HEALTH BENEFITS OPEN ENROLLMENT
OCTOBER 1–29, 2021

SAN FRANCISCO
HEALTH SERVICE SYSTEM

Municipal Executive Employees

Step-by-Step Open Enrollment Guide

STEP 1: Review your Open Enrollment Letter for current medical, dental and vision elections and new 2022 rates.

Do you have any changes you want to make?

- If **YES**, go to **Steps 2 through 8** on how to make changes.
- If **NO**, please continue to **Step 2** if you would like to enroll in a Healthcare or Dependent Care Assistance FSA and **Step 3** to see if you need to add or drop dependents. Otherwise, no further action is required. Please proceed to **Step 9.**

STEP 2: FSA accounts require annual re-enrollments. Learn about your FSA options and rules on page 8. Would you like to set aside pre-tax dollars for upcoming healthcare or dependent care expenses?

- If **YES**, determine how much you would like to set aside.
- Complete the ***Choose a Flexible Spending Account*** page in ***eBenefits***.
- If **NO**, please review **Step 3**.

STEP 3: Review dependent eligibility rules online at **sfhss.org/eligibility-rules** and the dependent(s) listed in your enclosed Open Enrollment letter. Do you need to add or drop a dependent?

- If **NO**, and you have no changes to your benefit elections, then you have no further actions to take.
- If **YES,** complete the ***Review Dependents*** page in ***eBenefits*** to add dependents or modify existing dependents.
- Save and continue through all the screens and confirm at the end to submit your changes.
- Submit copies of supporting documents. New dependents must have supporting documentation submitted with their elections in order to be enrolled (e.g. birth certificate, certified marriage certificate).

STEP 4: Are you interested in voluntary benefits that could protect your savings from an injury or illness?

- Go to page 9 to review the different voluntary benefits.
- Contact WORKTERRA at **(866) 528-5360** or enroll online. To access the WORKTERRA application, go to **https://myapps.sfgov.org** and click on the WORKTERRA tile where you can self-enroll, dis-enroll, or confirm any existing elections.

STEP 5: Making changes to your health plan benefits.

- Review the Service Areas of the medical plans available to you online at **sfhss.org/actives-service-areas**.
- Review coverage details on pages 4 and 5.
- Review the rates for available plans in your area on page 2 of your enclosed Open Enrollment letter.
- Select your plan and complete ***Choose a Medical Plan*** page in ***eBenefits***.

STEP 6: Making changes to your vision benefits.

- Review the Vision benefits options and rates on page 6.
- 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 be enrolled in the VSP Premier Plan.
- Complete the ***Enroll in a Vision Premier Plan*** page in ***eBenefits.***

STEP 7: Making changes to your dental benefits.

- Review your Dental benefit options and costs on page 7.
- Complete the ***Enroll in a Dental Plan*** page in ***eBenefits***.

STEP 8: Complete your ***eBenefits*** elections online. Refer to the enclosed Self-Service instructions attached to your letter or go to **sfhss.org/ebenefits** to get started. Be sure to click **Save and Continue** through each screen. You must click **Submit** at the end in order to complete your enrollment. Otherwise your elections will not be recorded.

If you are unable to enroll online, download an Open Enrollment Application form and return your form and documentation by fax or mail to SFHSS. Our mailing address is **1145 Market Street, 3rd Floor, San Francisco, CA 94103** or fax to **(628) 652-4701**. To download an Open Enrollment Application form, visit **sfhss.org/oe2022**

STEP 9: You'll receive your Confirmation Statement in the mail from SFHSS in December.

Please review the Confirmation Statement to make sure your benefit elections are correct. *Changes made during Open Enrollment take effect January 1, 2022.* **In order to serve as many members as possible, we are providing consultations by telephone only. For HELP**, call SFHSS Member Services at **(628) 652-4700** or visit **sfhss.org**

The Open Enrollment deadline is October 29, 2021, 5:00pm, PST.

MEA-SS

Executive Director's Message

I used to sew my own clothes when I was younger. I don't mean taking up the hem of my trousers or patching a hole—I followed a pattern and sewed my own clothes. It was quite common back then.

My family had a tradition of taking the scrap cloths and turning them into quilts. I realize this story dates me, but one of my fondest memories was my mom's 75th birthday. My sister organized a quilting party where three generations of women from my family gathered in a quilting circle with pillow size blocks and my mom taught us all how to create a quilt using materials and scraps from five generations of my family. We each made a pillow cover that day and I still have mine.

The COVID-19 pandemic gave me lots of time for reflection. I thought about my own family and how there's so much more I want to share with them, including the gifts my mom passed on to me. I thought about the importance of having strong foundations, not just for our families, but for our community as well. Our community, along with the entire world, was tested this past year.

