Superior Court Employees

2018 HEALTH BENEFITS

Excellent benefits for our amazing city family

SAN FRANCISCO
HEALTH SERVICE SYSTEM

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

What's New for 2018

Blue Shield of California Offers Trio HMO Option for Actives and Non-Medicare Enrolled Retirees

In addition to Access+ HMO, Blue Shield will offer SFHSS non-Medicare members a new choice: Trio HMO. Trio HMO has the same benefits and plan design as Access+, and access to many of the same hospitals and physicians, but with lower premium contributions. **Current Blue Shield members whose primary care doctors are Trio HMO doctors will be automatically enrolled in the Trio HMO plan, which is the lowest cost plan, unless you complete an SFHSS Open Enrollment form electing another plan.** For more information, please go to blueshieldca.com/sfhss or call 855-747-5800.

VSP Vision Care Adds an Enhanced Plan Choice

Pay a little more to enroll in the new VSP Premier Plan. Under this new plan, you can get glasses **every year** with a $300 frame allowance or contacts every year with a $250 allowance. Anti-reflective and progressive lenses are covered in full with a $25 co-pay for each. See pages 18-19 of this Guide for more information or go to sfhss.vspforme.com. If you would like to enroll in the VSP Premier Plan, or would like to speak to a VSP representative about the Premier Plan, please call 1-800-400-4569.

2018 Medical and Dental Plan Premium Contributions Are Changing

Review the rates for your bargaining unit at sfhss.org before making Open Enrollment decisions.

Enroll in Voluntary Benefits through EBS Workterra

Voluntary benefits can help provide additional financial protection for you and your family. SFHSS has partnered with Employee Benefits Specialists (EBS) to offer a suite of quality insurance plans to SFHSS members at discounted rates. Enrollment is optional. You can pay plan premiums through payroll deduction. See page 24 of this booklet or learn more by calling 1-888-392-7597 or visiting sfhss.org.

Best Doctors Expert Medical Case Review for Employees, Retirees, and Dependents

This confidential service is available to all employees, retirees, spouses, domestic partners, and dependents enrolled in an SFHSS medical plan. It provides expert case review whenever you or covered family members face an important medical decision. Contact Best Doctors at 1-866-904-0910 or visit members.bestdoctors.com to confirm a diagnosis, learn more about a prescribed medication, or review a recommended treatment plan. There is no additional cost to the member to use this service.

Increased Infertility and Assisted Reproductive Technology Benefits

For SFHSS Active and Early Retiree health plans, starting January 1, 2018, infertility benefits have been increased to two cycles per lifetime. Cryopreservation of reproductive tissue is being offered for up to 12 months across all plans.

SFHSS Remains a Pioneer in Gender Dysphoria Coverage and Anti-Discrimination in Health Care

In 2001, the San Francisco Health Service System became the first large public employer in the United States to include gender dysphoria care as part of its employee health design. SFHSS, in collaboration with its health plan providers, continues to champion anti-discrimination efforts and recognize medically necessary treatment options for gender dysphoria. For more information, please review the 2017 SFHSS Gender Dysphoria Policy Statement at sfhss.org.

UnitedHealthcare Offers 'Real Appeal' Weight-Loss Program

Free to all SFHSS Members, Real Appeal provides tools and support to help employees lose weight, feel good, and prevent weight-related health conditions. To find out if you are eligible to participate in this program, and to enroll, visit realappeal.com/enroll, or call 1-844-344-7325.

Online Benefits Coming in 2018

SFHSS will pilot online benefits enrollment in October and will go live in 2018 offering employees the choice to go paperless.

Review Your Dependent Coverage

SFHSS Member Rules require members to notify SFHSS immediately when an enrolled dependent is no longer eligible. You can drop these dependents from your coverage **without penalty** during Open Enrollment. If you are legally separated, divorced, or annulled, your spouse or former spouse is not eligible for SFHSS benefits. Former domestic partners are not eligible for SFHSS benefits.

How to Enroll in Health Benefits

- Learn about your health benefits options by reading this Guide and visiting sfhss.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 6-7 for more information about qualifying events.
- To enroll, submit a completed enrollment application and required eligibility documentation to the San Francisco 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. 2018 premiums are on pages 36-39.
- 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. It is also your opportunity to drop ineligible dependents without being charged a penalty.
- Questions about health benefits, premium contributions or eligibility documentation? **Call 1-415-554-1750**.

Comprehensive, Affordable Benefits for Eligible Employees and their Families

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

Member Eligibility

The following are eligible to participate in the San Francisco 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 SFHSS health coverage. Proof of legal marriage or domestic partnership is required, as well as the dependent's Social Security number. Enrollment in SFHSS benefits must be completed within 30 days of the date of marriage or partnership. In that case, coverage begins on the first day of the coverage period after a completed application and eligibility documentation is filed with SFHSS. 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 SFHSS with proof of guardianship, court order, or decree by required deadlines.

Adult Disabled Children

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

1. Disabled adult child ("Adult Child") is enrolled in a San Francisco Health Service System medical plan on the his or her 26th birthday; and
2. Adult Child has met the requirements of being an eligible dependent child under SFHSS Member Rules Section B.3 before turning 26 years old; and
3. Adult Child must have been physically or mentally disabled on the date coverage would have otherwise terminated due to age, i.e. turning 26 years old, and continue to be disabled from age 26 on; and
4. Adult Child is incapable of self-sustaining employment due to the physical or mental disability; and
5. Adult Child is dependent on SFHSS Member for substantially all of his or her economic support, and is declared as an exemption on the Member's federal income tax;
6. Member is required to comply with their enrolled medical plan's disabled dependent certification process and recertification process every year thereafter or upon request.
7. All enrolled dependents, including an Adult Child, who qualify for Medicare due to a disability are required to enroll in Medicare (see SFHSS Member Rules Section J). Members must notify SFHSS of any dependent's eligibility for Medicare, as well as any dependent's subsequent enrollment in Medicare.
8. To maintain ongoing eligibility after the Adult Child has been enrolled, the Member must re-enroll the Adult Child with SFHSS each year and must ensure that he or she remains continuously enrolled Medicare (if eligible) without interruption.
9. A newly hired employee who adds an eligible dependent Adult Child, who is age 26 or older, must meet all requirements listed, except (1.) and (2.) above and comply with their enrolled medical plan's disabled dependent certification process specified in (6.) within (30) days of employee hire date.

Medicare Enrollment Requirements for Dependents

SFHSS 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 in 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 SFHSS 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.

