2016 HEALTH BENEFITS Superior Court Employees

HEALTH SERVICE SYSTEM
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

What's New 2016 2

How to Enroll in Health Benefits 2

Working Together to Stay Healthy and Manage Costs 3

Eligibility 4

Eligibility Documentation 6

Domestic Partner Health Benefits Taxation 7

Changing Benefit Elections: Qualifying Events 8

The Health Service System Provides You With Medical Plan Options 10

Medical Plan Service Areas 11

Choosing Your Medical Plan 12

Nurseline and Urgent Care 13

Medical Plan Benefits At-a-Glance 14

Preventive Care 16

Condition Management 17

Mental Health Benefits 18

Live a Healthy Lifestyle: Small Steps, Big Rewards 19

Well-being at Work 19

Take Care of Your Teeth–Take Advantage of Dental Coverage 20

Dental Plan Service Areas 21

Dental Plan Benefits At-a-Glance 22

Dental Plan Comparison 23

Protect Your Eyes–Use Your Vision Plan Benefits 24

VSP Benefits At-a-Glance 25

Flexible Spending Accounts (FSAs) 26

Long Term Disability Insurance (LTD) 28

Group Life Insurance 29

You Must Notify the Health Service System About a Leave of Absence 30

Health Benefits During a Paid or Unpaid Leave of Absence 31

Transition to Retirement 32

It's Important to Plan as You Approach Retirement 33

Holdover, COBRA and Covered California 34

Health Coverage Calendar 36

Health Service Board 37

Glossary of Healthcare Terms 38

Premium Contributions 40

Key Contact Information 41

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 Superior Court employee health benefits as of January 1, 2016

No Changes to Plan Choices or Covered Benefits

Good news! The same medical, dental and vision plans available 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. For most employees there will be only a modest adjustment to premium contributions. Please review premium contribution changes before making your 2016 enrollment decisions. See pages 40-43 of this guide for 2016 premium contribution rates.

P&A Group Will Administer FSAs Effective January 1, 2016

Effective January 1, 2016 there is a new administrator for FSAs (Flexible Spending Accounts). P&A Group is replacing WageWorks. Visit P&A Group online at padmin.com. Also, there are updates to HSS rules regarding FSAs and leave of absence. See page 31 of this guide for details.

How to Enroll in Health Benefits

Don't Miss the 30-Day Deadline

- Learn about your health 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. See pages 8-9 for more information about qualifying events.
- To enroll, submit a completed enrollment application and required eligibility documentation to the Health Service System by the **30-day deadline**. Submit copies, not originals, 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 application and eligibility documentation. The fax number is 1-415-554-1721.
- Employee premium contributions are deducted from paychecks bi-weekly. Review your paycheck to verify that the correct employee premium contribution is being deducted. 2016 premiums are on pages 40–43.
- October Open Enrollment is your annual opportunity to change benefit elections without any qualifying events. Changes made during October Open Enrollment are effective the following January 1.
- Questions about health benefits, premium contributions or eligibility documentation? **Call 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.

Eligibility

The following rules govern which employees and dependents may be eligible for HSS health coverage.

Member Eligibility

The following are eligible to participate in the Health Service System as members:

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

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 health coverage for a child, that child is eligible up to age 19. Coverage terminates at the end of the coverage period in which the child turns 19. The member must provide HSS with proof of guardianship, court order, or decree by required deadlines.

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 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

	Evidence Of Hire	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 legal 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.

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 legal 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 legal 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 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.

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 HSS at 1-415-554-1750.

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 active 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 4.) 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.

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 my.kp.org/ccsf	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

Medical Group	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 service.

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.

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.

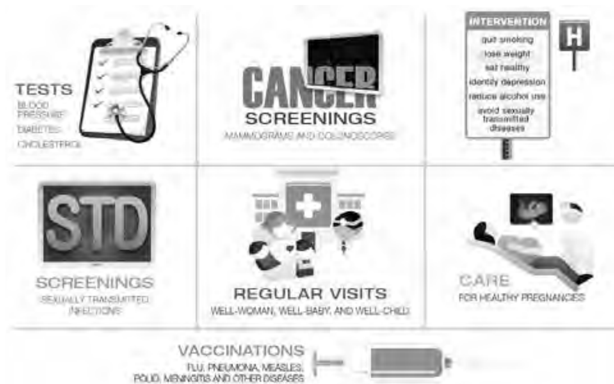
	BLUE SHIELD HMO ACCESS+ IN-NETWORK ONLY	KAISER HMO TRADITIONAL PLAN IN-NETWORK ONLY	CITY PLAN PPO UNITEDHEALTHCARE CHOICE PLUS IN-NETWORK AND OUT-OF-AREA	OUT-OF-NETWORK
Choice of physician	Access+ plan network only. Primary Care Physician assignment required.	Kaiser network only. Primary Care Physician 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

Preventive Care

If Everyone in the United States Received Recommended Clinical Preventive Care, We Could Save 100,000 Lives Each Year

Most preventive care services are covered 100%, at no cost to you. Preventive care services include regular checkups, screenings, vaccinations and healthy lifestyle programs. Preventive care and healthy lifestyle choices are small steps that can improve your well-being. With appropriate preventive care you may avoid or delay the onset of a condition. Early diagnosis increases the probability that treatment will be effective. Members who receive appropriate preventive care also help the Health Service System manage costs. For more information, visit myhss.org/well-being/prevention.html.



Get Started With Your Preventive Care

1. Go to cdc.gov/prevention, enter your sex and age to receive a personalized list of recommended preventive care.

2. Contact your health care provider to schedule your preventive care and learn about services they offer to help you live a healthy lifestyle. Don't forget to take care of your teeth and eyes with routine dental and vision checkups too.

Alternative and Complementary Care

Blue Shield of California HMO	Kaiser Permanente HMO	City Plan PPO
Acupuncture and Chiropractic Self-refer up to 30 visits per year through the American Specialty Health network at a $15 co-pay per visit. Find a practitioner at: ashcompanies.com or call 1-800-678-9133. After the 30 visits covered by your plan, you can book additional visits using the discount program below. **Acupuncture, Chiropractic, Massage and Wellness Discounts** 25% off usual and customary fees for acupuncture, chiropractic and massage booked through the ChooseHealthy program. Visit choosehealthy.com/Default.aspx?hp=BSCA or call 1-888-999-9452. For additional discounts visit: blueshieldca.com/wellnessdiscounts.	**Chiropractic** Self-refer up to 30 visits per year through the American Specialty Health network at a $15 co-pay per visit. Find a practitioner at: ashlink.com/ash/kp or call 1-800-678-9133. After the 30 visits covered by your plan, you can book additional visits using the discount program below. **Acupuncture, Chiropractic, Massage and Wellness Discounts** 25% off usual and customary fees for acupuncture, chiropractic and massage booked through the ChooseHealthy program. Visit kp.org/choosehealthy or call 1-877-335-2746. For additional discounts visit: kp.org/choosehealthy.	**Acupuncture and Chiropractic** Self-refer to a licensed practitioner at 50% reasonable and customary co-insurance, up to $1,000 maximum per year, after paying your deductible. **Acupuncture, Chiropractic, Massage and Wellness Discounts** Up to 50% off fees for acupuncture, chiropractic, massage and other wellness resources. Visit unitedhealthallies.com.

Condition Management

Chronic Conditions Are Long-Term Diseases That Can Be Controlled But Not Cured

If you are living with a chronic condition, your health plan may offer chronic condition management at no cost to you. The most common conditions facing Health Service System members are diabetes, COPD, congestive heart failure, obesity and depression. With proper treatment, monitoring, education and motivation those who manage their chronic condition will have an improved quality of life, can avoid getting worse, are able to continue working and have reduced long-term medical costs.

Having a Chronic Condition Puts You at Greater Risk of Depression

It is common to overlook the symptoms of depression, but it is vital that you prioritize your mental health when you have a chronic condition. Untreated depression in people with a chronic condition is associated with twice as many days of limited activity, increased mortality and a 50% to 100% increase in healthcare costs.

Working Together to Manage Conditions and Costs

1. Communicate openly and regularly with your physician. Your doctor provides the best care when he or she knows what is going on.
2. Keep your appointments and follow treatments including taking medications as prescribed.
3. Be a proactive patient. Track your lab results and request copies of lab tests or view them online. Learn more about your condition so you can manage it and feel better about it.
4. Live a healthy lifestyle. Be physically active each day, eat nutritious foods, limit alcohol, avoid tobacco and strive for a healthy weight. Take advantage of health plan and workplace programs that can help you manage stress.
5. Plan for the future. Consider preparing an advance directive to document your wishes regarding medical treatment options.

Condition Management From Your Health Plan

Blue Shield of California HMO	Kaiser Permanente HMO	City Plan PPO
Receive nurse support, educational resources and online tools to help you manage a variety of conditions including asthma, diabetes, coronary artery disease, heart failure and chronic obstructive pulmonary disease. Visit blueshieldca.com/hw or call 1-866-954-4567. Your physician's medical group may also have condition management programs–ask your PCP. Receive support during your pregnancy. Visit blueshieldca.com/prenatal to enroll online or call 1-877-371-1511.	Care teams work together using a single electronic health record to coordinate care for asthma, arthritis, cancer, CAD, COPD, chronic pain, CHF, depression, diabetes and low back pain. Members are automatically enrolled. Your Primary Care Physician will coordinate your care. For pregnancy support, call the nurse advice line at 1-866-454-8855 or email your doctor. Free educational classes and support groups are also available. Visit kp.org/pregnancy.	Receive treatment decision support and advice for conditions such as COPD, CAD, diabetes, heart failure and pregnancy. Call 1-888-688-4043 for Disease Management. Call 1-888-246-7389 for the Healthy Pregnancy Program.

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.html.

	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.html **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.

Live a Healthy Lifestyle: Small Steps, Big Rewards

Based on the 2014 Well-being Assessment, employees would like to be more active, eat better, manage stress, quit tobacco and lose weight. Commit to taking small steps to achieve the big reward of a healthier lifestyle.

- 78% of employees want to get more exercise, but only 30% are meeting minimum daily physical activity requirements.
- 73% want to eat more fruits and vegetables, but only 17% are meeting the recommended intake of five servings daily.
- 65% want to improve their stress management skills. 37% of employees report feeling very stressed every day.

Discover free, low cost and discounted services available through the Health Service System, health plans and the City by visiting:

myhss.org/well-being/movement.html

myhss.org/well-being/nutrition.html

myhss.org/well-being/prevention.html

myhss.org/well-being/peaceofmind.html

Well-being at Work

We spend over 50% of our time at work. Our work environment can make a big difference in our health. Let's create a culture of well-being that supports making healthy choices.

Last year the Health Service System launched a well-being program. The goal is to enhance employees' quality of life, improve morale, reduce injuries and contain healthcare costs. A key component of this program is bringing well-being to the workplace.

Champions at various work locations promote and support the programs and services listed below. These programs are also available at the HSS Wellness Center at 1145 Market Street. Find out who your Champion is at myhss.org/well-being. Then join us by participating in workplace well-being programs.

Worksite Well-being Programs

- Walking Challenge
- Nutrition Challenge
- Daily Challenge

Onsite Well-being Services

- Group Exercise Classes
- Wellness Coaching
- Well-being Seminars
- EAP Trainings and Seminars
- Flu Shot Clinics
- Biometric Screenings

Take Care of Your Teeth – Take Advantage of Dental Coverage

PPO-Style Dental Plans

A 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. There is a maximum benefit of $2,500 per year per enrollee.

HSS offers the following PPO-style dental plan:

- **Delta Dental**

If You Enroll in Delta Dental, Save Money By Choosing PPO Dentists

The Delta Dental plan has two different networks. Ask your dentist if he or she is PPO or Premier. Both networks are held to the same quality standards, but choosing a PPO dentist will save you money.

With Delta Dental PPO dentists, you pay lower out-of-pocket costs. Most preventive services are covered at 100%; many other services are covered at 90%.

Delta Dental Premier dentists charge higher out-of-pocket fees. Covered charges are based on pre-arranged charges with each contracted dentist. Most preventive services are covered at 100%; many other services are covered at 80%.

You can also choose any dentist outside of the PPO and Premier networks. When you receive service from an out-of-network dentist, many services are covered at a lower percentage, so you pay more. Also, payment is based on reasonable and customary fees for the geographic area. Your out-of-pocket costs will be higher if your out-of-network dentist charges more than reasonable and customary fees.

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 1-888-335-8227.

HMO-Style Dental Plans (DMOs)

Similar to medical HMOs, a Dental Maintenance Organization (DMO) plans require that you receive all of your dental care from within a network of participating dental offices. DMOs charge a flat rate for all services. These networks are generally smaller than a dental PPO network. There is no monthly premium for DMOs. Before you elect a DMO plan, make sure that the plan's network includes the dentist of your choice.

HSS offers the following DMO plans:

- **DeltaCare USA**
- **UnitedHealthcare Dental**
  (Pacific Union Dental)

Can you enroll in only a dental plan?

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 UnitedHealthcare Dental, you must reside within a ZIP code serviced by the plan.

County	Delta Dental PPO	DeltaCare USA DMO	UnitedHealthcare Dental DMO
Alameda	■	■	■
Contra Costa	■	■	■
Marin	■	■	■
Napa	■	■	■
Sacramento	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Clara	■	■	■
Solano	■	■	■
Sonoma	■	■	■
Stanislaus	■	■	■
Tuolomne	■		
Outside of California	■		

■ = Available in this county.

If you do not see your county listed above, contact the dental plan to see if service is available to you:

Delta Dental: 1-888-335-8227

DeltaCare USA: 1-800-422-4234

UnitedHealthcare Dental: 1-800-999-3367

Superior Court Employees

Dental Plan Benefits At-a-Glance 2016

	Delta Dental			DeltaCare USA	UnitedHealthcare
Choice of dentist	You may choose any licensed dentist. You will receive a higher level of benefit and lower out-of-pocket costs when using a Delta Dental PPO dentist.			DeltaCare dental network only	UnitedHealthcare dental network only
Deductible	None			None	None
Plan year maximum	$2,500 per person Per year, excluding orthodontia benefits			None	None
Covered Services	**PPO Dentists**	**Premier Dentists**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
Cleanings and exams	100% covered 2x/year; pregnant women 3x/year	100% covered 2x/year; pregnant women 3x/year	80% covered 2x/year; pregnant women 3x/year	100% covered 1 every 6 months	100% covered 1 every 6 months
X-rays	100% covered full mouth 1x/5 years bitewing 2x/year to age 18; 1x/year over age 18	100% covered full mouth 1x/5 years bitewing 2x/year to age 18; 1x/year over age 18	80% covered full mouth 1x/5 years bitewing 2x/year to age 18; 1x/year over age 18	100% covered	100% covered
Extractions	90% covered	80% covered	60% covered	100% covered	100% covered
Fillings	90% covered	80% covered	60% covered	100% covered Limitations apply to resin materials	100% covered Limitations apply
Crowns	90% covered	80% covered	50% covered	100% covered Limitations apply to resin materials	100% covered Limitations apply
Dentures, pontics and bridges	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	100% covered Full and partial dentures 1x/5 years; fixed bridgework, limitations apply	100% covered Full and partial dentures 1x/5 years; fixed bridgework, limitations apply
Endodontic/ Root Canals	90% covered	80% covered	60% covered	100% covered Excluding the final restoration	100% covered
Oral surgery	90% covered	80% covered	60% covered	100% covered	100% covered
Implants	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	Not covered	Not covered
Orthodontia	50% covered 6-month wait; child $2,500 lifetime max; adult $1,500 lifetime max	50% covered 6-month wait; child $2,000 lifetime max; adult $1,000 lifetime max	50% covered 6-month wait; child $1,500 lifetime max; adult $500 lifetime max	Employee pays: $1,600/child $1,800/adult $350 startup fee; limitations apply	Employee pays: $1,660/child $1,880/adult $350 startup fee; limitations apply

This chart provides a summary of benefits. It is not a contract. For a more detailed description of benefits and exclusions for each plan, please review each plan's Evidence of Coverage, available on myhss.org.

Dental Plan Comparison

Dental Plan Quick Comparison

	Delta Dental	DeltaCare USA	UnitedHealthcare Dental
Can I choose to receive services from any dentist?	Yes. You can use any licensed dental provider. You pay less when you choose a PPO in-network 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, implants 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
Is there a monthly premium contribution?	Yes	No	No
Must I live in a certain service area to enroll in the plan?	No	Yes. To enroll, you must live in this DMO's service area.	Yes. To enroll, you must live in this DMO's service area.

Protect Your Eyes – Use Your Vision Plan 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.

Computer VisionCare Benefit (VDT)

Some union contracts provide for employer-paid computer vision care benefits. Coverage includes an annual computer vision exam, $75 in-network retail frame allowance every 24 months and single vision, lined bifocal, lined trifocal lenses. Superior Court reporters have the VDT benefit.

No Medical Plan, No Vision Benefits

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

Superior Court Employees

Vison 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 enhance-ments	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.

Superior Court Reporters have Computer VisionCare benefits (VDT)

Flexible Spending Accounts (FSAs)

Save by paying for many everyday expenses, such as healthcare, child daycare and elder daycare, with tax-free money.

How an FSA Works

Flexible Spending Accounts (FSAs) let you set aside money pre-tax to pay for eligible healthcare and/or dependent care expenses. For every $100 you set aside you save approximately $30 in taxes. An FSA account can pay qualifying expenses incurred by you, your spouse, or qualifying child or relative (as defined in Internal Revenue Code Section 152). You can enroll in either a Healthcare FSA, a Dependent Care FSA, or both.

Before enrolling in your FSA, calculate a detailed estimate of the eligible expenses you are likely to incur in 2016. Budget conservatively. You are allowed to carry over between a minimum of $10 and a maximum of $500 of your healthcare FSA each plan year for one year, if you do not use your funds during 2016. Unreimbursed funds under $10 and beyond $500 are forfeited and cannot be returned to you. You can submit claims incurred during the plan year for up to 90 days after the plan year ends. FSA expenses must meet Internal Revenue Service (IRS) eligibility criteria. Learn more online: irs.gov/pub/irs-pdf/p502.pdf and irs.gov/pub/irs-pdf/p503.pdf.

FSA Rules

- FSA enrollment is required each year. You must re-enroll in Flexible Spending Account(s) every Open Enrollment if you want to continue this benefit.
- Expenses for services incurred before January 2016 or after December 2016 are not eligible unless covered by the Healthcare FSA Carryover provision.
- You cannot transfer money between Healthcare and Dependent Care Flexible Spending Accounts.
- You cannot change FSA contributions during the January to December plan year unless you have a qualifying event. For details, visit myhss.org/benefits/fsa.html.
- If your employment ends, in some cases you have the option of continuing your FSA with COBRA. (See page 35). Without COBRA, you can only file claims for eligible FSA expenses that were incurred while you were actively employed.

New FSA Administrator: P&A Group

- FSA benefits are administered by P&A Group.
- For a complete list of FSA eligible healthcare and dependent care expenses, visit padmin.com.
- For FSA account information, visit padmin.com or call 1-800-688-2611. Monday-Friday, 5:00AM–7:00PM Pacific Time.
- P&A will issue a debit card for you to use to make spending your FSA easier.

Avoid Forfeiting FSA Contributions

FSA expenses for the 2016 plan year must be incurred in 2016 and received by P&A no later than March 31, 2017. Per IRS rules, you forfeit all funds remaining in an FSA by the end of the claim filing period unless they are covered by the Healthcare FSA Carryover provision. There are no exceptions.

Flexible Spending Accounts (FSAs)

Learn about the two different types of FSAs you are eligible to participate in.

Healthcare FSA with Carryover

A Healthcare FSA can pay for medical expenses such as medical, pharmacy, dental and vision co-payments, other dental and vision care expenses, acupuncture and chiropractic care, weight loss programs and more. For a complete list of eligible healthcare expenses, visit padmin.com.

- Set aside between $250 and $2,500 pre-tax per employee for the plan year. Depending on the amount you elect, deductions between $10 and $100 be taken bi-weekly from your paycheck January–December 2016.
- Submit reimbursement documentation by mail, online, or by smartphone app for eligible out-of-pocket medical expenses to P&A Group.
- P&A will issue a debit card for you to use to make spending your FSA easier.
- When you elect a Healthcare FSA, the total annual amount you designate becomes available for eligible healthcare expenses as of January 1, 2016. You do not have to wait for your contributions to accumulate in your account.
- HSS administers a carryover minimum of $10. At the end of the plan year claim filing period, unreimbursed healthcare FSA funds below $10 and over $500 will be forfeited.
- Carryover fund amounts between $10 and $500 are determined after the end of the claim filing period and are then available for any claims incurred as of the first day of the new plan year.
- A domestic partner's medical expenses cannot be reimbursed under an FSA unless the domestic partner is a "qualifying relative."
- Carryover funds can be accessed for one plan year. Any remaining carryover funds will be forfeited.

Childcare/Eldercare Dependent Care FSA

A Dependent Care FSA can pay for qualifying child and elder care expenses with tax-free funds, such as certified day care, pre-school, day camp, before/after school programs and dependent care expenses for a qualified relative such as elder care or adult day care. These dependent care expenses must be incurred to enable you (and, if married, your spouse) to work. Children must be under age 13. For a complete list of eligible dependent care expenses, visit padmin.com.

- Set aside between $250 and $5,000 pre-tax per household for the plan year. ($2,500 each if you are married filing separate federal tax returns.) Depending on the amount you elect, deductions between $10 and $200 will be taken biweekly from your paycheck in 2016.
- If you have a stay-at-home spouse, you may not enroll in the Dependent Care FSA.
- Submit reimbursement documentation to P&A Group by mail, online, or by smartphone app for eligible out-of-pocket expenses.
- Funds for a Dependent Care FSA are available after being deducted from your paycheck and received by the plan administrator. Unlike a Healthcare FSA, the entire annual amount for a Dependent Care FSA is not available January 1, 2016.
- Funds for a Dependent Care FSA must be used for incurred qualifying expenses during the plan year or be forfeited. **Unlike a Healthcare FSA, there is no carryover option.**

Long Term Disability Insurance (LTD)

Employer-paid LTD can replace lost income if you are injured or ill.

Employer-Paid Long Term Disability Insurance

Some union contracts provide for Long Term Disability Insurance. A long-term disability is an illness or injury that prevents you from working for an extended period of time. If you submit a long-term disability claim and it is approved, the LTD plan may replace part of your lost income by paying you directly on a monthly basis. (LTD payments will be reduced if you qualify for other sources of income or disability earnings, such as workers' compensation or state disability benefits.)

LTD coverage begins the first of the month following date of hire. You are eligible for LTD coverage if you:

- Have a union contract that provides for employer-paid LTD insurance.
- Are actively at work more than 20 hours per week at the time of disability.
- Are a temporary exempt employee and complete 1,040 work hours in one consecutive 12 month period. Coverage begins the first day of the following month after you complete 1,040 hours.

Leave of Absence and LTD Coverage

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

If you are not actively at work due to non-medical reasons, including temporary lay-off, personal leave, family care leave, or administrative leave, LTD coverage will terminate at the end of the month following the month your absence began. Call HSS at 1-415-554-1750 for more information about leave of absence and long-term disability coverage.

Returning To Work

LTD programs can help you get back on the job when it's medically safe for you to do so. You may be able to return to work part-time, or work at a different type of job. If you qualify, LTD can continue paying a portion of your benefits.

Bargaining Units Covered by LTD

180-day elimination period; up to 60% of monthly base earnings; $5000 monthly maximum:

Superior Court Reporters
Superior Court SEIU 1021
Superior Court Unrepresented Clerical
Superior Court Interpreters

90-day elimination period; up to 66.6667% of monthly base earnings; $7500 monthly maximum:

Superior Court Local 21
Superior Court Attorneys 311C, 312C, 316C
Superior Court Unrepresented Professionals

If your bargaining unit is not listed above you are not eligible for LTD benefits.

This is a general summary. For LTD coverage details, see plan documents on myhss.org or call Aetna at 1-866-326-1380.

Group Life Insurance

Some union contracts provide for employer-paid group life insurance.

Employer-Paid Group Life Insurance

Life insurance offers your loved ones basic financial protection if you die. It can help pay your final expenses or help those you leave behind pay bills, like a mortgage or college tuition.

You are eligible for employer-paid life insurance if you:

- Have a union contract that provides for employer-paid life insurance coverage.
- Are actively at work.

Coverage begins the first day of the month following your date of hire.

Life Insurance Beneficiaries

A beneficiary is the person or entity who receives the life insurance payment when the insured person dies. You may designate multiple beneficiaries. It is your responsibility to keep your beneficiary designations current. To update beneficiary designations, download and complete the Change Beneficiary Form and return to HSS: myhss.org/benefits/ccsf_other_benefits.html.

Leaves of Absence

If you are not actively at work due to a temporary lay-off, personal leave, family care leave, or administrative leave (non-medical reasons), your coverage will terminate at the end of the month following the month your absence started.

If you are not actively at work due to illness or injury, your life insurance coverage will continue for 18 months from the start of your absence for medical reasons. After six months, you may qualify for a further extension of your life insurance benefits (Permanent and Total Disability Benefit); however, you must provide Aetna with a written notice of claim for this extended benefits within the 18-month coverage period. Call HSS at 1-415-554-1750 for information about how a leave of absence can impact your life insurance coverage.

Outline of Life Insurance Plan Basics

Bargaining Unit	Coverage
Superior Court Attorneys 311C, 312C, 316C	$125,000
Superior Court Reporters Superior Court Local 21 Superior Court Misc Unrepresented	$50,000
Superior Court SEIU 1021 Superior Court Interpreters	$25,000

If your bargaining unit is not listed above, you do not have employer-paid group life insurance.

Life Insurance Benefits Change Over Time

When you reach age 65, your benefits will drop to 65% of the original coverage amount. At age 70, your benefits will drop to 50%. At age 75, your benefits will drop to 30%.

Facing a Terminal Illness

If you are diagnosed with a terminal illness, you may request an Accelerated Death Benefit payment which pays you up to 75% of your life insurance coverage if you have 24 months or less to live. Also, Aetna Life Essentials offers no cost legal assistance for preparation of a living will or power of attorney, funeral planning and phone counseling by a licensed social worker. Visit aetna.com/aetnalifeessentials or contact Aetna Care Advocacy at 1-800-276-5120.

Portability

If you leave your job or otherwise lose eligibility you can convert your group life coverage to an individual policy, but you must pay life insurance premiums.

This is a general summary. For Life Insurance details, see plan documents on myhss.org or call Aetna at 1-800-523-5065.

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.

Medical, Dental and Vision

While you are on an unpaid leave, premiums for health coverage cannot be deducted from your paycheck. To maintain coverage, you must pay premium contributions directly to HSS. Contact HSS **within 30 days** of when leave begins to either waive coverage or arrange for payment of premiums. Failure to do so can result in the termination of your health benefits, which may not be reinstated until you return to work or during Open Enrollment. When you return to work, contact HSS immediately (**within 30 days**) to request that health premium payroll deductions be returned to active status.

Group Life Insurance

If you go on an approved leave due to illness or injury, employer-paid group life coverage continues for up to 18 months. For other types of leave, group life coverage ends the last day of the month after the month in which your leave begins. Group life insurance resumes the first day of the coverage period after you officially return to work.

Long Term Disability (LTD) Insurance

If you go on an approved leave due to illness or injury, employer-paid long term disability coverage continues for up to 12 months. Health premiums are not deducted from LTD payments. Call HSS to arrange to pay your premiums. For other types of leave, LTD coverage ends the last day of the month after the month in which your leave begins. LTD coverage resumes the first day of the coverage period after you officially return to work.

Domestic Partner Imputed Income

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.

Health Benefits During a Paid or Unpaid Leave of Absence

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.

Flexible Spending Accounts (FSAs)

Healthcare FSA

During an unpaid leave, no FSA payroll deductions can be taken. To maintain your FSA coverage, you must pay your FSA contributions directly to HSS. Contact HSS **within 30 days** of when leave begins to arrange for payment of your FSA contributions. You may suspend your Healthcare FSA if you notify HSS at the beginning of your leave. Accounts that remain unpaid for three consecutive pay periods will be suspended retroactively to the first missed pay period. Your Healthcare FSA will be reinstated once you return to work. If you want to maintain your annual election amount for expenses incurred before and after your leave, you must notify HSS **within 30 days** of your return to work. Your payroll deductions will be increased and spread proportionally over the remaining pay periods in the Plan Year. If you do not contact HSS, your annual election amount will be reduced by the amount of contributions missed (if any) during your leave of absence.

Dependent Care FSA

A Dependent Care FSA must be suspended while you are on leave. Claims incurred during leave are not reimbursable. To reinstate, you must notify HSS **within 30 days** of your return to work. Reinstatement of a Dependent Care FSA is only allowed on a go-forward basis. You may reinstate at the original bi-weekly FSA deduction amount, or you can increase bi-weekly deductions for the plan year. If you increase deductions, total FSA contributions for the year must equal and cannot exceed, the amount designated during Open Enrollment.If you do not notify HSS **within 30 days** of your return to work and request reinstatement of your FSA payroll deduction, FSA(s) will be canceled for the remainder of the plan year. There are no exceptions. If you return to work after December 2016, a suspended Healthcare or Dependent Care FSA initiated during the 2016 plan year cannot be reinstated. There are no exceptions.

Questions?

Call HSS at 1-415-554-1750 if you have questions about health benefits during a leave of absence.

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 domestic partner of an active 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.

It's Important to Plan as You Approach Retirement

Proposition B amended Charter provisions regarding retiree health benefits for employees hired after January 9, 2009.

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

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

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

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

If eligible, different premium contribution rates apply for employees hired after January 9, 2009, based on years of credited service with the City employers.

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

Thinking About Retiring?

Make an informed decision. Confirm years of credited service with City employers with your retirement system: SFERS, CalPERS, CalSTRS or PARS. (There is no reciprocity with other government employment under Proposition B for health benefits.) Then contact the Health Service System. A benefits analyst will review your service credits, health benefits eligibility, retiree health plan options and premium contributions.

Holdover, COBRA and Covered California

Holdover Rights

Employees who are placed on a holdover roster may be eligible to continue HSS medical, dental and vision coverage for themselves and covered dependents. Eligibility requirements include:

1. Employees must certify annually that they are unable to obtain other health coverage.
2. Premium contributions must be paid by the due date listed on the 2016 Health Coverage Calendar (see page 36). Rates are subject to increase each plan year.

COBRA

Under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), employees without holdover rights, or whose holdover rights have ended, may be eligible to continue medical, dental and vision coverage for themselves and eligible dependents at the employee's expense. Current year FSAs (Flexible Spending Accounts) may also be COBRA-eligible.

For Cobra information, visit padmin.com or call 1-800-688-2611

Employees may elect to continue healthcare coverage through COBRA if coverage is lost due to:

- Voluntary or involuntary termination of employment (except for gross misconduct).
- Hours of employment reduced, making the employee ineligible for employer health coverage.

Covered spouses or domestic partners may also elect to be covered under COBRA if coverage is lost due to:

- Voluntary or involuntary termination of the employee's employment (except for misconduct).
- Divorce, legal separation, or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

Covered dependent children may elect COBRA coverage if healthcare coverage is lost due to:

- Loss of dependent child status under the plan rules.
- Voluntary or involuntary termination of the employee employment (except for misconduct).
- Hours of employment reduced, making the employee ineligible for employer health coverage.
- Parent's divorce, legal separation, or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

COBRA Notification and Election Time Limits

If an employee and any enrolled dependents lose HSS coverage due to separation from employment, P&A Group will notify the employee of the opportunity to elect COBRA coverage. The employee or dependent has **60 days** from the COBRA notification date to complete enrollment and continue coverage. Coverage will be retroactive to the date of the COBRA-qualifying event, so there is no break in coverage. Employee coverage ends on the last day of the coverage period in which employment terminates. However, if the termination date falls on the first day of the coverage period, coverage ends that same day. If an enrolled dependent of an employee loses cover-age due to divorce, dissolution of partnership, or aging out, the employee or the dependent must notify P&A Group **within 30 days** of the qualifying event and request COBRA enrollment information.

Paying for COBRA

It is the responsibility of covered individuals enrolled in COBRA to pay required healthcare premium payments directly to P&A Group. COBRA premiums are not subsidized by the employer.

Dependents dropped from coverage during Open Enrollment are not eligible for COBRA.

Holdover, COBRA and Covered California

2016 Monthly COBRA Premium Rates

Blue Shield of California HMO	
Employee Only	$735.96
Employee +1	$1,469.89
Employee +2 or More	$2,079.00

Kaiser Permanente HMO	
Employee Only	$565.10
Employee +1	$1,128.13
Employee +2 or More	$1,595.44

City Plan (UnitedHealthcare) PPO	
Employee Only	$771.80
Employee +1	$1,514.62
Employee +2 or More	$2,147.99

Delta Dental PPO	
Employee Only	$65.30
Employee +1	$137.13
Employee +2 or More	$195.89

DeltaCare USA DMO	
Employee Only	$27.49
Employee +1	$45.35
Employee +2 or More	$67.08

UnitedHealthcare Dental DMO	
Employee Only	$28.36
Employee +1	$46.82
Employee +2 or More	$69.22

Duration of COBRA Continuation Coverage

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. Employees and dependents who are eligible for less than 36 months of federal COBRA may also be eligible for Cal-COBRA. Continuation coverage under both federal and California state COBRA will not exceed 36 months.

Employees who are disabled on the date of their qualifying event, or 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% of group rate.

Flexible Spending Accounts and COBRA

To continue FSA benefits under COBRA, year-to-date FSA contributions must exceed year-to-date claims as of your employment termination date. To keep your FSA open, apply under COBRA and continue making the bi-weekly contribution plus a 2% administrative charge. COBRA Flexible Spending Account contributions are made post-tax.

Termination of COBRA Continuation Coverage

COBRA coverage will end if:

- You obtain coverage under another group plan.
- You fail to pay the premium required under the plan within the grace period.
- The applicable COBRA period ends.

Covered California

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.

Health Coverage Calendar

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. Employee premium contributions for benefits coverage period are paid concurrent with the coverage period.

Flexible Spending Account (FSA) deductions will only occur on pay dates during the 2016 tax 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 pages 30-31 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 Premium Contributions

Premium contribution rates were unavailable at the time this guide was posted. As soon as they are available this digital guide will be updated and rates will be posted at myhss.org.

Superior Court Employees

Key Contact Information

HEALTH SERVICE SYSTEM

Member Services
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

SUPERIOR COURT

Human Resources
400 McAllister Street, Room 205
San Francisco, CA 94102
1-415-551-5936
sfsuperiorcourt.org

MEDICAL PLANS			
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 administered by UnitedHealthcare	1-866-282-0125	welcometouhc.com/sfhss	Group 752103
DENTAL and VISION PLANS			
Delta Dental	1-888-335-8227	deltadentalins.com	Group 9502-0003
DeltaCare USA	1-800-422-4234	deltadentalins.com	Group 01797-0001
UnitedHealthcare Dental formerly Pacific Union Dental	1-800-999-3367	welcometouhc.com/sfhss	Group 752103-0027
VSP Vision	1-800-877-7195	vsp.com	Group 12145878
FSAs and COBRA			
P&A Group FSA	1-800-688-2611	padmin.com	
P&A Group COBRA	1-800-688-2611	padmin.com	
LONG TERM DISABILITY (LTD) and GROUP LIFE			
Aetna LTD (Long Term Disability)	1-866-326-1380	aetna.com/group/ aetna_life_essentials	Group 839201
Aetna Group Life	1-800-523-5065	aetna.com/group/ aetna_life_essentials	To initiate a claim, contact HSS at 1-800-541-2266

OTHER AGENCIES			
Human Resources	1-415-557-4800	sfgov.org/dhr	employee relations
SFERS Employees' Retirement System	1-415-487-7000	mysfers.org	pension benefits
Dept of the Environment	1-415-355-3700	sfenvironment.org	commuter benefits
CalPERS	1-888-225-7377	calpers.ca.gov	pension benefits
Covered California	1-888-975-1142	coveredca.com	health insurance exchange

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. When you retire you must visit the Health Service System to learn about, and enroll in, retiree health benefits.