When the pandemic hit, I had a front row seat allowing me to witness how all those years of community outreach, education, listening and learning from residents and building public private partnership had created a foundation of trust where our community had faith that we would get through this pandemic together. The San Francisco Bay Area vaccination rates are just remarkable compared to other urban areas in America.

We know the work can't stop here. There's always more we can do to build upon a good foundation. At the San Francisco Health Service System, we issued a health plan Request for Proposals (RFP) last year for our Active Employee and Early Retiree health benefits and we decided to add more choices and enhance our PPO plan. Please review your new choices carefully and select the plan that best meets the healthcare needs for you and your family.

As we continue our journey to pandemic recovery, I want to encourage you to reflect on the foundation of the relationships you have with your family and friends. The biggest lesson I learned after a year where I couldn't spend time with those I love is that we can all improve the quality of the time when we can spend time together. Maybe that means turning off our cell phones to give our loved ones our undivided attention or maybe it's sharing a recipe or craft, like quilting, that has been passed down from generations.

Be well,

Abbie Yant, *RN, MA*
Executive Director

Most Preventive Care is 100% FREE.

Your Health Matters. Don't Wait until You Get Sick. Schedule Your Preventive Care Check Up Today.

Schedule Your Annual Preventive Care Exams Today

	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 2 dental exams and 2 cleanings per calendar year)* ■ Additional Benefits during pregnancy; 1 additional oral exam and either 1 additional routine cleaning or periodontal scaling and root planing per quadrant.	■ Annual Vision Exam
Make an Appointment	**Health Net CanopyCare HMO:** Contact your primary care physician listed on your ID card. **Blue Shield of California:** ■ **Trio HMO (855) 747-5800** ■ **Access+ HMO (855) 256-9404** ■ **PPO-Accolade (866) 336-0711** **Kaiser Permanente HMO: (800) 464-4000**	**Delta Dental PPO (888) 335-8227**, or request a virtual consultation with a PPO dentist from your home by visiting **www1.deltaden-talins.com/virtual-consult** **DeltaCare USA DHMO (800) 422-4234** **UnitedHealthcare Dental DHMO (800) 999-3367**	**VSP Vision Care (800) 877-7195**

How to Get Care

	Health Net CanopyCare HMO	Blue Shield of California Trio HMO, Access+ HMO and PPO-Accolade	Kaiser Permanente HMO
24/7 Nurseline			
	(800) 893-5597	**Trio HMO: (877) 304-0504** **Access+ HMO: (877) 304-0504** **PPO-Accolade: (866) 336-0711**	**Nurse Advice 24/7 (866) 454-8855**
Urgent After-Hours Care			
	Visit **CanopyHealth.com** for in-network Urgent Care Centers located throughout the Bay Area. You can also log in to **MyCanopyHealth.com** to get a virtual visit with a physician for many urgent issues no matter where you are in the U.S.	**Trio HMO: (855) 747-5800** **blueshieldca.com/sites/imce/trio.sp** **Access+ HMO: (855) 256-9404** **blueshieldca.com/sfhss** **PPO-Accolade: (866) 336-0711** **member.accolade.com**	**(866) 454-8855** **my.kp.org/ccsf**
Telemedicine			
	Ask your doctor if a video or telephone visit is right for you. If you have an urgent issue you can log into **MyCanopyHealth.com** for a non-emergency physician virtual visit 24/7/365.	Blue Shield members can access *Teladoc's* U.S. board-certified doctors 24/7/365 to resolve non-emergency medical issues by phone or video. Visit **teladoc.com/bsc** or call **(800) 835-2362.**	When scheduling an appointment in person or through the *Appointment and Advice line* **(866) 454-8855**, ask if a video visit is right for your symptoms

Medical Plans

This chart provides a summary of benefits only. To enroll in Health Net CanopyCare HMO, Kaiser Permanente HMO, or Blue Shield of California Trio or Access+ HMO, you must live or work in a zip code serviced by the plan. Contact the medical plan if you have questions about covered service areas. Blue Shield of California PPO-Accolade does not have service area requirements. In any instance where information in this chart or Guide conflicts with the plan's Evidence of Coverage (EOC), the plan's EOC shall prevail. Review your plan's EOC (available for download) at **sfhss.org/oe2022**.