Penalties for Failing to Disenroll Ineligible Dependents

Members must notify SFHSS within 30 days and cancel coverage for a dependent who becomes ineligible. If a member fails to notify SFHSS, the member may be held responsible for the costs of ineligible dependents' health premiums and any medical service provided. October open enrollment is the only time to drop ineligible dependents without a penalty.

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 San Francisco Health Service System (SFHSS) healthcare coverage, submit a completed SFHSS enrollment application, a copy of a marriage certificate or certificate of domestic partnership and a birth certificate for each child to SFHSS **within 30 days** of the legal date of the marriage or partnership. Certificates of marriage or partnership must be issued in the United States. 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 SFHSS 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 SFHSS 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 SFHSS 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 SFHSS 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

SFHSS 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, SFHSS 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 SFHSS coverage begins.

Obtaining Other Health Coverage

You may waive SFHSS 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 SFHSS 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, SFHSS 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 SFHSS coverage terminates. You must pay premium contributions up to the termination date of SFHSS 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 SFHSS plan that offers service based on your new address. Complete an SFHSS 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 SFHSS receives your enrollment application and any required documentation.

Death of a Dependent

If an enrolled dependent dies, notify SFHSS 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 SFHSS 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 SFHSS benefits. Other restrictions apply.

After being notified of a member's death, SFHSS 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 SFHSS benefits at the time of the member's death, the following must be submitted to SFHSS **within 30 days** of the member's date of death:

- Completed surviving dependent enrollment form
- Copy of member's death certificate
- Copy of U.S. certificate of marriage or partnership (If not already on file at SFHSS)
- 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, be enrolled at the time of the member's death and are only eligible for benefits under a surviving spouse or surviving domestic partner. Many union members also have life insurance coverage; see page 23.

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 SFHSS 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 SFHSS. You must pay any premiums that are owed. Unpaid premium contributions will result in termination of coverage.

The San Francisco Health Service System Provides You With Medical Plan Options

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

Health Maintenance Organization (HMO)

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

- Blue Shield of California Trio HMO
- Blue Shield of California Access+ 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. Like the HMO plans, the PPO has 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. SFHSS 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 SFHSS medical plan within 30 calendar days of their start work date. Submit a completed enrollment application and eligibility documentation to SFHSS. 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 SFHSS. Verify the date coverage will start with SFHSS when you enroll. Once enrolled, you must pay all required employee premium contributions. Review your paycheck to make sure correct deductions are being taken.

SFHSS 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 2018. 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 sfhss.org.

Medical Plan Service Areas

County	Kaiser Permanente HMO	Blue Shield Trio HMO	Blue Shield Access +	City Plan PPO
Alameda	■	■	■	■
Contra Costa	■	■	❍	■
Marin	■	❍	■	■
Napa	❍			■
Sacramento	■	❍	■	■
San Francisco	■	■	■	■
San Joaquin	■	■	■	■
San Mateo	■	■	■	■
Santa Clara	❍	■	■	■
Santa Cruz	■	■	■	■
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.

Blue Shield of California and Kaiser Permanente: Service Area Limits

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 Trio HMO call 1-855-747-5800. For Blue Shield of California Access+ HMO call 1-855-256-9404. For Kaiser Permanente call 1-800-464-4000.

City Plan PPO: No Service Area Limits

City Plan, administered by UnitedHealthcare, does not have any service area requirements. If you have questions contact UnitedHealthcare at 1-866-282-0125.

Change of Address: Notify SFHSS

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 San Francisco 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 Trio HMO & Access+ 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 Permanente 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 Permanente.	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?	Trio HMO: 1-855-747-5800 blueshieldca.com/triosfhss Access+ HMO: 1-855-256-9404 blueshieldca.com/sites/sfhss	1-800-464-4000 my.kp.org/ccsf	1-866-282-0125 welcometouhc.com/sfhss

Nurseline, Urgent Care, Telemedicine, Online Resources

Get care how and when you need it. Medical care is getting more convenient. Save yourself time and money by using these different services.

24/7 Nurse Line

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.

Urgent Care

Sometimes you need medical care quickly, but a trip to the emergency room isn't necessary. Visit an urgent care center when it is after hours for your regular provider and you need prompt attention for an illness or injury that is not life-threatening. Urgent care offers the convenience of same-day appointments and walk-in service.

Telemedicine

Kaiser Permanente and City Plan Members: A video or virtual visit is an appointment with your doctor that is done through the camera on your mobile device or computer.

Blue Shield Members: Access board-certified doctors 24/7/365 by phone or video through teladoc.com/bsc.

Go Online

Email your doctor, access your records online, or renew your prescriptions.

Blue Shield of California Trio HMO & Access+ HMO	Kaiser Permanente HMO	City Plan PPO
24/7 Nurseline		
Trio HMO: 1-877-304-0504 Access+: 1-877-304-0504	Nurse Advice 24/7 1-866-454-8855	Nurseline 24/7 1-800-846-4678
Urgent After Hours Care		
Blue Shield Trio HMO: 1-855-747-5800 blueshieldca.com/triosfhss Blue Shield (Access+): 1-855-256-9404 blueshieldca.com	1-866-454-8855 kp.org	1-866-282-0125 welcometouhc.com/sfhss
Telemedicine		
Blue Shield members can access Teladoc's U.S. board-certified doctors 24/7/365 to resolve many non-emergency medical issues through phone or video consults. Visit teladoc.com/bsc or call 1-800-835-2362.	When scheduling an appointment in person or through the Appointment and Advice line (1-866-454-8855), ask if a video visit is right for your symptoms. You may be offered a video visit.	Members can access Virtual Visits by registering on myuhc.com, tab on the right, or by accessing health4me app, under Menu – Find and Price Care. Costs are the same as an office visit.

Superior Court Employees

2018 Medical Plans

To enroll in Kaiser Permanente or Blue Shield of California, you must live or work in a zip code serviced by the plan. Contact the medical plan if you have questions about covered service areas. City Plan (UHC) PPO does not have service area requirements.

This chart provides a summary of benefits. In the instance where information in this chart conflicts with the plan's Evidence of Coverage, the plan's Evidence of Coverage shall prevail. For a detailed description of benefits and exclusions for each plan, please review each plan's Evidence of Coverage (EOC), available on sfhss.org.

