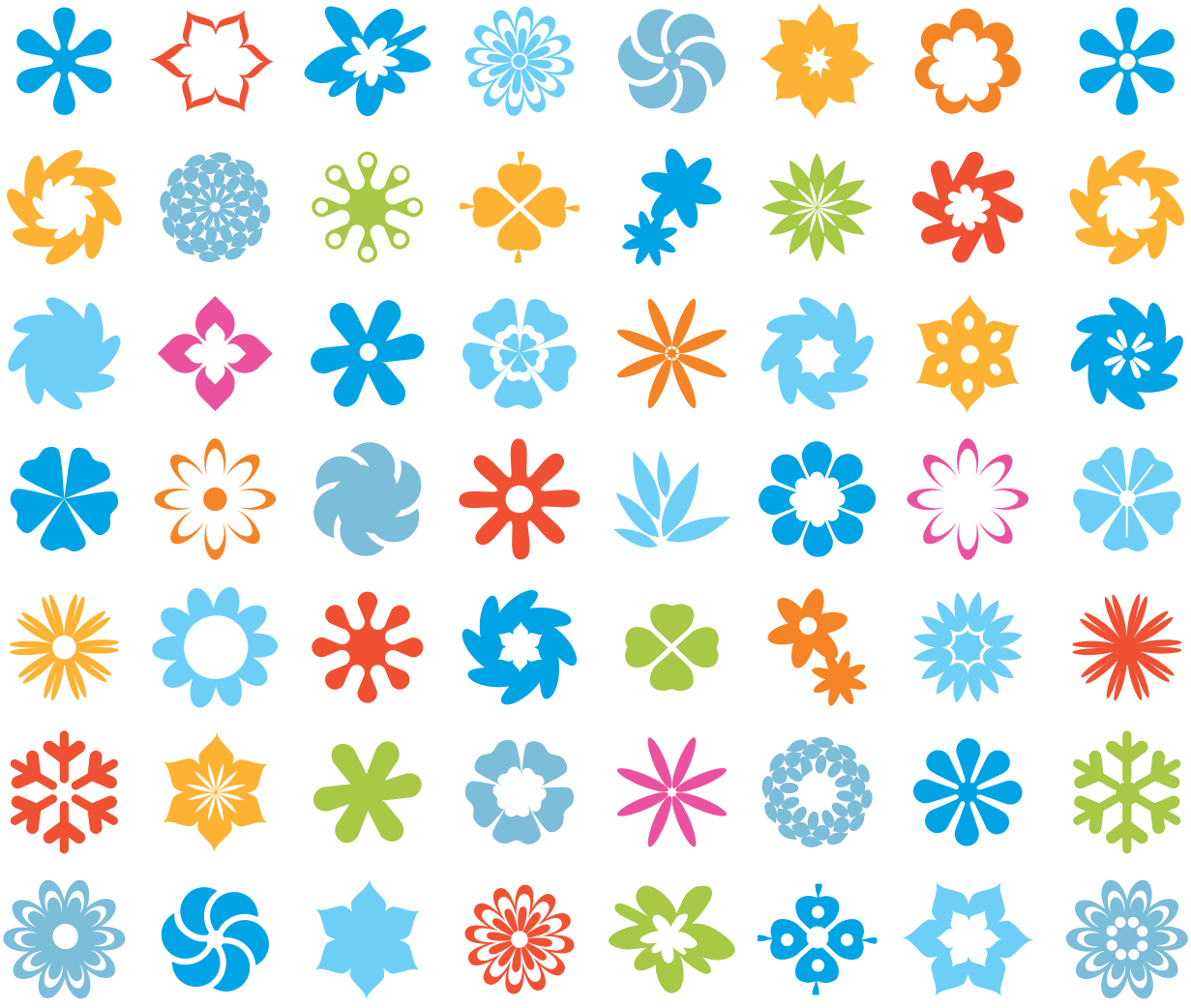
2008-2009 Active Employees Benefits Guide



Each individual is unique. Take the time to learn about your healthcare benefit options so you can make the best choices for you and your family.

Health Service System
CITY & COUNTY OF SAN FRANCISCO

The City of San Francisco Health Service System is dedicated to providing our active and retired members with affordable, quality healthcare and the information they need to make informed decisions about their healthcare options.

Welcome

Members of the Health Service System can take part in a variety of benefit programs and events. HSS invites your participation and values your feedback.

Table of Contents

Overview

The Health Service System is committed to ongoing innovation in member services, operations and communications.

Plan Updates 2008-2009

For the Plan Year 2008-2009 there are no changes to the healthcare plans offered or the benefit levels provided to HSS members.

New or Rehired Employees

Eligible new and rehired employees must enroll in an HSS medical and/or dental plan within 30 days of their initial appointment or within 30 days of meeting the eligibility requirements for coverage. If you don't enroll within your initial 30-day enrollment period, you must wait until the next annual Open Enrollment period or you have a qualifying change in family status. (See pages 30-31 of this guide.)

Additional Benefits

Some employees are also eligible for Long Term Disability, Life Insurance and other benefits. Contact HSS member services or visit myhss.org to learn more and to verify your eligibility.

Register Online for E-Updates

Each month HSS sends out an email update to members who have registered on myhss.org. The updates include information about upcoming events, benefits highlights and tips designed to help you navigate the HSS healthcare eligibility and application process. In addition, members who are registered on myhss.org are invited to participate in surveys, polls, vendor report card reviews and other opportunities to offer feedback.

HSS Health Fair October 21 & 22, 2008

Save the date! The third annual HSS member Health Fair is scheduled to take place this fall on October 21 and 22, 2008. In the past the HSS fair has offered free flu shots, wellness screenings, chair massages, movement seminars and more. Watch for announcements on myhss.org.

HSS Member Seminars

This spring HSS is introducing its first series of member seminars. Seminar topics include Pre-Open Enrollment planning, fitness demonstrations and other subjects relating to health and well-being. Watch for seminar announcements on myhss.org.

HSS Board Meetings

The Health Service Board meets the second Thursday of every month in Room 416 of City Hall. HSS members are encouraged to attend these public meetings. Visit myhss.org for meeting details.

Open Enrollment

Open Enrollment offers you the opportunity to make changes to your healthcare elections without any qualifying event requirements.

Things You Can Do During Open Enrollment

During Open Enrollment you can:

- Elect a different medical or dental plan.
- Add or drop eligible dependents from medical or dental coverage.
- Enroll in the 2008-2009 Healthcare Flexible Spending Account.
- Enroll in the 2008-2009 Dependent Care Flexible Spending Account.

To make changes you must submit a completed Open Enrollment Application in person, by mail or by fax to HSS no later than 5pm on April 30, 2008.

If you are enrolling new dependents HSS requires that you provide documentation proving that your dependents meet eligibility requirements for the upcoming year.

You must re-enroll in the Flexible Spending Accounts during the April Open Enrollment period to continue your pre-tax contributions after July 1, 2008.

What To Expect If You Make a Change to Your Elections During Open Enrollment

Any changes you elect to make during the April 2008 Open Enrollment period will take effect July 1, 2008, and remain in effect through June 30, 2009.

Dependents who are deleted from coverage during the Open Enrollment period are not eligible for COBRA continuation coverage.

If you elect to change your medical plan, the plan will issue you a new medical ID card. You will receive your new ID card before July 1.

If You Don't Make Any Changes During Open Enrollment

If you don't make any changes during the April 2008 Open Enrollment period, your current medical and dental plan elections as well as the eligible dependents you have covered on your plans will remain the same. You will, however, not continue to be enrolled in a Healthcare or Dependent Care FSA.

Benefit Election Changes Outside of Open Enrollment

Outside the annual Open Enrollment period, you must have a qualifying event in order to make any changes to your healthcare elections. See pages 30-31 of this guide for Qualifying Event guidelines.

Payroll Deduction Amounts

The amount deducted from your paycheck may change in accordance with any approved changes to the rates for Plan Year 2008-2009. See pages 41-43 of this guide for 2008-2009 rates.

No Dual HSS Plan Coverage

HSS members and their dependents may not be enrolled in two HSS administered medical or dental plans at the same time. For those members who do submit dual enrollment elections, HSS will eliminate dual coverage as follows:

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

New Twice Monthly Premium Contributions

Good news for our members: we're making your healthcare coverage periods easier to understand. Effective July 2008 healthcare contributions will only be deducted from paychecks twice monthly.

New Twice Monthly Premium Contributions

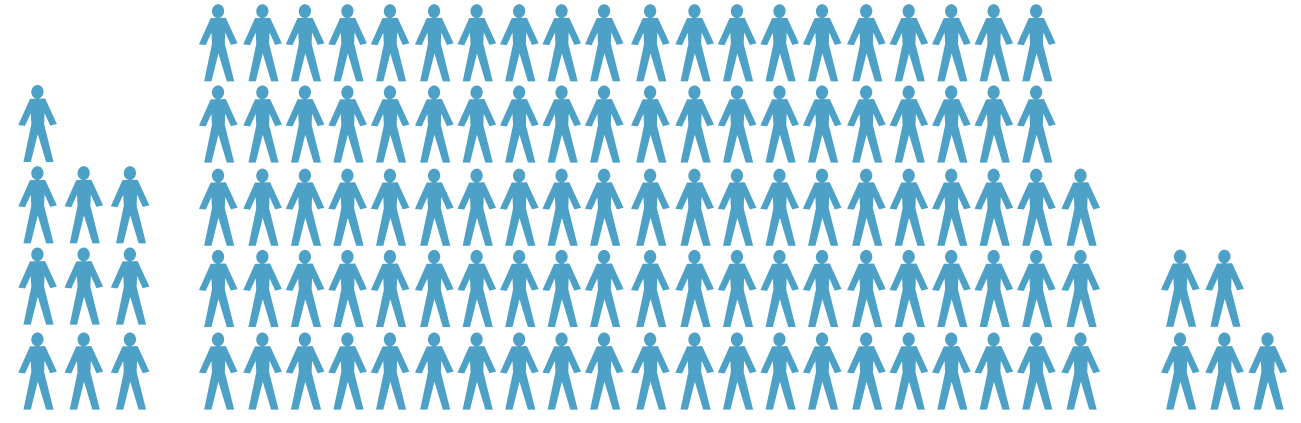
In order to simplify the relationship between healthcare contributions deducted from your paycheck and the associated healthcare coverage dates, HSS is moving to a twice monthly deduction system. This allows new HSS members (and existing members adding eligible dependents) to more easily determine the effective date of their healthcare coverage. It also assists members who are terminating HSS coverage or going on leave to be clear about when their healthcare coverage ends.

Two Paychecks Per Year With No Deductions

The new healthcare contribution deduction calendar results in a total of 24 payroll deductions per year. (Previously, employee contributions were made on a biweekly basis, for a total of 26 deductions per year.) Effective July 2008, your first paycheck each month will have a deduction that pays for healthcare coverage for the first half of that month. Your second paycheck each month will have a deduction that pays for healthcare coverage for the second half of the month. There will be no healthcare contribution deduction taken from your third paycheck in the months of September 2008 and March 2009. While the twice monthly deductions will be nominally higher amounts, the amount of the total annual deduction will remain the same.