	HEALTH NET CANOPYCARE HMO	BLUE SHIELD of CALIFORNIA HMO		KAISER PERMANENTE HMO	BLUE SHIELD of CALIFORNIA PPO-ACCOLADE	
	CANOPYCARE HMO	TRIO HMO	ACCESS+ HMO	TRADITIONAL HMO	BLUE SHIELD OF CALIFORNIA PPO-ACCOLADE	
Choice of Physician	PCP assignment required.	PCP assignment required.	PCP assignment required.	KP network only. PCP assignment required.	You may use any licensed provider. You receive a higher level of benefit and pay lower out-of-pocket costs when choosing in-network providers.	
Deductible	No deductible	No deductible		No deductible	IN-NETWORK AND OUT-OF-AREA $250 employee only $500 +1 $750 +2 or more	OUT-OF-NETWORK $500 employee only $1,000 +1 $1,500 +2 or more
Out-of-Pocket Maximum does not include premium contributions	$2,000 per individual $4,000 per family	$2,000 per individual $4,000 per family		$1,500 per individual $3,000 per family	$3,750 per individual $7,500 per family	$7,500 per individual
General Care and Urgent Care						
Annual Physical; Well Woman Exam	No charge	No charge		No charge	100% covered no deductible	50% covered after deductible
Doctor Office Visit	$25 co-pay	$25 co-pay		$20 co-pay	85% covered after deductible	50% covered after deductible
Urgent Care Visit	$25 co-pay in-network and out-of-network	$25 co-pay in-network		$20 co-pay	85% covered after deductible	50% covered after deductible
Family Planning	No charge	No charge		No charge	100% covered no deductible	50% covered after deductible
Immunizations	No charge	No charge		No charge	100% covered no deductible	100% covered no deductible
Lab and X-ray	No charge	No charge		No charge	85% covered after deductible & prior notification	50% covered after deductible & prior notification
Doctor's Hospital Visit	No charge	No charge		No charge	85% covered after deductible	50% covered after deductible
Prescription Drugs						
Pharmacy: Generic	$10 co-pay 30-day supply	$10 co-pay 30-day supply		$5 co-pay 30-day supply	$10 co-pay 30-day supply	$10 co-pay plus 50% Coinsurance; 30-day supply
Pharmacy: Brand-Name	$25 co-pay 30-day supply	$25 co-pay 30-day supply		$15 co-pay 30-day supply	$25 co-pay 30-day supply	$25 co-pay plus 50% Coinsurance; 30-day supply
Pharmacy: Non-Formulary	$50 co-pay 30-day supply	$50 co-pay 30-day supply		Physician authorized only	$50 co-pay 30-day supply	$50 co-pay, plus 50% Coinsurance; 30-day supply
Mail Order: Generic	$20 co-pay 90-day supply	$20 co-pay 90-day supply		$10 co-pay 100-day supply	$20 co-pay 90-day supply	Not covered
Mail Order: Brand-Name	$50 co-pay 90-day supply	$50 co-pay 90-day supply		$30 co-pay 100-day supply	$50 co-pay 90-day supply	Not covered
Mail Order: Non-Formulary	$100 co-pay 90-day supply	$100 co-pay 90-day supply		Physician authorized only	$100 co-pay 90-day supply	Not covered
Specialty	20% up to $100 co-pay; 30-day supply	20% up to $100 co-pay; 30-day supply		20% up to $100 co-pay; 30-day supply	$50 co-pay 30-day supply	$50 co-pay, plus 50% Coinsurance; 30-day supply

	HEALTH NET CANOPYCARE HMO	BLUE SHIELD of CALIFORNIA HMO		KAISER PERMANENTE HMO	BLUE SHIELD of CALIFORNIA PPO-ACCOLADE	
	CANOPYCARE HMO	TRIO HMO	ACCESS+ HMO	TRADITIONAL HMO IN-NETWORK ONLY	IN-NETWORK AND OUT-OF-AREA	OUT-OF-NETWORK
Hospital Outpatient and Inpatient						
Hospital Outpatient	$100 co-pay per surgery	$100 co-pay per surgery		$35 co-pay	85% covered after deductible	50% covered after deductible
Hospital Inpatient	$200 co-pay per admission	$200 co-pay per admission		$100 co-pay per admission	85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification
Hospital Emergency Room	$100 co-pay waived if hospitalized	$100 co-pay waived if hospitalized		$100 co-pay waived if hospitalized	85% covered after deductible if non-emergency, 50% after deductible	85% covered after deductible if non-emergency, 50% after deductible
Skilled Nursing Facility	No charge 100 days per plan year	No charge 100 days per plan year		No charge 100 days per benefit period	85% covered after deductible; 120 days per plan year; limits apply	50% covered after deductible; 120 days per plan year; limits apply
Hospice	No charge authorization required	No charge authorization required		No charge when medically necessary	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Maternity and Infertility						
Hospital or Birthing Center	$200 co-pay per admission	$200 co-pay per admission		$100 co-pay per admission	85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification
Pre-/Post-Partum Care	No charge	No charge		No charge	85% covered after deductible	50% covered after deductible
Well Child Care	No charge must enroll newborn within 30 days of birth; see EOC	No charge must enroll newborn within 30 days of birth; see EOC		No charge must enroll newborn within 30 days of birth; see EOC	100% covered no deductible	100% covered no deductible
IVF, GIFT, ZIFT and Artificial Insemination	50% covered limitations apply; see EOC	50% covered limitations apply; see EOC		50% covered limitations apply; see EOC	50% covered after deductible; limitations apply; prior notification	50% covered after deductible; limitations apply; prior notification
Mental Health and Substance Abuse						
Outpatient Treatment	$25 co-pay non-severe and severe	$25 co-pay non-severe and severe		$10 co-pay group; $20 co-pay individual	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Inpatient Facility including detox and residential rehab	$200 co-pay per admission	$200 co-pay per admission		$100 co-pay per admission	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Other						
Hearing Aids 1 aid per ear every 36 months; evaluation no charge	Up to $5,000, combined for both ears, every 36 months; no charge for evaluation	Up to $2,500 per ear, every 36 months; no charge for evaluation		Up to $2,500 per ear, every 36 months; no evaluation charge	85% covered after deductible; up to $2,500 per ear, every 36 months	50% covered after deductible; up to $2,500 per ear, every 36 months
Medical Equipment, Prosthetics and Orthotics	No charge as authorized by PCP	No charge as authorized by PCP		No charge as authorized by PCP	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Physical and Occupational Therapy	$25 co-pay	$25 co-pay		$20 co-pay authorization required	85% covered after deductible; limitations may apply, see EOC	50% covered after deductible; limitations may apply, see EOC
Acupuncture/ Chiropractic	$15 co-pay 30 visits max for each per plan year; ASH network	$15 co-pay 30 visits max for each per plan year; ASH network		$15 co-pay up to a combined total of 30 chiropractic and acupuncture visits/year; ASH network	50% covered after deductible; $1,000 max per plan year	50% covered after deductible; $1,000 max per plan year
Gender Dysphoria office visits and outpatient surgery	Co-pays apply authorization required	Co-pays apply authorization required		Co-pays apply authorization required	85% covered after deductible; prior notification	50% covered after deductible; prior notification

