2016 HEALTH BENEFITS

City College Employees

HEALTH SERVICE SYSTEM
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

This guide provides an overview of the Health Service System rules approved by the Health Service Board. The rules can be found at myhss.org/member_services/rules.html. To request a paper copy of the rules call 1-415-554-1750.

What's New 2016

Changes to City College employee medical benefits as of January 1, 2016.

No Changes to Medical Plan Choices or Covered Benefits

Good news! The same medical, dental and vision plans offered in 2015 are being offered in 2016. There are no changes in covered benefits or related out-of-pocket costs such as co-pays or co-insurance.

2016 Premium Contribution Changes

Employee premium contributions will change as of January 2016. Please review premium contribution changes before making your 2016 enrollment decisions.

HSS EAP Available to City College as of January 1, 2016

EAP provides confidential, voluntary, no-cost mental health services, including short-term, solution-oriented counseling for individuals, couples and families. To learn more visit myhss.org/eap.html.

How to enroll in medical benefits

Don't Miss the 30-Day Deadline

- Learn about your medical and vision benefits options by reading this Guide and visiting myhss.org.
- Eligible new and rehired employees must enroll in health coverage within **30 calendar days**. If you do not enroll within this 30-day period, you can only apply for benefits during the next Open Enrollment or within 30 days of a qualifying event, such as losing other coverage.
- To enroll, submit a completed enrollment application and all required eligibility documentation to the Health Service System by the 30-day deadline. Be prepared by making copies of eligibility documentation such as a marriage certificate, domestic partner certification, and children's birth certificates. You may mail, fax or drop off your enrollment documents to the Health Service System. The fax number is 1-415-554-1721.
- Employee premium contributions are deducted from paychecks. Review your paycheck to verify that the correct employee premium contribution is being deducted.
- October Open Enrollment is your annual opportunity to change benefit elections without any qualifying events.
- Questions about health benefits or premium contributions? **Call Member Services at 1-415-554-1750.**

Working Together to Stay Healthy and Manage Costs

In the next year, the Health Service System will spend over $718 million on health benefits for over 113,000 members and dependents. It is important that HSS, the health plans, and the members work together to manage costs.

Overall premiums increased by less than 4% for 2016. This includes increases in vision and dental care. In 2018, the Affordable Care Act requires a 40% excise tax be charged on every dollar above a specified amount. This will greatly increase the cost of benefits. The Health Service Board has taken actions to keep costs below the excise tax. There are ways you can help us manage everyone's costs and improve your health at the same time.

Ten Ways You Can Stay Healthy and Manage Costs

1. **Live a healthy lifestyle.** Be physically active each day, eat nutritious foods, limit alcohol, avoid tobacco, and strive for a healthy weight. HSS offers an Employee Assistance Program (EAP), healthy challenges (Daily Challenge, Walking Challenge), the Well-being Assessment, worksite-specific programming (group exercise classes, biometric screenings, wellness coaching, flu shot clinics, Champion network) and the Wellness Center to help HSS members take small steps toward the big reward of a healthier lifestyle.
2. **Go to regular checkups.** Take advantage of 100% covered or low co-pay regular medical, dental and vision checkups.
3. **Talk to your doctor.** Communicate openly and regularly with your physician. Your doctor provides the best care when he or she knows what is going on.
4. **Get vaccinated.** Prevent illness by getting vaccinations. Ask your doctor to recommend appropriate vaccinations, including seasonal flu, tetanus, adult boosters for childhood immunizations and more.
5. **Get screened.** Detect conditions early by getting the recommended screenings (blood pressure, cholesterol, colon cancer and other cardiovascular and cancer screenings).
6. **Don't ignore your mental health and well-being.** If you have a mental health condition, get relief by seeking care. Protect your mental and emotional well-being by learning stress management techniques and seeking help before challenges escalate.
7. **Manage existing conditions.** If you have a condition, live a healthy lifestyle and follow treatments (including medications) as prescribed by your physician. Condition management can slow disease progression, help avoid certain complications and improve quality of life.
8. **Call ahead.** Use your plan's nurse advice phone line service to determine the best place to seek care.
9. **Consider urgent care after hours.** After your doctor's hours, urgent care is often the least expensive and quickest way to get the care you need. Use the emergency room for emergencies only.
10. **Plan your end of life care.** Advance directives give you and your family peace of mind that your wishes will be respected. Ask your health plan or physician for more information.

Medical and Vision Plan Eligibility

Eligibility for health coverage is determined by the Governing Board of the Community College District.

City College Employee Benefits Eligibility

	FT FACULTY	LTS FACULTY	PT FACULTY	PERMANENT CLASSIFIEDS	TEMP STO CLASSIFIEDS	TEMPORARY CLASSIFIEDS
Medical	■	■	❖	■	❖	❖
Flexible Spending Account	■	■	■	■	■	■
Employer Paid Dental	■	■	❖	■	❖	❖
Life Insurance	■	■		■	❖	❖
Transit One Parking and Commute	■	■	■	■	■	■

❖ = Certain Restrictions Apply

Dependent Eligibility

Spouse or Domestic Partner

A member's spouse or registered domestic partner may be eligible for HSS health coverage. Proof of legal marriage or domestic partnership is required, as well as the dependent's Social Security number. Enrollment in HSS benefits must be completed within **30 days** of the date of marriage or partnership. In that case, coverage begins on the first day of the coverage period after a completed application and eligibility documentation is filed with HSS. A spouse or registered domestic partner can also be added to a member's coverage during Open Enrollment. A spouse covered on an employee's medical plan is not required to enroll in Medicare. A registered domestic partner who is eligible for Medicare is required to enroll in Medicare.

Natural Children, Stepchildren, Adopted Children

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

Legal Guardianships and Court-Ordered Children

Children under 19 years of age placed under the legal guardianship of an enrolled member, a member's spouse or domestic partner are eligible. If a member is required by a court's judgement, decree, or order to provide coverage for a child, that child is eligible up to age 19. Coverage terminates at the end of the coverage period in which the child turns 19. The member must provide HSS with proof of guardianship, court order, or decree by required deadlines.

Medical and Vision Plan Eligibility

Adult Disabled Children

Children who are disabled may be covered beyond the age limits stated previously, provided all of the following criteria are met. (A newly hired employee who enrolls an adult disabled child age 26 or older must meet all requirements below, except 1 and 2.)

1. Adult child was enrolled in an HSS medical plan on the child's 19th birthday and is continuously covered for at least one year prior to the child's 19th birthday.
2. Adult child was continuously enrolled in an HSS medical plan from age 19 to 26.
3. Adult child is incapable of self-sustaining employment due to the disability.
4. Adult child is unmarried.
5. Adult child permanently resides with the employee member.
6. Adult child is dependent on the member for substantially all of his or her economic support and is declared as an exemption on the member's federal income tax.
7. Member submits to HSS acceptable medical documentation–a certification that an adult child is enrolled in Medicare due to a Social Security-qualifying disability, or HSS disabled dependent forms completed and signed by a physician at least 60 days prior to child's attainment of age 26 and every year thereafter as requested.
8. All enrolled dependents who qualify for Medicare due to a disability are required to enroll in Medicare. Members must notify HSS of any dependent's eligibility for, and enrollment in, Medicare.
9. Once enrolled, the member must continuously enroll the disabled adult child in HSS coverage and Medicare (if eligible) to maintain future eligibility.

Medicare Enrollment Requirements for Dependents

HSS Rules require registered domestic partners, dependents with End Stage Renal Disease (ESRD) and children who have received Social Security insurance for more than 24 months to enroll in premium-free Medicare Part A and Part B. Medicare coverage begins 30 months after disability application. Note that a member or dependent with ESRD may be prohibited from changing medical plan enrollment.

Medicare Enrollment Requirements When You Retire

Retirees and dependents who are eligible for Medicare must have Medicare Part A and Part B in effect when retiring. Proof of Medicare coverage is required by HSS before any Medicare-eligible individual can be enrolled in retiree health coverage. Failure to enroll in Medicare when first eligible may also result in a late-enrollment penalty from Medicare. The Medicare application process at Social Security often takes three months so plan ahead.

Financial Penalties for Failing to Disenroll Ineligible Dependents

Members must notify HSS within 30 days and cancel coverage for a dependent who becomes ineligible. If a member fails to notify HSS, the member may be held responsible for the costs of ineligible dependents' health premiums and any medical service provided.

