aid(s), combined for both ears, every 36 months
MENTAL HEALTH		
Inpatient Hospitalization	$100 co-pay per admission	$150 co-pay per admission
Outpatient Treatment	$10 co-pay group $20 co-pay individual	$5 co-pay group $15 co-pay individual
Inpatient Detox	$100 co-pay per admission	$150 co-pay per admission
Residential Rehabilitation	$100 co-pay per admission; physician approval required	$150 co-pay per admission
EXTENDED & END-OF-LIFE CARE		
Skilled Nursing Facility	No charge up to 100 days per year	No charge up to 100 days/benefit period; no custodial care
Hospice	No charge when medically necessary	Covered by Original Medicare
OUTSIDE SERVICE AREA		
Care Access and Limitations	Only emergency services before condition permits transfer to Kaiser facility; co-pays apply	Nationwide coverage provided Services obtained outside the United States and UnitedHealthcare PPO covered United States territories will only be authorized in the case of urgently needed services or in case of emergency.

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2021. If any discrepancy exists between the information provided in this Guide and the EOC, the EOC shall prevail. Download EOCs at **sfhss.org**.

Medical Plan Options: Retirees *without* Medicare

What is Health Maintenance Organization (HMO)?

An HMO is a medical plan that offers benefits through a network of participating physicians, hospitals and other healthcare providers. For non-emergency care, access service through your Primary Care Physician (PCP) or an affiliated urgent care center. There is no plan year deductible before accessing your benefits. Most services are available for a fixed dollar amount (co-payment).

SFHSS offers the following HMO medical plans:

- **Trio HMO - Blue Shield of California -** A network of local doctors, specialists and hospitals working closely together to coordinate your care. Trio has a dedicated Concierge Service and Heal (home visits) based on location. California Pacific Medical Center (CPMC) is in network.
- **Access+ HMO - Blue Shield of California -** Your PCP coordinates all your care and refers you to specialists and hospitals within their medical group/Independent Practice Association (IPA). Each family member can choose a different physician and medical group/IPA.
- **Kaiser Permanente Traditional HMO -** Most medical services are under one roof (ex. specialty care, pharmacy, lab work). No referrals required for certain specialties, like obstetrics-gynecology.

What is a Preferred Provider Organization (PPO)?

A PPO is a medical plan that offers benefits through in-network and out-of-network healthcare providers. PPOs allow for a greater selection of providers however, out-of-network providers cost more. You are not assigned to a PCP, giving you more responsibility for coordinating your care.

Compared to an HMO, enrolling in a PPO usually results in higher out-of-pocket costs. Unlike HMO plans, PPOs may have deductibles. Generally, you must pay a plan year deductible and a coinsurance percentage when accessing services.

Kaiser Permanente HMO

Traditional Plan
(non-Medicare HMO)

- Must not be eligible for Medicare
- Must live in a Kaiser service area
- In-network service only
- Out-of-pocket, fixed co-pays
- No annual deductible
- Primary Care Physician required
- Change your personal plan physician at any time for any reason

Your **Medicare** dependents will be in **Kaiser Permanente Senior Advantage HMO.**

Blue Shield of California HMO

Trio HMO
(non-Medicare HMO)

Access+ HMO
(non-Medicare HMO)

- Must not be eligible for Medicare
- Must live in a plan service area
- In-network service only
- Out-of-pocket, fixed co-pays
- No annual deductible
- Primary Care Physician required
- Can change PCP at anytime throughout year, up to one time per month, as long as new PCP is part of a medical group in your plan

Your **Medicare** dependents will be enrolled in **UnitedHealthcare MAPD PPO.**

UnitedHealthcare PPO (City Plan)

UnitedHealthcare
(non-Medicare PPO)

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

Your **Medicare** dependents will be enrolled in **UnitedHealthcare MAPD PPO.**

Note: UHC PPO (City Plan) enrollees who live in a zip code where in-network providers are not available may access out-of-area providers with the same in-network coinsurance. Your out-of-area status may change as doctors join or leave the UHC PPO (City Plan) network. Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2021. If any discrepancy exists between this Guide and the EOC, the EOC shall prevail. EOCs are available for download at **sfhss.org**.

Medical Plan Options: Retirees *with* Medicare

What is a Health Maintenance Organization (HMO)?

An HMO is a medical plan that offers benefits through a network of participating physicians, hospitals and other healthcare providers. For non-emergency care, access service through your Primary Care Physician or an affiliated urgent care center. There is no deductible before accessing your benefits. Most services are available for a fixed dollar amount (co-payment).

SFHSS offers the following Medicare HMO plan:

- **Kaiser Permanente Senior Advantage HMO**

What is a Preferred Provider Organization (PPO)?

A PPO is a medical plan that offers benefits through in-network and out-of-network healthcare providers. PPOs allow for a greater selection of providers however, for some PPO plans, out-of-network providers cost more. You are not assigned to a Primary Care Physician, giving you more responsibility for coordinating your care.

Compared to an HMO, enrolling in a PPO usually results in higher out-of-pocket costs. Like HMO plans, PPOs have maximum out-of-pocket expenses. Generally, you must pay a plan year deductible and a coinsurance percentage when accessing services.

SFHSS offers the following Medicare PPO plan:

- **UnitedHealthcare Medicare Advantage PPO**

For most services offered through the United Healthcare Medicare Advantage PPO plan, members will be responsible for co-pays, versus a coinsurance percentage. Additionally, receiving services from out-of-network providers will not cost you more.

Kaiser Permanente Senior Advantage HMO

Senior Advantage *(Medicare Advantage HMO)*

- Must be eligible for Medicare Part B
- Must live in a Kaiser service area
- In-network service only
- Out-of-pocket, fixed co-pays
- No deductible
- One ID card for all your covered services and prescription drugs
- Primary Care Physician required
- Medicare Advantage Plan
- ***Silver&Fit*** fitness program

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

UnitedHealthcare Medicare Advantage PPO

UnitedHealthcare *(Medicare Advantage PPO)*

- Must be eligible for Medicare
- Live anywhere in the USA
- Obtain service from any willing Medicare provider in the USA
- One ID card for all your covered services and prescription drugs from a network of 67,000 pharmacies nationwide
- Out-of-pocket; fixed co-pay
- No deductible
- Medicare Advantage Plan
- ***Silver Sneakers*** fitness program
- Enhanced coverage for diabetic supplies
- UHC Hearing - 5,000+ nationwide locations which offers hundreds of name brand and private-labeled hearing aids from the leading manufacturers, providing up to 80% off industry prices

Your **non-Medicare** dependents may be enrolled in **UHC PPO (City Plan), Blue Shield of California's Trio HMO** or **Access+ HMO.**

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2021. If any discrepancy exists between this Guide and the EOC, the EOC shall prevail. EOCs are available for download at **sfhss.org**.