Vision Plans

SFHSS members and dependents enrolled in a medical plan automatically receive VSP Vision Care's Basic Vision coverage.

You may go to a VSP network or non-network provider. Visit **www.vsp.com** for a complete list of network providers. To receive services from a network provider, contact the provider and identify yourself as a VSP Vision Care member *before* your appointment. VSP 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 HMO), you are responsible for payment in full to the provider. You may submit an itemized bill to VSP for partial reimbursement. Download claim forms at **www.vsp.com**.

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 **Lined Bifocal Lenses** **Lined Trifocal Lenses**	$25 co-pay every other calendar year[2] $25 co-pay every other calendar year[2] $25 co-pay every other calendar year[2]	$0 every calendar year $0 every calendar year $0 every calendar year
Standard Progressive Lenses **Premium Progressive Lenses** **Custom Progressive Lenses**	100% coverage every other calendar year $95–$105 co-pay every other calendar year $150–$175 co-pay every other calendar year	100% coverage every calendar year $25 co-pay every calendar year $25 co-pay every calendar year
Standard Anti-Reflective Coating **Premium Anti-Reflective Coating** **Custom Anti-Reflective Coating**	$41 co-pay every other calendar year $58–$69 co-pay every other calendar year $85 co-pay every other calendar year	$25 co-pay every calendar year $25 co-pay every calendar year $25 co-pay every calendar year
Scratch-Resistant Coating	Fully covered every other calendar year	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
Contacts 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**	**VSP Premier Contribution (Biweekly)**
	Included with your medical premium.	**Employee Only $4.85** **Employee + 1 Dependent $7.35** **Employee + Family $15.13**

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.

IFPTE Local 21, SEIU 1021 and miscellaneous unrepresented employees are also eligible for VDT Computer VisionCare benefits. In any instance where information in this chart conflicts with the plan's Evidence of Coverage (EOC), the plan's EOC shall prevail.

Dental Plans

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

To enroll in **DeltaCare USA DHMO** or **UnitedHealthcare Dental DHMO**, you must reside in a California zip code serviced by the plan. Contact the dental plan to confirm covered service areas. **Delta Dental PPO** does not have service area requirements. Eligible members may enroll in dental coverage only, without enrolling in medical coverage. In the instance where information in this Chart conflicts with the plan's Evidence of Coverage (EOC), the plan's EOC shall prevail. For detailed description of benefits and exclusions for these plans, please review each plan's EOC, available for download at **sfhss.org/oe2022**.