Eligibility Documentation

Required Eligibility Documentation

	Employment Evidence	Marriage Certificate	Domestic Partner Cert	Birth Certificate	Adoption Certificate	Proof Of Placement	Court Order Or Decree	Medical Evidence	Social Security #
Employee: Permanent/Provisional	■								■
Employee: Temporary/Exempt	■								■
Spouse		■							■
Domestic Partner			■						■
Child: Natural				■					■
Stepchild: Spouse		■		■					■
Stepchild: Domestic Partner			■	■					■
Child: Adopted					■				■
Child: Placed for Adoption						■			■
Child: Legal Guardianship							■		■
Child: Court Ordered							■		■
Adult Child: Disabled				■				■	■

Proof of Medicare enrollment is required for a registered domestic partner who is age 65 and any employee or dependent who is Medicare-eligible due to disability or End Stage renal Disease (ERSD). If you have questions about eligibility or required documentation, contact HSS Member Services at 1-415-554-1750.

Part-time Faculty and Classified Temporary Employee Eligibility

Important information for part-time faculty and classified temporary employees.

Eligible part-time faculty who are currently enrolled in a medical plan and meet the FTE eligibility for the spring semester will retain coverage through the summer months.

Eligible classified and temporary school term-only employees who are currently enrolled in a medical plan and meet the 20-hour or more per week assignment will retain coverage through summer months.

In order to continue medical and vision coverage through the summer months, additional premiums will be taken from employee paychecks from January to May.

Part-time faculty and classified temporary school term-only employees who lose eligibility for healthcare coverage during any semester may continue medical and dental coverage through COBRA.

Part-time faculty who later become eligible for health coverage must re-enroll for available health benefits.

Full-time employees must enroll in a HSS medical plan within 30 calendar days of their start work date.

Questions about coverage over the summer break? Visit ccsf.edu/hr, or contact the City College benefits office at 1-415-241-2246

Options for Maintaining Coverage

Covered California: The state health insurance exchange, created under the federal Patient Protection and Affordable Care Act, allows you to compare and shop for health insurance. In some cases, you may qualify for Medi-Cal, tax credits and other assistance to make health insurance more affordable. For information about Covered California, call 1-888-975-1142 or visit coveredca.com.

COBRA: The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted in 1986 allows employees and covered dependents to elect temporary extension of healthcare coverage in certain instances where coverage would end. The COBRA administrator will notify you of the opportunity to elect COBRA coverage. You have 60 days from the notification date to complete COBRA enrollment. When enrolled in COBRA you pay the full cost of premiums.

Individual Coverage: You may be able to purchase individual health coverage from your healthcare plan or other insurers. Contact plans directly for details and costs. All employees and dependents who were covered under an HSS-administered medical plan are entitled lto a certificate showing evidence of prior health coverage.

School Term Employee? Don't Miss the 30-Day Deadline to Enroll

Full-time employees must enroll in a HSS medical plan within 30 calendar days of their start work date.

Changing Benefit Elections: Qualifying Events

You may change health benefit elections outside of Open Enrollment if there is a qualifying event.

To change benefit elections, you must complete the election change process, including the submission of all required documentation, no later than **30 calendar days** after the qualifying event occurs. If the election change process is not completed **within 30 days** of the date of the qualifying event, you must wait until the next Open Enrollment to make the change. Note: an individual with End Stage Renal Disease may be prohibited from changing medical plans.

Marriage or Domestic Partnership

To enroll a new spouse or domestic partner and eligible children of a spouse or partner in Health Service System (HSS) healthcare coverage, submit a completed HSS enrollment application, a copy of the marriage certificate or certificate of domestic partnership and a birth certificate for each child to HSS **within 30 days** of the legal date of the marriage or partnership. A Social Security number must be provided for each of the family members being enrolled. Proof of Medicare enrollment is also required for a domestic partner who is Medicare-eligible due to age or disability. Coverage for your spouse or domestic partner and his or her eligible children will be effective the first day of the coverage period following the submission of the required application and documentation.

Birth or Adoption

To enroll your newborn or newly adopted child, you must submit a completed 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 an enrolled newborn child will be effective on the child's date of birth. Coverage for an enrolled adopted child will be effective on the date the child is placed. A Social Security number must be provided within six months of the date of birth or adoption, or your child's coverage may be terminated.

Legal Guardianship or Court Order

Coverage for a child under legal guardianship is effective the date guardianship takes effect, if all documentation is submitted by the **30-day deadline**. Coverage for a dependent per a court order will be effective the date of court order, if all documentation is submitted to HSS by the **30-day deadline**.

Divorce, Separation, Dissolution, Annulment

By law, you must disenroll ineligible dependents **within 30 days** from the date of a divorce, legal separation, annulment or dissolution of partnership. Submit a completed HSS application with a copy of the legal documentation of your family status change. Coverage for an ex-spouse, domestic partner and stepchildren will terminate on the last day of the coverage period in which the divorce, legal separation, annulment or dissolution of domestic partnership occurred, provided you complete disenrollment **within 30 days**. Failure to notify HSS can result in significant financial penalties equal to the total cost of benefits and services provided for any ineligible dependents.

Loss of Other Health Coverage

HSS members and eligible dependents who lose other coverage may enroll by submitting a completed application and proof of loss of coverage **within 30 days** of the date other coverage terminates. Coverage can be lost due to termination of employment, change from full-time to part-time work, dropping other employer coverage during Open Enrollment, ineligibility for Medicare or Medicaid, unpaid leave of absence or return from military service. Documentation of lost coverage must state the date other coverage ends and the names of individuals losing coverage. If required documentation is submitted, HSS coverage will be effective on the first day of the next coverage period. There may be a break in coverage between the date other coverage terminates and the date HSS coverage begins.

Changing Benefit Elections: Qualifying Events

Obtaining Other Health Coverage

You may waive HSS coverage for yourself or a dependent who enrolls in other health coverage. (If you waive coverage for yourself, coverage for all your enrolled dependents must also be waived.) Submit a completed HSS application and proof of enrollment **within 30 days** of the date of enrollment in the other health plan. Proof of coverage must indicate the effective date of coverage and the names of enrolled individuals. After all required documentation is submitted, HSS coverage will terminate on the last day of the coverage period. There may be an overlap of coverage between the date other coverage begins and the date HSS coverage terminates. You must pay premium contributions up to the termination date of HSS coverage.

Moving Out of Your Plan's Service Area

If you move your primary residence to a location outside your health plan's service area, you cannot obtain services through that plan. Don't risk termination of coverage. You must enroll in a different HSS plan that offers service based on your new address. Complete an HSS application to elect a new plan **within 30 days** of your move. Coverage under the new plan will be effective the first day of the coverage period following the date HSS receives your enrollment application and any required documentation.

Death of a Dependent

If an enrolled dependent dies, notify HSS as soon as possible and submit a copy of the death certificate **within 30 days** of the date of death. Coverage terminates the day after the dependent's death.

Death of a Member

In the event of a member's death, the surviving dependent or survivor's designee should contact HSS to obtain information about eligibility for survivor health benefits. To be eligible for health benefits, the surviving spouse or domestic partner of an employee must have been married to the member, or registered as the member's domestic partner, for at least one year prior to the death of the member. The surviving spouse or domestic partner of an employee member hired after January 9, 2009, may not be eligible for HSS benefits. Other restrictions apply.

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

- Completed surviving dependent enrollment form
- Copy of member's death certificate
- Copy of certificate of marriage or partnership (if not already on file at HSS)
- Copy of survivor's Medicare card (if survivor is Medicare-eligible)

A surviving spouse or partner who is not enrolled on the deceased member's health plan at the time of the member's death may be eligible for coverage, but must wait until Open Enrollment to enroll. Surviving dependent children of a member must meet eligibility requirements for dependent children and be enrolled at the time of the member's death and are only eligible for benefits under a surviving spouse or surviving domestic partner.

Changing FSA Contributions

Per IRS regulations, some qualifying events may allow you to initiate or modify Flexible Spending Account (FSA) contributions. For questions about qualifying events and authorized FSA contribution changes contact City College at 1-415-241-2246.

Responsibility for Premium Contributions

Change in coverage due to a qualifying event may change premium contributions. Review your paycheck or pension check to make sure premium deductions are correct. If the premium deduction is incorrect, contact HSS. You must pay any premiums that are owed. Unpaid premium contributions can result in termination of coverage.

The Health Service System Provides You With Medical Plan Options

These medical plan options are available to employee members and eligible dependents.