2021 Medical Premiums: Retiree or Survivor *without* Medicare (California)

Retirees hired BEFORE January 9, 2009

Medical Premiums (Monthly)	Blue Shield of California				Kaiser Permanente HMO		UHC PPO (City Plan)		UHC PPO (No HMO Available)	
	Trio HMO		Access+ HMO							
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$1,812.29	$35.82	$2,035.83	$97.26	$1,370.10	$0	$1,463.11	$284.61	$1,650.46	$97.26
Retiree/Survivor +1 Dependent *without* Medicare	$2,227.04	$450.56	$2,514.48	$575.91	$1,709.85	$339.75	$1,856.77	$678.28	$2,044.13	$490.92
Retiree/Survivor +2 or More Dependents *without* Medicare	$2,227.04	$1,112.70	$2,514.48	$1,340.06	$1,709.85	$903.72	$1,856.77	$1,306.86	$2,044.13	$1,119.50
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$2,025.39	$248.91	$2,248.93	$310.35	$1,545.77	$175.67	$1,676.21	$497.70	$1,863.56	$310.35
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$2,025.39	$911.05	$2,248.93	$1,074.50	$1,545.77	$739.64	$1,676.21	$1,126.28	$1,863.56	$938.93

Retirees hired AFTER January 9, 2009[1] with *at least* 10 years but *less than* 15 years of service

Medical Premiums (Monthly)	Blue Shield of California				Kaiser Permanente HMO		UHC PPO (City Plan)		UHC PPO (No HMO Available)	
	Trio HMO		Access+ HMO							
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$906.15	$941.96	$1,017.92	$1,115.17	$685.05	$685.05	$731.56	$1,016.16	$825.23	$922.49
Retiree/Survivor +1 Dependent *without* Medicare	$1,113.52	$1,564.08	$1,257.24	$1,833.15	$854.93	$1,194.67	$928.39	$1,606.66	$1,022.07	$1,512.98
Retiree/Survivor +2 or More Dependents *without* Medicare	$1,113.52	$2,226.22	$1,257.24	$2,597.30	$854.93	$1,758.64	$928.39	$2,235.24	$1,022.07	$2,141.56
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$1,012.70	$1,261.60	$1,124.47	$1,434.81	$772.89	$948.55	$838.11	$1,335.80	$931.78	$1,242.13
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$1,012.70	$1,923.74	$1,124.47	$2,198.96	$772.89	$1,512.52	$838.11	$1,964.38	$931.78	$1,870.71

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

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

2021 Medical Premiums: Retiree or Survivor *without* Medicare (Outside of California)

Retirees hired BEFORE January 9, 2009

Medical Premiums (Monthly)	Kaiser Permanente HMO						UHC PPO (No HMO Available)	
	Northwest		Washington		Hawaii			
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$1,211.49	$0	$1,462.25	$0	$902.51	$0	$1,650.46	$97.26
Retiree/Survivor +1 Dependent *without* Medicare	$1,815.74	$604.25	$2,191.89	$729.63	$1,352.28	$449.76	$2,044.13	$490.92
Retiree/Survivor +2 or More Dependents *without* Medicare	$1,815.74	$1,607.30	$2,191.89	$1,940.81	$1,352.28	$1,196.36	$2,044.13	$1,119.50
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$1,420.65	$209.16	$1,631.82	$169.56	$1,086.59	$184.08	$1,863.56	$310.35
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$1,420.65	$1,212.21	$1,631.82	$1,380.74	$1,086.59	$930.68	$1,863.56	$938.93

Retirees hired AFTER January 9, 2009[1] with *at least* 10 years but *less than* 15 years of service

Medical Premiums (Monthly)	Kaiser Permanente HMO						UHC PPO (No HMO Available)	
	Northwest		Washington		Hawaii			
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$605.75	$605.74	$731.13	$731.12	$451.26	$451.25	$825.23	$922.49
Retiree/Survivor +1 Dependent *without* Medicare	$907.87	$1,512.12	$1,095.95	$1,825.57	$676.14	$1,125.90	$1,022.07	$1,512.98
Retiree/Survivor +2 or More Dependents *without* Medicare	$907.87	$2,515.17	$1,095.95	$3,036.75	$676.14	$1,872.50	$1,022.07	$2,141.56
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$710.33	$919.48	$815.91	$985.47	$543.30	$727.37	$931.78	$1,242.13
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$710.33	$1,922.53	$815.91	$2,196.65	$543.30	$1,473.97	$931.78	$1,870.71

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

2021 Medical Premiums: Retiree or Survivor *with* Medicare Part A and Part B (California)

Retirees hired BEFORE January 9, 2009

Medical Premiums (Monthly)	Kaiser Permanente Senior Advantage HMO		UHC Medicare Advantage PPO		UHC Medicare Advantage PPO with Non-Medicare Dependents			
					Blue Shield of CA Trio HMO		Blue Shield of CA Access+ HMO	
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$354.32	$0	$429.17	$0	$429.17	$0	$429.17	$0
Retiree/Survivor +1 Dependent *without* Medicare	$694.07	$339.75	$822.83	$393.67	$843.92	$414.74	$907.82	$478.65
Retiree/Survivor +2 or More Dependents *without* Medicare	$694.07	$903.72	$822.83	$1,022.25	$843.92	$1,076.88	$907.82	$1,242.80
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$529.99	$175.67	$642.27	$213.09	$642.27	$213.09	$642.27	$213.09
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$529.99	$739.64	$642.27	$841.67	$642.27	$875.23	$642.27	$977.24

Retirees hired AFTER January 9, 2009[1] with *at least* 10 years but *less than* 15 years of service