	BLUE SHIELD HMO		KAISER PERMANENTE HMO	CITY PLAN PPO	
	TRIO HMO	ACCESS+	TRADITIONAL PLAN	UNITEDHEALTHCARE CHOICE PLUS	
Choice of physician	Primary Physician assignment required.	Primary 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	IN-NETWORK AND OUT-OF-AREA $250 employee only $500 + 1 $750 + 2 or more	OUT-OF-NETWORK $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		20% up to $100 co-pay 30-day supply	Same as 30-day above limitations apply; see EOC	Same as 30-day above limitations apply; see EOC

2018 Medical Plans

	BLUE SHIELD HMO		KAISER PERMANENTE HMO	CITY PLAN PPO	
				UNITEDHEALTHCARE CHOICE PLUS	
	TRIO HMO	ACCESS+	TRADITIONAL PLAN IN-NETWORK ONLY	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/ chiropractic	$15 co-pay 30 visits max for each per plan year; ASH network		$15 co-pay up to a combined total of 30 chiropractic and acupuncture visits/year; ASH network	50% covered after deductible; $1,000 max per plan year	50% covered after deductible; $1,000 max per plan year
Gender Dysphoria office visits and outpatient surgery	Co-pays apply authorization required		Co-pays apply authorization required	85% covered after deductible; prior notification	50% covered after deductible; prior notification

Superior Court Employees

2018 Medical Plans

To enroll in Kaiser Permanente or Blue Shield of California, you must live or work in a zip code serviced by the plan. Contact the medical plan if you have questions about covered service areas. City Plan (UHC) PPO does not have service area requirements.

This chart provides a summary of benefits. In the instance where information in this chart conflicts with the plan's Evidence of Coverage, the plan's Evidence of Coverage shall prevail. For a detailed description of benefits and exclusions for each plan, please review each plan's Evidence of Coverage (EOC), available on sfhss.org.

	BLUE SHIELD HMO		KAISER PERMANENTE HMO	CITY PLAN PPO	
	TRIO HMO	ACCESS+	TRADITIONAL PLAN	UNITEDHEALTHCARE CHOICE PLUS	
Choice of physician	Primary Physician assignment required.	Primary 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	IN-NETWORK AND OUT-OF-AREA $250 employee only $500 + 1 $750 + 2 or more	OUT-OF-NETWORK $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		20% up to $100 co-pay 30-day supply	Same as 30-day above limitations apply; see EOC	Same as 30-day above limitations apply; see EOC

2018 Medical Plans

	BLUE SHIELD HMO		KAISER PERMANENTE HMO	CITY PLAN PPO	
				UNITEDHEALTHCARE CHOICE PLUS	
	TRIO HMO	ACCESS+	TRADITIONAL PLAN IN-NETWORK ONLY	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/ chiropractic	$15 co-pay 30 visits max for each per plan year; ASH network		$15 co-pay up to a combined total of 30 chiropractic and acupuncture visits/year; ASH network	50% covered after deductible; $1,000 max per plan year	50% covered after deductible; $1,000 max per plan year
Gender Dysphoria office visits and outpatient surgery	Co-pays apply authorization required		Co-pays apply authorization required	85% covered after deductible; prior notification	50% covered after deductible; prior notification

Mental Health and Substance Abuse Benefits

The Affordable Care Act protects mental health coverage. All medical plans must cover behavioral health treatment, such as psychotherapy and counseling, mental health inpatient services and substance abuse treatment. Due to federal mental health parity law, there is no yearly or lifetime dollar limit for essential mental health benefits. Also, deductibles, co-payments, coinsurance, out-of-pocket limits, number of days or visits covered, and any pre-authorization of treatment must be the same for mental health and medical/surgical services.

For urgent mental health issues, members should call 911 or go to the nearest emergency department.

Blue Shield of California Trio HMO and Access+ HMO	Kaiser Permanente HMO	City Plan PPO
Mental Health and Substance Abuse Services		
Call 877-263-9952 to find a provider and schedule an appointment.	Call 1-800-464-4000 to make an appointment or contact your Primary Care Physician. You can make an appointment to see a therapist without a referral from your primary care physician.	Call 1-866-282-0125 to find a provider and schedule an appointment. Telemental Health services are available with participating providers. To find providers online, go to welcometouhc.com/sfhss. Members can also access providers at www.liveandworkwell.com.
Mental Well Being Services		
Counseling: LifeReferrals is available with no co-payment. Topics include relationship problems, stress, grief, and community referrals. Legal and identify theft consultations are available. Call 1-800-985-2405, 24/7. Online Coaching: Take well-being one day at a time with the DailyChallenge: mywellvolution.com. Tobacco Cessation: Visit QuitNet at mywellvolution.com.	Classes, Support Groups: Contact your local Kaiser Permanente facility for a calendar 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 Permanente facility for classes. Call 1-866-251-4514 for a telephonic coach. For HealthMedia Breathe and other resources visit kp.org/quitsmoking.	Call 1-866-282-0125 anytime for Confidential Help. Telemental Health services are available with participating providers. To find providers online, go to www.liveandworkwell.com or welcometouhc.com/sfhss. Tobacco Cessation: Visit welcometouhc.com/sfhss or www.liveandworkwell.com for the online smoking cessation information. Mental Health Providers and Online resources can be found at www.liveandworkwell.com. Members can also link to this directly from their www.myuhc.com profile.

Free, Confidential Counseling, and More through the SFHSS Employee Assistance Program (EAP)

EAP provides confidential, voluntary, free mental health services to all employees and their family members. EAP is staffed by licensed therapists. EAP services include:

- Short-term, solution-focused counseling for individual, couples, and families
- Seminars and workshops
- Critical incident debriefing and trauma response
- Mediation and conflict resolution

Resources and referral EAP services are confidential in accordance with state and federal law. Appointments are available 9:00am-5:00pm, Monday through Friday. Call 1-800-795-2351.

Best Doctors: Expert Medical Case Review

Expert physicians provide free and confidential case review when you or a family member faces any important medical decision.

Get an in-depth medical review by a world-renowned expert when concerned about a medical service or treatment plan. Consider using Best Doctors if you or a family member needs to:

- Confirm a diagnosis
- Decide if a recommended surgery is necessary
- Review a recommended treatment plan for a life-threatening illness like cancer or heart disease
- Learn more about a prescribed medication or medication interactions
- Evaluate options for treating chronic joint pain or back pain
- Manage a complex chronic condition, or multiple conditions

The Best Doctors benefit includes:

In-Depth Medical Case Review

At your request, Best Doctors collects and reviews your medical records, including images and tests. Expert physicians review your information and you receive a detailed report and a confidential recommendation about your diagnosis and treatment plan. Best Doctors will discuss this report with you and with your treating physician if you request it. This service helps you make the treatment decisions that are right for you.

Ask the Expert

If you have a basic question about a diagnosis or treatment options, you can obtain personalized guidance from a physician with specific expertise.

Critical Care

If you or your dependent family member is admitted to an emergency room with a traumatic injury requiring critical care or neonatal unit for an acute medical event, Best Doctors' emergency medical experts can provide early intervention along with your treating medical team. A nurse will be sent within two hours to review your care and coordinate with the Best Doctors' expert if needed to help make critical decisions.

Find a Doctor

Best Doctors can locate an in-network physician using their network of medical experts.

Medical Records eSummary

Best Doctors can collect and organize all your medical records along with a personal health summary from a Best Doctor and provide them to you on an easy-to-access USB drive.

Contact Best Doctors

To get started, call Best Doctors at 1-866-904-0910 or visit members.bestdoctors.com. You will be assigned a Best Doctors clinician to help you through the process and to select the best option for you. With your permission Best Doctors will gather and review your medical records, including images, lab results and pathology slides to make their recommendations.

Prevent Type 2 Diabetes

Prevent Type 2 Diabetes before it starts: Take advantage of the no-cost resources from your health plan today.

Did you know that one in three people are at risk for developing Type 2 diabetes?

More than 86 million Americans[1] have prediabetes—and most don't even know it. Prediabetes means that your blood sugar level is higher than normal but not yet high enough to be type 2 diabetes.[2]

Certain factors can increase the risk of developing diabetes or prediabetes: weight (having a BMI of 25 or more), age 45 or older, family history (having a parent or sibling with diabetes), ethnicity, and physical activity level (being sedentary).

The good news is that prediabetes can be reversed! And your health plan has resources that can help you if you are eligible for the services.

Blue Shield of California Members

Make lasting lifestyle changes with the new Diabetes Prevention Program. Simply take a short quiz to find your risk level. If you qualify, you're ready to begin.

When you enroll, you get to choose the type of support you prefer: in-person, online or even via smart phone. To help you reach your goal, the Diabetes Prevention Program typically offers:

- Access to a personal health coach
- Easy tips
- Tools like wireless scales and activity trackers

If you are eligible, programs you can select may include: Weight Watchers, Healthslate, Jenny Craig, Noom, Retrofit, Skinny Gene Project, and more!

It only takes one minute to see if you're eligible to take part in the program:

1. Visit solera4me.com/shield
2. Answer a handful of questions
3. Discover your risks for diabetes
4. Select the program you prefer
5. Start the path to a healthier you

For more information, call 1-844-206-3730 or email support@solera4me.com.

Kaiser Permanente Members

Depending on your preference, Kaiser Permanente offers several types of diabetes prevention classes for members:

In-Person

- Diabetes Prevention 2-hour class: Book online at kp.org/appointments
- Healthy Weight classes (6 sessions): Find services near you at kp.org/mydoctor/healthyweight

Online

- Diabetes Prevention Online 2-hour Class (via Webex): Have your clinician staff book yours, or call the local Health Education Center. Find the number here: mydoctor.kaiserpermanente.org/ncal/diabetes/index.html
- Healthy Weight 6-Week Online Class: Visit thrive.kaiserpermanente.org.

By Phone

- Wellness coaches can help you make lifestyle behavior changes around healthy eating, physical activity, and weight management. Call 1-866-862-4295 for an appointment.

UnitedHealthcare's Real Appeal Program

Coming in 2018! Check sfhss.org/well-being for details.

Open to all members, this program includes:

1. A personalized transformation coach for an entire year. The Online Virtual Coaches guide you through the program, step by step, customizing it to fit your needs, personal preferences, goals and medical history.

2. 24/7 online support and a mobile app that helps you stay accountable to your goals with:

- Customizable food, activity, weight and goal trackers
- Unlimited access to digital content, including workout videos
- Success group support that lets you chat with others in the Real Appeal program
- The weekly Real Appeal All-Star Show, featuring healthy tips from celebrities, athletes and health experts
- Weekly analysis, feedback and goal reporting

3. A Success Kit. All the gadgets you need to kick-start your weight loss and keep you going strong will be delivered to your door after you attend your first group coaching session. You'll get these helpful tools:

- Personal blender, digital food scale, and a "perfect" portion plate
- Resistance band, Real Success Guides, and exercise DVDs
- Electronic body weight scale and more

1 https://www.cdc.gov/diabetes/prevention/prediabetes-type2/index.html 2 http://www.mayoclinic.org/diseases-conditions/prediabetes/home/ovc-20270022

Superior Court Employees

2018 Dental Plan Benefits-at-a-Glance

	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	Covered, Refer to co-pay schedule
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: $1,250/child $1,250/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 sfhss.org.

Vision Plan Benefits

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

Vision Plan Benefits

SFHSS members and dependents enrolled in a medical plan administered by SFHSS have vision coverage through VSP Vision Care. You may use a VSP Vision Care network doctor or a non-VSP doctor. To locate a VSP network doctor visit vsp.com or contact Member Services at 1-800-877-7195.

Accessing Your Vision Benefits

No ID cards are issued for the vision plan. To receive service from a VSP Vision Care network doctor, contact the doctor, identify yourself as a VSP Vision Care member and make an appointment. VSP Vision Care 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 Vision Care network doctor without prior authorization, or obtain services from a vision care service provider outside of the VSP Vision Care network (including Kaiser Permanente), you are responsible for payment in full to the provider. You may then submit an itemized bill directly to VSP Vision Care for partial reimbursement. Compare the costs of out-of-network vision services to VSP Vision Care 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 Vision Care doctor.

Premier Vision Plan

You now have choices—as a new hire or during open enrollment you can stay enrolled in the Basic Plan or choose the Premier Plan for enhanced benefits, such as a $300 allowance on frames or a $250 allowance on contacts lenses every calendar year. Anti-reflective and Progressive lenses are covered in full with a $25 copay for each. For more information contact SFHSS member services.

Computer Vision Care Benefit (VDT)

Some union contracts provide employer-paid computer vision (VDT) 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.

VSP Vision Care Member Extras

VSP Vision Care offers exclusive special offers and discounts, including an extra $20 on featured frame brands, and rebates on popular contact lenses. VSP also provides savings on hearing aids through TruHearing® for you, covered dependents and extended family including parents and grandparents.

No Medical Plan, No Vision Benefits

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

Superior Court Employees

2018 Vision Plan Benefits-at-a-Glance

Covered Services	Basic	Premier
Well vision exam	$10 co-pay every calendar year	$10 co-pay every calendar year
Single vision lenses	$25 co-pay every other calendar year*	$0 every calendar year
Lined bifocal lenses	$25 co-pay every other calendar year*	$0 every calendar year
Lined trifocal lenses	$25 co-pay every other calendar year*	$0 every calendar year
Standard progressive lenses	$55 co-pay every other calendar year	$25 co-pay every calendar year
Premium progressive lenses	$95–$105 co-pay every other calendar year	
Custom progressive lenses	$150–$175 co-pay every other calendar year	
Standard Anti-Reflective Coating	$41 co-pay every other calendar year	$25 co-pay every calendar year
Premium Anti-Reflective Coating	$58–$69 co-pay every other calendar year	$25 co-pay every calendar year
Custom Anti-Reflective Coating	$85 co-pay every other calendar year	$25 co-pay every calendar year
Scratch-resistant coating	Fully covered every other calendar year	Fully Covered every calendar year
Frames	$150 allowance for a wide selection of frames $170 allowance for featured frames $80 allowance use at Costco® $25 co-pay applies; 20% savings on amount over the allowance; every other calendar year	$300 allowance for a wide selection of frames $320 allowance for featured frames $165 allowance at Costco® No additional co-pay; 20% savings on the amount over your allowance every calendar year
Contacts (instead of glasses)	$150 allowance every other calendar year*	$250 allowance every calendar year
Contact lens exam	Up to $60 co-pay fitting and evaluation exam covered; every other calendar year*	Up to $60 co-pay every calendar year
Primary eye care (for the treatment of urgent or acute ocular conditions)	$5 co-pay	$5 co-pay
Vision Care Discounts		
Laser vision correction	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities
	Employee Contribution	**Employee Bi-Weekly Contribution**
	Included in medical premium	Employee Only $5.01 Employee + 1 Dependent $7.17 Employee + Family $14.23

Your Coverage with Out-of-Network Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

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

* With the Basic Plan, new eyeglass lenses may be covered the next year if Rx change is more than .50 diopters. Based on your last date of service.

IFPTE Local 21, SEIU 1021 and miscellaneous unrepresented employees are also eligible for VDT Computer VisionCare benefits.

Flexible Spending Accounts (FSAs)

Pay for everyday expenses, such as healthcare, child daycare and elder daycare, with tax-free dollars.

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. FSAs are administered by P&A Group. Please visit padmin.com for more information.

Before enrolling in your FSA, calculate a detailed estimate of the eligible expenses you are likely to incur in 2018. 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 2018. Unreimbursed funds under $10 and beyond $500 are forfeited and cannot be returned to you. 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/p15b.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 your 2018 FSA must be incurred during calendar year 2018. Carryover funds (up to $500) from 2017 must also be incurred during calendar year 2018.
- 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 sfhss.org/benefits/fsa.html.
- If your employment ends, in some cases you have the option of continuing your FSA with COBRA. (See page 31). Without COBRA, you can only file claims for eligible FSA expenses that were incurred while you were actively employed.

If you miss two payroll deductions during an unpaid leave, your FSA will be terminated. You may reinstate your FSA if you contact SFHSS within 30 days of your return to work. See page 27 for more information.

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 to Friday, 5:30AM–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 2018 plan year must be incurred in 2018 and received by P&A no later than March 31, 2019. 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 2018.
- 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, 2018. You do not have to wait for your contributions to accumulate in your account.
- SFHSS 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 certified day care, pre-school, day camp, and before or after school programs for children under age 13. The Dependent Care FSA can also pay for adult day care for an aging parent or adult disabled child. These expenses must allow you (and, if married, your spouse) to continue working. 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 bi-weekly from your paycheck in 2018.
- Funds for a Dependent Care FSA cannot be used for dependent medical expenses. The Dependent Care FSA is for qualified child care and elder care expenses only.
- 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, 2018.
- 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, 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 continues 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, such as personal leave, family care leave, or administrative leave, LTD coverage terminates at the end of the month following the month your absence began. Call SFHSS at 1-415-554-1750 for information about leave of absence and LTD 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:

Auto Machinists Local 1414
Brick Layers Local 3
Hodcarriers Local 166
Building Inspectors
Carpenters Local 22
Carpet, Linoleum, Soft Tile Local 12
Cement Masons Local 300
Electrical Workers Local 6
Glaziers Local 718
Iron Workers Local 377
Laborers Int Local 261
Operating Engineers Local 3
Painters Local 4
Pile Drivers Local 34
Plasterers Local 66
Plumbers and Pipefitters Local 38
Roofers Local 40
SEIU Local 1021 Miscellaneous
SEIU Local 1021 Staff Nurses
Sheet Metal Workers Local 104
Stationary Engineers Local 39
Supervising Registered Nurses Local 856 Teamsters Local 853
Teamsters Local 856
Theatrical Stage Local 16
TWU Local 200 SEAM
TWU Local 250A (7410, 9132)

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

Municipal Attorney's Association
IFTPE Local 21
UAPD 8CC 17, 18

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 sfhss.org or call Aetna at 1-866-326-1380.

Group Life Insurance

Some union contracts provide employer-paid 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, complete the Change Beneficiary Form and return to SFHSS: sfhss.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 SFHSS 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.

Additional Voluntary Benefits

To purchase additional life insurance or if you are not eligible for employer-paid life insurance, see page 24 and 25 to learn about Voluntary Benefits.

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

Voluntary Benefits

These optional insurance plans can help protect you and your family.

SFHSS has partnered with Employee Benefits Specialists (EBS) to offer quality insurance plans at the best cost.

- San Francisco Health Service System reviewed and approved
- In most cases, guaranteed issue - no medical history or exam required
- Discounted group premium rates
- Optional enrollment - if you choose to enroll, premiums can be paid by payroll deduction

Aetna Life group term life insurance provides a tax-free lump sum benefit to your designated beneficiary if you die. It can help your loved ones pay for funeral expenses. It can also shield them from the loss of your income, by helping pay a mortgage, debts, college tuition and other living expenses. Guaranteed Issue available to $100,000 for new hires and to all active employees. Higher policy amounts are available which require additional medical certification, and $50,000 policies are available for spouses/domestic partners.

Kansas City Life short term disability insurance replaces part of your income if you can't work due to a covered illness or injury. It provides income in addition to California State Disability payments. This can help you and your family meet financial obligations until you can get back to work. Available to employees only.

Voya Financial accident insurance provides tax-free payments for covered injuries that happen off the job. Benefits paid directly to you, to help pay for out-of-pocket medical costs related to an injury, assist with living expenses, or anything else you choose. Available to employees and eligible dependents.

Voya Financial critical illness insurance pays a lump sum benefit if you are diagnosed with a covered disease or condition, including heart attack, stroke and certain types of cancer. This can ease the financial stress of facing a life-threatening illness. This benefit can help pay for out-of-pocket medical costs related to the diagnosis, assist with living expenses, or anything else you choose. Available to employees and eligible dependents.

LifeLock identity theft protection monitors and notifies you if your information is being used fraudulently in credit card applications, loans, mortgages and other digital data. The plan also provides identity restoration services and coverage up to $1,000,000 if you become a victim of identity theft. Available to employees and eligible dependents.

LegalShield legal plan allows you to speak with a lawyer on any personal legal matter without high hourly costs. Includes letters or calls made on your behalf, review of small contracts and documents, IRS audit support, assistance with preparing a Will, Living Will, and healthcare power of attorney. 24/7 emergency access is available for covered situations. LegalShield membership offers an optional identity theft plan. Available to employees and eligible dependents.

Pets Best pet insurance can reimburse you for vet bills when your cat or dog is sick or injured with a covered condition. Use any licensed veterinarian, pay your bill, then submit a claim for reimbursement. When enrolling you can choose coverage tiers from 70% to 100%, with deductible choices from $0 to $1,000. Available to employees.

Voluntary Benefits FAQ

Learn more and decide if these benefits are right for you.

What are voluntary benefits?

Voluntary benefits give you access to a variety of optional, supplemental insurance options. You can choose the coverage that meets your needs. Voluntary benefit plans offered through your employer provide quality coverage at group discounted rates.

Why do I need voluntary benefits?

Voluntary benefits can help protect you and your family financially during an illness, injury, death or other life events. If your family depends on your income to pay routine living expenses, you should learn more about voluntary benefits. If you do not have enough savings to cover your living expenses for three to six months, or do not want to use your savings, then some of these voluntary benefits might be right for you.

Who pays for voluntary benefits?

The premiums for voluntary benefits are 100% paid by the employee. If you choose to enroll, the voluntary plan premium will be deducted from your paycheck. Please review coverage details and premium costs carefully before choosing to enroll.

How do I learn more about voluntary benefits coverage and costs?

Voluntary benefits are administered by EBS. For details about plan coverage options and premium costs, visit sfhss.org or call EBS at 1-888-392-7597.

Is a medical exam required?

Since they are offered through your employer, no medical exam or medical records are required for basic coverage. In some cases, medical evidence is required if you decide to purchase higher tiers of coverage. Check with EBS for details.

How do I enroll in voluntary benefits?

These benefits are administered by EBS. Visit www.workterra.net to enroll online For details about plan coverage options and premium costs, call EBS at 1-888-392-7597.

When can I enroll in voluntary benefits?

You can enroll in voluntary benefits when you are first hired or during open enrollment. There may be other special enrollment periods if new benefits are offered.

I changed my mind. How do I disenroll from voluntary benefits?

For benefits that have post tax deductions, you can dis-enroll at any time. If you have a benefit that has a pre-tax deduction (similar to your medical plan), you will need to have a qualifying event in order to disenroll. See pages 6-7 of this Guide for more information on qualifying events.

For More Information About Voluntary Benefits Contact EBS

Employee Benefits Specialists (EBS) administers voluntary benefits for SFHSS. For more details about coverage and costs, enrollment and disenrollment, contact EBS at 1-888-392-7597 or visit sfhss.org.

You Must Notify the San Francisco 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 San Francisco Health Service System (SFHSS) as soon as your leave begins– within 30 days. You may elect to continue or waive coverage for the duration of your approved leave of absence. Notify SFHSS immediately upon return to work to avoid a break in coverage.
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 by contacting SFHSS. Notify SFHSS immediately upon return to work to avoid a break in coverage.
Educational Leave Personal Leave Leave for Employment as an Employee Organization Officer or Representative	Notify SFHSS 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. Notify SFHSS immediately upon return to work to avoid a break in coverage. 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 premium contribution plus your employer's premium contribution. Contact SFHSS for details.

Your Responsibilities

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

Contact the San Francisco 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 SFHSS directly. Failure to do so will result in termination of your health benefits.

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

Health Benefits During a Paid or Unpaid Leave of Absence

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 SFHSS. Contact SFHSS **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 SFHSS immediately (**within 30 days**) to request that health premium payroll deductions be returned to active status.

Healthcare FSA

During an unpaid leave, no FSA payroll deductions can be taken. To maintain your FSA, you must pay FSA contributions directly to SFHSS. Contact SFHSS **within 30 days** of when leave begins to arrange for payment of FSA contributions. You may suspend your Healthcare FSA if you notify SFHSS 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 SFHSS **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 SFHSS, 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 SFHSS **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 SFHSS **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 2018, a suspended Healthcare or Dependent Care FSA initiated during the 2018 plan year cannot be reinstated. There are no exceptions.

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 SFHSS 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.

Questions About Health Benefits During a Leave

If you have questions about health benefits during a leave of absence call SFHSS at 1-415-554-1750.

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 SFHSS. **Contact SFHSS three months before your retirement date** to learn about enrolling in retiree benefits. You are required to notify SFHSS of your retirement, even if you are not planning to elect SFHSS coverage on your retirement date.

A retiree must have been a member of SFHSS at some time during his or her active employment in order to be eligible for retiree health benefits. Other restrictions may apply.

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 SFHSS coverage. Call SFHSS 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 SFHSS 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. Health premium contributions will be taken from your pension check. If monthly premium contributions are greater than your pension check, you must contact SFHSS to make payment arrangements. Premium rates are subject to change every plan year.

Lump-Sum Pension Distribution Will Affect 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 SFHSS 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 SFHSS plan is not required to enroll in Medicare until you retire. A Medicare-eligible spouse must have enrolled in Medicare to be covered on a retiree's health plan.

Domestic Partner Medicare Enrollment

A registered domestic partner of an employee who is eligible for Medicare must be enrolled in Medicare to qualify for SFHSS medical coverage. The federal government charges a premium for Medicare Part B and in some cases, for Part D. All Medicare premium payments must be paid to maintain continuous Medicare enrollment. A domestic partner who fails to enroll in Medicare Part B when first eligible may be charged Medicare late enrollment penalties.

Contact the Employee Assistance Program

Contact EAP at 1-800-795-2351 before your retirement date to plan for a meaningful retirement. Address any emotional or psychological changes and make your retirement years be the best they can be.

It's Important to Plan as You Approach Retirement

City 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 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 San Francisco Health Service System. A benefits analyst will review your service credits, health benefits eligibility, retiree health plan options and premium contributions.

COBRA, Covered California and Holdover

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 SFHSS 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 coverage 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.

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.

2018 Monthly COBRA Premium Rates

Blue Shield of California Trio HMO	
Employee Only	$722.21
Employee +1	$1,439.95
Employee +2 or More	$2,035.63
Blue Shield of California Access+ HMO	
Employee Only	$805.86
Employee +1	$1,607.27
Employee +2 or More	$2,272.38
Kaiser Permanente HMO	
Employee Only	$625.80
Employee +1	$1,247.13
Employee +2 or More	$1,762.84
City Plan (United Healthcare) PPO	
Employee Only	$902.15
Employee +1	$1,761.33
Employee +2 or More	$2,483.63
Delta Dental PPO	
Employee Only	$64.30
Employee +1	$135.03
Employee +2 or More	$192.89
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

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: Alternative to COBRA

Individuals who are not eligible for SFHSS 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.

Holdover Rights

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

Employees must certify annually that they are unable to obtain other health coverage.

Holdover premium contributions must be paid by the due date listed on the 2018 Health Coverage Calendar (see page 32). Rates may increase each plan year.

Health Coverage Calendar

Work Dates	Pay Date	Benefits Coverage Period
December 30, 2017–January 12, 2018	January 23, 2018	December 30, 2017–January 12, 2018
January 13, 2018–January 26, 2018	February 6, 2018	January 13, 2018–January 26, 2018
January 27, 2018–February 9, 2018	February 20, 2018	January 27, 2018–February 9, 2018
February 10, 2018–February 23, 2018	March 6, 2018	February 10, 2018–February 23, 2018
February 24, 2018–March 9, 2018	March 20, 2018	February 24, 2018–March 9, 2018
March 10, 2018–March 23, 2018	April 3, 2018	March 10, 2018–March 23, 2018
March 24, 2018–April 6, 2018	April 17, 2018	March 24, 2018–April 6, 2018
April 7, 2018–April 20, 2018	May 1, 2018	April 7, 2018–April 20, 2018
April 21, 2018–May 4, 2018	May 15, 2018	April 21, 2018–May 4, 2018
May 5, 2018–May 18, 2018	May 29, 2018	May 5, 2018–May 18, 2018
May 19, 2018–June 1, 2018	June 12, 2018	May 19, 2018–June 1, 2018
June 2, 2018–June 15, 2018	June 26, 2018	June 2, 2018–June 15, 2018
June 16, 2018–June 29, 2018	July 10, 2018	June 16, 2018–June 29, 2018
June 30, 2018–July 13, 2018	July 24, 2018	June 30, 2018–July 13, 2018
July 14, 2018–July 27, 2018	August 7, 2018	July 14, 2018–July 27, 2018
July 28, 2018–August 10, 2018	August 21, 2018	July 28, 2018–August 10, 2018
August 11, 2018–August 24, 2018	September 4, 2018	August 11, 2018–August 24, 2018
August 25, 2018–September 7, 2018	September 18, 2018	August 25, 2018–September 7, 2018
September 8, 2018–September 21, 2018	October 2, 2018	September 8, 2018–September 21, 2018
September 22, 2018–October 5, 2018	October 16, 2018	September 22, 2018–October 5, 2018
October 6, 2018–October 19, 2018	October 30, 2018	October 6, 2018–October 19, 2018
October 20, 2018–November 2, 2018	November 13, 2018	October 20, 2018–November 2, 2018
November 3, 2018–November 16, 2018	November 27, 2018	November 3, 2018–November 16, 2018
November 17, 2018–November 30, 2018	December 11, 2018	November 17, 2018–November 30, 2018
December 1, 2018–December 14, 2018	December 25, 2018	December 1, 2018–December 14, 2018
December 15, 2018–December 28, 2018	January 8, 2019	December 15, 2018–December 28, 2018

New Hires: Health Coverage Does Not Begin on Your Start Work Date

You have 30 days from your start work date to enroll in health benefits. If you enroll by the 30-day deadline, health coverage will begin on the first day of the coverage period following your start work date.

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 2018 tax year.

If you take an approved unpaid leave of absence, you must pay SFHSS 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 26-27 for more information about maintaining health coverage during a leave.

Health Service Board Achievements

Randy Scott
Appointee
President

Wilfredo Lim
Elected
Employee
Vice President

Karen Breslin
Elected
Retiree

Jeff Sheehy
Appointee
Board of
Supervisors

Sharon Ferrigno
Elected
Retiree

Stephen
Follansbee, MD
Appointee

Gregg Sass
Appointee

Steps to Improve and Maintain Affordable Benefits:

1. Approved active and early retiree rates overall below 4% for 2018. This required allocation of $4.53M from the City Plan Stabilization Reserve to reduce 2018 City Plan premiums for employees and early retirees. This allocation reduced premium rates and will reduce the base rate used to calculate the 40% federal excise tax in 2020.
2. Continued flex-funding of the Blue Shield of California plan allowing the San Francisco Health Service System to reduce insurance costs by paying hospital, pharmacy, and physician costs directly.
3. Approved a proposal to implement the Blue Shield of California Trio Plan for actives and early retirees for plan year 2018. This plan will be offered in addition to the current Blue Shield of California Access+ plan with identical benefits but with a narrow network of hospitals. The premiums are 5.9% lower than the existing Access+ plan.
4. Through the Health Service Board Education Policy, the Board continues to be fully committed to being knowledgeable and apply understanding to business principles and practices of the San Francisco Health Service System and the Health System Trust.
5. Maintaining oversight and providing guidance for the recruitment of the San Francisco Health Service System Executive Director.
6. Adopted a policy statement on Gender Dysphoria stating San Francisco Health Service System and the Health Service Board will fully recognize medically necessary treatment for gender dysphoria as part of the full scope of benefits offered to members.

Benefit Additions:

- Approved the Blue Shield Trio HMO. Trio HMO has the same benefits and plan design as Access+ HMO with lower premium contributions and access to many of the same hospitals and physicians.
- Approved the new VSP Premier Plan. For an increased premium, members will gain the benefit of increased allowances for frames and contacts as well as being able to obtain coverage once a calendar year versus once every 48 months.
- Approved increase of Infertility and Reproductive Technology benefits through existing medical plans offered through SFHSS. Current infertility benefits have been increased to two cycles per lifetime. Cryopreservation of reproductive tissue is being offered for up to 12 months.
- UnitedHealthcare Offers 'Real Appeal' Weight-loss Program. Free and available to all SFHSS members, Real Appeal provides tools and support to help members lose weight, feel good, and prevent weight-related health conditions.
- Approved Kaiser Permanente extension of coverage to Retirees in Hawaii, Oregon, and Washington. Retirees will now have the option of selecting a Kaiser Permanente health plan in three other Kaiser regions, including Kaiser's Northwest, Washington, and Hawaii regions.
- Approved Delta Dental PPO increase of Annual Benefit Maximum for Retirees. The annual benefit maximum for Delta Dental PPO for Retirees will increase from $1,000 to $1,250 in 2018.

Glossary of Healthcare Terms

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

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 SFHSS 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 sfhss.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.

Guaranteed Issue
There are insurance policies that are guaranteed to be issued. That means regardless of your health, you cannot be declined or turned down for coverage.

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 SFHSS 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
SFHSS complies with federal and state laws that protect personal health information. For details visit: sfhss.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.

2018 Bi-Weekly Medical Premium Contribution Rates: Employee Only

Medical: Employee Only

	BLUE SHIELD OF CALIFORNIA TRIO HMO		BLUE SHIELD OF CALIFORNIA ACCESS+ HMO		KAISER PERMANENTE HMO		CITY PLAN PPO	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Superior Court Employees Local 21 Superior Court Employees Local 1021 Superior Court Judges Superior Court Reporters Superior Court Staff Attorneys Superior Court Staff Attorneys Cash Back[1] Superior Court Interpreters Superior Court Unrepresented Professionals	$326.79	$0.00	$364.64	$0.00	$283.16	$0.00	$408.21	$0.00

Medical: Plus One

	BLUE SHIELD OF CALIFORNIA TRIO HMO		BLUE SHIELD OF CALIFORNIA ACCESS+ HMO		KAISER PERMANENTE HMO		CITY PLAN PPO	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Superior Court Employees Local 21 Superior Court Employees Local 1021 Superior Court Judges Superior Court Reporters Superior Court Staff Attorneys Superior Court Staff Attorneys Cash Back[1] Superior Court Interpreters Superior Court Unrepresented Professionals	$651.56	$0.00	$727.27	$0.00	$564.31	$0.00	$796.98	$0.00

Medical: Plus Two or More

	BLUE SHIELD OF CALIFORNIA TRIO HMO		BLUE SHIELD OF CALIFORNIA ACCESS+ HMO		KAISER PERMANENTE HMO		CITY PLAN PPO	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Superior Court Employees Local 21	$921.11	$0.00	$1,028.22	$0.00	$797.66	$0.00	$1,038.00	$85.81
Superior Court Employees Local 1021	$921.11	$0.00	$1,028.22	$0.00	$797.66	$0.00	$1,038.00	$85.81
Superior Court Judges	$921.11	$0.00	$1,028.22	$0.00	$797.66	$0.00	$1,123.81	$0.00
Superior Court Reporters	$921.11	$0.00	$1,028.22	$0.00	$797.66	$0.00	$1,038.00	$85.81
Superior Court Staff Attorneys	$921.11	$0.00	$1,028.22	$0.00	$797.66	$0.00	$1,038.00	$85.81
Superior Court Staff Attorneys Cash Back[1]	$921.11	$0.00	$941.08	$87.14	$797.66	$0.00	$941.08	$182.73
Superior Court Interpreters	$921.11	$0.00	$1,028.22	$0.00	$797.66	$0.00	$1,038.00	$85.81
Superior Court Unrepresented Professionals	$921.11	$0.00	$1,028.22	$0.00	$797.66	$0.00	$1,038.00	$85.81

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

2018 Bi-Weekly Dental Premium Contribution Rates

Dental

	DELTA DENTAL PPO		DELTACARE USA DMO		UNITEDHEALTHCARE DMO	
ALL SUPERIOR COURT EMPLOYEES	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Employee Only	**$29.10**	**$0.00**	**$12.44**	**$0.00**	**$12.83**	**$0.00**
Employee + 1 Dependent	**$61.10**	**$0.00**	**$20.52**	**$0.00**	**$21.18**	**$0.00**
Employee + 2 or More Dependents	**$87.28**	**$0.00**	**$30.35**	**$0.00**	**$31.32**	**$0.00**

2018 Bi-Weekly VSP Premier Contribution Rates

	VSP Premier
Vision	Employee Cost
Employee Only	**$5.01**
Employee + 1 Dependent	**$7.17**
Employee + 2 or More Dependents	**$14.23**

Key Contact Information

San Francisco Health Service System
1145 Market Street, 3rd Floor
San Francisco, CA 94103
Tel: 1-415-554-1750
Toll Free: 1-800-541-2266
Fax: 1-415-554-1721
Web: sfhss.org

Well-Being Program
1145 Market Street, 1st Floor
San Francisco, CA 94103
Tel: 1-415-554-0643
Email: wellness@sfgov.org

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

Health Service Board
Tel: 1-415-554-0662
Email: health.service.board@sfgov.org

MEDICAL PLANS			
Blue Shield of California	Trio HMO: 1-855-747-5800 Access+: 1-855-256-9404	Trio HMO: blueshieldca.com/triosfhss Access+: blueshieldca.com	Group W0051448 (Access+ and Trio HMO)
Kaiser Permanente	1-800-464-4000	kp.org	Group 888 (North CA) Group 231003 (South CA)
City Plan 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 71797-0001
UnitedHealthcare Dental formerly Pacific Union Dental	1-800-999-3367	welcometouhc.com/sfhss	Group 275550
VSP Vision Care	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	
VOLUNTARY BENEFITS			
EBS Workterra	1-888-392-7597	www.workterra.net	
SECOND MEDICAL OPINION			
Best Doctors	1-866-904-0910	members.bestdoctors.com	
LONG TERM DISABILITY (LTD) and GROUP LIFE			
Aetna LTD Long Term Disability	1-866-326-1380	www.aetnadisability.com/login.aspx	Group 839201
Aetna Group Life	1-800-523-5065	aetna.com/group/aetna_life_essentials	To initiate a claim, contact SFHSS at 1-800-541-2266
OTHER AGENCIES			
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

6 Things All Employees Should Know...

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

New hire? New spouse, new domestic 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 domestic 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 domestic partnership? Your ex-spouse, ex-domestic partner, or stepchild is no longer eligible for health coverage. Don't risk paying significant penalties. Contact SFHSS and drop ineligible dependents.

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

You must contact the San Francisco 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 San Francisco Health Service System

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

Retiree Health Benefits Are Different From Employee Benefits

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

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