Health Maintenance Organization (HMO)

An HMO is a medical plan that offers benefits through a network of participating physicians, hospitals and other healthcare providers. For non-emergency care, you access service through your PCP (Primary Care Physician) or an affiliated urgent care center. You do not pay a deductible before accessing benefits and co-pays at the point of service are set at a contracted rate. This helps to limit out-of-pocket costs. HSS offers the following HMO plans:

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

Preferred Provider Organization (PPO)

A PPO is a medical plan that offers benefits through in-network and out-of-network healthcare providers. PPOs allow for a greater selection of providers. (Out-of-network providers will cost you more.) You are not assigned to a Primary Care Physician, so you have more responsibility for coordinating your care. Compared to an HMO, enrolling in a PPO usually results in higher out-of-pocket costs, although there is an out-of-pocket limit. You must pay a plan year deductible. You also pay a coinsurance percentage each time you access service. Because the City Plan PPO is a self-insured plan, individual premiums are determined by the total cost of services used by the plan's group of participants. HSS offers the following PPO plan:

- **City Plan PPO**
  (UnitedHealthcare Choice Plus)

How To Enroll In Medical Benefits

Eligible full-time employees must enroll in an HSS medical plan **within 30 calendar days** of their start work date. (Part-time or temporary employees see page 7.) Submit a completed enrollment application and eligibility documentation to HSS. If you do not enroll by required deadlines, you can only apply during Open Enrollment or due to a qualifying event. Coverage will start the first day of the coverage period after eligibility has been approved by HSS. Verify the date coverage will start with HSS when you enroll. Once enrolled, you must pay all required employee premium contributions. Review your paycheck to make sure correct deductions are being taken.

HSS does not guarantee the continued participation of any particular doctor, hospital or medical group in a medical plan. You cannot change your benefit elections because a doctor, hospital or medical group chooses not to participate. You will be assigned or required to select another provider.

An enrolled individual with End Stage Renal Disease may be prohibited by federal Medicare rules from changing health plans.

The Evidence of Coverage (EOC) contains a complete list of benefits and exclusions in effect for each plan from January to December 2016. Review your EOC for plan details. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Download plan EOCs at myhss.org.

Medical Plan Service Areas

County	Kaiser Permanente HMO	Blue Shield of California HMO	City Plan PPO
Alameda	■	■	■
Contra Costa	■	■	■
Marin	■	■	■
Napa	❍		■
Sacramento	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Clara	❍	■	■
Solano	■	■	■
Sonoma	❍	■	■
Stanislaus	■	■	■
Tuolomne			■
Outside of California	Urgent/ER Care Only	Urgent/ER Care Only	No service area limits

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

To enroll in a Blue Shield or Kaiser Permanente HMO, you must reside in a zip code serviced by the plan. If you do not see your county listed above, contact the medical plan to see if service is available to you. For Blue Shield of California call 1-855-256-9404. For Kaiser Permanente call 1-800-464-4000.

City Plan PPO does not have any service area requirements.

Change of Address?

If you move out of the service area covered by your plan, you must elect an alternate medical plan that provides coverage in your area. Failure to change your health benefit elections may result in the non-payment of claims for services received. Contact the Health Service System at 1-415-554-1750 to update your information and review plan options if you are changing your address.

2016 Medical Plan Benefits At-a-Glance

This chart provides a summary of benefits. It is not a contract. In some cases, billed amounts for out-of-network and out-of-area services provided through the City Plan PPO may exceed reasonable and customary fees, resulting in higher out-of-pocket costs.

For a detailed description of benefits and exclusions for each plan, please review your plan's Evidence of Coverage, available on myhss.org.

	BLUE SHIELD HMO ACCESS+ IN-NETWORK ONLY	**KAISER HMO** TRADITIONAL PLAN IN-NETWORK ONLY	**CITY PLAN PPO** UNITEDHEALTHCARE CHOICE PLUS IN-NETWORK AND OUT-OF-AREA	 OUT-OF-NETWORK
Choice of physician	Access+ plan network only. Primary Care Physician assignment required.	Kaiser network only. Primary Care Physician assignment required.	You may use any licensed provider. You receive a higher level of benefit and pay lower out-of-pocket costs when choosing in-network providers.	
Deductible	No deductible	No deductible	$250 employee only $500 + 1 $750 + 2 or more	$250 employee only $500 + 1 $750 + 2 or more
Out-of-pocket maximum does not include premium contributions	$2,000 per individual $4,000 per family	$1,500 per individual $3,000 per family	$3,750 per individual $12,700 per family	$7,500 per individual
General Care and Urgent Care				
Routine physical; well woman exam	No charge	No charge	100% covered no deductible	50% covered after deductible
Doctor's office visit	$25 co-pay	$20 co-pay	85% covered after deductible	50% covered after deductible
Urgent care visit	$25 co-pay in-network	$20 co-pay	85% covered after deductible	50% covered after deductible
Family planning	No charge	No charge	100% covered no deductible	50% covered after deductible
Immunizations	No charge	No charge	100% covered no deductible	50% covered after deductible
Lab and x-ray	No charge	No charge	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Doctor's hospital visit	No charge	No charge	85% covered after deductible	50% covered after deductible
Prescription Drugs				
Pharmacy: generic	$10 co-pay 30-day supply	$5 co-pay 30-day supply	$5 co-pay 30-day supply	50% covered after $5 co-pay; 30-day supply
Pharmacy: brand-name	$25 co-pay 30-day supply	$15 co-pay 30-day supply	$20 co-pay 30-day supply	50% covered after $20 co-pay; 30-day supply
Pharmacy: non-formulary	$50 co-pay 30-day supply	Physician authorized only	$45 co-pay 30-day supply	50% covered after $45 co-pay; 30-day supply
Mail order: generic	$20 co-pay 90-day supply	$10 co-pay 100-day supply	$10 co-pay 90-day supply	Not covered
Mail order: brand-name	$50 co-pay 90-day supply	$30 co-pay 100-day supply	$40 co-pay 90-day supply	Not covered
Mail order: non-formulary	$100 co-pay 90-day supply	Physician authorized only	$90 co-pay 90-day supply	Not covered
Specialty	20% up to $100 co-pay; 30-day supply	Same as all above limitations apply; see EOC	Same as 30-day above limitations apply; see EOC	Same as 30-day above limitations apply; see EOC

	BLUE SHIELD HMO ACCESS+ IN-NETWORK ONLY	KAISER HMO TRADITIONAL PLAN IN-NETWORK ONLY	CITY PLAN PPO UNITEDHEALTHCARE CHOICE PLUS IN-NETWORK AND OUT-OF-AREA	 OUT-OF-NETWORK
Hospital Outpatient and Inpatient				
Hospital outpatient	$100 co-pay per surgery	$35 co-pay	85% covered after deductible	50% covered after deductible
Hospital inpatient	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification
Hospital emergency room	$100 co-pay waived if hospitalized	$100 co-pay waived if hospitalized	85% covered after deductible if non-emergency, 50% after deductible	85% covered after deductible if non-emergency, 50% after deductible
Skilled nursing facility	No charge 100 days per plan year	No charge 100 days per benefit period	85% covered after deductible; 120 days per plan year; limits apply	50% covered after deductible; 120 days per plan year; limits apply
Hospice	No charge authorization required	No charge when medically necessary	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Maternity and Infertility				
Hospital or birthing center	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification
Pre-/post-partum care	No charge	No charge	85% covered after deductible	50% covered after deductible
Well child care	No charge must enroll newborn within 30 days of birth; see EOC	No charge must enroll newborn within 30 days of birth; see EOC	100% covered no deductible	100% covered no deductible
IVF, GIFT, ZIFT and artificial insemination	50% covered limitations apply; see EOC	50% covered limitations apply; see EOC	50% covered after deductible; limitations apply; prior notification	50% covered after deductible; limitations apply; prior notification
Mental Health and Substance Abuse				
Outpatient treatment	$25 co-pay non-severe and severe	$10 co-pay group $20 co-pay individual	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Inpatient facility including detox and residential rehab	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Other				
Hearing aids 1 aid per ear every 36 months, evaluation no charge	Up to $2,500 each	Up to $2,500 each	85% covered after deductible; up to $2,500 each	50% covered after deductible; up to $2,500 each
Medical equipment, prosthetics and orthotics	No charge as authorized by PCP	No charge as authorized by PCP	85% covered after deductible; prior notification	50% covered after deductible; prior notification
Physical and occupational therapy	$25 co-pay	$20 co-pay authorization required	85% covered after deductible; 60 visits max per plan year	50% covered after deductible; 60 visits max per plan year
Acupuncture	$15 co-pay 30 visits max per plan year; ASH network	Not covered 25% discount at kp.org/choosehealthy	50% covered after deductible; $1,000 max per plan year	50% covered after deductible; $1,000 max per plan year
Chiropractic	$15 co-pay 30 visits max per plan year; ASH network	$15 co-pay 30 visits max per plan year; ASH network; 25% discount at kp.org/choosehealthy	50% covered after deductible; $1,000 max per plan year	50% covered after deductible; $1,000 max per plan year
Transgender office visits and outpatient surgery	Co-pays apply authorization required	Co-pays apply authorization required	85% covered after deductible; prior notification	50% covered after deductible; prior notification