Medical Premiums (Monthly)	Kaiser Permanente Senior Advantage HMO		UHC Medicare Advantage PPO		UHC Medicare Advantage PPO with Non-Medicare Dependents			
					Blue Shield of CA Trio HMO		Blue Shield of CA Access+ HMO	
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$177.16	$177.16	$214.59	$214.58	$214.59	$214.58	$214.59	$214.58
Retiree/Survivor +1 Dependent *without* Medicare	$347.04	$686.78	$411.42	$805.08	$421.96	$836.70	$453.91	$932.56
Retiree/Survivor +2 or More Dependents *without* Medicare	$347.04	$1,250.75	$411.42	$1,433.66	$421.96	$1,498.84	$453.91	$1,696.71
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$265.00	$440.66	$321.14	$534.22	$321.14	$534.22	$321.14	$534.22
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$265.00	$1,004.63	$321.14	$1,162.80	$321.14	$1,196.36	$321.14	$1,298.37

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

2021 Medical Premiums: Retiree or Survivor *with* Medicare Part A and Part B (Outside of California)

Retirees hired BEFORE January 9, 2009

Medical Premiums (Monthly)	Kaiser Permanente Senior Advantage HMO						UHC Medicare Advantage PPO	
	Northwest		Washington		Hawaii			
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$421.30	$0	$342.11	$0	$371.14	$0	$429.17	$0
Retiree/Survivor +1 Dependent *without* Medicare	$1,025.55	$604.25	$1,071.75	$729.63	$820.91	$449.76	$822.84	$393.66
Retiree/Survivor +2 or More Dependents *without* Medicare	$1,025.55	$1,607.30	$1,071.75	$1,940.81	$820.91	$1,196.36	$822.84	$1,022.24
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$630.46	$209.16	$511.68	$169.56	$555.22	$184.08	$642.27	$213.09
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$630.46	$1,212.21	$511.68	$1,380.74	$555.22	$930.68	$642.27	$841.67

Retirees hired AFTER January 9, 2009[1] with *at least* 10 years but *less than* 15 years of service

Medical Premiums (Monthly)	Kaiser Permanente Senior Advantage						UHC Medicare Advantage PPO	
	Northwest		Washington		Hawaii			
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$210.65	$210.65	$171.06	$171.05	$185.57	$185.57	$214.59	$214.58
Retiree/Survivor +1 Dependent *without* Medicare	$512.78	$1,117.02	$535.88	$1,265.50	$410.46	$860.21	$411.42	$805.08
Retiree/Survivor +2 or More Dependents *without* Medicare	$512.78	$2,120.07	$535.88	$2,476.68	$410.46	$1,606.81	$411.42	$1,433.66
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$315.23	$524.39	$255.84	$425.40	$277.61	$461.69	$321.14	$534.22
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$315.23	$1,527.44	$255.84	$1,636.58	$277.61	$1,208.29	$321.14	$1,162.80

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

Vision Plans

Retirees and dependents enrolled in a medical plan are automatically enrolled in basic vision benefits.

Vision Plan Benefits

SFHSS members and dependents enrolled in a medical plan automatically receive vision coverage through VSP Vision Care. You may go to a VSP network or non-network provider. Visit **www.vsp.com** for a complete list of network providers.

Accessing Your Vision Benefits

To receive services from a network provider, contact the provider and identify yourself as a VSP Vision Care member *before* your appointment. VSP Vision Care will provide benefit authorization directly to the provider. Services must be received prior to the benefit authorization expiration date.

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

Basic Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every other calendar year unless enrolled in the VSP Premier Plan. If examination reveals prescription change of 0.50 diopter or more after 12 months, replacement lenses are covered.
- Eligible dependent children are covered in full for polycarbonate prescription lenses.
- Cosmetic extras, including progressive, tinted or oversize lenses, cost more.

Expenses Not Covered by Plan

- Orthoptics (and any associated supplemental testing), plano (non-prescription) lenses or two pairs of glasses in lieu of a pair of bifocals.
- Replacement of lenses or frames furnished that are lost or broken (except at the contracted intervals).
- Medical or surgical eye treatment (except for limited Primary eye care as described on page 23).
- Corrective vision treatments such as, but not limited to, LASIK and PRK laser surgery. You may be eligible for discounts from a VSP doctor.

VSP Basic and Premier Vision Plans

You now have a choice. As a new hire or during Open Enrollment, you can remain in the VSP Basic Plan or enroll in the VSP Premier Plan for enhanced benefits. See page 23 for more details.

VSP Vision Care Member Extras

VSP Vision Care offers exclusive special offers and discounts and rebates on popular contact lenses.

VSP also provides savings on *hearing aids* through TruHearing® for you, covered dependents and extended family including parents and grandparents.

No Medical Plan = No Vision Benefits

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

Vision Plan Benefits-at-a-Glance

Covered Services	VSP Basic[1]	VSP Premier
Well Vision Exam	$10 co-pay every calendar year	$10 co-pay every calendar year
Single Vision Lenses	$25 co-pay every other calendar year[2]	$0 every calendar year
Lined Bifocal Lenses	$25 co-pay every other calendar year[2]	$0 every calendar year
Lined Trifocal Lenses	$25 co-pay every other calendar year[2]	$0 every calendar year
Standard Progressive Lenses	100% coverage every other calendar year	100% coverage every calendar year
Premium Progressive Lenses	$95–$105 co-pay every other calendar year	$25 co-pay every calendar year
Custom Progressive Lenses	$150–$175 co-pay every other calendar year	$25 co-pay every calendar year
Standard Anti-Reflective Coating	$41 co-pay every other calendar year	$25 co-pay every calendar year
Premium Anti-Reflective Coating	$58–$69 co-pay every other calendar year	$25 co-pay every calendar year
Custom Anti-Reflective Coating	$85 co-pay every other calendar year	$25 co-pay every calendar year
Scratch-Resistant Coating	Fully covered every other calendar year[2]	Fully Covered every calendar year
Frames	$150 allowance for a wide selection of frames $170 allowance for featured frames $80 allowance use at Costco® $25 co-pay applies; 20% savings on amount over the allowance; every other calendar year	$300 allowance for a wide selection of frames $320 allowance for featured frames $165 allowance at Costco® No additional co-pay; 20% savings on the amount over your allowance every calendar year
Contacts *(instead of glasses)*	$150 allowance every other calendar year[2]	$250 allowance every calendar year
Contact Lens Exam	Up to $60 co-pay every other calendar year[2]	Up to $60 co-pay every calendar year
Primary Eye Care *(for the treatment of urgent or acute ocular conditions)*	$5 co-pay	$5 co-pay

Vision Care Discounts		
Laser Vision Correction	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities

Vision Care Premium Rates	VSP Basic Plan	Retiree/Survivor Monthly Contribution
	Included with your medical premium.	**Retiree/Survivor Only $10.50** **Retiree/Survivor + 1 Dependent $15.92** **Retiree/Survivor + Family $32.79**

Your Coverage with Out-of-Network Providers

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

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

[1]VSP Basic Plan coverage is included with your medical premium.