2008 PAY DATE	COVERAGE PERIOD	2009 PAY DATE	COVERAGE PERIOD
July 8, 2008	July 1-15, 2008	January 6, 2009	January 1-15, 2009
July 22, 2008	July 16 -30, 2008	January 20, 2009	January 16-31, 2009
August 5, 2008	August 1-15, 2008	February 3, 2009	February 1-15, 2009
August 19, 2008	August 16-31, 2008	February 17, 2009	February 16-28, 2009
September 2, 2008	September 1-15, 2008	March 3, 2009	March 1-15, 2009
September 16, 2008	September 16-30, 2008	March 17, 2009	March 16-31, 2009
September 30, 2008	NO DEDUCTION	March 31, 2009	NO DEDUCTION
October 14, 2008	October 1-15, 2008	April 14, 2009	April 1-15, 2009
October 28, 2008	October 16-31, 2008	April 28, 2009	April 16-30, 2009
November 11, 2008	November 1-15, 2008	May 12, 2009	May 1-15, 2009
November 25, 2008	November 16-30, 2008	May 26, 2009	May 16-31, 2009
December 9, 2008	December 1-15, 2008	June 9, 2009	June 1-15, 2009
December 23, 2008	December 16-31, 2008	June 23, 2009	June 16-30, 2009

Membership Demographics



The Health Service System provides medical benefits to eligible employees and retirees of four major San Francisco public-sector employers–the City and County of San Francisco, the San Francisco Unified School District, the City College of San Francisco and the San Francisco Superior Court. As of July 1, 2007, HSS members totaled 107,406 covered lives. This reflected an increase of 1,857 in total covered lives under HSS medical plans since July 1, 2006.

In addition, the Health Service System provides dental benefits to eligible active employees of the City and County of San Francisco and the San Francisco Superior Court and to all retired members and their dependents. Since our last report of July 1, 2006, the System has seen an increase of 2,350 in total covered lives under our dental plans.

Finally, the Health Service System provides an option to participate in medical reimbursement accounts and dependent care reimbursement accounts to eligible active employees of the City and County of San Francisco and the San Francisco Superior Court. The significant increase in participation in both of these types of accounts from Plan Year 2006-2007 to Plan Year 2007-2008 is due in part to enhanced communication about the advantages of these accounts to our members.

Eligibility

These rules govern which employees can become members of the Health Service System and which member dependents may be eligible for coverage.

Member Eligibility

The following are eligible to participate in the Health Service System as defined in San Francisco Administrative Code Section 16.700:

- City and County Employees
  - All permanent employees of the City and County of San Francisco whose normal work week is not less than 20 hours;
  - All regularly scheduled provisional employees of the City and County of San Francisco whose normal work week is not less than 20 hours;
  - All other employees of the City and County of San Francisco, including temporary exempt "as needed" employees, who have worked more than 1040 hours in any consecutive 12 month period and whose normal work week is not less than 20 hours.
- Elected Officials
- 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, San Francisco Redevelopment Agency, Treasure Island Development Authority, San Francisco Superior Court and any other employees as determined eligible by ordinance.

Spouse/Domestic Partner

- A member's legal spouse or domestic partner may be eligible for healthcare coverage administered by the Health Service System. Proof of marriage or registered domestic partnership is required when enrolling a spouse or domestic partner.
- An individual who has been granted a final dissolution of marriage or is legally separated from an HSS member is not eligible. If a domestic partnership has been dissolved, the former partner of the HSS member is not eligible.

Natural Children, Step-Children, Adopted Children, Legal Guardianships

Children who may be covered under an HSS plan include a member's natural child, a step-child (as long as the HSS member is married to the natural parent), a legally adopted child, a child under legal guardianship and a natural or legally adopted child of an eligible spouse or domestic partner. Legal documentation is required to enroll an adopted child or a child under guardianship.

To qualify, a child must meet all of the following five criteria:

1. Child must be under 25 years of age.
2. Child must be unmarried.
3. Child cannot be working full time.
4. Child must reside in the member's home (except for full-time college students and children living with a divorced spouse).
5. Child must be declared as an exemption on the member's federal income tax return.

Eligibility

Other Children Residing in a Member's Home (IRS Exemption)

Children who are not a member's natural child, step-child, legally adopted child, child under legal guardianship or the natural or legally adopted child of an eligible spouse or domestic partner may also be eligible for coverage under an HSS plan. To qualify, a child must meet all of the following five criteria:

1. Child must be under 19 years of age.
2. Child must be unmarried.
3. Child cannot be working full time.
4. Child must reside in the member's home and be economically dependent on the member.
5. Child must be declared as an exemption on the member's federal income tax return. A copy of the member's federal income tax return must be submitted to HSS annually.

Court Ordered Children

Children covered by a National Medical Support Notice (Court Order) can be covered to age 19.

Disabled Children

Children who are disabled may be covered under an HSS plan beyond the age limits stated previously provided all of the following six criteria are met:

1. Child must be unmarried.
2. Child is incapable of self-sustaining employment due to physical handicap or mental retardation that existed prior to the child's attainment of age 25.
3. Child must permanently reside in the member's home and be economically dependent on the member for substantially all of his or her economic support.
4. Child must be declared as an exemption on the member's federal income tax return. A copy of the member's federal income tax return must be submitted to HSS annually if requested.
5. Child must have been enrolled in an HSS health plan on a continuous basis prior to the child's 19th birthday.
6. Member submits acceptable medical documentation of the disability as may be periodically requested by HSS.

REQUIRED ELIGIBILITY DOCUMENTATION

	EVIDENCE OF HIRE	BENEFIT AUTH. FORM	MARRIAGE CERTIFICATE	DOMESTIC PARTNER REG.	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	COURT ORDER	INCOME TAX RETURN	MEDICAL EVIDENCE
Employee: Permanent/Provisional	■								
Employee: Temporary/Exempt		■							
Spouse			■						
Domestic Partner				■					
Child: Natural					■				
Child: Step-child			■		■				
Child: Domestic Partner				■	■				
Child: Adopted						■			
Child: Legal Guardianship							■		
Child: IRS Exemption								■	
Child: Court Ordered							■		
Child: Disabled									■

Choosing a Medical Plan

When choosing a medical plan there is more to consider than just the payroll deduction amount. A variety of factors determine the true value of a plan and which option is best for you.

PPO vs HMO QUICK COMPARISON CHART

	City Plan PPO	Blue Shield HMO	Kaiser HMO	PacifiCare HMO
Do I have to select a Primary Care Physician (PCP) to coordinate my care?	No	Yes	Kaiser will assign you a PCP after you enroll.	Yes
Do I have to use a contracted network provider?	No. You can use any licensed provider.	Yes. All services must be received from a contracted network provider.	Yes. All services must be received from a Kaiser facility.	Yes. All services must be received from a contracted network provider.
Do I have to pay an annual deductible?	Yes	No	No	No
Is preventative care covered, such as a routine physical and well baby care?	Yes	Yes	Yes	Yes
Does the plan have a maximum amount that it will pay for healthcare services?	Yes. The plan will pay a maximum lifetime benefit of $2 million per covered person.	No	No	No
Do I have to file claim forms?	Only if you use an out-of-network provider.	No	No	No

This guide offers general information only. Do not rely solely on this guide when making your health insurance decisions. Before enrolling in a plan, you should consult the plan document (Evidence of Coverage) to get specific information about the benefits, costs and way the plan works. Plan documents are available as downloadable PDFs on myhss.org.

Choosing a Medical Plan

Vendor report cards, quality ratings, member comments and other resources are available online to assist you in your decision making process.

Step 1 **PPO vs. HMO**

Learn about the differences between a PPO plan and an HMO plan.
(See the chart on page 8 of this guide.)

Step 2 **Plan Service Areas**

Find out which plans offer service to you based on your home zip code.
(See the chart on page 11 of this guide.)

Step 3 **Doctors and Hospitals**

Determine which medical plan networks include the doctors, hospitals and other medical services that you and your family want to use.

Step 4 **Vendor Report Cards and Quality Ratings**

Visit online resources that can assist you in your decision making process.

HSS
myhss.org

California Office of the Patient Advocate
www.opa.ca.gov

Integrated Healthcare Association
http://www.iha.org/p4ptoprf.htm

NCQA
http://web.ncqa.org/

America's Best Health Plans
http://health.usnews.com/sections/health/health-plans/index.html

AHRQ
www.ahrq.gov/consumer/insuranceqa/

Step 5 **Services Covered**

Make sure you understand how your plan works. Don't wait until you need emergency care to ask questions about plan details.

- What types of services are covered by the plan?
- What steps do you need to take to get the care you and your family members need?
- When do you need prior approval to ensure coverage for care, such as a hospitalization or scheduled surgery?
- How are benefits paid?

Step 6 **Medical Needs**

- Do you or a family member require specialists or specific treatments?
- Does someone in your family need ongoing care or costly medication?
- Will the location of doctors or medical facilities make transportation an issue?
- Do you or your family members require mental health benefits?

Step 7 **Plan Costs**

Compare the costs of each available medical plan. See pages 41-43 of this guide for cost comparison charts.

Medical Plan Options

These medical plan options are available to active HSS members and eligible dependents. Required contributions, if any, will be deducted from the member's paycheck twice monthly.

This section highlights the different medical plans available to eligible employees and their dependents. For your convenience, we've included a medical plan Benefits-at-a-Glance chart on pages 12-15 that summarizes key plan features and benefits for each plan. Please refer to each plan's Evidence of Coverage (EOC) for a detailed list of covered services, exclusions and limitations. EOCs are available online at myhss.org.

Health Maintenance Organization (HMO)

An HMO is a medical plan that requires you to receive all of your care from within a network of participating physicians, hospitals, and other healthcare providers. Generally, to be covered for non-emergency benefits, you need to access medical care through your Primary Care Physician (PCP). HSS offers you the following HMO plans:

- **Blue Shield of California HMO**
- **Kaiser HMO**
- **PacifiCare HMO**

Preferred Provider Organization (PPO)

A PPO is a medical plan that gives you freedom of choice by allowing you to go to any in-network or out-of-network healthcare providers. When you go to in-network providers the plan pays higher benefits and you pay less. A PPO typically does not assign you a primary care physician, so you have more responsibility for coordinating your care.

HSS offers you the following PPO plan:

- **City Health Plan (administered by UnitedHealthcare)**

Evidence of Coverage (EOC)

The EOC contains a complete list of benefits and exclusions in effect July 1, 2008 through June 30, 2009 for each plan. This benefits guide cannot cover every detail of your plan contract; you should review the EOC for plan details. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. You can read or download plan EOCs at myhss.org.

Medical Plan Service Areas

To enroll in Blue Shield, Kaiser or PacifiCare, you must reside in a zip code serviced by the plan. Refer to the chart below or contact the plan to determine whether or not you live in the plan's service area.

■ = Available in this County.
❍ = Available in some zip codes; verify your zip code with the plan to confirm availability.

COUNTY	CITY HEALTH PLAN	BLUE SHIELD	KAISER	PACIFICARE
Alameda	■	■	■	■
Alpine	■			
Calaveras	■			
Contra Costa	■	■	■	■
Madera	■	■	❍	❍
Marin	■	■	■	❍
Mariposa	■		❍	
Merced	■	■		■
Mono	■			
Napa	■		❍	
Sacramento	■	■	■	■
San Francisco	■	■	■	■
San Joaquin	■	■	■	■
San Mateo	■	■	■	■
Santa Clara	■	■	❍	■
Santa Cruz	■	■		■
Solano	■	■	■	■
Sonoma	■	■	❍	■
Stanislaus	■	■	■	■
Tuolumne	■			
Yolo	■	■	❍	■
Outside of California	■	Urgent Care/ER Only	Urgent Care/ER Only	Urgent Care/ER Only

If you do not see your County listed above please contact the medical plan to see if service is available to you.