Choosing Your Medical Plan

	Blue Shield of California HMO	Kaiser Permanente HMO	City Plan PPO
Must I select a PCP (Primary Care Physician)?	You can choose your PCP after you enroll, or Blue Shield will assign.	You can choose your PCP after you enroll, or Kaiser will assign.	No PCP– you have more responsibility for coordinating care.
Can I change my PCP during the plan year?	Yes, monthly.	Yes, anytime.	
Am I required to use the plan's contracted network of service providers?	Yes. Services must be received from the contracted network.	Yes. Services must be received from Kaiser.	No, but out-of-network providers will cost you more.
Is access to hospitals and specialists determined by medical group assignment?	Yes. PCP referrals to specialists and hospitals will be determined by medical group affiliation.	Yes. All services must be received from a Kaiser facility.	No
Do I have to pay an annual deductible?	No	No	Yes
Do I have to file claim forms?	No	No	Only if you use an out-of-network provider.
How do I get more information about the plan?	1-855-256-9404 blueshieldca.com	1-800-464-4000 kp.org	1-866-282-0125 welcometouhc.com/sfhss

Blue Shield of California: Your Medical Group Determines You Provider and Hospital Network

If you enroll in Blue Shield, carefully review your choice of Primary Care Physician (PCP). Your PCP affects the network of providers and hospitals that will provide your care. You can change your PCP during the plan year by calling Blue Shield at 1-800-642-6155.

Blue Shield Medical Groups in San Francisco	Affiliated Hospitals
Hill Physicians hillphysicians.com	UCSF Medical Center
	St. Francis Memorial Hospital
	St. Mary's Medical Center
Brown & Toland brownandtoland.com	California Pacific Medical Center (CPMC)
Chinese Community Health Care Association cchca.com	Chinese Hospital

Nurseline and Urgent Care

Save Time and Money. Call for Nurse Advice. Visit an Urgent Care Center. Email Your Doctor.

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

Visit an urgent care center when your physician is not available, after hours or on weekends. Urgent care offers the convenience of same-day appointments and walk-in service. Use urgent care when you need prompt attention for an illness or injury that is not life-threatening.

If available, take advantage of your doctor's online patient portal. Email your physician, view lab results, make appointments and renew your prescriptions online.

Blue Shield of California HMO	Kaiser Permanente HMO	City Plan PPO
NurseHelp 24/7	**Nurse Advice 24/7**	**Nurseline 24/7**
1-877-304-0504	1-866-454-8855	1-800-846-4678
Urgent After Hours Care	**Urgent After Hours Care**	**Urgent After Hours Care**
For the urgent after hours care nearest you contact Blue Shield: 1-855-256-9404 blueshieldca.com	San Francisco 1-415-833-2200 Adult and Pediatric Oakland 1-510-752-1190 Adult 1-510-752-1200 Pediatric Redwood City 1-650-299-2015 Adult 1-650-299-2015 Pediatric Walnut Creek 1-925-295-4070 Adult 1-925-295-4200 Pediatric San Rafael 1-415-444-2940 Adult 1-415-444-4460 Pediatric This is a partial list. For additional Kaiser urgent care facilities call 1-866-454-8855.	San Francisco Golden Gate Urgent Care 1-415-746-1812 Hayward St. Francis Urgent Care 1-510-780-9400 Rohnert Park Concentra 1-866-944-6046 This is a partial list. For more current and additional urgent care facilities call 1-866-282-0125 or visit welcometouhc.com/sfhss.

The Health Service System Administers Your Vision Benefits

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

Vision Plan Benefits

HSS members and eligible dependents who enroll in the Kaiser HMO, Blue Shield HMO or City Plan PPO can access vision coverage administered by Vision Service Plan (VSP). You may use a VSP network doctor or a non-VSP doctor. Locate a VSP network doctor in your area by visiting vsp.com or contacting VSP Member Services at 1-800-877-7195.

In addition, Kaiser members also receive a 25% discount on frames, lenses and materials at Kaiser facilities.

Accessing Your Vision Benefits

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

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

Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every 24 months, per last date of service. If examination reveals prescription change of 0.50 diopter or more after 12 months, replacement lenses covered.
- Eligible dependent children are covered in full for polycarbonate prescription lenses.
- Cosmetic extras, including progressive, tinted or oversize lenses, will cost you more.

Vision Plan Expenses Not Covered

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

Acute and Urgent Eye Care

With a $5 co-pay, VSP offers limited coverage for urgent and acute eye conditions, including pink eye, sudden onset of flashers and floaters and diagnosis of eye pain or sudden changes in vision. Contact a VSP network doctor or call the customer service number for the closest location. VSP acute eye care does not cover chronic eye conditions like diabetes-related eye disease or glaucoma. Chronic eye disease may be covered by your medical plan. Check your medical plan's Evidence of Coverage, available on myhss.org.

No Medical Plan, No Vision Benefits

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

City College Employees

Vision Service Plan Benefits At-a-Glance

2016 Covered Services	In-Network	Out-of-Network
Well vision exam	$10 co-pay every 12 months*	Up to $50 after $10 co-pay; every 12 months*
Single vision lenses	$25 co-pay every 24 months*	Up to $45 after $25 co-pay; every 24 months*
Lined bifocal lenses	$25 co-pay every 24 months*	Up to $65 after $25 co-pay; every 24 months*
Lined trifocal lenses	$25 co-pay every 24 months*	Up to $85 after $25 co-pay; every 24 months*
Standard progressive lenses	$55 co-pay	Up to $85 After $25 co-pay; every 24 months*
Premium progressive lenses	$95–$105 co-pay	
Custom progressive lenses	$150–$175 co-pay every 24 months*	
Scratch-resistant coating	Fully covered every 24 months*	Not covered
Frames	$150 allowance $170 allowance for featured frames $80 allowance for Costco $25 co-pay applies; 20% savings on amount over the allowance; every 24 months*	$70 allowance after $25 co-pay; every 24 months*
Contacts (instead of glasses)	$150 allowance every 24 months*	$105 allowance for contacts and contact lens exam every 24 months*
Contact lens exam	Up to $60 co-pay fitting and evaluation exam covered; every 24 months*	
Urgent eye care	$5 co-pay	Not covered
Savings and Discounts	**In-Network**	**Out-of-Network**
Non-covered lens options (anti-reflective coating, photochromic, polycarbonate)	Average 20%–25% savings after co-pay; available on most enhancements	Not applicable
Laser Vision Correction	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities	Not applicable

*Based on your last date of service.

Mental Health and Well-being

Mental Health Condition Management

Changes in thought patterns, mood or behavior can signal a mental health condition. Mental health conditions are the second largest cause of disability nationwide. Depression is the most common. It affects more than 26% of the U.S. adult population. The HSS EAP (Employee Assistance Program) can help your assess a mental health condition and assist you in accessing treatment. For EAP call 1-800-795-2351. For more information about mental health services visit myhss.org/well-being/eap.

	Blue Shield of California HMO	Kaiser Permanente HMO	City Plan PPO
Mental Health Condition Services	Inpatient/outpatient mental health, professional services.	Inpatient/outpatient mental health, professional services.	Outpatient counseling, immediate care and intensive case management.
Substance Abuse Services	Inpatient/outpatient including detox and residential rehabilitation.	Inpatient/outpatient including detox and residential rehabilitation.	Inpatient/outpatient including detox and residential rehabilitation.
How to Access	Call 1-877-263-9952.	Call 1-800-464-4000 to make an appointment for therapy and other counseling services, or contact your Primary Care Physician.	Call 1-866-282-0125.

Mental Well-being Services

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

Blue Shield of California HMO	Kaiser Permanente HMO	City Plan PPO	HSS EAP
Counseling LifeReferrals is available 24/7 for mental health, marriage, family and relationship services. Also find resources to help you manage the impact of home, health and career. Call 1-800-985-2405. **Online Coaching** Take well-being one day at a time with the Daily Challenge: myhss.org/well-being/dailychallenge. **Tobacco Cessation** Visit QuitNet at mywellvolution.com.	**Classes, Support Groups** Contact your local Kaiser facility for a comprehensive list, or visit kp.org/mentalhealth. **Telephone/Online Coaching** Call 1-866-251-4514 or visit kp.org and search for HealthMedia Relax. **Tobacco Cessation** Contact your local Kaiser facility for classes. Call 1-866-251-4514 for a telephonic coach. For HealthMedia Breathe and other resources visit kp.org/quitsmoking.	**Online Coaching** Visit welcometouhc.com/sfhss for the online stress management program. **Tobacco Cessation** Visit welcometouhc.com/sfhss for the online smoking cessation program.	**Counseling** EAP (Employee Assistance Program) offers up to six confidential and free counseling appointments for individuals, couples and families. Call 1-800-795-2351. **In-Person Coaching** Work one-on-one with a coach to reach your goals. Schedule an appointment by calling 1-415-554-0643.