[2]Under the VSP Basic plan, new lenses may be covered the next year if Rx change is more than .50 diopters.

In the instance where information in this chart conflicts with the plan's Evidence of Coverage, the plan's Evidence of Coverage shall prevail.

Dental Plans

Dental benefits are a valuable part of your healthcare coverage and fundamental to your overall good health.

PPO Dental Plans

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

SFHSS offers the following PPO dental plan:

- Delta Dental PPO

Save Money By Choosing PPO Dentists

Delta Dental PPO has two different networks. Ask your dentist if they are a Delta Dental PPO network or a Premier network dentist. Both networks are held to the same quality standards.

You can also choose a dentist outside of the PPO and Premier networks. However, services may be covered at a lower percentage, so you pay more. Payment is based on reasonable and customary fees for the area.

Ask your Delta Dental dentist about costs *before* receiving services. You can request a pre-treatment estimate of costs before you receive care.

DHMO Dental Plans

Similar to medical HMOs, Dental Health Maintenance Organization (DHMO) plans require that you receive all of your dental care from within a network of participating dental offices. These networks are generally smaller than dental PPO networks.

Before you elect a DHMO plan, make sure that the plan's network includes the dentist of your choice.

Under these plans, services are covered either at no cost or a fixed co-pay. Out-of-pocket costs for these plans are generally lower than PPO plans.

SFHSS offers the following DHMO plans:

- DeltaCare USA DHMO
- UnitedHealthcare Dental DHMO

Delta Dental SmileWay

Delta Dental PPO's ***SmileWay*** program features 100% coverage for one annual periodontal scaling and root planing procedure and an increased number of teeth cleaning or periodontal maintenance services for members with specific chronic conditions. Deductibles and Calendar Year Benefit Maximum apply. To enroll, call Delta Dental PPO directly at **(888) 335-8227**.

2021 Dental Premiums: All Retirees (and Survivors)

2021 MONTHLY DENTAL PREMIUMS	DELTA DENTAL PPO		DELTACARE USA DHMO		UNITEDHEALTHCARE DENTAL DHMO	
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree Only	$0	$43.90	$0	$30.93	$0	$15.98
Retiree +1 Dependent	$0	$87.32	$0	$51.04	$0	$26.38
Retiree +2 or More Dependents	$0	$130.32	$0	$75.50	$0	$39.01

Dental Plan Benefits-at-a-Glance

	Delta Dental PPO			DeltaCare USA DHMO	UnitedHealthcare Dental DHMO
Choice of Dentist	You may choose any licensed dentist. You will receive a higher level of benefit and lower out-of-pocket costs with Delta Dental PPO or Premier network dentists.			DeltaCare USA **network only**	UHC Dental **network only**
Deductible	$75 per person; $150 for family for Premier and out-of-network services, excluding diagnostic and preventive care			None	None
Plan Year Maximum	$1,250 per person Per calendar year, excluding orthodontia benefits, diagnostic and preventive care			None	None
Covered Services	**PPO Dentists**	**Premier Dentists**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
Cleanings[1] and Exams	100% covered annual - 2x/yr.; pregnancy - 3x/yr.	80% covered annual - 2x/yr.; pregnancy - 3x/yr.	80% covered annual - 2x/yr.; pregnancy - 3x/yr.	100% covered 1 every 6 months	100% covered 1 every 6 months
X-rays	100% covered full mouth 1x/5 years; bitewing 1x year over age 18; not subject to annual maximum	80% covered full mouth 1x/5 years; bitewing 1x year over age 18; not subject to annual maximum	80% covered full mouth 1x/5 years; bitewing 1x year over age 18; not subject to annual maximum	100% covered some limitations apply	100% covered some limitations apply
Extractions	80% covered	80% covered	80% covered	100% covered	$5-$25 co-pay
Fillings	80% covered	80% covered	80% covered	100% covered limitations apply to resin materials	$5-$25 co-pay
Crowns	60% covered	50% covered	50% covered	100% covered limitations apply to resin materials	100% covered limitations apply
Dentures, Pontics, and Bridges	60% covered	50% covered	50% covered	100% covered full and partial dentures 1x/5yrs.; fixed bridgework, limitations apply	$90-$100 co-pay
Endodontic/ Root Canals	60% covered	50% covered	50% covered	100% covered excluding the final restoration	$15-$60 co-pay
Oral Surgery	80% covered	80% covered	80% covered	100% covered authorization required	Co-pays vary
Implants	60% covered	50% covered	50% covered	Not covered	Covered Refer to co-pay schedule
Orthodontia	Not Covered	Not Covered	Not Covered	Member pays: $1,600/child $1,800/adult $350 startup fee; limitations apply	Member pays: $2,000/child $2,000/adult $350 startup fee; limitations apply
Night Guards	80% covered (1x3yr.)	80% covered (1x3yr.)	80% covered (1x3yr.)	$100 co-pay	100% covered

[1]Members with Chronic Conditions (diabetes, heart disease, HIV/AIDS, rheumatoid arthritis and stroke) may receive up to 4 cleanings per year.
In any instance where information in this chart conflicts with a plan's Evidence of Coverage (EOC), the plan's EOC shall prevail.

Eligibility

The following rules govern which retirees and dependents may be eligible for SFHSS health coverage.

Retiree Member Eligibility

- An employee must meet age and minimum service requirements *and* have been enrolled in SFHSS health benefits at some time during active employment to be eligible for retiree health coverage. SFHSS calculates service eligibility (requirements may vary).
- **If hired on or after January 9, 2009, Proposition B applies** (see page 28). If a retiree chooses to take a lump sum pension distribution, retiree health premium contributions will be *unsubsidized* and paid at *full cost* (other restrictions may apply). Contact SFHSS for an eligibility assessment of retiree health benefits.
- **Newly eligible retirees must enroll in retiree medical and/or dental coverage within 30 days of their effective retirement date.**
- To enroll, submit a completed Enrollment Application form and copies of your required eligibility documentation and retirement system paperwork by fax or mail. To download an Enrollment Application forms, visit **sfhss.org/benefits/retirees-with-medicare** or **sfhss.org/benefits/retirees-without-medicare**.
- Members eligible for Medicare at the time of retirement must also provide proof of Medicare enrollment. **Medicare applications take three to four months to process**, so plan ahead *before* your 65th birthday. **If you fail to meet required deadlines, you must wait until the next Open Enrollment period to enroll in benefits.**
- New retiree coverage will take effect on the first day of the month following the retirement effective date. Depending on your retirement date, there can be a gap between when your employee coverage ends and retiree coverage begins. **Setting a retirement date at the end of the month will help avoid a gap in your coverage.**
- Contact SFHSS Member Services at **(628) 652-4700** *at least three months* before your retirement date to prepare for enrollment in retiree benefits. **You must notify SFHSS, even if you are not planning to elect SFHSS coverage on your retirement date**.