Medical Plan Benefits-at-a-Glance

	blue of california	KAISER PERMANENTE®	PacifiCare®
DEDUCTIBLES			
Plan-year deductible	None	None	None
Lifetime maximum	None	None	None
PREVENTIVE & GENERAL CARE			
Routine physical	No charge	$10 co-pay	$10 co-pay
Immunizations & Innoculations	No charge	No charge	No charge
Gynecologic exam	No charge	$10 co-pay	No charge
Well baby care	No charge	$10 co-pay	No charge
PHYSICIAN CARE			
Office & home visits	$10 co-pay	$10 co-pay	$10 co-pay
Hospital visits	No charge	No charge	No charge
PRESCRIPTION DRUGS			
Pharmacy - generic drugs	$5 co-pay 30 day supply	$5 co-pay 30 day supply	$5 co-pay 30 day supply
Pharmacy - brand-name drugs	$15 co-pay 30 day supply	$15 co-pay 30 day supply	$15 co-pay 30 day supply
Pharmacy - non-formulary drugs	$25 co-pay 30 day supply	Physician authorized only	$25 co-pay 30 day supply
Mail order - generic drugs	$10 co-pay 90 day supply	$10 co-pay 100 day supply	$10 co-pay 90 day supply
Mail order - brand-name drugs	$30 co-pay 90 day supply	$30 co-pay 100 day supply	$30 co-pay 90 day supply
Mail order - non-formulary drugs	$50 co-pay 90 day supply	Physician authorized only	$50 co-pay 90 day supply
OUTPATIENT SERVICES			
Diagnostic X-ray & laboratory	No charge	No charge	No charge
EMERGENCY			
Hospital emergency room	$50 co-pay waived if hospitalized; $10 co-pay urgent care	$50 co-pay waived if hospitalized; $10 co-pay urgent care	$50 co-pay waived if hospitalized $30 co-pay urgent care
HOSPITALIZATION			
Inpatient	$100 co-pay per admittance	$100 co-pay per admittance	$100 co-pay per admittance
Oupatient	$50 co-pay	$10 co-pay	$10 co-pay
SURGERY			
In Hospital	$100 co-pay per admittance	$100 co-pay per admittance	$100 co-pay per admittance

This chart is intended to provide a quick comparison of benefits; it is not a contract. For a more detailed description of benefits and exclusions for each plan, please review the individual plan documents (Evidence of Coverage), available on myhss.org.

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
$250 employee only $500 employee + 1 $750 employee + 2 or more	$250 employee only $500 employee + 1 $750 employee + 2 or more	$250 employee only $500 employee + 1 $750 employee + 2 or more
$2,000,000 per covered person for any combination of In Network, Out-of-Network and Out-of-Area options utilized.		
85% covered after deductible	Not covered	85% covered after deductible
100% covered no deductible	50% covered no deductible	100% covered no deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
$5 co-pay 30 day supply	50% covered after $5 co-pay; 30 day supply	$5 co-pay 30 day supply
$15 co-pay 30 day supply	50% covered after $15 co-pay; 30 day supply	$15 co-pay 30 day supply
$25 co-pay 30 day supply	50% covered after $25 co-pay; 30 day supply	$25 co-pay 30 day supply
$10 co-pay 90 day supply	Not covered	$10 co-pay 90 day supply
$30 co-pay 90 day supply	Not covered	$30 co-pay 90 day supply
$50 co-pay 90 day supply	Not covered	$50 co-pay 90 day supply
85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	85% covered after deductible; may require 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: if non-emergency 50% after deductible
85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	85% covered after deductible; may require prior notification
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	85% covered after deductible; may require prior notification

*City Plan Benefits are based on Reasonable & Customary charges. In some cases, billed amounts may exceed Reasonable & Customary fees, resulting in higher out-of-pocket costs for you.

Medical Plan Benefits-at-a-Glance

	blue of california	KAISER PERMANENTE®	PacifiCare®
REHABILITATIVE			
Physical/Occupational therapy	$10 co-pay	$10 co-pay authorization req.	$10 co-pay
Acupuncture	$10 co-pay 30 visits / year max	Not covered authorization req.	$10 co-pay 30 visits / year max
Chiropractic	$10 co-pay 30 visits / year max	$10 co-pay 30 visits / year max	$10 co-pay 30 visits / year max
PREGNANCY & MATERNITY			
Pre/post-natal physician care For hospital stay, see Hospitalization.	No charge newborn must be enrolled within 30 days of birth	$10 co-pay newborn must be enrolled within 30 days of birth	$10 co-pay newborn must be enrolled within 30 days of birth
INFERTILITY			
IVF, GIFT, ZIFT & Artificial Insemination	50% covered limitations apply	50% covered limitations apply	50% covered limitations apply
TRANSGENDER			
Office visits & outpatient surgery	Co-pays apply authorization req. $75,000 lifetime max.	Co-pays apply authorization req. $75,000 lifetime max.	Co-pays apply authorization req. $75,000 lifetime max.
DURABLE MEDICAL EQUIPMENT			
Home medical equipment	No charge	No charge as authorized by PCP according to formulary	No charge when medically necessary
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary	No charge when medically necessary
Hearing aids	No charge 1 per ear every 36 months; $2,500 max.	No charge 1 per ear every 36 months; $2,500 max.	No charge $2,500 max. every 36 months
MENTAL HEALTH			
Inpatient hospitalization	$100 co-pay per admittance	$100 co-pay per admittance; max 45 days per year	$100 co-pay per admittance
Outpatient treatment	$25 co-pay non-severe; 60 visit max. $10 co-pay severe; no limit	$10 co-pay	$10 co-pay
SUBSTANCE ABUSE			
Inpatient	$100 co-pay per admittance for short-term detox	$100 co-pay per admittance for up to 30 day detox	$100 co-pay per admittance for up to 30 day detox
Outpatient	$25 co-pay	$5 co-pay group $10 co-pay individual	No charge
EXTENDED & END-OF-LIFE CARE			
Skilled nursing facility	No charge up to 100 days per year	No charge up to 100 days per year	No charge up to 100 days per year
Hospice	No charge authorization required	No charge when medically necessary	No charge when medically necessary; authorization required

This chart is intended to provide a quick comparison of benefits; it is not a contract. For a more detailed description of benefits and exclusions for each plan, please review the individual plan documents (Evidence of Coverage), available on myhss.org.

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers	Out-of-Network Option*	Out-of-Area Option*
85% covered after deductible; 60 visits / year	50% covered after deductible; 60 visits / year	85% covered after deductible; 60 visits / year
50% covered after deductible; $1,000 / year	50% covered after deductible; $1,000 / year	50% covered after deductible; $1,000 / year
50% covered after deductible; $1,000 / year	50% covered after deductible; $1,000 / year	50% covered after deductible; $1,000 / year
85% covered after deductible; newborn must be enrolled within 30 days of birth	50% covered after deductible; newborn must be enrolled within 30 days of birth	85% covered after deductible; newborn must be enrolled within 30 days of birth
50% covered after deductible; limitations apply; prior notification required	50% covered after deductible; limitations apply; prior notification required	50% covered after deductible; limitations apply; prior notification required
85% covered after deductible; prior notification required; $75,000 lifetime max.	50% covered fter deductible; prior notification required; $75,000 lifetime max.	85% covered fter deductible; prior notification required; $75,000 lifetime max.
85% covered after deductible; rental not to exceed purchase price	50% covered after deductible; rental not to exceed purchase price	85% covered after deductible; rental not to exceed purchase price
85% covered after deductible; when medically necessary	50% covered after deductible; when medically necessary	85% covered after deductible; when medically necessary
100% covered after deductible; 1 per ear every 36 months; $2,500 max.	100% covered after deductible; 1 per ear every 36 months; $2,500 max.	100% covered after deductible; 1 per ear every 36 months; $2,500 max.
85% covered after deductible; up to 30 hospital days per year max; auth. required	50% covered after deductible; up to 30 hospital days per year max; auth. required	85% covered after deductible; up to 30 hospital days per year max; auth. required
85% covered after deductible; up to 25 visits per year max; authorization required	50% covered after deductible; up to 25 visits per year max; authorization required	85% covered after deductible; up to 25 visits per year max; authorization required
85% covered after deductible; 30 day detox / 60 day rehab; authorization required	50% covered after deductible; 30 day detox / 60 day rehab; authorization required	85% covered after deductible; 30 day detox / 60 day rehab; authorization required
85% covered after deductible; up to 25 visits per year max; authorization required	50% covered after deductible; up to 25 visits per year max; authorization required	85% covered after deductible; up to 25 visits per year max; authorization required
85% covered after deductible; 120 days per year; prior authorization required; custodial care not covered	50% covered after deductible; 120 days per year; prior authorization required; custodial care not covered	85% covered after deductible; 120 days per year; prior authorization required; custodial care not covered
85% covered after deductible; $10,000 max; prior notification required	50% covered after deductible; $10,000 max; prior notification required	85% covered after deductible; $10,000 max; prior notification required

*City Plan Benefits are based on Reasonable & Customary charges. In some cases, billed amounts may exceed Reasonable & Customary fees, resulting in higher out-of-pocket costs for you.

Dental Plan Options

Dental benefits are an important part of your healthcare coverage and are key to your overall health. HSS offers a choice of plans, providers, and coverage options at no premium cost to most HSS members.

Below is a brief overview of the types of dental plans available. See pages 18-19 for a comparison chart of key dental plan features and benefits.

HMO-Style Dental Plans

Much like medical HMO's, Dental Maintenance Organization (DMO) dental plans require that you receive all of your dental care from within a network of participating dental offices. These networks are generally much smaller that a dental PPO network.

Please note that you will be required to select a dental office which becomes your primary care office and you must go to this office for all of your dental care. You should make sure that the dentist you wish to see is in the plan before selecting it.

HSS offers you the following DMO plans:

- **DeltaCare USA**
- **Pacific Union**

PPO-Style Dental Plans

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

HSS offers you the following PPO-style dental plan:

- **Delta Dental**

The Delta Dental PPO has two different networks of participating dentists and dental care providers:

- The Delta Preferred Option network offers the highest benefit. Most preventive services are covered at 100%; many other services are covered at 90%.
- The Delta Premier network pays benefits based on a pre-arranged fee agreed to by the network's dentists. Most preventive services are covered at 100%; many other services are covered at 80%.

You may go to any dentist from either network, or you may also go to a dentist that is in neither network. When you go to any licensed dentist not in one of the newtworks described above, the plan pays the same percentage of cost that it pays a Delta Participating Dentist. However, the payment is based on what is considered reasonable and customary (R&C) for the geographical area. This means that your share of the expenses will be higher if your out-of-network dentist charges more than R&C. Don't be shy about asking a dentist financial questions upfront before receiving services. Delta can also help you understand what your costs will be. Call Delta with any questions.

Dental Plan Only

Yes, you can elect to enroll in an HSS dental plan even if you elect not to enroll in an HSS medical plan.

Dental Plan Service Areas

To enroll in either DeltaCare USA or Pacific Union Dental, you must reside in a zip code serviced by the plan. Be sure to ask your dentist which plan(s) they contract with before making your selection.

■ = Available in this County

COUNTY	DELTA DENTAL	DELTACARE USA DMO	PACIFIC UNION DMO
Alameda	■	■	■
Alpine	■		
Calaveras	■		
Contra Costa	■	■	■
Madera	■	■	■
Marin	■	■	■
Mariposa	■		
Merced	■	■	■
Mono	■		
Napa	■	■	■
Sacramento	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Clara	■	■	■
Santa Cruz	■	■	■
Solano	■	■	■
Sonoma	■	■	■
Stanislaus	■	■	■
Tuolumne	■		
Yolo	■	■	
Outside of California	■		

Refer to the chart above to determine whether or not you live in the plan's service area. If you do not see your County listed above please contact the dental plan to confirm that service is available to you.