	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	None			None	None
Plan Year Maximum	$2,500 per person Per calendar year, excluding orthodontia benefits			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.	100% 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 2x/year to age 18; 1x/year over age 18	100% covered full mouth 1x/5 years; bitewing 2x/year to age 18; 1x/year over age 18	80% covered full mouth 1x/5 years; bitewing 2x/year to age 18; 1x/year over age 18	100% covered some limitations apply	100% covered
Extractions	90% covered	80% covered	60% covered	100% covered	100% covered
Fillings	90% covered	80% covered	60% covered	100% covered limitations apply to resin materials	100% covered limitations apply
Crowns	90% covered	80% covered	50% covered	100% covered limitations apply to resin materials	100% covered limitations apply
Dentures, Pontics, and Bridges	50% covered	50% covered	50% covered	100% covered full and partial dentures 1x/5yrs.; fixed bridgework, limitations apply	100% covered full and partial dentures 1x/5yrs.; fixed bridgework, limitations apply
Endodontic/ Root Canals	90% covered	80% covered	60% covered	100% covered excluding the final restoration	100% covered
Oral Surgery	90% covered	80% covered	60% covered	100% covered authorization required	100% covered
Implants	50% covered	50% covered	50% covered	Not covered	Covered Refer to co-pay schedule
Orthodontia	50% covered child $2,500 lifetime max; adult $2,500 lifetime max.	50% covered child $2,000 lifetime max; adult $2,000 lifetime max.	50% covered child $1,500 lifetime max; adult $1,500 lifetime max.	Employee pays: $1,600/child $1,800/adult $350 startup fee; limitations apply	Employee pays: $1,250/child $1,250/adult $350 startup fee; limitations apply
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, Calendar Year Benefit Maximum does not apply. In any instance where information in this chart conflicts with a plan's Evidence of Coverage (EOC), the plan's EOC shall prevail.

Flexible Spending Accounts (FSAs)

FSA accounts require annual re-enrollments. IRS rules require annual enrollment in Flexible Spending Account(s) during Open Enrollment if you want to continue this benefit for the next plan year. If you do not re-enroll, your FSA will terminate at the end of the current plan year.

An FSA account allows you to set aside pre-tax dollars for qualified expenses incurred by you, your legal spouse, or a dependent or relative (as defined in Internal Revenue Code Section 125, which excludes certified domestic partners) with *pre-tax* dollars. FSAs are administered by the P&A Group.

If you are enrolled in an FSA and go on a leave of absence, you must contact SFHSS to arrange for contributions to be made directly to SFHSS in order to access your FSA funds while you are on your leave of absence.

Healthcare FSAs help pay for eligible healthcare expenses. This includes medical, pharmacy, dental and vision co-pays, other dental and vision care expenses, acupuncture and chiropractic care, and more.

For a complete list of eligible healthcare expenses, visit **padmin.com/participants/reimbursement-accounts/health-fsa**.

- Start by designating between $250 and $2,750 pre-tax dollars for the plan year. Deductions between $10 and $110 and will be taken biweekly from your paycheck in 2022.
- P&A will issue a debit card for you to use to make spending your FSA easier or you can submit a claim. smartphone app, online through P&A's website, fax, or mail.
- SFHSS administers a **Carryover minimum** of $10 and maximum of $550. At the end of the plan year claim. Claims can be submitted using P&A's filing period, unreimbursed Healthcare FSA funds below $10 and over $550 will be forfeited.
- **Carryover fund** amounts between $10 and $550 are determined after the end of the claim filing period and become available for any claims incurred as of the first day of the new plan year. **Carryover funds** can only be accessed for one plan year and any remaining **Carryover funds** will be forfeited. **There are no exceptions.**[1]

[1]Per IRS rules, you forfeit all funds remaining in an FSA by the end of the claim filing period unless covered by the Healthcare FSA Carryover provision.

2022 FSA expense reimbursement claims must be submitted to P&A by March 31, 2023, 11:59pm PST.

Contact **P&A Group** at **(800) 688-2611**, M–F, 5:30am to 7pm PST or visit **padmin.com**.

Dependent Care Assistance FSAs help pay for qualifying child care and dependent care expenses, such as certified nursery schools, after school programs, children's day care, day camps, caregiver for a disabled spouse or elderly dependent or eldercare (disabled spouse/elder must be a dependent on your tax return). Dependent Care Assistance FSAs are "pay as you go" accounts. You can only change your election if you have a change in status or a change in dependent care expenses. Dependent Care expenses must be incurred to enable you (and, if married, your spouse) to work. Children must be under age 13.

For a complete list of eligible dependent care expenses, visit **padmin.com/participants/reimbursement-accounts/dependent-care-assistance-account**.