Dependent Eligibility

Spouse and Domestic Partners

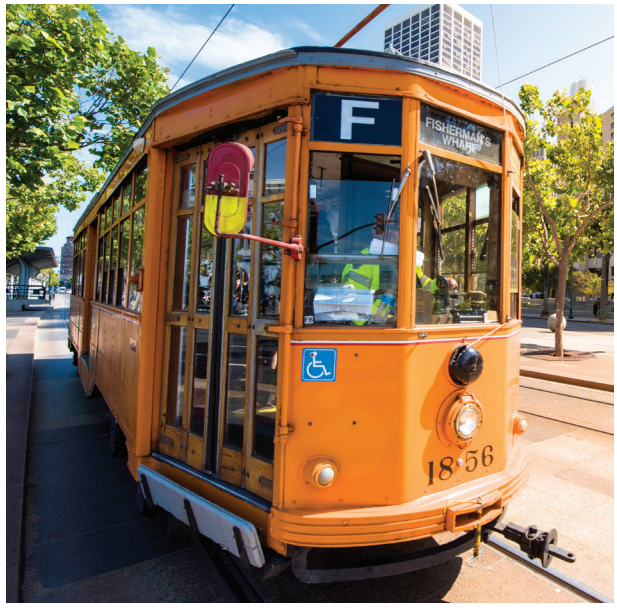
A member's spouse or registered domestic partner may be eligible for SFHSS health coverage. Proof of legal marriage or domestic partnership is required, as well as the dependent's Social Security number.

Enrollment in SFHSS benefits must be completed **within 30 days** of the date of marriage or partnership. A spouse or registered domestic partner can also be added during the Open Enrollment period in October.

A spouse who is eligible for Medicare and covered on an employee's medical plan is *not* required to enroll in Medicare. A registered domestic partner who is eligible for Medicare *is required* to enroll in Medicare.

Natural Children, Stepchildren, Adopted Children

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



Legal Guardianships and Court-Ordered Children

Children under 19 years of age placed under the legal guardianship of an enrolled member, a member's spouse, or domestic partner are eligible for coverage

If a member is required by a court's judgement, decree, or order to provide health coverage for a child, that child is eligible up to age 19. Coverage terminates at the end of the coverage period in which the child turns 19.

The member must provide SFHSS with proof of guardianship, court order, or decree with required deadlines. To continue coverage beyond age 19, the member will need to provide a copy of the child's birth certificate.

Adult Disabled Children

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

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

COBRA Continuation Coverage

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

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

For more information about COBRA, visit **sfhss.org/benefits/cobra** or contact us at **(628) 652-4700.**

Eligibility Under City Charter

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

Retirees and Proposition B

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

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

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

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

Different premium contribution rates apply for employees hired *after* January 9, 2009, based on eligibility and years of credited service.

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

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

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

If enrolled in SFHSS retiree health benefits administered by SFHSS:

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

Changing Benefit Elections: Qualifying Life Events

You may change health benefits elections outside of Open Enrollment if you have a Qualifying Life Event.

Certain life events count as a "Qualifying Life Event" where you can modify your benefits elections to support your new Qualifying Life Event. If you have a Qualifying Life Event, you can submit your elections and required documentation online using *eBenefits*, which you can access from the *Life Events* link under *Employee Links* on the City's Employee Portal. Visit sfhss.org/how-to-enroll to get started. Or you can submit your Enrollment Application form by fax to (628) 652-4701 or mail to SFHSS no later than 30 calendar days after the Qualifying Life Event occurs.

New Spouse or Domestic Partnership

Your election and required documents must be submitted **within 30 days** of the legal date of the marriage or partnership. You can also submit an Enrollment Application form and copies of required documentation by fax or mail. Certificates of domestic partnership must be issued in the United States. A Social Security number must be provided for each enrolling family member. Proof of Medicare is also required for a domestic partner who is Medicare-eligible due to age or disability. Coverage for your spouse or domestic partner is effective the first day of the coverage period following receipt and approval of required documentation.

Newborn or Newly Adopted Child

Coverage for an enrolled newborn child begins on the child's date of birth. Coverage for an enrolled adopted child will be effective on the date the child is placed. SFHSS provides a one-time benefit reimbursement to an eligible member for qualified expenses incurred from an eligible adoption or eligible surrogacy. For more information, visit **sfhss.org/surrogacy-and-adoption**. A Social Security number must be provided to SFHSS **within six months** of the date of birth or adoption, or your child's coverage may be terminated. Use ***eBenefits*** to enroll online.

Legal Guardianship or Court Order

Coverage for a child under legal guardianship or court order shall begin upon effective date of guardianship or court order is submitted by the **30-day deadline.** Coverage for a dependent per a court order will be effective 30 days from the date of receipt of the court order, if all documentation is submitted to SFHSS by the **30-day deadline**. Use ***eBenefits*** to enroll online.

Divorce, Separation, Dissolution, Annulment

A member must immediately notify SFHSS in writing and provide documentation when the legal separation, divorce or final dissolution of marriage has been granted. Coverage of an ex-spouse, step-children, domestic partner and children of domestic partner will terminate on the last day of the coverage period of the event date. Use ***eBenefits*** to enroll online.

Loss of Other Health Coverage

SFHSS members and eligible dependents who lose other healthcare coverage may enroll within 30 days in SFHSS benefits of the loss of other coverage. Once required documentation is submitted and processed, coverage will be effective on the first day of the next coverage period. Use ***eBenefits*** to enroll online.

Obtaining Other Health Coverage

You may waive SFHSS coverage for yourself or a dependent who enrolls in other health coverage **within 30 days**. If you waive coverage, all coverage for enrolled dependents will also be waived. After all required documentation (proof of coverage must be on letterhead) is submitted, coverage will terminate on the last day of the coverage period following receipt and approval of required documentation. Use ***eBenefits*** to enroll online.