Dental Plan Benefits-at-a-Glance

	DELTA DENTAL		DELTACARE	PACIFIC UNION
	In-Network Providers	Out-of-Network Providers*		
Types of Service				
Cleanings & Exams	100% covered Limit 2x per plan year	100% covered Limit 2x per plan year	100% covered Limit 1 every 6 months	100% covered Limit 1 every 6 months
X-rays	100% covered	100% covered	100% covered	100% covered
Extractions	90% covered	80% covered	100% covered	100% covered
Fillings	90% covered	80% covered	100% covered	100% covered
Crowns	90% covered	80% covered	100% covered Limitations apply to resin materials.	100% covered
Dentures, Pontics & Bridges	50% covered	50% covered	100% covered Full and partial dentures 1x every 5 yrs; fixed bridgework; certain limitations apply	100% covered Full and partial dentures 1x every 5 yrs; fixed bridgework; certain limitations apply
Root Canals	90% covered	80% covered	100% covered Excluding the final restoration	100% covered
Orthodontia	50% covered Adults and children; up to $2500 lifetime max	50% covered Adults and children; up to $2500 lifetime max	Employee pays: $1,600/child $1,800/adult Adult limitations apply.	Employee pays: $1,600/child $1,800/adult $350 startup fee. Limitations apply.
Annual Maximum				
Total Dental Benefits	$2,500 per year excluding orthodontia benefits	$2,500 per year excluding orthodontia benefits	None	None

This guide offers general information only. Do not rely solely on this guide when making your health insurance decisions. Before enrolling in a plan, you should consult the plan document (Evidence of Coverage) to get specific information about the benefits, costs and way the plan works. Plan documents are available as downloadable PDFs on myhss.org.

Dental Plan Benefits-at-a-Glance

When reviewing dental plan options make sure you understand the plan details before deciding which plan will best serve your needs.

DENTAL PLAN QUICK COMPARISON CHART			
	Delta Dental PPO	**Pacific Union DMO**	**Deltacare USA DMO**
Can I choose to receive services from any dentist?	Yes. You can use any licensed dental provider.	No. All services must be received from a contracted network provider. These networks are generally quite small.	No. All services must be received from a contracted network provider. These networks are generally quite small.
Must my primary care dentist refer me to a specialist for certain kinds of dental work?	No	Yes	Yes
Is there a waiting period before I can access treatment?	No waiting period, except for dentures, pontics, bridges and orthodontia which require a 6 month wait.	No waiting period.	No waiting period.
Will I pay a flat rate for most services?	No. Your out-of-pocket costs are based on a percentage of applicable charges.	Yes	Yes
Must I live in a certain service area to enroll in the plan?	No	Yes. You must live in this DMO's service area to enroll.	Yes. You must live in this DMO's service area to enroll.

Vision Plan Benefits

All HSS members and eligible dependents who are enrolled in an HSS medical plan receive vision benefits, including an annual eye exam.

VSP Vision

All HSS members and eligible dependent(s) who enroll in the City Health Plan, Blue Shield HMO, Kaiser HMO or PacifiCare HMO can access vision benefits administered by Vision Service Plan (VSP).

The vision plan provides you and your eligible dependents with one eye exam every 12 months when using a VSP network doctor. The vision plan also helps you and your eligible dependents cover the cost of eyewear, such as glasses or contacts.

Choice of Providers

Under the vision plan, you have the choice of using a VSP network doctor or a non-VSP provider. It is usually to your advantage financially to use a VSP network doctor because covered services are provided to you at a higher benefit and you will have lower out-of-pocket costs.

You can find a VSP network doctor in your area by visiting www.vsp.com or contacting VSP Member Services at (800) 877-7195.

Accessing Your Vision Benefits

There are no ID cards issued for the vision plan. If you wish to receive services from a VSP network doctor, simply contact the doctor and make your appointment. VSP will then provide benefit authorization to the doctor. Services must be received prior to the benefit authorization expiration date.

If you receive services from a VSP network doctor without benefit authorization or obtain services from an out-of-network provider, you are responsible for payment in full to the provider. You then submit an itemized bill directly to VSP for partial reimbursement. You can download a claim form from the VSP website at www.vsp.com.

VISION PLAN BENEFITS AT-A-GLANCE

	VSP NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
Vision Exam	Covered in full once every 12 months* after the $10 co-pay	up to $40 every 12 months* after the $10 co-pay
Single Vision Lenses	Covered in full once every 24 months* after the $25 co-pay	up to $45 every 24 months* after the $25 co-pay
Lined Bifocal Lenses	Covered in full once every 24 months* after the $25 co-pay	up to $65 once every 24 months* after the $25 co-pay
Lined Trifocal Lenses	Covered in full once every 24 months* after the $25 co-pay	up to $85 once every 24 months* after the $25 co-pay
Frames	Covered up to $150 every 24 months* after the $25 co-pay	up to $55 once every 24 months* after the $25 co-pay
Contact Lenses	Covered up to $150 every 24 months* no co-pay; in lieu of frames/lenses; allowance applies toward contact lens fitting, evaluation exam and contacts	Covered up to $105 every 24 months* no co-pay; in lieu of frames/lenses; allowance applies toward contact lens fitting, evaluation exam and contacts

*Based on your last date of service

Vision Plan Limits & Exclusions

The HSS vision plan is designed to cover your visual correction needs. If you select cosmetic options, you will be responsible for paying those additional costs.

Plan Limits and Exclusions

- The vision plan covers one set of contacts or eyeglass lenses every 24 months.
- If you choose contact lenses, you'll be eligible for lenses and an eyeglass frame benefit 24 months after the last date of obtaining the contact lenses. This rule also applies to your eligible dependents.
- Cosmetic extras such as progressive lenses, tinted lenses or oversize lenses will cost you extra. If you use a VSP network doctor, you'll pay the VSP discounted price for these cosmetic extras. If you're using an out-of-network provider, you'll pay the retail price.
- The vision plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, the plan will pay the basic cost of the allowed lenses and you'll be responsible for any additional cost for the options, unless the extra is defined in the Schedule of Benefits.
    - Blended lenses
    - Contact lenses (except as noted in the Schedule of Benefits)
    - Oversize lenses
    - Photochromic and tinted lenses
    - Progressive multi-focal lenses
    - Coatings of the lens or lenses, except scratch resistant coatings
    - Laminating of the lens or lenses
    - A frame that costs more than the Plan allowance
    - Certain limitations on low vision care
    - Cosmetic lenses
    - Optional cosmetic processes
    - UV (ultraviolet) protected lenses

Vision Expenses Not Covered

- Orthoptics or vision training and any associated supplemental testing, plano (non-prescription) lenses or two pairs of glasses in lieu of bifocals.
- Replacement of lenses or frames furnished under this plan that are lost or broken, except at the normal intervals.
- Medical or surgical treatment of the eyes.
- Costs for securing materials such as lenses and a frame under the vision plan.
- Corrective vision treatments such as, but not limited to, LASIK and PRK laser surgery. (You may be eligible for discounts when services are provided by a VSP network doctor. To inquire about discounts, call VSP.)

Coordinating Vision Benefits with Medical Plan Benefits

The VSP vision plan is designed to cover visual correction needs, such as eyeglasses and contact lenses. Some HMOs also offer optometry services where you can get eye exams and purchase glasses and lenses. HSS recommends that you compare the out-of-pocket cost you will incur using your HMO's vision services to your out-of-pocket costs when using a VSP network doctor. In addition, be aware that your medical plan may offer coverage for medical conditions and diseases relating to the eyes.

No Medical Plan, No Vision Benefits

If you don't enroll in an HSS medical plan, you won't have the vision benefits available through VSP.

Flexible Spending Accounts (FSAs)

If you anticipate spending money on regular healthcare or dependent care expenses that are not covered by your insurance plan, consider an FSA.

How an FSA Works

A Flexible Spending Account (FSA) allows a fixed amount of pre-tax wages to be set aside for qualified healthcare or dependent care expenses. You designate an annual amount to be set aside at the beginning of each plan year. This amount is deducted pre-tax from your paycheck throughout the year and deposited in your individual FSA account. When you incur a qualified expense, submit the required documentation to the Fringe Benefits Management Company (FBMC), the account administrator. Once your request is approved, the expense is refunded to you. Be aware that unused dollars remaining in a flex account at year-end cannot be rolled forward, reimbursed or refunded.

Types of FSAs

Eligible employees may enroll in a Healthcare FSA as well as a Dependent Care FSA. If you incur both types of expenses during a Plan Year, you can establish both types of FSAs.

Is an FSA Right for Me?

If you anticipate incurring regular healthcare or dependent care expenses that are not covered by your insurance plan, an FSA may be a good choice for you. An FSA can offer the security of setting aside funds to cover these anticipated expenses and tax benefits.

To calculate your potential FSA tax savings, visit www.myFBMC.com and click on the tax calculator.

Healthcare FSA

Medical expenses not covered by your insurance plan may be eligible for reimbursement using your healthcare FSA, including but not limited to:

- Birth control pills
- Eyeglasses
- Orthodontia
- Over-the-Counter medications

Dependent Care FSA

Dependent care expenses, whether for a child or elder, include any expenses that allow you to work, including but not limited to:

- Daycare services
- In-home care
- Nursery and pre-school
- Summer day camps

Refer to the following pages of this guide for more specifics on each type of FSA, including more complete lists of the types of expenses that can be reimbursed per the IRS.

Budget Conservatively

No reimbursement or refund of FSA funds is available for services that do not occur within the plan year. When it comes to your annual FSA contributions, if you don't use it, you lose it.

Flexible Spending Account: Healthcare

A healthcare FSA is an IRS-approved tax favored account you can use to pay for eligible medical expenses not covered by insurance. These funds are set aside from your salary pre-tax.

Overview

A Healthcare FSA is an IRS-approved tax favored account you can use to pay for your eligible medical expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free.

Contributions

On your Open Enrollment application form you designate an annual Healthcare Flexible Spending Account contribution. The minimum annual contribution for Plan Year 2008-2009 is $120. The maximum annual contribution is $5,000. The annual amount you designate divided by 24 equals your semi-monthly payroll deduction.

Availability of Funds

When you sign-up for a Healthcare FSA the total annual amount you designate becomes available for eligible healthcare expenses at the start of the Plan Year. You don't have to wait for your contributions to accumulate in your account.

General Eligibility

You may use your Healthcare FSA to receive reimbursement for eligible expenses incurred by:

- Yourself
- Your spouse
- Your qualifying child
- Your qualifying relative

A qualified child of divorced parents is treated as a dependent of both, so either or both parents can establish a Healthcare FSA.

Qualifying Children

An individual is a qualifying child for a Healthcare FSA expense if he or she meets all of the following criteria:

1. is a U.S. citizen, national or a resident of the U.S., Mexico or Canada;
2. has a specified family-type relationship to you;
3. lives in your household for more than half the taxable year;
4. has not provided more than one-half of their own support during the taxable year;
5. receives more than one-half of their support from you during the taxable year and
6. is 18 years old or younger OR 23 years old or younger and a full-time student.

Qualifying Child Age Exception

If a qualifying child is physically and/or mentally incapable of self-care there is no age requirement.

Qualifying Relatives

An individual is a qualifying relative for a Healthcare FSA expense if he or she meets one or the other of the following two sets of criteria:

1. has a specified family-type relationship to you;
2. is not someone else's qualifying child;
3. and receives more than one-half of their support from you during the taxable year and;

OR

1. does not have a specified family-type relationship to you;
2. is a member or and lives in your household without violating local law for the entire tax year;
3. and receives more than one-half of their support from you during the taxable year.

Flexible Spending Account: Healthcare

A wide variety of healthcare expenses, from acupuncture to x-rays, are eligible for FSA reimbursement. You can even save valuable tax dollars on eligible over-the-counter remedies.

Eligible Expenses

Subject to change per IRS regulations, the following medically necessary expenses may be eligible for your Healthcare FSA reimbursement:

- Acupuncture
- Alcoholism treatment
- Ambulance
- Birth control
- Chiropractic
- Contact lenses
- Dental fees
- Diagnostic tests
- Doctor fees
- Drug addiction treatment
- Experimental medical treatment
- Eyeglasses
- Guide dogs
- Health screenings
- Hearing aids
- Hearing exams
- In vitro fertilization
- Injections
- Nursing services
- Optometrist fees
- Orthodontics
- Over-the-counter drugs and devices
- Prescription drugs
- Smoking cessation programs
- Surgery
- Transportation for medical care
- Weight loss programs
- Wheelchairs

If you have any questions about whether an expense is eligible for reimbursement, contact Fringe Benefits Management Company, the plan provider, by calling (800) 342-8017 Monday - Friday (4 a.m.-7 p.m. PT) or visit www.myFBMC.com.