- Set aside between $250 and $5,000 pre-tax per household for the plan year ($2,500 each if you are married filing separate federal tax returns). Deductions between $10 and $200 will be taken biweekly from your paycheck in 2022.
- Funds **cannot be used for dependent medical, dental, or vision expenses.** A birth or adoption is a qualifying event and allows you to enroll in Dependent Care midyear.
- You can submit reimbursement claims to P&A Group by mail, online, or smartphone app.
- Funds are available after being deducted from your paycheck and received by P&A Group. The entire annual amount is not available on January 1, 2022.
- If you or your spouse were providing care and then return to work, you may enroll or increase your Dependent Care election. If you were previously using dependent care elections and you or your spouse now work from home, you may decrease or stop your election. **There are no refunds for canceling or reducing elections.**
- **Unlike a Healthcare FSA, there is no Carryover option with Dependent Care Assistance FSAs.** Expenses and services need to be incurred in the same plan year or be forfeited. **There are no exceptions.**[1]

Flex Benefits

2022 Dollar Value of Flex Credits (Biweekly)

	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE +2 OR MORE				
			Health Net CanopyCare HMO	Blue Shield of California		Kaiser Permanente HMO	Blue Shield of CA PPO-Accolade
				Trio HMO	Access+ HMO		
CITY AND COUNTY OF SF							
MEA Miscellaneous Unrep. Managers Unrep. Employees MEA Fire and Police	$391.43	$451.65	$929.17	$883.51	$1,007.70	$774.10	$1,007.70
MTA							
MEA Unrep. Managers	$391.43	$451.65	$929.17	$883.51	$1,007.70	$774.10	$1,007.70
SUPERIOR COURT OF SF							
MEA Unrep. Managers Court Duty Officer Courts Comm. Assoc.	$1,299.00	$1,299.00	$1,299.00	$1,299.00	$1,299.00	$1,299.00	$1,299.00

Eligible employees of the City and County of San Francisco and Superior Court of San Francisco may apply these Flex Credit dollars to a variety of benefit options, including payment of employee medical and dental premium contributions. The amount of Flex Credits for employees +2 or more has been increased to reflect the City's commitment to ensuring affordable health coverage for families.

How Flex Benefits Work

The City and County of San Francisco provides qualifying employees with Flex Credits, which can be spent on a variety of *pre-tax and post-tax* benefit options, paid via payroll deduction. If the premium contributions for your benefit choices cost more than your flex credits, you pay the balance from salary.

If your benefits choices cost less than flex credits, you will receive cash back as taxable, non-pensionable earnings in your paycheck.

$150,000 Group Term-Life Insurance

Starting January 1, 2022, a $150,000 Group Term-Life Insurance policy is also provided at no cost to employees who are eligible for flex credit benefits. You are responsible for keeping your designated beneficiaries up-to-date.

New Hires

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

Open Enrollment

During Open Enrollment, Municipal Executives may change flex benefit elections, based on available *pre-tax and post-tax* options. Flex benefit changes are administered by **WORKTERRA** and must be completed during Open Enrollment. For questions, contact **WORKTERRA** at **(866) 528-5360**.

Flex Credit Benefit Options (Except FSAs) Will Roll Forward in 2022

If you are not making any changes to benefit selections, you do not need to contact **WORKTERRA** during Open Enrollment. Your current benefit elections (except FSAs) will roll forward in 2022.

Qualifying Life Event Changes

Members may reallocate flex credits outside of Open Enrollment if there is a Qualifying Life Event.

Leaves of Absence

If you are going on an unpaid leave of absence, you are responsible for making premium payments for your benefits while no payroll deductions are taken.

Flex Benefits

Maximize Your Benefits

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

Pre-Tax Flex Benefit Options

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

	EOI Required
Medical and Dental Premium Contributions	**No**
Healthcare Flexible Spending Account P&A Group	**No**
Dependent Care Flexible Spending Account P&A Group	**No**
Long-Term Disability Insurance (Employee Only and Employee +1) The Hartford	**Yes**[1]

Taxable Flex Benefit Options

	EOI Required
Accident Insurance MetLife*	**No**
Short-Term Disability Insurance Manhattan Life	**No** - Up to $3,000/Month **Yes** - Above $3,000/Month
Long-Term Care Insurance John Hancock, MetLife, Mass Mutual, Mutual of Omaha	**Yes**
Pet Insurance Pets Best	**No**
Group Legal Plan LegalShield	**No**
Critical Illness MetLife*	**No**
Supplemental Group Term-Life Insurance and Accidental Death & Disability Insurance (AD&D) The Hartford	**Yes**[2]
Identity Protection Benefits Plus Allstate Identity Protection*	**No**

Evidence of Insurability (EOI)

Some benefits require additional information from the applicant before enrollment is completed. This can include medical evidence. The insurer will contact you if specific records are required. It is your responsibility to provide all requested documentation. Enrollment may be denied by the insurer. In 2022, no payroll deductions will be taken until enrollment is approved by insurer(s). If approved, there may be a catch-up payroll deduction retroactive to the effective date of your policy. If denied coverage, no premiums for that benefit will be deducted from your paycheck.

To access the WORKTERRA application, go to https://myapps.sfgov.org and click on the WORKTERRA tile where you can self-enroll, dis-enroll, or confirm any existing elections.

[1] Evidence of Insurability (EOI) is not required for new hires or newly eligible employees. [2] Evidence of Insurability (EOI) is not required for new hires or newly eligible employees, for up to $150,000 life/AD&D insurance.