Moving Out of Your Plan's Service Area

If you move your residence to a location outside of your plan's service area, you can enroll in an SFHSS plan that offers service where your new address is located **within 30 days**. Coverage will be effective the first day of the coverage period following receipt and approval of required documentation. Therefore, it is important to notify SFHSS before you move. If you do not contact us in advance of your move, a lapse in coverage may occur from the date you notify SFHSS and the effective coverage date.

Death of a Dependent

In the event of the death of a dependent, notify SFHSS as soon as possible and submit a copy of the death certificate **within 30 days** of the event.

Death of a Member

In the event of a member's death, the **surviving dependent** or **survivor's designee** should contact SFHSS to obtain information about eligibility for survivor health benefits.

Upon notification, SFHSS will mail instructions to the spouse or partner, including a list of required documents for enrolling in surviving dependent health coverage.

A surviving spouse or partner who is not enrolled on the deceased member's health plan at the time of the member's death may be eligible for coverage, but must wait to enroll during the next Open Enrollment period.

Responsibility for Premium Contributions

Changes in coverage due to a qualifying event may change premium contributions. **If your premium is deducted from your pension check, review your pension check statement to make sure premium deductions are correct. If your premium deduction is incorrect, contact SFHSS.** You must pay any premiums that are owed. Unpaid premium contributions will result in termination of coverage.

Failure to notify SFHSS of your dependent(s) ineligibility can result in significant financial penalties equal to the total cost of benefits and services provided to ineligible dependent(s).

Retirees Living or Traveling Outside of the United States

For Medicare and non-Medicare Members.

Traveling Outside of Your Plan's Service Area

Contact your health plan *before* traveling to determine available coverage and for information about how to contact your plan from outside of the United States.

In general, if you are traveling outside of the United States:

- Blue Shield of California's Trio HMO and Access+ HMO for retirees without Medicare only covers *emergency services* outside of California service areas.
- Kaiser Permanente HMO and Kaiser Permanente's Senior Advantage HMO plans only cover *urgent and emergency services* outside of their service areas.
- UnitedHealthcare Medicare Advantage PPO covers *urgently needed* or *emergency services* outside of the United States or U.S. Territories.
- Pre-Medicare retirees in the UnitedHealthcare PPO (City Plan) are covered outside of the United States. If you obtain service outside of the United States, you will pay Non-Network coinsurance.

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

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

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

Retirees Residing Permanently Outside of the United States

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

Medicare enrollment is not required for retired members over 65 residing outside of the United States (foreign residents). However, healthcare services within the United States will not be covered for foreign residents who are not enrolled in Medicare.

Members who choose to not enroll in Medicare must complete an SFHSS form certifying that they are waiving Medicare enrollment and waiving health coverage within the United States.

Before you drop Medicare, read this!
Before you disenroll in Medicare, the federal government may charge you significant penalties if you disenroll from Medicare and decide to re-enroll in the future.

If you are currently enrolled in a Medicare plan offered through SFHSS, and you are planning to move outside of the continental United States, you must contact SFHSS Member Services at **(628) 652-4700** for information on other health plan options that may be available to you which are different than those available in the United States.

Legal Notices

Women's Health and Cancer Rights Notice

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

Use and Disclosure of Your Personal Health Information

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

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

If you authorize SFHSS to disclose your health information, you may revoke that authorization in writing at any time. You have the right to express complaints to SFHSS and the Federal Health and Human Services Agency if you feel your privacy rights have been violated. Any privacy complaints made to SFHSS should be made in writing. This is a summary of a legal notice that details SFHSS privacy policy. The full legal notice of our privacy policy is available at **sfhss.org/sfhss-privacy-policy-and-forms**. You may also contact SFHSS to request a written copy of the full legal notice.

Medicare Part D Creditable Coverage Disclosure

Your SFHSS Medicare plan already includes pharmacy coverage that counts as Creditable Coverage for Medicare Part D.

The following disclosure applies if you plan to waive SFHSS medical benefits and secure your own coverage: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 33 or visit **sfhss.org/creditable-coverage** for more details.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

Patient Protection Provider Choice Notice

Participating SFHSS HMO plans require the designation of a primary care provider (PCP). You have the right to designate any primary care provider who participates in the health plan's network and who is available to accept you or your family members. Until you make a PCP designation, the HMO insurance provider you elect may designate one for you. For information on how to select a PCP, and for a list of the participating PCPs, contact your health plan or visit their website. For children, you may designate a pediatrician as the PCP. You do not need prior authorization from your health plan or from any other person (including your PCP) in order to obtain access to obstetrical or gynecological care from a health care professional within your PCP's medical group who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit **https://my.kp.org/ccsf** or **blueshieldca.com/sfhss** or contact the number on the back of your insurance card.

Medicare Creditable Coverage Notice

Medicare Part D Prescription Drug Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with San Francisco Health Service System (SFHSS) and about your options under Medicare's prescription drug coverage.

This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. SFHSS has determined that the prescription drug coverage offered by the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Drug Plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you do decide to join a Medicare drug plan, your SFHSS coverage will be affected. Benefits will not be coordinated with a Medicare Part D plan. If you do decide to join a Medicare drug plan and drop your SFHSS prescription drug coverage, be aware that you may not be able to get this coverage back (does not apply to active employees/dependents).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your coverage with SFHSS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium.

You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following Open Enrollment period in October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact SFHSS at **(628) 652-4700** for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, or if this coverage through SFHSS changes. You also may request a copy at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. If Medicare-eligible, you'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage, visit **medicare.gov** or call your **State Health Insurance Assistance Program** (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. They can be reached at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **(877) 486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit Social Security at **ssa.gov**, or call **(800) 772-1213. (TTY: 1 (800) 325-0778)**.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Prevention is worth more than the cure. Most Preventive Care is 100%[1] FREE.

Don't wait! Schedule your annual check-ups today!

Why wait for illness or injury to see your doctor when preventive care is FREE? **No co-pays or deductibles.** Get on your health care provider's calendar today. For more information about your benefits, visit **sfhss.org** or contact **SFHSS** at **(628) 652-4700** or toll-free at **(800) 542-2266**.

Annual Preventive Care Exams

	Medical	Dental	Vision
Type of Appointment	■ Annual Physical/Well-Check/Well-woman exam ■ Vaccinations recommended by your Primary Care Physician ■ Cancer Screenings recommended by your Primary Care Physician	■ Dental Exam and Cleaning Every 6 Months *(limit of two (2) dental exams and two (2) cleanings per calendar year)*	■ Annual Vision Exam
Make an Appointment	**Kaiser Permanente HMO: (800) 464-4000** **Blue Shield of California** ■ **Trio HMO: (855) 747-5800** ■ **Access+ HMO: (855) 256-9404** **UnitedHealthcare PPO (City Plan): (866) 282-0125** **UnitedHealthcare Medicare Advantage PPO (877) 259-0493**	**Delta Dental PPO: (888) 335-8227** **DeltaCare USA DHMO: (800) 422-4234** **UnitedHealthcare Dental DHMO: (800) 999-3367**	**VSP Vision Care: (800) 877-7195**

Preventive Care Scheduler

Appointment Type	Date	Time	Doctor	Address
Annual Well Check-up. Ask if your vaccinations are up to date.				
Annual Well-Woman Exam				
Flu Vaccination				
Cancer Screenings				
Bi-Annual Dental Cleaning				
Bi-Annual Dental Cleaning				
Annual Vision Exam				

[1]Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions.

Mental Health and Substance Abuse Benefits

Health Plans: Mental Health, Well-Being and Substance Abuse Benefits[1]

Kaiser Permanente HMO	Blue Shield of California HMO	UHC Medicare Advantage PPO and UHC PPO (City Plan)
Kaiser Permanente Traditional HMO members call **(800) 464-4000**. Kaiser Permanente Senior Advantage members call **(800) 443-0815**. Members can access self-care resources through *Calm* and *myStrength* apps.	Call **(877) 263-9952** to find a provider and schedule an appointment with *Teladoc Behavioral Health*.	UHC PPO (City Plan) members can call **(866) 282-0125** to make an appointment. UHC Medicare Advantage PPO members call **(877) 259-0493**. **Telemental Health:** To learn more, go to **welcometouhc.com/sfhss** or sign in to your account at **uhcretiree.com**.

Well-Being Services

To learn more, visit **sfhss.org/Using-Your-Benefits/using-your-benefits-retirees.**

Kaiser Permanente HMO	Blue Shield of California HMO	UHC Medicare Advantage PPO and UHC PPO (City Plan)
Medicare and Non-Medicare Plans	**Non-Medicare Only**	**Medicare and Non-Medicare Plans**
Silver&Fit Program (Medicare only): Join a fitness facility or get fit at home. Get online resources, rewards and be physically active. Visit **kp.org/silverandfit** or call **(877) 750-2746**.	**Gym Discounts:** Get started with discounts through *Fitness Your Way.* Trio HMO members can call **(855) 747-5800**. Access+ HMO members can call **(855) 256-9404**	**Silver Sneakers (Medicare only):** Memberships to participating gyms (in-network) and fitness classes for all adults 65+ and of all abilities. Visit **silversneakers.com** or call **(888) 423-4632** for more details.
Medical Weight Management Program: A health-conscious solution that is based on treating the whole you, not just your weight. Visit **kphealthyweight.com**.	**Weight Management Programs**: Make lasting lifestyle through **Wellvolution.com**.	Discounts are now available through the **Rally Marketplace**. Redeem **Rally Coins** for savings on purchases from consumer brands in fitness, entertainment and well-being categories.
Active & Fit Direct Discount Program: Flexible, low-cost fitness program, product & specialty provider discounts. Visit **choosehealthy.com** or call **(877) 335-2746** for more details.	**Chiropractic & Acupuncture Benefits:** Services are provided through the *American Specialty Health Network* with a $15 co-pay per visit. To find a practitioner, call **(800) 678-9133**.	**Real Appeal Program (Medicare and non-Medicare members):** A practical solution for members at risk of obesity-related diseases and those who want to maintain a healthy lifestyle. Enroll at **uhc.realappeal.com** or **(844) 344-7325.**
Chiropractic & Acupuncture Benefits: Available through *ASH Network*. Visit **my.kp.org/ccsf/chiroandacu** or call **(800) 678-9133** for more details.		**Chiropractic & Acupuncture Benefits (Medicare and non-Medicare members):** Self-refer to a licensed practitioner. Find a practitioner at **welcometouhc.com/sfhss**.
Programs and Classes: Visit **my.kp.org/ccsf/healthy-extra** for more details.		

[1]As a result of mental health parity law, there is no yearly, or lifetime dollar amounts for mental health benefits. Please contact EAP if you have difficulty accessing mental health or substance abuse services through your health plan.

Health Service Board Achievements

Karen Breslin
President
Elected Retiree

Stephen Follansbee, M.D.
VP, Appointed by
Former Mayor Lee

Chris Canning
Elected by SFHSS
Membership

Dean Preston
Appointed by
Supervisor Yee

Randy Scott
Appointed by
Controller's Office

Mary Hao
Appointed by
Mayor Breed

Claire Zvanski
Appointed by
Board of
Supervisors

To accommodate the shelter-in-place public health order due to the COVID-19 pandemic, the Health Service Board (Board) fully migrated all Board Meetings onto a virtual platform in time for the Rates and Benefits approval process.

Following a month of preparation, multiple board training sessions, support, and the full participation of all Board Commissioners, the first virtual Board meeting was held on May 14, 2020. All members of the Board are commended for their dedication in learning how to navigate a new digital platform so quickly and ensuring that the Board meetings continued during uncertain times. As of July 2020, three Board meetings were broadcast virtually during the Rates and Benefits cycle.

Health Service Board Annual Self Evaluation

The Board completed their annual self-evaluation in December 2019 and worked with the Health Service Board Governance Committee and Department of Human Resources to review the results and prepare the final report to present to the full Board at the February 13, 2020 regular meeting. The Board plans to enhance the self-evaluation process in the future to recalibrate and ensure the Board is capturing the correct metrics.

Health Service Board Elections

The Board Secretary called for nominations and planned to conduct an election for one open Board Member Representative Commission Seat throughout the months of October through February. By February 13, one eligible member submitted their nomination form, list of signatures, and candidacy forms for the 2020 election.

Under Administrative Code Section 16.553, if there are no competing candidates for an open seat, then the Department of Elections is not required to hold an election, and the eligible candidate is declared a member of the Board.

The candidate, Commissioner Claire Zvanski, assumed the open seat on May 15, 2020.

Health Service Board Commissioner Re-Appointments and Orientation Processing

At the May 14 Board meeting, the Board had the full Board seated. Commissioner Stephen Follansbee, M.D., was re-appointed to the Board by Mayor Breed to serve a five-year term concluding in May 2025. Commissioner Randy Scott was re-appointed by the San Francisco Controller to serve a five-year term ending May 2025. SFHSS Leadership offered Board orientation materials digitally to the re-appointed Commissioners and to Commissioner Zvanski. Orientation materials include a comprehensive overview of the SFHSS departments and roles, the Board Commissioner role as a governing body, the Rates and Benefits Cycle and overall Board responsibilities.

Health Service Board Education

The Board's Finance and Budget Committee reviewed an educational outline for a Medical Plan's Rating Methodology at the February 13, 2020 Committee meeting. The Committee Members reviewed the materials and provided input to SFHSS's actuarial and benefit consultant, Aon, to ensure the materials were beneficial for the public as well as the Board.

A series of online educational videos were created and published on the Board Education page focusing on the medical plan rating methodologies used by Aon. A presentation document was prepared and delivered in the video series by the lead actuary, from Aon, in early April 2020. The four-part video presentation outlines the process that the health plans use to set the rates for SFHSS health plans. The videos covered rate-setting methodologies for active employee and early retiree populations (i.e. non-Medicare members).

Health Service Board Approval on Benefit and Plan Enhancements

Premium increase of 5.8% for Kaiser Permanente HMO Plan for Non-Medicare members who live in California.

Per member per month rate reduction of -5% for Kaiser Permanente Medicare Advantage Plan, which includes the approval of a Post-Hospital Discharge Meal Delivery Rider and expansion of existing appointment and post-discharge transportation services to include wheelchair and gurney transport in 2021.

Overall average rate decrease of -1.7% for Kaiser Permanente Multi-Region Plan for early retirees and an overall average rate decrease of -0.1% for Medicare retirees across the Hawaii, Northwest and Washington regions.

A rate decrease of -1.75% for Delta Dental PPO for retirees that included an added benefit for coverage of nitrous oxide/non-IV sedation.

A rate increase of 0.6% for Delta Dental PPO for Actives with no change in employee contributions, and an added benefit for coverage of nitrous oxide/non-IV sedation is included.

A rate decrease of -1.75% for DeltaCare USA HMO for Actives and Retirees.

Overall premium rate decrease of -1.5% for Life Insurance and Long-term Disability insurance, which included a decrease of -7.9% on basic life insurance and no rate increase for long-term disability insurance, employee and dependent supplemental life and child life insurance, and AD&D insurance.

A rate increase of 9% for UnitedHealthcare PPO (City Plan) and City Plan–Choice Not Available.

A rate decrease of -3.0% for UnitedHealthcare Dental HMO for actives and retirees.

A rate decrease of -2.9% for UnitedHealthcare Medicare Advantage PPO approved.

A 0% rate increase for VSP Basic and 4.1% increase for VSP Premier Vision Plans.

Key Contacts

SFHSS
1145 Market Street, 3rd Floor
San Francisco, CA 94103
Tel: (628) 652-4700
Toll Free: (800) 541-2266
Fax: (628) 652-4701
sfhss.org

Telephone hours: Monday, Tuesday, Wednesday and Friday from 9am-12pm and 1pm to 5pm and Thursday from 10am to 12pm and 1pm to 5pm.

Well-Being
Catherine Dodd Wellness Center
1145 Market Street, 1st Floor
San Francisco, CA 94103
Tel: (628) 652-4650
Fax: (628) 652-4601
wellbeing@sfgov.org
sfhss.org/well-being

Health Service Board
Attn. Board Secretary
1145 Market Street, 3rd Floor
San Francisco, CA 94103
Tel: (628) 652-4719
Fax: (628) 652-4702
health.service.board@sfgov.org
sfhss.org/health-service-board

PENSION BENEFITS

SFERS
Employees' Retirement System
(415) 487-7000
mysfers.org

CalPERS
(888) 225-7377
calpers.ca.gov

CalSTRS
(800) 228-5453
calstrs.org

PARS
(800) 540-6369
parsinfo.org

NON-MEDICARE PLANS

Trio HMO
Blue Shield of California
(855) 747-5800
blueshieldca.com/sites/imce/trio.sp
Group W0051448

Access+ HMO
Blue Shield of California
(855) 256-9404
blueshieldca.com/sfhss
Group W0051448

UnitedHealthcare PPO (City Plan)
(866) 282-0125
welcometouhc.com/sfhss
Group 752103

Kaiser Permanente
Traditional HMO
my.kp.org/ccsf

In CA: (800) 464-4000
North CA - Group 888
South CA - Group 231003

In NW: (800) 813-2000
Group 21227

In WA: (206) 630-4636
Group 225512

In HI: (800) 966-5955
Group 10119

MEDICARE ADVANTAGE PLANS

UnitedHealthcare
Medicare Advantage PPO
(877) 259-0493
myuhc.com
Group 13694
Group 12786 Part B Only

Kaiser Permanente
Senior Advantage HMO
my.kp.org/ccsf

In CA: (800) 443-0815
North CA - Group 888
South CA - Group 231003

In NW: (877) 852-5081
Group 21227

In WA: (206) 630-4600
Group 225512

In HI: (877) 852-5081
Group 10119

MEDICARE ADVANTAGE FITNESS PLANS

SilverSneakers Fitness Program
(UHC Medicare Advantage PPO)
(866) 584-7389
silversneakers.com

Silver&Fit **Fitness Program**
(Kaiser Senior Advantage HMO)
(877) 750-2746
silverandfit.com

DENTAL AND VISION PLANS

Delta Dental PPO
(888) 335-8227
deltadentalins.com/ccsf
Group 01673

DeltaCare USA DHMO
(800) 422-4234
deltadentalins.com/ccsf
Group 71797-0001

UHC Dental DHMO
(800) 999-3367
welcometouhc.com/sfhss
Group 275550

VSP Vision Care
(800) 877-7195
www.vsp.com
Group 12145878

OTHER AGENCIES

Social Security
Medicare Enrollment
(800) 772-1213
(800) 325-0778 (TTY)
ssa.gov

Medicare
Medicare Administration
(800) 633-4227
(877) 486-2048 (TTY)
medicare.gov

Health Insurance Exchange
Covered California
(888) 975-1142
coveredca.com

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