Ineligible Expenses

Expenses not eligible for reimbursement through your Healthcare FSA include:

- Health insurance premiums
- Vision warranties and service contracts
- Cosmetic surgery that is not necessary to alleviate or prevent a medical condition.

General Healthcare FSA Reimbursements

Be certain you obtain and submit the following information when requesting your Healthcare FSA reimbursement. This information is required with each request for reimbursement.

1. A completed FSA reimbursement form.
2. A receipt, invoice or bill from your healthcare provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided.

   OR

   An Explanation of Benefits (EOB) from your insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost.

Cosmetic Services Reimbursement

If a service could be deemed cosmetic in nature, you must submit all of the following three items:

1. A completed FSA reimbursement form;
2. A written statement from your healthcare provider indicating the service was medically necessary and
3. Your receipt, invoice or bill for the service.

Healthcare FSA Reimbursement Forms

Download Healthcare FSA reimbursement forms from www.FBMC.com or myhss.org.

Flexible Spending Account: Healthcare

Signing up for FSA Direct Deposit, which places approved reimbursements automatically into your checking or savings account, can expedite your FSA reimbursement requests.

Orthodontic Services Reimbursement

Orthodontic treatment designed to treat a specific medical condition may be reimbursable. Remember to submit all of the following four items of documentation:

1. A completed FSA reimbursement form.
2. A written statement from the treating dentist or orthodontist listing the type of service, the date service was incurred, the name of the eligible individual receiving the service and the service cost.
3. An Explanation of Benefits (EOB) from your insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost.
4. The orthodontia contract.

Over-the-Counter Items

Over-the-Counter items, such as allergy, antacid, cold and pain relief remedies may be eligible for reimbursement through your Healthcare FSA if all of the following four criteria are met:

1. The item, medicine or drug was used for a specific medical condition for you, your spouse and/or your qualified child or relative.
2. The submitted receipt clearly states the purchase date and name of the item, medicine or drug.
3. The reimbursement request is for an expense allowed by the Healthcare FSA plan and IRS regulations.
4. You submit your reimbursement request in a timely and complete manner.

OTC items, medicines and drugs, including bulk purchases, must be used in the same plan year in which you claim reimbursement for their cost.

Over-the-Counter Item Updates

A list of eligible Over-the-Counter categories are updated quarterly online by FBMC. It is your responsibility to remain informed of the updates to this list, which can be found at www. myFBMC.com.

Be sure to maintain sufficient documentation to submit receipts for reimbursement. You may resubmit a copy of your receipt from your records if a rejected expense becomes eligible for reimbursement later in the same plan year.

Newly eligible Over-the-Counter items, medicines and drugs are not considered a change in status event that would allow you to change your annual Healthcare FSA election or salary reduction amount.

Healthcare FSA Reimbursement

Fax toll-free to:
(866) 440-7145

Mail to:
Fringe Benefits Management Company
PO Box 1800
Tallahassee, FL 32302-1800

Flexible Spending Account: Dependent Care

A Dependent Care FSA is an IRS-approved tax favored account you can use to pay for eligible dependent care expenses. These funds are set aside from your salary pre-tax.

Overview

A Dependent Care FSA is an IRS tax-favored account you can use to pay for eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free.

Contributions

On your Open Enrollment application form designate an annual Dependent Care Flexible Spending Account contribution. The minimum annual contribution for Plan Year 2008-2009 is $120. The maximum annual contribution is $5,000. The annual amount you designate divided by 24 equals your semi-monthly payroll deduction.

Availability of Funds

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depends on the actual funds in your account, once payroll deductions are received and processed each pay period. Unlike a Healthcare FSA, the entire annual amount you designate is not available at the start of the Plan Year.

General Eligibility

You may use your Dependent Care FSA for eligible expenses related to:

- A qualifying child
- A qualifying spouse
- A qualifying relative

Tax Return Considerations

Be aware of the following:

- You cannot claim a qualifying individual if they have filed a joint tax return with a spouse.
- If you are claimed as a dependent on the tax return of another person you cannot claim qualifying individuals for yourself.

Qualifying Children

An individual is a qualifying child for a Dependent Care FSA expense if he or she meets all of the following five criteria:

1. is a U.S. citizen, national or a resident of the U.S., Mexico or Canada;
2. has a specified family-type relationship to you;
3. lives in your household for more than half the taxable year;
4. has not provided more than one-half of their own support during the taxable year and
5. is 12 years old or younger.

If you are legally separated or divorced you must be the legal custodial parent to claim Dependent Care FSA expenses for a child.

Qualifying Spouse

An individual is a qualifying spouse for a Dependent Care FSA expense if he or she meets all of the following four criteria:

1. is legally married to you;
2. is physically and/or mentally incapable of self-care;
3. lives in your household for more than half the taxable year and
4. spends at least 8 hours per day in your home.

Flexible Spending Account: Dependent Care

Depending on the amount of income taxes you're required to pay, participation in a Dependent Care FSA may produce a greater tax benefit than claiming tax credits or exclusions alone.

Qualifying Relatives

An individual is a qualifying relative for a Dependent Care FSA expense if he or she meets all of the following six criteria:

1. is a U.S. citizen, national or a resident of the U.S., Mexico or Canada;
2. is physically and/or mentally incapable of self-care;
3. is not someone else's qualifying child;
4. lives in your household for more than half the taxable year;
5. spends at least 8 hours per day in your home and
6. and receives over one-half of their financial support from you during the taxable year.

Eligible Expenses

Subject to change per IRS regulations, the following expenses may be eligible for FSA Dependent Care reimbursement:

- After school programs
- Day camps
- Child day care
- Pre-school
- At-home elder-sitting
- Senior day care

Ineligible Expenses

Expenses that are not eligible for FSA Dependent Care reimbursement include, but are not limited to:

- Child support payments
- Childcare costs incurred by a non-custodial parent
- Food, clothing and entertainment
- Healthcare costs
- School tuition, books and supplies
- Services provided by your dependent, spouse's dependent or your child who is under age 19

FSA versus Tax Credits and Exclusions

Since money set aside in your Dependent Care FSA is always tax-free, you guarantee savings by paying for eligible expenses through your tax-favored FSA account. Depending on the amount of income taxes you're required to pay, participation in a Dependent Care FSA may produce a greater tax benefit than claiming tax credits or exclusions alone. (Remember, you can't use the dependent care tax credit if you are married and filing separately. Further, any dependent care expenses reimbursed through your Dependent Care FSA can't be filed for the dependent care tax credit, and vice versa. To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information.

Dependent Care FSA Reimbursements

This information is required with each request for Dependent Care reimbursement.

1. A completed FSA reimbursement form;
2. A receipt that shows all of the following:
   a. the name, age and school grade (if applicable) of the dependent receiving the service;
   b. the cost of the service;
   c. name and address of the service provider and
   d. the beginning and end dates of the service.

Dependent Care FSA Reimbursement

Fax toll-free to: (866) 440-7145

Mail to:
Fringe Benefits Management Company
PO Box 1800
Tallahassee, FL 32302-1800

Important Information about FSAs

FBMC Website & Interactive Voice Response

Visit www.myFBMC.com or call 1-800-865-3262 on Monday – Friday (4 a.m.-7 p.m. PT) to get detailed information about your FSA. You can use the FBMC website or IVR to:

- Review the status of your reimbursement requests.
- Review your account balance and available funds.
- Download forms.
- Review frequently asked questions.

Direct Deposit Reimbursement

To apply, complete the Direct Deposit Enrollment Form on www.myFMBC.com or contact FBMC Customer Service by at 1-800-342-8017. Processing your Direct Deposit enrollment may take 4-6 weeks.

- FSA reimbursement funds are automatically deposited into your checking or savings account.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement. (However, you will receive notification that the claim has been processed).

Annual Re-enrollment Required

You must re-enroll in your Flexible Spending Accounts every Open Enrollment period.

No Transferring Between Accounts

You cannot transfer money between Healthcare and Dependent Care Flexible Spending Accounts.

Changing Contribution Amounts

You can't change the amounts you contribute to your Flexible Spending Account(s) during the Plan Year unless the change is on account of and consistent with a qualifying change in family status.

Pre-Retirement Planning

If you plan to retire and have money in these accounts, you should file claims for reimbursement prior to your retirement date. Retirees are not eligible to participate in an FSA.

Leaves of Absence

During an unpaid leave of absence, no contributions are being made toward these accounts, unless otherwise provided by law. Accounts that remain unpaid for three consecutive pay periods will be terminated, and you may only reinstate your Flexible Spending Account upon your return to work by contacting HSS and requesting a reinstatement.

Eligibility Time Period

Expenses for services incurred before or after the period for which you enroll aren't eligible for reimbursement. For example, a medical expense incurred in June isn't eligible for reimbursement from a Healthcare Flexible Spending Account because your account is not open until July 1.

IRS Eligibility Criteria

Your expenses must meet the Internal Revenue Service (IRS) eligibility criteria. Please refer to IRS Publications 502 and 503 for details.

Avoid Forfeiting Your FSA Contributions

All FSA claims must be postmarked no later than September 30, 2009. You will forfeit any money left in your FSA(s) after the end of the claim filing period. There are no exceptions to this rule!

Frequently Asked Questions

What should I do if my healthcare contribution is incorrect or isn't being deducted from my paycheck?

When you select your initial healthcare coverage or change your coverage during the annual Open Enrollment period or because of a qualifying change in family status, you should carefully check your paycheck stub to verify that the correct healthcare contribution is being deducted.

If the deduction is incorrect or doesn't appear on your paycheck stub, you should contact HSS Member Services at (415) 554-1750 for assistance. You are responsible for all required healthcare contributions, whether they are deducted from your paycheck or not.

Who do I contact if I need an insurance ID card or if I have a question about my coverage?

Contact the plan directly. Refer to the Key Contact Information on page 44 of this guide for benefit plan telephone numbers and website addresses. You may also obtain a copy of your plan's Evidence of Coverage from the HSS website at www.myhss.org

What if my healthcare provider chooses not to participate in my plan's network?

The healthcare plans administered by HSS do not guarantee the continued network participation of any particular doctor, dentist, hospital, medical group or other provider during the Plan Year. After the annual Open Enrollment deadline, you won't be allowed to change your healthcare elections because your provider and/or your medical group choose not to participate in a particular benefit plan. You'll be assigned or will be required to select another provider.

What happens if I move outside the service area covered by my medical or dental plan?

If you move out of the service area covered by your plan, you must elect healthcare coverage under an option that provides coverage in your area. Failure to change your healthcare elections will result in the non-payment of claims for services received. Contact HSS Member Services at (415) 554-1750 for assistance.

Is healthcare coverage available for dependents who no longer meet HSS eligibility requirements?

Yes. Dependents who no longer meet the eligibility requirements for participation may be eligible to continue healthcare coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). See pages 34-35 of this guide for more information.

In the event of my death, what happens to the coverage of my dependents?

Generally, surviving dependents of an employee may continue healthcare coverage after the death of the employee. Upon your death, covered dependents should contact HSS Member Services for information on available healthcare coverage options.

What happens to my coverage when I retire?

Eligible employees who retire on a service, disability or vesting retirement may be eligible to continue healthcare coverage at the rates then in effect for retired employees, provided a completed retiree healthcare application is submitted to HSS within 30 days of the retirement effective date. Other conditions may apply. Contact HSS Member Services for details.

When do I lose coverage if I leave employment with the City?

When you leave City employment, if your termination date falls between the 1st and the 15th day of the month HSS coverage will terminate on the 15th of the month. If your termination date falls between the 16th and the last day of the month HSS coverage will terminate on the last day of the month. You may be eligible to continue healthcare coverage pursuant to COBRA. (See pages 34-35 of this guide for details.)

This information is general in nature. Please contact HSS Member Services at (415) 554-1750 for assistance with your particular situation.