Mental Health and Substance Abuse Benefits

Everyone struggles sometimes. You're not alone.

Employee Assistance Program (EAP) – Available 24/7.

EAP, staffed by licensed therapists, provides confidential, voluntary and free mental health services to all Employees. **Appointments are available 24/7**. Call **(628) 652-4600** or toll-free **(800) 795-2351** to schedule an appointment. Visit us at **sfhss.org/eap.**

Individual Services	Organizational Services
■ Short Term solution focused counseling for individuals and couples ■ Assessments and referrals ■ Consultations and coaching	■ Management Consultation and Coaching ■ Mediation and Conflict Resolution ■ Critical Incident Response ■ Non-Violent Crisis Intervention Training ■ Workshops and Training

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

Please contact EAP if you have difficulty accessing Mental Health or Substance Abuse services through your health plan.

Health Net CanopyCare HMO	Blue Shield of California HMO and PPO-Accolade	Kaiser Permanente HMO
Mental Health and Substance Abuse		
Call Health Net's behavioral health administrator, MHN, at **(833) 996-2567** to obtain referrals for mental health and substance use disorder treatment services. You can also access outpatient providers through the MHN website at **www.mhn.com/members**. No authorization is required for psychotherapy or medication support services.	**Trio HMO and Access+ HMO:** Call **(877) 263-9952** to find a provider and schedule an appointment with *Blue Shield's Mental Health Service Administrator.* **PPO-Accolade:** Call **(866) 336-0711** to access mental health services.	Call **(800) 464-4000** to make an appointment. You don't need a referral from your Primary Care Physician (PCP) to see a therapist.
Mental Well-Being Services		
MHN members can access well-being resources through *myStrength*, personalized website offering clinically-proven mental health applications: **mystrength.com/go/healthnet/HNSFHSS** If you have questions about myStrength or additional wellness resources call MHN at **(833) 996-2567** to learn more.	**Counseling and Consultation:** *LifeReferrals* is available with no co-pay for up to three sessions. Topics include relationship problems, stress, grief, legal or financial issues, and community referrals.	**Classes and Support Groups:** Contact your local Kaiser Permanente facility for a calendar or visit **kp.org/mentalhealth**. **Health/Wellness Coaching:** Call **(866) 862-4295** to make an appointment for a Wellness Coach to contact you. **Apps:** Members can access self-care apps, *Calm* and *myStrength*, through **kp.org/selfcareapps**.

[1]As a result of mental health parity law, there is no yearly, or lifetime dollar amounts for mental health benefits.

Additional Benefits and Important Notices

Surrogacy and Adoption Reimbursement

Effective January 1, 2017, employees eligible for SFHSS benefits can apply for a one-time reimbursement of up to $15,000 for qualified expenses resulting from adoption or surrogacy. For information about how to apply for surrogacy or adoption reimbursement, contact SFHSS at (628) 652-4700 or go to **sfhss.org.**

Fertility and Infertility Services

Whether you're starting a family now or in the future, SFHSS has fertility treatment coverage available to all members regardless of age, race, relationship status or sexual orientation on all medical plans. Members must first consult their obstetrician or gynecologist to develop a plan to move forward with obtaining these benefits.

Employer-Paid Long-Term Disability Insurance

Some union contracts provide for Long-Term Disability Insurance (LTD). A long-term disability is an illness or injury that prevents you from working for an extended period of time.

If you submit a long-term disability claim and it is approved, the LTD plan may replace part of your lost income by paying you directly on a monthly basis.

LTD payments will be reduced if you qualify for other sources of income or disability earnings, such as workers' compensation or state disability benefits.

Benefit levels listed below depend on your bargaining unit:

- 60% or 66.6667% of monthly base earnings (as defined by The Hartford)
- $5,000 or $7,500 monthly maximum
- 90-180 day elimination period
- There may be a waiting period based on start work date

If you become disabled, notify The Hartford of your disability as soon as possible by calling **(888) 301-5615**. Within 30 days after the date of your disability, you should begin filing a long-term disability insurance claim with The Hartford. The Hartford will work with your doctor to certify that your illness or injury will keep you away from your job. For more information about Long-Term Disability Insurance, visit **sfhss.org/long-term-disability-insurance.**

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

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 primary care provider, and for a list of the participating primary care providers, contact your health plan or visit their website.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your health plan or from any other person (including your primary care provider) 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 **my.kp.org/ccsf**, **blueshieldca.com/sfhss**, **healthnet.com/sfhss**, or contact the number on the back of your insurance card.

Important Notices

Health Benefits Eligibility

The following are eligible to enroll as members in health plans offered by the San Francisco Health Service System:

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

Outside of Open Enrollment, members may enroll eligible dependents listed below or make election changes with a Qualified Life Event online using ***eBenefits*** (**sfhss.org/how-to-enroll**) or by completing and submitting an Enrollment Application and required documentation via fax or mail by the required deadlines:

- Spouse or registered domestic partner
- Natural child, stepchild, adopted child until the child's 26th birthday
- Child under legal guardianship or court order until the child's 19th birthday
- Adult disabled children who meet all SFHSS requirements

For more information about eligibility, visit **sfhss.org**.

Summary of Benefits and Coverage (SBCs)

The Affordable Care Act requires each insurer provide a standardized summary of benefits and coverage to assist people in comparing medical plans. Federally mandated SBCs are available online at **sfhss.org**.

Use and Disclosure of Your Personal Health Information

The San Francisco Health Service System maintains policies to protect your personal health information, in accordance with HIPAA, the federal Health Insurance Portability and Accountability Act. These policies restrict disclosure of your health information, except to:

- Make or obtain payments from contracted plan vendors
- Facilitate administration of health insurance coverage and services for SFHSS members
- Assist actuaries in negotiating health plan premiums
- Provide you with information about health benefits
- Disclose legally required information per federal, state or local law (incl. Workers' Compensation regulations), crime investigation and court order or subpoena
- Prevent a serious or imminent threat to individual or public health and safety

Other than the uses listed above, the SFHSS will not disclose your health information without your written authorization. For more information, visit **sfhss.org/sfhss-privacy-policy-and-forms**.

Health Service Board

Per the San Francisco City Charter, the Health Service Board conducts an annual review of health benefit costs, ensures benefits are applied without favor or privilege and administers the business of SFHSS. Board meetings are held the second Thursday of the month, at 1pm. For more information, visit **sfhss.org/health-service-board**.

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.

Covered California

Individuals who are not eligible for SFHSS coverage may obtain health insurance through the state insurance exchange, Covered California. In some cases, tax credits and other assistance may be available to make health insurance more affordable. For more details, call (**888) 975-1142** or visit **coveredca.com**. For information about exchanges in other states, visit **healthcare.gov**.

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

Medicaid or 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**.

If you or your dependents are already enrolled in **Medicaid** or **CHIP** and you live in a State listed below, contact your State **Medicaid** or **CHIP** office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in **Medicaid** or **CHIP**, and you think you or any of your dependents might be eligible for either of these programs, contact your State **Medicaid** or **CHIP** office or dial **(877) 543-7669** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under **Medicaid** or **CHIP**, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **(866) 444-3272**.

You may be eligible for assistance paying your employer health plan premiums.

For a complete list of participating states, visit: **sfhss.org/CHIP.**

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
(866) 444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
(877) 267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

For a complete list and contact information of states participating in the **CHIP** and **Medicaid Assistance** program, visit **sfhss.org/CHIP**.

California Medicaid

Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp or call **916-445-8322**.

Medicare Creditable Coverage

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 or 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). Visit **sfhss.org/creditable-coverage** for more details.

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

Employee Assistance Program
Catherine Dodd Wellness Center
1145 Market Street, 1st Floor
San Francisco, CA 94103
Tel: (628) 652-4600 - 24/7
Fax: (628) 652-4601
eap@sfgov.org
sfhss.org/eap

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

CCSF PAYMENT PORTAL

To make health premium payments online, visit the **City and County of San Francisco Payment Portal**:
sfhss.org/how-make-payment

MEDICAL PLANS

Health Net CanopyCare HMO
(833) 448-2042
healthnet.com/sfhss
Group G0727A

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

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

Kaiser Permanente HMO
(800) 464-4000
my.kp.org/ccsf
Group 888 (North CA)
Group 231003 (South CA)

Blue Shield of California
PPO-Accolade
(866) 336-0711
member.accolade.com
Group W0072990

DENTAL & VISION PLANS

Delta Dental PPO
(888) 335-8227
deltadentalins.com/ccsf
Group 09502-00003

DeltaCare USA DHMO
(800) 422-4234
deltadentalins.com/ccsf
Group 71797-00001

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

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

FSAs & COBRA

P&A Group (FSA)
(800) 688-2611
padmin.com

P&A Group (COBRA)
(800) 688-2611
padmin.com

VOLUNTARY BENEFITS

WORKTERRA Enrollment Services
(866) 528-5360
workterra.net

WORKTERRA Customer Service
(888) 327-2720

LTD & GROUP LIFE INS.

The Hartford Long-Term Disability
(888) 301-5615
abilityadvantage.thehartford.com
Group 804927

The Hartford Group Life Insurance
(888) 563-1124 or (888) 755-1503
thehartford.com/employee-benefits/value-added-services

To initiate a claim, contact SFHSS at **(628) 652-4700**

OTHER AGENCIES

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

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

Commuter Benefits
Department of the Environment
(415) 355-3700
sfenvironment.org

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