Other Benefits Administered by City College

Delta Dental

City College offers eligible employees the opportunity to enroll in dental benefits administered by Delta Dental. Enrollment in dental benefits is handled through the City College Benefits Office. Visit the City College website below for details about details about covered services under this plan.

This PPO-style dental plan allows you to visit any in-network or out-of-network dentist. The plan pays higher benefits (and you pay less) when you visit an in-network PPO dentist.

Ask your Delta Dental dentist about costs before receiving services. You can request a pre-treatment estimate of costs before you receive care. For more information, call Delta Dental at 1-888-499-3001.

Flexible Spending Accounts

FSAs can save you money by reducing your taxable income. You can enroll in a Healthcare FSA, a Dependent Care FSA, or both. Once enrolled, you set aside money pre-tax via payroll deduction to fund your FSA account/s. To receive FSA reimbursements you must submit documentation to the plan administrator by required deadlines.

A Healthcare FSA allows each employee to pay for qualifying medical expenses pre-tax. Qualifying expenses include medical, pharmacy, dental and vision co-pays and deductibles for the enrolled employee and eligible dependents.

A Dependent Care FSA can help pay pre-tax for qualifying dependent care expenses. Qualifying expenses include certified day care, pre-school and elder care. Children in day care must be under age 13.

Before enrolling in your FSA, you should work out a detailed estimate of the eligible expenses you are likely to incur in 2015. Budget conservatively. Note: with a FSA your taxable income will be reduced for Social Security purposes so there may be a corresponding reduction in Social Security benefits.

City College employee FSAs are administered by WageWorks: takecarewageworks.com.

Transit One Parking and Commuter Benefits

The City College Benefits Office offers employees the opportunity to enroll in a Commuter Transit Account. This pre-tax benefit account can used to pay for public transit—including train, subway, bus, and ferry—as part of your daily commute to and from work. Save an average of up to 30% on public transit as part of your daily commute to and from work. Reduce your overall tax burden—funds are withdrawn from your paycheck for deposit into your account before taxes are deducted. Sign up any time to start saving—and no "use it or lose it" as long as you're enrolled.

The commuter transit account for City College employees is administered by WageWorks: takecarewageworks.com.

Other Voluntary Benefits

Eligible City College employees may also purchase these and other voluntary benefits. Contact the City College Benefits Office for more information.

- life insurance
- short term disability insurance
- long term disability insurance
- accident insurance
- cancer insurance
- heart/stroke insurance
- supplemental dental insurance

For more information about benefits administered through City College visit:
ccsf.edu/en/employee-services/district-business-office/human-resources/benefits.html

You Must Notify the Health Service System About a Leave of Absence

Type of Leave	Health Benefits Eligibility
Family and Medical Leave (FMLA) **Workers' Compensation Leave** **Family Care Leave** **Military Leave**	Notify the Heath Service System (HSS) as soon as your leave begins–**within 30 days.** You may elect to continue or waive health coverage for the duration of your approved leave of absence.
Personal Leave Following Family Care Leave	If you have been on an approved Family Care Leave and are approved to extend this as a Personal Leave, you may elect to continue or waive health coverage for the duration of your approved Personal Leave. Contact the Health Service System.
Educational Leave **Personal Leave** **Leave for Employment as an Employee Organization Officer or Representative**	Notify the Heath Service System as soon as your leave begins–**within 30 days.** You may elect to continue or waive health coverage for the duration of your approved leave of absence. If your leave lasts beyond 12 weeks, you must pay the total cost of health coverage for yourself and any enrolled dependents. This includes your employee premium contribution plus your employer's premium contribution. Contact HSS for details.

Your Responsibilities

Notify your supervisor and your department's Human Resources Professional (HRP) prior to your leave. (If your leave is due to an unexpected emergency contact your HRP as soon as possible.) Your HRP will help you understand the process and documentation required for an approved leave. Your HRP will also provide the Health Service System with important information about your leave.

Contact the Health Service System as soon as your leave begins–within 30 days. You may choose to continue or waive health coverage while on leave. If you continue coverage, you must pay employee premium contributions while you are on leave. If premium payments are not deducted from your paycheck while you are on leave you must pay the Health Service System directly. Failure to do so will result in termination of your health benefits.

When leave ends, contact the Health Service System to reinstate your benefits within 30 days of return to work. If you continued your health coverage while on an unpaid leave, you must request that HSS resume health premium payroll deductions. If coverage was waived or terminated while you were on leave, you must request that the Health Service System reinstate your benefits and resume your payroll deductions.

You must pay premiums to maintain medical coverage while on leave. If premium contributions cannot be deducted from your paycheck, you must pay premiums directly to HSS. Failure to do so can result in the termination of your medical benefits, which may not be reinstated until you return to work or during Open Enrollment. If you have a domestic partner enrolled on your health coverage while you are on unpaid leave, you will have a catch-up payroll deduction for taxation related to imputed income when you return from leave. Contact HSS to learn about the options for making premium payments while on leave.

Transition to Retirement

Enrollment in Retiree Benefits Does Not Happen Automatically

The transition of health benefits from active to retiree status does not happen automatically. If eligible, you must elect to continue retiree health coverage by submitting the retiree enrollment form and supporting documents to HSS. **Contact HSS three months before your retirement date** to learn about enrolling in retiree benefits. You are required to notify HSS of your retirement, even if you are not planning to elect HSS coverage on your retirement date.

Depending on your retirement date, there can be a gap between when active employee coverage ends and retiree coverage begins. Setting a retirement date at the end of the month will help avoid a gap in HSS coverage. Call HSS at 1-415-554-1750 to review your options before deciding on your retirement date.

Medicare Enrollment Required for Medicare-eligible Retirees and Dependents

All retirees and dependents who are Medicare-eligible due to age or disability are required to enroll. Failure of a retired member or dependent to enroll in Medicare when eligible will result in penalties, limitations in retiree member coverage and the termination of retiree dependent coverage. Processing of Medicare eligibility takes at least three months.

Retiree Premium Contributions

If you choose to continue medical and/or dental coverage through HSS after you retire, your retiree premium contribution may be higher than your active employee contributions. As a retired member, you will also be required to pay for dental coverage. Costs will depend on your plan choices, number of dependents covered and your Medicare status. A retiree must have been a member of HSS at some time during his or her active employment in order to be eligible for retiree health benefits. Other restrictions may apply.

Health premium contributions will be taken from your pension check. If required monthly premium contributions are greater than the total amount of your pension check, you must contact HSS to make payment arrangements. Premium contribution rates are subject to change every plan year.

Lump-Sum Pension Distribution Will Afftect Retiree Premium Contributions

If you choose to take a lump-sum pension distribution, your retiree healthcare premium contributions will be unsubsidized and you will pay the full cost.

Active Employee Medicare Enrollment

If you are working and eligible for HSS health coverage at age 65 or older, you are not required to enroll in Medicare. Even though it is not required, you are eligible for Medicare at age 65 and can enroll if you choose. Some employees over age 65 choose to enroll in premium-free Medicare Part A while they are still working. If you enroll in Part A, you must contact the Social Security Administration and enroll in Medicare Part B **three months before you retire** or otherwise leave City employment. If you are over age 65 and not enrolled in both Medicare Part A and Part B upon retirement, you may be charged penalties by the federal government and you will be enrolled in City Plan 20.

Married Spouse Medicare Enrollment

A spouse covered on an active employee's HSS plan is not required to enroll in Medicare until you retire. A Medicare-eligible spouse must have enrolled in Medicare to be covered on a retiree's health plan.

Domestic Partner Medicare Enrollment

A registered domestic partner of an employee who is eligible for Medicare must be enrolled in Medicare to qualify for HSS medical coverage. If enrolled in HSS medical coverage without Medicare, domestic partner benefits will be terminated. The federal government charges a premium for Medicare Part B and in some cases, for group employer Part D. All Medicare premium payments must be paid to maintain continuous Medicare enrollment. Be aware that domestic partners who fail to enroll in Medicare Part B when first eligible may later be charged significant late enrollment penalties by the federal government.

Domestic Partner Health Benefits Taxation

Health coverage for a domestic partner and a partner's children is a taxable benefit under federal law.

Federal Tax Treatment of Domestic Partner Health Benefits

The federal government does not recognize domestic partnership for tax purposes. Employer contributions to domestic partner health premiums, including domestic partner children, are counted as taxable imputed income by the Internal Revenue Service (IRS). By comparison, no taxable imputed income results from employer contributions to a spouse's health premiums. In addition, employee or retiree premium contributions for domestic partner health benefits are paid post-tax. Employee or retiree premium contributions for a spouse are paid pre-tax.

Federal Tax Exemption for Dependents Who Meet Certain Requirements

The Internal Revenue Service offers a tax break for health-related expenses incurred by a "qualifying relative." Under IRS code section 152 (as modified by Code 105 (b)), a domestic partner and children of a domestic partner, qualify for favorable tax treatment if:

1. Partner or child receives more than half of his or her financial support from the employee or retiree; and
2. Partner or child lived with the employee or retiree as a member of his or her household for the entire calendar year (January 1–December 31), with the exception of temporary absences due to vacation, education or military service; and
3. Partner or child is a citizen of the United States, or a resident of the United States, Canada or Mexico.

If an enrolled dependent meets all these requirements the employee or retiree can submit a declaration form to HSS and there will be no imputed income for the employer contribution to dependent health premiums.

The HSS declaration form must be filed by required deadlines and is valid for one tax year. An individual declaration must be submitted every year for each qualifying dependent. The Declaration for Pre-Tax Premium Deduction form can be downloaded here: myhss.org/downloads/forms_guides/dp.pdf

If the dependent of an employee or retiree does not qualify for favorable federal tax treatment under the IRS requirements described above, employer contributions will accrue as imputed income and will be taxed by the federal government. Also, employee or retiree premium contributions will be paid post-tax.

Equitable California State Tax Treatment

The health benefits of a registered domestic partner age 62 or older, and children of a domestic partner, are entitled to equitable tax treatment under California state law. Equitable tax treatment under state law requires obtaining the California State Declaration of Domestic Partnership from the Secretary of the State of California. An employee can then deduct the value of employer paid health insurance premiums for a domestic partner and his or her children, when filing a California state income tax return. An employee with a domestic partner may take advantage of equitable California state tax treatment even if a domestic partner does not qualify for the federal tax exemption defined by the IRS.

Consult with Your Tax Advisor

This is a brief overview regarding the tax treatment of health benefits for domestic partners. Laws are subject to change. Please consult with a professional tax advisor. It is your responsibility to comply with state and federal tax law.

COBRA and Covered California

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows employees and covered dependents to elect a temporary extension of health coverage in certain instances where coverage would end. These include:

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

Time Limits for COBRA Elections

The COBRA administrator will notify you of the opportunity to elect COBRA coverage. You have 60 days from the notification date to complete COBRA enrollment. Coverage will be retroactive to the date of the COBRA qualifying event, so there is no break in coverage. While covered under COBRA, you have 30 days to add newly eligible dependents (spouse, domestic partner, newborn or adopted child) to COBRA coverage, based on the date of the qualifying event (marriage, partnership, birth, adoption).

In the case of a dependent losing coverage (due to divorce or aging out of a plan) the employee or dependent must notify the COBRA Administrator within 30 days of the qualifying event. Dependents dropped from coverage during Open Enrollment are not eligible for COBRA.

Duration of COBRA Continuation Coverage

Group COBRA coverage is generally available for a maximum of 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a coverage extension for up to 36 months.

COBRA enrollees who are disabled on the date of their qualifying event, or at any time during the first 60 days of COBRA coverage, are eligible for 29 months of coverage. Beginning the 19th month of coverage, the cost will rise to 150 percent of the group rate. Retirees and dependents who are eligible for less than 36 months of federal COBRA may be eligible for Cal-COBRA. Continuation coverage under both federal and California state COBRA will not exceed 36 months.

Termination of COBRA Continuation Coverage

COBRA coverage will end if:

- 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 individuals to remit the required healthcare premium payments directly lto the COBRA administrator. For COBRA rate information, visit myhss.org or contact HSS.

COBRA Continuation Coverage Alternatives

Individuals who are not eligible for HSS coverage should consider obtaining health insurance through the state insurance exchange, Covered California. In some cases, you may qualify for tax credits and other assistance to make health insurance more affordable. For information about Covered California health plans, call 1-888-975-1142 or visit coveredca.com.

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

Employees and dependents who were covered under an HSS-administered health plan are entitled to a certificate showing evidence of prior coverage.

Medical Coverage Calendars

CLASSIFIED EMPLOYEES AND ADMINISTRATORS PAID BI-WEEKLY

Work Dates	Pay Date	Benefits Coverage Period
January 2, 2016–January 15, 2016	January 26, 2016	January 2, 2016–January 15, 2016
January 16, 2016–January 29, 2016	February 9, 2016	January 16, 2016–January 29, 2016
January 30, 2016–February 12, 2016	February 23, 2016	January 30, 2016–February 12, 2016
February 13, 2016–February 26, 2016	March 8, 2016	February 13, 2016–February 26, 2016
February 27, 2016–March 11, 2016	March 22, 2016	February 27, 2016–March 11, 2016
March 12, 2016–March 25, 2016	April 5, 2016	March 12, 2016–March 25, 2016
March 26, 2016–April 8, 2016	April 19, 2016	March 26, 2016–April 8, 2016
April 9, 2016–April 22, 2016	May 3, 2016	April 9, 2016–April 22, 2016
April 23, 2016–May 6, 2016	May 17, 2016	April 23, 2016–May 6, 2016
May 7, 2016–May 20, 2016	May 31, 2016	May 7, 2016–May 20, 2016
May 21, 2016–June 3, 2016	June 14, 2016	May 21, 2016–June 3, 2016
June 4, 2016–June 17, 2016	June 28, 2016	June 4, 2016–June 17, 2016
June 18, 2016–July 1, 2016	July 12, 2016	June 18, 2016–July 1, 2016
July 2, 2016–July 15, 2016	July 26, 2016	July 2, 2016–July 15, 2016
July 16, 2016–July 29, 2016	August 9, 2016	July 16, 2016–July 29, 2016
July 30, 2016–August 12, 2016	August 23, 2016	July 30, 2016–August 12, 2016
August 13, 2016–August 26, 2016	September 6, 2016	August 13, 2016–August 26, 2016
August 27, 2016–September 9, 2016	September 20, 2016	August 27, 2016–September 9, 2016
September 10, 2016–September 23, 2016	October 4, 2016	September 10, 2016–September 23, 2016
September 24, 2016–October 7, 2016	October 18, 2016	September 24, 2016–October 7, 2016
October 8, 2016–October 21, 2016	November 1, 2016	October 8, 2016–October 21, 2016
October 22, 2016–November 4, 2016	November 15, 2016	October 22, 2016–November 4, 2016
November 5, 2016–November 18, 2016	November 29, 2016	November 5, 2016–November 18, 2016
November 19, 2016–December 2, 2016	December 13, 2016	November 19, 2016–December 2, 2016
December 3, 2016–December 16, 2016	December 27, 2016	December 3, 2016–December 16, 2016
December 17, 2016–December 30, 2016	January 10, 2017	December 17, 2016–December 30, 2016

Employee premium contributions are deducted from paychecks bi-weekly, for a total of 26 payroll deductions for the 2016 plan year.

If you take an approved unpaid leave of absence, you must pay HSS directly for the premium contributions that were being deducted from your paycheck. Employee premium contributions are due no later than the pay date of the benefits coverage periods above. See page 21 for more information about maintaining health coverage during a leave.

Medical Coverage Calendars

CLASSIFIED SCHOOL TERM EMPLOYEES PAID BI-WEEKLY

Work Dates	Pay Date	Benefits Coverage Period
January 2, 2016–January 15, 2016	January 26, 2016	January 2, 2016–January 15, 2016
January 16, 2016–January 29, 2016	February 9, 2016	January 16, 2016–January 29, 2016
January 30, 2016–February 12, 2016	February 23, 2016	January 30, 2016–February 12, 2016
February 13, 2016–February 26, 2016	March 8, 2016	February 13, 2016–February 26, 2016
February 27, 2016–March 11, 2016	March 22, 2016	February 27, 2016–March 11, 2016
March 12, 2016–March 25, 2016	April 5, 2016	March 12, 2016–March 25, 2016
March 26, 2016–April 8, 2016	April 19, 2016	March 26, 2016–April 8, 2016
April 9, 2016–April 22, 2016	May 3, 2016	April 9, 2016–April 22, 2016
April 23, 2016–May 6, 2016	May 17, 2016	April 23, 2016–May 6, 2016
May 7, 2016–May 20, 2016	May 31, 2016	May 7, 2016–May 20, 2016
May 21, 2016–June 3, 2016	June 14, 2016	May 21, 2016–June 3, 2016
Summer Break *off from regular work*	June 28, 2016 July 12, 2016 July 26, 2016 August 9, 2016 August 23, 2016	*Summer Coverage Period* *extra payroll deductions taken January to June* *pre-pay this summer coverage period*
August 13, 2016–August 26, 2016	September 6, 2016	August 13, 2016–August 26, 2016
August 27, 2016–September 9, 2016	September 20, 2016	August 27, 2016–September 9, 2016
September 10, 2016–September 23, 2016	October 4, 2016	September 10, 2016–September 23, 2016
September 24, 2016–October 7, 2016	October 18, 2016	September 24, 2016–October 7, 2016
October 8, 2016–October 21, 2016	November 1, 2016	October 8, 2016–October 21, 2016
October 22, 2016–November 4, 2016	November 15, 2016	October 22, 2016–November 4, 2016
November 5, 2016–November 18, 2016	November 29, 2016	November 5, 2016–November 18, 2016
November 19, 2016–December 2, 2016	December 13, 2016	November 19, 2016–December 2, 2016
December 3, 2016–December 16, 2016	December 27, 2016	December 3, 2016–December 16, 2016
December 17, 2016–December 30, 2016	January 10, 2017	December 17, 2016–December 30, 2016

Employee premium contributions are deducted from paychecks bi-weekly, for a total of 21 payroll deductions for the 2016 plan year. Employee premium deductions from January to June include an additional premium amount to fund benefits coverage during the summer months. During summer months with no paycheck, benefits coverage will continue as long as all summer premium contributions have been funded.

If you take an approved unpaid leave of absence, you must pay HSS directly for the premium contributions that were being deducted from your paycheck. Employee premium contributions are due no later than the pay date of the benefits coverage periods above. See page 21 for more information about maintaining health coverage during a leave.

Medical Coverage Calendars

FACULTY AND ADMINISTRATORS PAID MONTHLY

Work Dates	Pay Date	Benefits Coverage Period
January 1– 31, 2016	January 29, 2016	January 1– 31, 2016
February 1– 29, 2016	February 29, 2016	February 1– 29, 2016
March 1– 31, 2016	March 31, 2016	March 1– 31, 2016
April 1–30, 2016	April 29, 2016	April 1–30, 2016
May 1–31, 2016	May 31, 2016	May 1–31, 2016
June 1–31, 2016	June 30, 2016	June 1–31, 2016
July 1–16, 2016	July 29, 2016	July 1–16, 2016
August 1–31, 2016	August 31, 2016	August 1–31, 2016
September 1–30, 2016	September 30, 2016	September 1–30, 2016
October 1–31, 2016	October 31, 2016	October 1–31, 2016
November 1–30, 2016	November 30, 2016	November 1–30, 2016
December 1–31, 2016	December 30, 2016	December 1–31, 2016

PART-TIME FACULTY PAID MONTHLY

Work Dates	Pay Date	Benefits Coverage Period
January 1– 31, 2016	January 29, 2016	January 1– 31, 2016
February 1– 29, 2016	February 29, 2016	February 1– 29, 2016
March 1– 31, 2016	March 31, 2016	March 1– 31, 2016
April 1–30, 2016	April 29, 2016	April 1–30, 2016
May 1–31, 2016	May 31, 2016	May 1–31, 2016
Summer Break *off from regular work*	June 30, 2016 July 29, 2016 August 31, 2016	*Summer Coverage Period* *extra payroll deductions taken January to May* *pre-pay this summer coverage period*
September 1–30, 2016	September 30, 2016	September 1–30, 2016
October 1–31, 2016	October 31, 2016	October 1–31, 2016
November 1–30, 2016	November 30, 2016	November 1–30, 2016
December 1–31, 2016	December 30, 2016	December 1–31, 2016

Part-time faculty premium contributions are deducted from paychecks monthly, for a total of 9 payroll deductions for the 2016 plan year. Employee premium deductions from January to May include an additional premium amount to fund benefits coverage during the summer months. During summer months with no paycheck, benefits coverage will continue as long as all summer premium contributions have been funded.

If you take an approved unpaid leave of absence, you must pay HSS directly for the premium contributions that were being deducted from your paycheck. Employee premium contributions are due no later than the pay date of the benefits coverage periods above. See page 21 for more information about maintaining health coverage during a leave.

Health Service Board

Randy Scott
Appointee
President

Wilfredo Lim
Elected Employee
Vice President

Karen Breslin
Elected Retiree

Mark Farrell
Appointee

Sharon Ferrigno
Elected Retiree

Stephen Follansbee, MD
Appointee

Gregg Sass
Appointee

The Health Service Board conducts an annual review of health benefit costs, ensures benefits are applied without favor or privilege and administers the business of the Health Service System. Visit myhss.org/health_service_board.

Health Service Board Achievements

Well-being Program: Approved the City's wellness plan.

Steps to Avoid the 2018 Excise Tax: Allocated $5.4M from the City Plan Stabilization Reserve to reduce 2016 City Plan premiums for employees and early retirees. This allocation, along with the Blue Shield of California 2015 rate stabilization, will reduce the base rate used to calculate the 40% federal excise tax in 2018.

Competition Between Plans: Funded a stabilization reserve from excess 2013 underwriting gains and stabilized Blue Shield of California 2015 premiums. This helped balance the risk between the Blue Shield of California and Kaiser Permanente plans, keeping employee premium contributions affordable and competitive.

ACOs: Approved establishing two of the first Accountable Care Organizations (ACOs) in California. Through these ACOs, the Health Service System, Blue Shield of California, Brown & Toland Physicians, Hill Physicians and John Muir Medical Group are working together to improve patient care and reduce costs.

Flex Funding: Approved flex-funding of the Blue Shield of California plan, allowing the Health Service System to reduce insurance costs by paying hospital, pharmacy and physician costs directly.

Performance Guarantees: Approved plan vendor performance guarantees with financial penalties. The guarantees are based on unique criteria that align with providing quality care and service to Health Service System members.

All Payer Claims Database: Approved funding and implementation of a database that will power data-driven analysis focused on improving care and decreasing costs.

Flat Contribution Model: Supported an initiative by the City & County and the unions which changed the employee premium contribution methodology to a flat percentage of plan premium. This helped maintain competition and balance risk between plans, ensuring a choice of plans for Health Service System members.

HSS members may submit comments to the Board. Email: health.service.board@sfgov.org. Mail: Board Secretary, Health Service System, 1145 Market Street, 3rd Floor, San Francisco, CA 94103. Phone: 1-415-554-0662.

Glossary of Healthcare Terms

Accountable Care Organization (ACO)
A payment and healthcare delivery model that aligns medical group reimbursements with meeting coordinating care and quality and cost targets.

Ambulatory Care
Care provided in outpatient setting.

Benefits Coverage Period
Dates when your health insurance coverage begins and ends.

Brand-Name Drug
FDA-approved prescription drugs marketed under a specific brand name by the manufacturer.

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 specified by a percentage. For example, the employee pays 15% toward the charges for a covered service and the insurance company pays 85%.

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

Covered California
California state health insurance exchange where people can purchase affordable insurance if they lose coverage. coveredca.com

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 who meets the eligibility criteria established by HSS for health plan enrollment.

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

Effective Date
The calendar date your healthcare coverage begins. You are not covered until the effective date.

Employee Premium Contribution
The amount you must pay toward health plan premiums.

Employer Premium Contribution
The amount your employer pays toward health plan premiums.

Employer-Subsidized Benefits
Benefits that are paid for, all or in part, with money contributed by the employer.

Enrollee
Individual enrolled in a health plan.

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

Evidence of Coverage (EOC)
The Evidence of Coverage is a legal document that gives details about plan benefits, exclusions and how to get the care you need. It explains your rights, benefits and responsibilities as a member of your plan and the plan providers' responsibilities to you. EOCs are available on myhss.org.

Exclusions
The list of conditions, injuries, or treatments that are not covered under your health insurance policy. Exclusions are listed in the Evidence of Coverage.

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

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. The formulary is updated periodically.

Generic Drug
FDA-approved therapeutic equivalent to a brand-name prescription drug, containing the same active ingredient and costing less than the brand-name drug.

Glossary of Healthcare Terms

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 specific groups of providers. HMO participants typically need pre-approval from a primary care provider before seeing a specialist.

Imputed Income
IRS regulations require that the value of non-cash compensation, including employer contribution toward health premiums for an employee's domestic partner, be reported as taxable income on federal tax returns.

In-Network
Providers or facilities that contract with a health plan to provide services at pre-negotiated fees. Enrollees usually pay less when using an in-network provider.

In-Patient
Services that are provided in a hospital and require admission and an overnight stay.

Medical Group
An independent group of physicians and other healthcare providers that contract to provide services to members of an HMO.

Member
An employee or retiree designated as the primary plan subscriber, per HSS rules.

Non-Formulary Drug
A drug that is not on the insurer's list of approved medications. Can only be prescribed with a physician's special authorization.

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

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

Out-of-Network
Providers or facilities that are not in your health plan's provider network. Some plans do not cover out-of-network services. Others charge a higher co-insurance.

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

Out-of-Pocket Maximum
The highest total amount you will spend in a year on out-of-pocket medical costs. Once you reach out-of-pocket maximum, your plan pays 100% of covered service costs.

Out-Patient
Services that are provided in a clinic or doctor's office and do not require overnight admission to the hospital.

Preferred Provider Organization (PPO)
Provides in-network services to subscribers at negotiated rates, but allows subscribers to seek service from out-of-network providers, often at a higher cost.

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

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

Privacy
HSS complies with federal and state laws that protect personal health information. For details visit: myhss.org/health_service_board/privacy_policy.html

Qualifying Event
A life event that allows you to make a change in your benefit elections outside Open Enrollment. Includes marriage, domestic partnership, separation, divorce or dissolution of partnership, birth or adoption of a child, death of a dependent, obtaining or losing other health coverage.

Reasonable and Customary
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 pay 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.

Same Day Surgery
Surgery procedures performed at an ambulatory care center or in-patient hospital without an admission or over night stay.

Specialty Drug
New types of drugs to treat specific illnesses.

2016 Medical Plan Premium Contributions

BOARD MEMBERS AND CLASSIFIED ADMINISTRATORS — **BI-WEEKLY 26 PAY PERIODS**

	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	District Pays	Employee Pays	District Pays	Employee Pays	District Pays	Employee Pays
Employee Only	$307.72	$25.29	$255.70	0	$207.99	$141.24
Employee +1	$532.42	$132.69	$421.97	$88.50	$348.11	$337.24
Employee +2 or more	$636.14	$304.58	$477.01	$244.91	$397.63	$574.31

CLASSIFIED EMPLOYEES — **BI-WEEKLY 26 PAY PERIODS**

	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	District Pays	Employee Pays	District Pays	Employee Pays	District Pays	Employee Pays
Employee Only	$311.42	$21.59	$255.70	0	$211.15	$138.08
Employee +1	$505.08	$160.03	$394.80	$115.67	$365.71	$319.64
Employee +2 or more	$597.04	$343.68	$437.87	$284.05	$550.47	$421.47

CLASSIFIED SCHOOL TERM EMPLOYEES — **BI-WEEKLY 21 PAY PERIODS**

	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	District Pays	Employee Pays	District Pays	Employee Pays	District Pays	Employee Pays
Employee Only						
January 2 – June 3	$452.97	$31.40	$371.93	0	$307.13	$200.84
August 13 – December 30	$311.42	$21.59	$255.70	0	$211.15	$138.08
Employee +1						
January 3 – June 5	$734.66	$232.77	$574.25	$168.25	$531.94	$464.93
August 15 – December 31	$505.08	$160.03	$394.80	$115.67	$365.71	$319.64
Employee +2 or more						
January 3 – June 5	$868.42	$499.90	$636.90	$413.16	$613.05	$800.68
August 15 – December 31	$597.04	$343.68	$437.87	$284.05	$550.47	$421.47

Classified School Term Employees January to May deductions (11 pay periods) include a 1.454 rate to pre-pay premiums for the summer coverage benefit period.

2016 Medical Plan Premium Contributions

FACULTY — **MONTHLY 12 PAY PERIODS**

	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	District Pays	Employee Pays	District Pays	Employee Pays	District Pays	Employee Pays
Employee Only	$666.72	$54.81	$554.02	0	$450.63	$306.04
Employee +1	$1,172.60	$268.47	$947.86	$158.15	$769.93	$714.99
Employee +2 or more	$1,413.10	$625.14	$1,089.48	$474.68	$890.11	$1,215.76

CERTIFICATED ADMINISTRATORS — **MONTHLY 12 PAY PERIODS**

	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	District Pays	Employee Pays	District Pays	Employee Pays	District Pays	Employee Pays
Employee Only	$666.72	$54.81	$554.02	0	$450.63	$306.04
Employee +1	$1,153.58	$287.49	$914.26	$191.75	$754.24	$730.68
Employee +2 or more	$1,378.30	$659.94	$1,033.53	$530.63	$861.52	$1,244.35

PART-TIME FACULTY EMPLOYEES — **MONTHLY 9 PAY PERIODS**

	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	District Pays	Employee Pays	District Pays	Employee Pays	District Pays	Employee Pays
Employee Only						
January 1 – May 31	$1,066.75	$87.70	$886.43	0	$721.01	$489.66
September 1 – December 31	$666.72	$54.81	$554.02	0	$450.63	$306.04
Employee +1						
January 1 – May 31	$1,876.16	$429.55	$1,516.58	$253.04	$1,231.89	$1,143.98
September 1 – December 31	$1,172.60	$268.47	$947.86	$158.15	$769.93	$714.99
Employee +2 or more						
January 1 – May 31	$2,260.96	$1,000.22	$1,743.17	$759.49	$1,424.18	$1,945.22
September 1 – December 31	$1,413.10	$625.14	$1,089.48	$474.68	$890.11	$1,215.76

Part-time Faculty Employees January to May deductions (5 pay periods) include a 1.60 rate to pre pay premiums for the summer coverage benefit period.

City College Employees

Key Contact Information

HEALTH SERVICE SYSTEM
1145 Market Street, 3rd Floor
San Francisco, CA 94103
Tel: 1-415-554-1750
1-800-541-2266
Fax: 1-415-554-1721
Web: myhss.org

WELL-BEING PROGRAM
1145 Market Street, 1st Floor
San Francisco, CA 94103
1-415-554-0643
wellness@sfgov.org

EAP (Employee Assistance Program)
1-800-795-2351

CITY COLLEGE BENEFITS
33 Gough Street
San Francisco, CA 94103
Tel: 1-415-241-2246
Web: ccsf.edu/hr

MEDICAL and VISION			
Blue Shield of California	1-855-256-9404	blueshieldca.com	Group W0051448
Kaiser Permanente	1-800-464-4000	kp.org	Group 888 (North CA) Group 231003 (South CA)
City Plan UnitedHealthcare	1-866-282-0125	welcometomyuhc.com/sfss	Group 752103
VSP Vision	1-800-877-7195	vsp.com	Group 12145878

DENTAL			
Delta Dental PPO dental enrollment is administered through the City College Benefits office	1-866-499-3001	deltadentalins.com	Group 15935-006 FT faculty and admin Group 15935-007 classifieds Group 15935-008 COBRA Group 15935-009 PT faculty Group 15935-010 Board of Trustees Group 15935-011 AB528 retirees

OTHER AGENCIES			
CalSTRS	1-800-228-5453	calstrs.com	pension benefits
SFERS	1-415-487-7000	mysfers.org	pension benefits
CalPERS	1-888-225-7377	calpers.ca.gov	pension benefits
Covered California	1-888-975-1142	coveredca.com	state health insurance exchange

For information about other benefits, including Flexible Spending Accounts, contact the City College Benefits office.

6 THINGS ALL EMPLOYEES SHOULD KNOW...

There is a 30-day Deadline to Enroll in Health Benefits for You and Your Family

New hire? New spouse, new partner, new child? Adding a family member who lost other coverage? If you miss the 30-day deadline you must wait until the next Open Enrollment.

To Enroll You Must Provide Eligibility Documentation

Be prepared to provide a copy of a marriage certificate, certification of partnership, children's birth certificates or proof of adoption as well as Social Security numbers for new enrollees.

You Must Disenroll Ineligible Family Members Within 30 Days

Divorce or dissolution of partnership? Your ex-spouse, partner or stepchild is no longer eligible for health coverage. Don't risk paying significant penalties. Contact HSS and drop ineligible dependents.

Contact the Health Service System if You Go on a Leave of Absence

You must contact the Health Service System at the start and end of any approved leave of absence. Health benefits premiums must be paid while you are on leave. Don't risk termination of coverage.

If You Change Your Home Address, Contact the Health Service System

Depending on the service areas covered by your plan, you may need to enroll in a different plan based on your new address. Don't risk termination of health benefits because of a move.

Retiree Health Benefits Are Different From Employee Benefits

You are not automatically enrolled in retiree benefits. Before you retire you must visit the Health Service System to learn about, and enroll in, retiree health benefits.

For more information visit myhss.org or call Member Services at 1-415-554-1750.