Qualifying Changes in Family Status

You can only change your benefit elections during annual Open Enrollment, unless there is a qualifying change in your family status.

Marriage or Domestic Partnership

To enroll your new spouse or domestic partner and their eligible child(ren) in your HSS healthcare coverage you must submit a completed HSS Enrollment Application and a copy of your marriage license or certificate of domestic partnership and birth certificates for their child(ren) to the Health Service System **within 30 days** from the date of your marriage or certification of domestic partnership. Coverage for your spouse or domestic partner and their eligible children will be effective on the date of marriage or certification of domestic partnership, provided you meet the enrollment deadline and documentation requirements stated above. If you do not complete the enrollment process **within 30 days** from the date of your marriage or certification of domestic partnership, you must wait until the next annual Open Enrollment period to add your new family members.

Domestic Partner Tax Alert: When you elect healthcare coverage for your domestic partner (and any dependent(s) of your domestic partner), you will be taxed on the value of the City and County of San Francisco's contribution toward the cost of healthcare coverage for these dependents, per IRS requirements. This is referred to as imputed income and may affect your net pay.

Birth or Adoption

To enroll your newborn/newly adopted child in your HSS healthcare coverage you must submit a completed HSS Enrollment Application and a copy of the birth certificate or adoption documentation **within 30 days** from the date of birth or placement for adoption. Coverage for your newborn child will be effective on the child's date of birth provided you meet the deadline and documentation requirements stated above. Coverage for your newly adopted child will be effective on the date the child is placed with you for adoption provided you meet the deadline and documentation requirements stated above. If you do not complete the enrollment process **within 30 days** from the date of birth or placement for adoption of a new child, you must wait until the next annual Open Enrollment period to do so.

Divorce, Separation and Dissolution of Partnership

To terminate healthcare coverage for your ex-spouse/domestic partner due to divorce, legal separation or dissolution of domestic partnership, you must submit a completed HSS Enrollment Application and a copy of your divorce decree, legal separation documents or dissolution of domestic partnership documents **within 30 days** from the date of divorce, legal separation or dissolution of domestic partnership. Coverage for your ex-spouse/domestic partner will terminate on the last day of the coverage period in which the divorce, legal separation or dissolution of domestic partnership occurred provided you meet the deadline and documentation requirements stated above. If you do not complete the coverage termination process **within 30 days** from the date of your divorce, legal separation or dissolution, coverage for your ex-spouse/domestic partner will terminate on the last day of the coverage period in which you submit a completed HSS Application and required documentation and you will be responsible for paying all required contributions up to the coverage termination date.

Qualifying Changes in Family Status

Take note of the 30 day time period during which you can make healthcare coverage changes after one of these qualifying changes in your family status.

Loss of Other Healthcare Coverage

You can enroll an eligible dependent that loses other healthcare coverage by submitting a completed HSS Enrollment Application and proof of the loss of cover-age **within 30 days** from the date the other coverage terminates. Coverage for your dependent will be effective on the first day of the coverage period following the date HSS receives a completed HSS Enrollment Application provided you meet the deadline and documentation requirements stated above. Please note that there may be a break in healthcare coverage between the date that other coverage terminates and the date that HSS coverage begins. If you do not complete the enrollment process **within 30 days** from the date that other coverage terminates, you must wait until the next annual Open Enrollment period to add your eligible dependent.

Obtaining Other Coverage

You may terminate healthcare coverage for yourself and/or your enrolled dependents if you or they become eligible for other healthcare coverage by submitting a completed HSS Enrollment Application and proof of other healthcare coverage enrollment **within 30 days** from the date of your enrollment in another healthcare plan. Your HSS healthcare coverage will terminate on the last day of the coverage period in which HSS receives a completed HSS Enrollment Application provided you meet the deadline and documentation requirements stated above. Please note that there may be an overlap of healthcare coverage between the date your other coverage begins and the date your HSS coverage terminates. You are responsible for paying all required contributions up to the termination date of your HSS healthcare coverage.

If you do not complete the coverage termination process **within 30 days** from the date of your enrollment in another healthcare plan, you must wait until the next annual Open Enrollment period to do so.

Death of a Dependent

If an enrolled dependent dies, you should notify HSS as soon as possible and submit a copy of the death certificate **within 30 days** from the date of death. Coverage for your deceased dependent will terminate at midnight on the date of the dependent's death.

Death of a Member

In the event of a member's death, surviving dependent(s) or another designee should contact HSS **within 30 days** from the date of the member's death to obtain information about any available survivor benefits.

Mark Your Calendar: 30 Day Rule

If you have a qualifying change in your family status and fail to submit a completed HSS Enrollment Application within the 30 day time period you must wait until the next Open Enrollment to do so.

Leaves of Absence and Your Benefits

You can continue healthcare coverage if you go on an approved leave of absence, but you must make contribution payments directly to HSS during your leave.

Type of Leave	Eligibility	Your Responsibilities
Family and Medical Leave (FMLA) **Worker's Compensation Leave** **Family Care Leave**	You may be eligible to continue your healthcare coverage for the duration of your approved leave of absence. You may have additional rights under an approved FMLA leave. Contact your departmental personnel representative for details.	1. Notify your department's personnel office. They will provide HSS with important information about your leave. 2. Contact HSS to arrange for the payment of any required contributions while you are on leave.
Personal Leave Following Family Care Leave	If you have been on an approved Family Care Leave and elect to extend your leave period as a Personal Leave, you may be eligible to continue your healthcare coverage for the duration of your approved Personal Leave, if: • The reason for the Personal Leave is the same as the reason for the prior Family Care Leave. • Your required healthcare contribution payments, if any, are current.	1. Notify your department's personnel office. They will provide HSS with important information about your leave. 2. Contact HSS to arrange for the payment of any required contributions while you are on leave.
Educational Leave **Personal Leave** **Leave for Employment as an Employee Organization Officer or Representative**	You may be eligible to continue your healthcare coverage for the duration of your approved leave of absence.	1. Notify your department's personnel office. They will provide HSS with important information about your leave. 2. Contact HSS to arrange for the payment of any required contributions while you are on leave. 3. If your leave lasts beyond 12 weeks, you are responsible for paying the total cost of medical and dental coverage for yourself and any covered dependents. This includes any contribution amount that was being deducted from your paycheck plus the City and County of San Francisco's contribution. Contact HSS for details.

Leaves of Absence and Your Benefits

Stay informed – failure to abide by HSS requirements could result in the loss of healthcare coverage for you and your dependents while you are on leave.

Contact HSS Before Starting Your Leave

The chart on page 32 summarizes the basic steps for how to continue healthcare coverage while you are on an approved leave. To ensure continued healthcare coverage, be sure to contact HSS about your individual situation before starting your leave.

HSS AUTO-PAY

If you are continuing health coverage while on leave, sign-up for the easy, secure HSS AUTO-PAY program to ensure your benefits will not be at risk of termination. With AUTO-PAY your monthly healthcare contribution is charged automatically to your VISA or Mastercard. Call HSS for more information. You can also download the authorization form for HSS AUTO-PAY at myhss.org.

Discontinuing HSS Healthcare Coverage During a Leave of Absence

If you wish to discontinue your healthcare coverage during an approved leave of absence, you must notify HSS in writing prior to the start of your leave.

Don't Risk Losing Healthcare Coverage While You Are On Leave

The most common reason members lose their healthcare coverage while on leave is failure to pay their healthcare contributions. Sign-up for HSS AUTO-PAY and have your contributions automatically charged to your credit/debit card.

Separation From Employment and COBRA

If you are separated from City service but placed on an eligible holdover roster you may be eligible to continue your enrollment in HSS medical, vision and dental coverage.

Employees with Holdover Rights

Employees who are separated from City service and placed on an eligible holdover roster may be eligible to continue medical, dental and vision benefits for themselves and their covered dependents for up to 5 years, as long as they meet all of the following three requirements:

1. Employees must certify that they are unable to obtain healthcare coverage from another source;
2. Employees must complete and submit a Certificate of Eligibility Form to the Health Service System on an annual basis; and
3. Employees must pay the same amount that was deducted from his/her paycheck prior to lay off (rates subject to increase each plan year).

Employees with No Holdover Rights

Employees who are separated from all City service and have no holdover rights may be eligible to continue medical, dental and vision coverage under COBRA. Your healthcare coverage will terminate on the last day of the coverage period in which you terminate employment.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted in 1986 offers employees and their covered dependents the opportunity to elect a temporary extension of healthcare coverage in certain instances where coverage would otherwise end.

COBRA Qualifying Events

Employees have the right to elect continuation of coverage if healthcare coverage is lost due to any of the following qualifying events:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct.
- Reduction in number of hours of employment that makes the employee ineligible for healthcare coverage.

Covered spouses or domestic partners have the right to elect continuation coverage if healthcare coverage is lost due to any of the following qualifying events:

- Voluntary or involuntary termination of the employee's employment for reasons other than gross misconduct.
- Divorce, legal separation or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

Covered dependent children have the right to elect continuation coverage if healthcare coverage is lost due to any of the following qualifying events:

- Loss of dependent child status under the plan rules.
- Voluntary or involuntary termination of the employee's employment for reasons other than gross misconduct.
- Reduction in number of hours of employment that makes the employee ineligible for healthcare coverage.
- Parent's divorce, legal separation or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

COBRA

COBRA is a Federal Law that provides for continuation of healthcare coverage when coverage may be lost due to specific qualifying events.

Time Limits for COBRA Elections

When a qualifying event occurs, the COBRA Administrator will notify you of your right to elect COBRA coverage. You will have 60 days from the date of this notification to elect COBRA coverage. The coverage will be continuous from the date of the qualifying event so you will not have a break in your healthcare coverage. While you are covered under COBRA, you have 30 days to add any newly eligible dependent (spouse, domestic partner, newborn or adopted child) to your COBRA coverage from the date of the event (birth, marriage, etc.).

Duration of COBRA Continuation Coverage

COBRA beneficiaries are generally eligible for group coverage for a maximum of 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

In the case of a dependent losing coverage (divorce or aging out of a plan) the employee or dependent must notify the COBRA Administrator within 30 days of the qualifying event.

Employees who are disabled on the date of their qualifying event or at any time during the first 60 days of continuation coverage, are eligible for a total of 29 months of COBRA coverage. The cost will be 150% of the group rate, beginning in the 19th month of coverage.

Termination of COBRA Continuation Coverage

COBRA coverage will end at the earliest of the date:

- You obtain coverage under another group plan if no pre-existing condition limitation under the new plan applies to the covered individual.
- You fail to pay the premium required under the plan within the grace period.
- The applicable COBRA period ends.

Paying for COBRA

Once COBRA continuation coverage is elected, it is the responsibility of the covered individual(s) to remit the required healthcare premium payments directly to the COBRA Administrator.

COBRA Continuation Coverage Alternatives

As an alternative to COBRA continuation coverage, you may be able to purchase individual health coverage, if available, from your healthcare plan. Contact your plan directly for details and costs.

All employees and dependents who were covered under a Health Service System administered health plan are entitled to a certificate that will show evidence of prior health coverage. This certificate of prior coverage may assist the employee and/or dependents to purchase new health coverage that excludes pre-existing medical conditions.

COBRA Questions?

For questions about your COBRA continuation coverage contact the COBRA Administrator FBMC at (800) 342-8017.

Glossary of Healthcare Terms

Brand Name Drug
FDA approved prescription drugs marketed under a specific brand name by the company that manufactures it.

COBRA
This federal law allows employees and dependents who are enrolled in an employer-sponsored plan to temporarily continue receiving health coverage after certain qualifying events like termination or divorce.

Co-Insurance
Co-insurance refers to the amount of money that a member is required to pay for healthcare services, after any required deductible has been paid. Co-insurance is often specified by a percentage. For example, the employee pays 15% toward the charges for a covered service and the insurance company pays 85%.

Co-payment
The flat fee you pay each time you utilize a healthcare service or fill a prescription.

Deductible
The specified amount you must pay for healthcare in a plan year before the plan will begin to cover all or a portion of your costs. Some plans have no deductible.

Dependent
A family member or other individual who meets the eligibility criteria established by HSS for enrollment in an available healthcare plan.

Dental Maintenance Organization (DMO)
An entity that provides dental services through a closed network. DMO participants can only obtain service from network dentists and typically need pre-approval from a primary care dentist before seeing a specialist.

Effective Date
The actual date your healthcare coverage is scheduled to begin. You are not covered until the effective date.

Employer Contribution
The amount your employer pays toward the cost of your health plan premiums.

Explanation of Benefits (EOB)
Written, formal statement sent to PPO enrollees that lists the services provided and costs billed by their health plan.

Evidence of Coverage (EOC)
The Evidence of Coverage gives details about the benefits and exclusions of your health plan and explains how to get the care you need. The EOC is an important legal document and is your contract with your Plan provider. It explains your rights, benefits and responsibilities as a member of your Plan. It also explains the Plan Providers responsibilities to you. The EOC should be reviewed in conjunction with this benefits guide because the guide does not list every service, every limitation or every exclusion of your Plan.

Exclusions
The list of conditions, injuries, or treatments that are not covered under your health insurance policy. Exclusions can be found in your plan document called the Evidence of Coverage.

Formulary
A comprehensive list of prescription drugs that are covered by a medical plan. The formulary is designed to assist physicians in prescribing drugs that are medically necessary and cost effective for members. The formulary is updated periodically.

Flexible Spending Account (FSA)
An account that you contribute to pre-tax and reimburses you for qualified healthcare expenses.

Generic Drug
FDA approved prescription drugs that are a therapeutic equivalent to the Brand Name Drug, contain the same active ingredient as the Brand Name Drug, and cost less than the Brand Name Drug equivalent.

Health Maintenance Organization (HMO)
An entity that provides health services through a closed network. Unlike PPOs, HMOs either employ their own staff or contract with groups of providers. HMO participants typically need pre-approval from a primary care provider before seeing a specialist.

Glossary of Healthcare Terms

In-Network
Providers or healthcare facilities which are part of a health plan's network of providers with which it has negotiated a discount. Enrollees usually pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts.

Lifetime Maximum Benefit
The maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime.

Open Enrollment
The period of time when you can change your health benefit elections without a qualifying event.

Out-of-Network
Providers or healthcare facilities which are not in your health plan's provider network. Some plans do not cover Out-of-Network service costs. Others charge a higher co-payment for this type of service.

Out-of-Pocket Costs
The actual costs you pay–including premiums and co-payments–for your healthcare.

Out-Of-Pocket Maximum
The amount of money that an individual must pay out of their own pocket, before an insurance company will pay 100% for an individual's healthcare expenses.

Out-of-Area
A location outside the geographic area covered by a health plan's network of providers.

Preferred Provider Organization (PPO)
An entity that contracts to provide healthcare services to subscribers at negotiated, often discounted, rates.

Premium
The amount charged by an insurer for healthcare coverage. This cost is usually shared by employer and employee.

Primary Care Physician (PCP)
The doctor (or nurse practitioner) who coordinates all your medical care and treatment. HMOs require all plan participants be assigned to a PCP.

Qualifying Event
A change in your life situation that allows you to make a change in your benefit elections outside Open Enrollment. This includes marriage, domestic partnership, separation, divorce or dissolution of partnership, the birth or adoption of a child and the death of a dependent as well as obtaining or losing other healthcare coverage.

Reasonable and Customary Charges
The average fee charged by a particular type of healthcare practitioner within a geographic area. Often used by medical plans as the amount of money they will approve for a specific test or procedure. If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference.

Privacy Policy

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read this notice carefully.

Use and Disclosure of Health Information

The City & County of San Francisco Health Service System (the "Health Service System") may use your health information, that is, information that constitutes Protected Health Information (PHI) as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Health Service System has established a policy to guard against unnecessary disclosure of your health information.

The following is a summary of the circumstances under which your healthcare information may be used and disclosed.

To Make or Obtain Payment

The Health Service System may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the City Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate the payment of benefits.

To Conduct Healthcare Operations

The Health Service System may use or disclose health information for its own operations to facilitate administration and as necessary to provide coverage and services to all Health Service System members. A health care operation includes:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guidelines and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of City Health Plan, including customer service and resolution of internal grievances.

For example, the Health Service System may use your health information to conduct case management, quality improvement and utilization review and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment Alternatives

The Health Service System may use and disclose your health information to tell you about or recommend treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services

The Health Service System may use or disclose your health information to provide you information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Actuaries

The Health Service System may provide summary health information to the plan sponsor; may solicit premium bids from other health plans; or may modify, amend or terminate the plan.

When Legally Required

The Health Service System will disclose your health information when it is required to do so by any federal, state or local law or by court order.

To Conduct Health Oversight Activities

The Health Service System may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Health Service System, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings

As permitted or required by state law, the Health Service System may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Health Service System makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information, or to obtain your consent for disclosure.

For Law Enforcement Purposes

As permitted or required by state law, the Health Service System may disclose your health information to a law enforcement official for certain law enforcement purposes, but not limited to, if the Health Service System has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety

The Health Service System may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Health Service System, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

Privacy Policy

For Specified Government Functions

In certain circumstances, federal regulations may require the Health Service System to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, Medicare and other similar entities and correctional institutions and inmates.

For Worker's Compensation

The Health Service System may release your health information to the extent necessary to comply with Workers' Compensation laws or similar programs.

Authorization To Use Or Disclose Health Information

Other than as related above, the Health Service System will not disclose your health information other than with your written authorization. If you authorize the Health Service System to use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights With Respect to Your Health Information

You have the following rights regarding your health information that the Health Service System maintains:

Right to Request Restrictions

You may request restrictions on certain uses and disclosures of your health information. You have the right to request in writing a limit on the Health Service System's disclosure of your health information to someone involved in the payment of your care. However, the Health Service System is not required to agree to your request.

Right to Receive Confidential Communications

You have the right to request in writing that the Health Service System communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Health Service System only communicate with you at a certain telephone number or by email. The Health Service System will make every attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information

You have the right to inspect and copy your health information. A written request to inspect and copy records containing your health information must be sent to the Health Service System. If you request a copy of your health information, the Health Service System may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information

If you believe that your health information records are inaccurate or incomplete, you may request in writing that the Health Service System amend the records. The request may be made as long as the information is maintained by the Health Service System. The Health Service System may deny the request if it does not include a reason to support the amendment. The request may be denied if your health information records were not created by the Health Service System, if the health information you are requesting to amend is not part of the Health Service System's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy or if the Health Service System determines the records containing your health information are accurate and complete.

Right to an Accounting

You have the right to request in writing a list of Health Service System disclosures of your health information for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Health Service System will provide you one accounting during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. If applicable, the Health Service System will inform you in advance of the fee.

Right to a Paper Copy of this Notice

You have a right to request in writing and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. You also may obtain a copy of the current version of this notice from the Health Service System website at www.myhss.org.

Duties of the Health Plan

The Health Service System is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Health Service System reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Health Service System changes its policies and procedures, a revised copy of this Notice will be provided to you within 60 days of the change. You have the right to express complaints to the Health Service System and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Health Service System should be made in writing. The Health Service System encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Written Authorizations & Requests

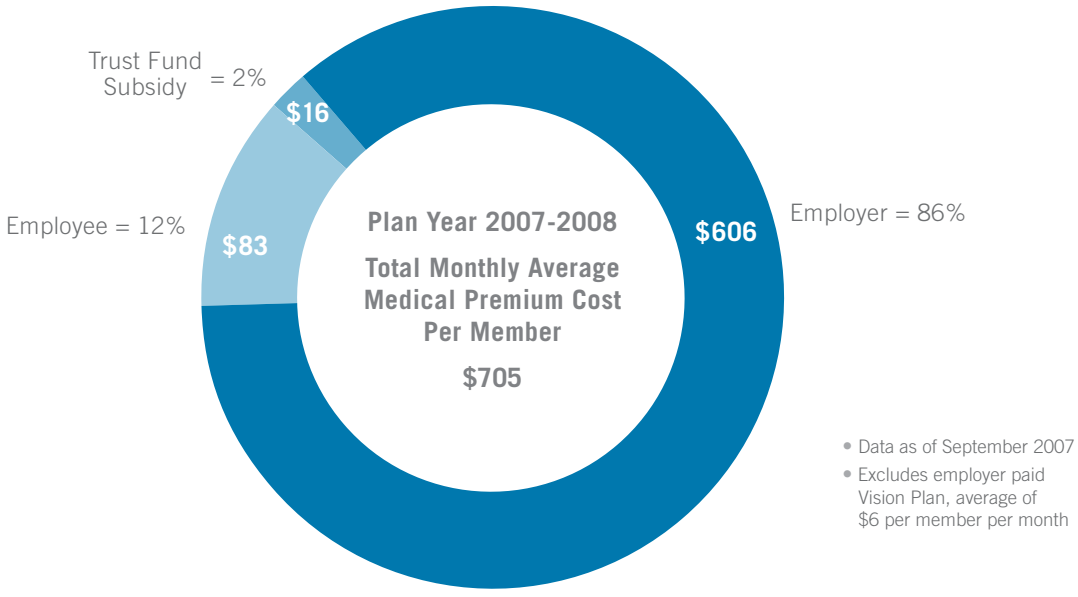
Any written authorizations or requests regarding your health information as described above should be directed to:

Health Service System
1145 Market Street, Suite 200
San Francisco, CA 94103
Attn: Privacy Officer

Effective Date

Original Effective Date: April 14, 2003
Revised January 1, 2008

Medical Plan Costs



The San Francisco Health Service System provides medical and other non-pension benefits to City and County employees, City College of San Francisco and San Francisco Unified School District employees, San Francisco Superior Court employees, and retirees and dependents. The Health Service System is responsible for designing healthcare benefits, selecting and managing plan providers and determining some aspects of benefit eligibility to supplement the eligibility rules contained in the Charter and applicable ordinances. In addition, the Health Service System is responsible for administration of health benefits, including maintaining employee membership and financial accounting records. Additional financial information, including audited Health Service System Trust Fund Financial Statements, is available online at myhss.org.

Medical Plan Rates: Employee Only

UPDATED APRIL 15,2008

COLLECTIVE BARGAINING AGREEMENT	BLUE SHIELD		KAISER		PACIFICARE		CITY PLAN	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Automotive Machinists Local 1414	234.20	0	219.17	0	252.70	0	370.94	0
Bldg Inspectors Class 6331 & 6333	234.20	0	219.17	0	252.70	0	370.94	0
Bricklayers Local 3/Hodcarriers Local 36	234.20	0	219.17	0	252.70	0	370.94	0
Carpenters Local 22	234.20	0	219.17	0	252.70	0	370.94	0
Cement Masons Local 580	234.20	0	219.17	0	252.70	0	370.94	0
DA Investigators Association	234.20	0	219.17	0	252.70	0	370.94	0
Deputy Probation Officers Association	234.20	0	219.17	0	252.70	0	370.94	0
Deputy Sheriffs Association	234.20	0	219.17	0	252.70	0	370.94	0
Electric Workers Local 6	234.20	0	219.17	0	252.70	0	370.94	0
Firefighters Local 798	234.20	0	219.17	0	252.70	0	370.94	0
Glazers Local 718	234.20	0	219.17	0	252.70	0	370.94	0
IFPTE Locals 21 & 22	234.20	0	219.17	0	252.70	0	370.94	0
Institutional Police Officers Association	234.20	0	219.17	0	252.70	0	370.94	0
Ironworkers Local 377	234.20	0	219.17	0	252.70	0	370.94	0
Laborers International Union Local 261	234.20	0	219.17	0	252.70	0	370.94	0
Municipal Attorneys Association	209.40	24.80	209.40	9.77	209.40	43.30	209.40	161.54
Operating Engineers Local 3	234.20	0	219.17	0	252.70	0	370.94	0
Painters Local 4	234.20	0	219.17	0	252.70	0	370.94	0
Physicians and Dentists Unit 8CC	234.20	0	219.17	0	252.70	0	370.94	0
Pile Drivers Local 34	234.20	0	219.17	0	252.70	0	370.94	0
Plasterers Local 66	234.20	0	219.17	0	252.70	0	370.94	0
Plumbers and Pipefitters Local 38	234.20	0	219.17	0	252.70	0	370.94	0
Police Officers Association	234.20	0	219.17	0	252.70	0	370.94	0
Roofers Local 40	234.20	0	219.17	0	252.70	0	370.94	0
SEIU Local 1021 Miscellaneous	234.20	0	219.17	0	252.70	0	370.94	0
SEIU Local 1021 Staff Nurses	209.40	24.80	209.40	9.77	209.40	43.30	209.40	161.54
SEIU Local 1021 Per Diem Nurses [1]	0	234.20	0	219.17	0	252.70	0	370.94
SEIU Local 1021 Fire Rescue Paramedics	234.20	0	219.17	0	252.70	0	370.94	0
Sheet Metal Workers Local 104	234.20	0	219.17	0	252.70	0	370.94	0
Stationary Engineers Local 39	209.40	24.80	209.40	9.77	209.40	43.30	228.73	142.21
Supervising Nurses Local 856	209.40	24.80	209.40	9.77	209.40	43.30	209.40	161.54
Supervising Probation Officers	234.20	0	219.17	0	252.70	0	370.94	0
Teamsters Local 350	209.40	24.80	209.40	9.77	209.40	43.30	209.40	161.54
Teamsters Local 856	234.20	0	219.17	0	252.70	0	370.94	0
Teamsters Local 853	234.20	0	219.17	0	252.70	0	370.94	0
Theatrical Stage Employees Local 16	234.20	0	219.17	0	252.70	0	370.94	0
TWU Local 200 & 250A, Class 7410	234.20	0	219.17	0	252.70	0	370.94	0
TWU Local 250A, Class 9163	209.40	24.80	209.40	9.77	209.40	43.30	209.40	161.54
TWU Local 250A, Multi Unit	234.20	0	219.17	0	252.70	0	370.94	0
Superior Court Employees Locals 21 & 790	234.20	0	219.17	0	252.70	0	370.94	0
Superior Court Judges	234.20	0	219.17	0	252.70	0	370.94	0
Superior Court Reporters	234.20	0	219.17	0	252.70	0	370.94	0
Superior Court Staff Attorneys	234.20	0	219.17	0	252.70	0	370.94	0
Superior Court Unrepresented	234.20	0	219.17	0	252.70	0	370.94	0
Commissioners (Monthly Rates) [1]	418.80	49.59	418.80	19.53	418.80	86.60	418.80	323.08

Rates shown are deducted twice monthly.
All rates that appear in this Benefits Guide are subject to final approval by the San Francisco Board of Supervisors.

[1] Per Diem Nurses and some Commissioners are also required to pay dental plan premiums. Contact HSS for details.

Medical Plan Rates: Employee +1 Dependent

UPDATED APRIL 15,2008

COLLECTIVE BARGAINING AGREEMENT	BLUE SHIELD		KAISER		PACIFICARE		CITY PLAN	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Automotive Machinists Local 1414	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Bldg Inspectors Class 6331 & 6333	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Bricklayers Local 3/Hodcarriers Local 36	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Carpenters Local 22	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Cement Masons Local 580	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
DA Investigators Association	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Deputy Probation Officers Association	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Deputy Sheriffs Association	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Electric Workers Local 6	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Firefighters Local 798	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Glazers Local 718	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
IFPTE Locals 21 & 22	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Institutional Police Officers Association	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Ironworkers Local 377	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Laborers International Union Local 261	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Municipal Attorneys Association	321.90	145.99	321.90	115.92	321.90	183.00	321.90	329.81
Municipal Attorneys Cash Back [2]	209.40	258.49	209.40	228.42	209.40	295.50	209.40	442.31
Operating Engineers Local 3	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Painters Local 4	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Physicians and Dentists Unit 8CC	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Pile Drivers Local 34	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Plasterers Local 66	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Plumbers and Pipefitters Local 38	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Police Officers Association	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Roofers Local 40	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
SEIU Local 1021 Miscellaneous	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
SEIU Local 1021 Staff Nurses	443.09	24.80	428.05	9.77	461.60	43.30	563.22	161.54
SEIU Local 1021 Per Diem Nurses [1]	0	467.89	0	437.82	0	504.90	0	651.71
SEIU Local 1021 Fire Rescue Paramedics	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Sheet Metal Workers Local 104	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Stationary Engineers Local 39	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Supervising Nurses Local 856	443.09	24.80	428.05	9.77	461.60	43.30	563.22	161.54
Supervising Probation Officers	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Teamsters Local 350	321.90	145.99	321.90	115.92	321.90	183.00	321.90	329.81
Teamsters Local 856	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Teamsters Local 853	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Theatrical Stage Employees Local 16	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
TWU Local 200 & 250A, Class 7410	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
TWU Local 250A, Class 9163	321.90	145.99	321.90	115.92	321.90	183.00	321.90	329.81
TWU Local 250A, Multi Unit	443.09	24.80	428.05	9.77	461.60	43.30	509.50	142.21
Superior Court Employees Locals 21 & 1021	467.89	0	437.82	0	503.75	1.15	503.75	147.96
Superior Court Judges	467.89	0	437.82	0	504.90	0	651.71	0
Superior Court Reporters	467.89	0	437.82	0	503.75	1.15	503.75	147.96
Superior Court Staff Attorneys	467.89	0	437.82	0	503.75	1.15	503.75	147.96
Superior Court Staff Attorneys Cash Back [2]	362.89	105.00	332.82	105.00	398.75	106.15	398.75	252.96
Superior Court Unrepresented	467.89	0	437.82	0	503.75	1.15	503.75	147.96
Commissioners (Monthly Rates) [1]	418.80	516.96	418.80	456.83	418.80	591.00	418.80	884.62

[1] Per Diem Nurses and some Commissioners are also required to pay dental plan premiums. Contact HSS for details.

[2] Attorneys with enrolled dependents who wish to elect the cashback rate must complete additional forms. Contact HSS for details.

Medical Plan Rates: Employee +2 or More Dependents

UPDATED APRIL 15,2008

COLLECTIVE BARGAINING AGREEMENT	BLUE SHIELD		KAISER		PACIFICARE		CITY PLAN	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Automotive Machinists Local 1414	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Bldg Inspectors Class 6331 & 6333	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Bricklayers Local 3/Hodcarriers Local 36	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Carpenters Local 22	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Cement Masons Local 580	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
DA Investigators Association	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Deputy Probation Officers Association	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Deputy Sheriffs Association	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Electric Workers Local 6	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Firefighters Local 798	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Glazers Local 718	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
IFPTE Locals 21 & 22	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Institutional Police Officers Association	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Ironworkers Local 377	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Laborers International Union Local 261	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Municipal Attorneys Association	321.90	339.94	321.90	297.40	321.90	392.32	321.90	593.73
Municipal Attorneys Cash Back [2]	209.40	452.44	209.40	409.90	209.40	504.82	209.40	706.23
Operating Engineers Local 3	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Painters Local 4	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Physicians and Dentists Unit 8CC	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Pile Drivers Local 34	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Plasterers Local 66	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Plumbers and Pipefitters Local 38	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Police Officers Association	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Roofers Local 40	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
SEIU Local 1021 Miscellaneous	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
SEIU Local 1021 Staff Nurses	637.04	24.80	609.53	9.77	670.92	43.30	754.09	161.54
SEIU Local 1021 Per Diem Nurses [1]	0	661.84	0	619.30	0	714.22	0	915.63
SEIU Local 1021 Fire Rescue Paramedics	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.14
Sheet Metal Workers Local 104	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.14
Stationary Engineers Local 39	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.14
Supervising Nurses Local 856	637.04	24.80	609.53	9.77	670.92	43.30	754.09	161.54
Supervising Probation Officers	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.14
Teamsters Local 350	321.90	339.94	321.90	297.40	321.90	392.32	321.90	593.74
Teamsters Local 856	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Teamsters Local 853	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Theatrical Stage Employees Local 16	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
TWU Local 200 & 250A, Class 7410	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
TWU Local 250A, Class 9163	321.90	339.94	321.90	297.40	321.90	392.32	321.90	593.73
TWU Local 250A, Multi Unit	509.50	152.34	509.50	109.80	509.50	204.72	509.50	406.13
Superior Court Employees Locals 21 & 1021	503.75	158.09	503.75	115.55	503.75	210.47	503.75	411.88
Superior Court Judges	661.84	0	619.30	0	714.22	0	915.63	0
Superior Court Reporters	503.75	158.09	503.75	115.55	503.75	210.47	503.75	411.88
Superior Court Staff Attorneys	503.75	158.09	503.75	115.55	503.75	210.47	503.75	411.88
Superior Court Staff Attorneys Cash Back [2]	398.75	263.09	398.75	220.55	398.75	315.47	398.75	516.88
Superior Court Unrepresented	503.75	158.09	503.75	115.55	503.75	210.47	503.75	411.88
Commissioners (Monthly Rates) [1]	418.80	904.86	418.80	819.78	418.80	1,009.63	418.80	1,412.46

[1] Per Diem Nurses and some Commissioners are also required to pay dental plan premiums. Contact HSS for details.

[2] Attorneys with enrolled dependents who wish to elect the cashback rate must complete additional forms. Contact HSS for details.

Key Contact Information

MEDICAL PLANS

City Health Plan (UnitedHealthcare)
Tel: (866) 282-0125
Group No. 705287
www.myuhc.com

Blue Shield of California
Tel: (800) 642-6155
Group No. H11054
www.blueshieldca.com

Kaiser Foundation Health Plan, Inc.
Tel: (800) 464-4000
Group No. 888
www.members.kp.org

PacifiCare
Tel: (800) 624-8822
Group No. 240803
www.pacificare.com

VISION PLAN

Vision Service Plan (VSP)
Tel: (800) 877-7195
Group No.12145878
www.vsp.com

FLEXIBLE SPENDING ACCOUNTS

Fringe Benefits Management Company (FBMC)
Tel: (800) 342-8017
Customer Service M-F 4am-7pm
(800) 865-3262
Automated Interactive Benefits 24 hrs
www.myFBMC.com

DENTAL PLANS

Delta Dental
Tel: (888) 335-8227
(800) 4-AREA-DR
(referrals to Delta dentists)
Group No. 9502-0003
www.deltadentalins.com

DeltaCare USA Dental
Tel: (800) 422-4234
Group No. 01797-0001
www.deltadentalins.com

Pacific Union Dental
Tel: (800) 999-3367
(925) 363-6000
Group No. 94227
www.myuhcdental.com

COBRA

Fringe Benefits Management Company (FBMC)
Tel: (800) 342-8017
www.myFBMC.com

CITY AGENCIES

Department of Human Resources
Tel: (415) 557-4800
www.sfgov.org/dhr

San Francisco Employees' Retirement System (SFERS)
Tel: (415) 487-7000
www.sfgov.org/site/sfers

HEALTH SERVICE SYSTEM

Member Services
1145 Market Street, Suite 200
San Francisco, CA 94103
(Civic Center Station between 7th & 8th Streets)
Tel: (415) 554-1750
(800) 541-2266 (outside 415 area code)
Fax: (415) 554-1752
www.myhss.org

This guide was printed in the USA on ancient forest friendly, recycled paper comprised of 40% post-consumer waste. When it has outlived its usefulness to you, please recycle.

Health Service System
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG