



SAN FRANCISCO
HEALTH SERVICE SYSTEM

Municipal Executives 2020 Health Benefits



What's New for 2020

Medical, Vision and Dental Contributions Changing

Premiums for the following plans will increase in 2020: UHC PPO (City Plan); Blue Shield of California Trio HMO and Access+ HMO; Kaiser Permanente HMO; VSP Premier; and UHC Dental DHMO (actives only). **See pages 12,14, and 17** for more information.

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

CPMC Medical Center Now Part of Blue Shield of CA's Trio HMO Network

Trio HMO's network for SFHSS's Brown and Toland medical group members now includes California Pacific Medical Center (CPMC). This exclusive arrangement expands access to the new 1101 Van Ness, Davies and Mission Bernal campuses only.

2020 Benefit Enhancements for Blue Shield of CA's Trio HMO and Access+ HMO plans

Blue Shield of California's Trio HMO and Access+ HMO plans now offers members the ability to receive, at participating retail pharmacies, certain no-cost vaccinations, including influenza (flu), HPV, pneumonia, meningitis, Tdap booster and shingles.

New for 2020, Blue Shield of California Trio HMO and Access+ HMO members will have the option to receive nutritional counseling visits without a specific medical diagnosis. If you enroll in the Blue Shield Trio HMO, you will also receive: \$0 Rx delivery through *HEAL* home visits; three to six months of meal delivery through *Lifespring* for members who are recovering from serious illness; and non-emergency transport through *HEAL*.

UHC PPO (City Plan) Reducing In-Network Family Out-of-Pocket Maximum

UHC PPO (City Plan) will offer a lower in-network Family Out-of-Pocket Maximum in 2020 to better align with other plans offered by SFHSS. This will reduce the in-network Family Out-of-Pocket Maximum from \$12,700 to \$7,500 (twice the amount of the individual in-network Out-of-Pocket Maximum). **See page 10.**

Enroll in Voluntary Benefits through WORKTERRA

Voluntary benefits can help provide additional financial protection for you and your family. SFHSS has partnered with WORKTERRA to offer a suite of quality voluntary insurance plans to SFHSS members at discounted rates. Plan premiums may be paid through post-tax payroll deductions. **See page 19.**

Kaiser Permanente Fertility Services Share of Cost Increase

Effective January 1, 2020, Kaiser Permanente has set the member share of costs for all infertility treatment services to a 50% coinsurance, to align with other plans. **See page 11.**

Aetna Will Now be Known as The Hartford

Effective January 1, 2020, Aetna will now be known as The Hartford Life and Accident Insurance Company.

Health FSA Maximum Increasing to \$2,700

The maximum amount of pre-tax dollars you can set aside for reimbursement for qualified medical and healthcare-related expenses will increase from \$2,650 to \$2,700 starting January 1, 2020. **See page 20.**

Best Doctors Discontinued as of December 31, 2019

The Health Service Board has elected to not renew the contract with Best Doctors for 2020. Please be aware that the second medical opinion benefit is available through all our health plans. For more information on obtaining a second medical opinion, please refer to your Evidence of Coverage or contact your selected health plan.

eBenefits Online Open Enrollment Available for Employees with Employee Portal Access

SFHSS is excited to announce that *eBenefits* is now available to all active employees of the City and County of San Francisco with access to the City's Employee Portal through their Department. Members from additional employers and retirees who are eligible to participate in *eBenefits* will receive special instructions in their 2020 Plan Year Open Enrollment letter.

Dependent Eligibility Audits and Penalties for Failing to Disenroll Ineligible Dependents

All members are required to notify SFHSS **within 30 days** and cancel coverage for a dependent who becomes ineligible. Dependent eligibility may be audited by SFHSS at any time. Audits may require submission of documentation that substantiates and confirms that the dependent's relationship with the employee or retiree is current. Acceptable documentation may include, but is not limited to, current federal tax returns and other documentation that demonstrates cohabitation or financial interdependency. Enrollment of a dependent who does not meet the plan's eligibility requirements as stated in SFHSS Rules and enrollment materials, or failure to disenroll when a dependent becomes ineligible, will be treated as an intentional misrepresentation of a material fact, or fraud. If a member fails to notify SFHSS, the member may be held responsible for the costs of ineligible dependent's health premiums and any medical service provided. Dependents can be dropped during open enrollment without penalty. **See page 5.**



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This Guide provides an overview of the San Francisco Health Service System Rules, as approved by the Health Service Board. Rules can be found at [sfhss.org](https://www.sfhss.org) or request a copy at (628) 652-4700.



Executive Director's Message

Welcome to eBenefits: The World of Self-Service Enrollment



Over the past two years, the team at San Francisco Health Service System (SFHSS) has successfully developed a straightforward self-service Open Enrollment system for our members called **eBenefits**. This system simplifies Open Enrollment with a convenient, on-line, and fully secure benefits election process, available to you twenty-four hours a day, throughout the entire month of October.

With **eBenefits**, SFHSS can dedicate more time to helping our members directly during Open Enrollment, whether by phone, email, or in-person at both 1145 Market Street and during our many on-site Open Enrollment events throughout the City.

As in previous years, to further assist you with your enrollment choices this October, the SFHSS team has carefully constructed your 2020 Benefits Guide. We ask you to please keep this Guide as a reference, both during and after Open Enrollment. At SFHSS, we remain committed to ensuring quality healthcare benefits and providing a seamless enrollment experience for all our members.

If at any time you find that you, or a fellow SFHSS member, has questions or concerns about Open Enrollment or your benefits, please do not hesitate to call us so that we may assist you. At all times, and as described in the SFHSS Strategic Plan, we are here for you, striving to:

- Provide quality, **affordable and sustainable** health care
- Reduce the **complexity and fragmentation** of the healthcare system
- **Engage and support** our members in using benefits
- Provide **choice and flexibility** in our product offerings
- Support the **whole person health** and **well-being**

We appreciate and value hearing directly from our members. As always, we are here to answer any questions or concerns you may have. We encourage you to share your stories with us of how you benefit from the healthcare services you receive and the extensive healthcare networks available to you as well.

We thank you for your support of our team and SFHSS, and look forward to seeing you or hearing from you at Open Enrollment.

Abbie Yant, RN, MA
Executive Director



How to Enroll in Health Benefits

Learn more about your health benefits by reading this Benefits Guide.



- **All new and rehired employees, who are eligible for benefits, must enroll in their health benefits within 30 calendar days from their hire date.** If you do not enroll **within this 30-day** period, you can only apply for health benefits during the next Open Enrollment period or **within 30 days** of a qualifying event (see pages 6-7).
- To enroll in health benefits with San Francisco Health Service System (SFHSS), **submit a completed Municipal Executives Enrollment Application Form and required eligibility documentation to SFHSS within the 30-day deadline.** Submit *copies* (not originals) of your eligibility documentation (e.g. certified marriage certificates, domestic partner certifications and children’s birth certificates).

Forms and eligibility documentation can be submitted by mail, fax or in-person during normal business hours. See *Key Contacts* on page 35 for our location, hours and fax number.

- **Employee premium contributions are deducted from paychecks biweekly.** Be sure to review your paycheck to verify that the correct employee premium contribution is being deducted. Premiums for 2020 are listed on pages 12, 14, and 17.
- **Outside of a qualifying event, Open Enrollment is your annual opportunity to change your benefit elections.** Open Enrollment takes place every October 1-31. Changes made during Open Enrollment are effective the following January 1st. This is also your opportunity to drop ineligible dependents *without* being charged a penalty.

For more information and a list of guides, forms and plan materials, visit sfhss.org.



As the gate operator for the water in the City, there is a lot of responsibility. We serve 785,000 residents but that number doubles every weekday. I love working for the City, it is like a family here.”

Bill Tehan
Master Plumber
Public Utilities Commission
Started 1980



Questions about health benefits, premium contributions or eligibility documentation?
Call (628) 652-4700.



Eligibility Rules

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

Member Eligibility

The following persons are eligible to participate in San Francisco Health Service System benefits:

- All permanent employees of the City and County of San Francisco whose normal work week is not less than 20 hours.
- All regularly scheduled provisional employees of the City and County of San Francisco whose normal work week is not less than 20 hours.
- All other employees of the City and County of San Francisco, including temporary exempt 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 and County of San Francisco.
- All designated board and commission members *during* their time in service to the City and County of San Francisco as defined in San Francisco Administrative Code Section 16.700(c).
- All officers and employees as determined eligible by the governing bodies of the San Francisco Transportation Authority, San Francisco Parking Authority, Treasure Island Development Authority, the Superior Court of San Francisco 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 of San Francisco 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 and Domestic Partners

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. A spouse or registered domestic partner can also be added during the Open Enrollment period in October.

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 for coverage.

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 SFHSS’ required deadlines.



Adult Disabled Children

To qualify a dependent disabled adult child (“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 is enrolled in a San Francisco Health Service System medical plan on their 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; *and*
3. Adult Child must have been physically or mentally disabled on the date coverage would have otherwise terminated due to age (turning 26), 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 their economic support, *and* is declared as an exemption on member’s federal income tax return;
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. An Adult Child who qualifies for Medicare due to a disability is required to enroll in Medicare (*see SFHSS Member Rules Section J*). Members must notify SFHSS of the Adult Child’s eligibility for Medicare, as well as the Adult Child’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 every 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 stated in **6.** **within 30 days** of 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. A member or dependent with ESRD may be prohibited from changing medical plan enrollment.

Medicare Enrollment Requirements Upon Retirement

Retirees and dependents who are eligible for Medicare must already be enrolled in Medicare Part A and Part B 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. Medicare applications placed with Social Security can take three months to process.

Dependent Eligibility Audits and Penalties for Failing to Disenroll Ineligible Dependents

All members are required to notify SFHSS **within 30 days** and cancel coverage for a dependent who becomes ineligible. Dependent eligibility may be audited by SFHSS at any time. Audits may require submission of documentation that substantiates and confirms that the dependent’s relationship with the employee or retiree is current. Acceptable documentation may include, but is not limited to, current federal tax returns and other documentation that demonstrates cohabitation or financial interdependency. Enrollment of a dependent who does not meet the plan’s eligibility requirements as stated in SFHSS Rules and enrollment materials, or failure to disenroll when a dependent becomes ineligible, will be treated as an intentional misrepresentation of a material fact, or fraud. If a member fails to notify SFHSS, the member may be held responsible for the costs of ineligible dependent’s health premiums and any medical service provided. Dependents can be dropped during open enrollment without penalty.



Changing Benefit Elections: Qualifying Events

You may change health benefits elections outside of Open Enrollment if you have a qualifying event.

To change benefit elections, you must have a **qualifying event**. **Submit your Enrollment Application Form and all required documentation no later than 30 calendar days after the qualifying event occurs.** Below is a list of **qualifying events** that allow changes to benefit elections outside of the Open Enrollment period.

New Spouse or Domestic Partnership

To enroll a new spouse or domestic partner and eligible children of spouse or domestic partner, submit a completed **Municipal Executive Enrollment Application Form**, a copy of your certified marriage certificate or certificate of domestic partnership and birth certificate for each child **within 30 days** of the legal date of the marriage or partnership. Certificates of domestic partnership must be issued in the United States.

A Social Security number must be provided for each enrolling family member. Proof of Medicare is also required for a domestic partner who is Medicare-eligible due to age or disability. Coverage for your spouse or domestic partner is effective the first day of the coverage period following approval.

Newborn or Newly Adopted Child

Coverage for an enrolled newborn child begins 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 to SFHSS **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 or court order shall begin upon effective date of guardianship or court order 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

Coverage of an ex-spouse, domestic partner and stepchildren will terminate on the last day of the coverage period of the event date, provided you complete disenrollment **within 30 days**.

Loss of Other Health Coverage

SFHSS members and eligible dependents who lose other health care coverage may enroll in SFHSS benefits. Once required documentation is submitted and processed, coverage will be effective on the first day of the next coverage period.

Obtaining Other Health Coverage

You may waive SFHSS coverage for yourself or a dependent who enrolls in other health coverage. If you waive coverage, all coverage for enrolled dependents will also be waived.

After all required documentation (proof of coverage must be on letterhead) is submitted, coverage will terminate on the last day of the coverage period.

Moving Out of Your Plan's Service Area

If you move your residence to a location outside of your plan's service area, you can enroll in an SFHSS plan that offers service where your new address is located. Coverage will be effective the first day of the coverage period following receipt and approval of required documentation.



Death of a Dependent

In the event of the death of a dependent, notify SFHSS as soon as possible and submit a copy of death certificate **within 30 days** of the event.

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.

Upon notification, SFHSS will mail instructions to the spouse or partner, including a list of required documents for enrolling in surviving dependent health coverage.

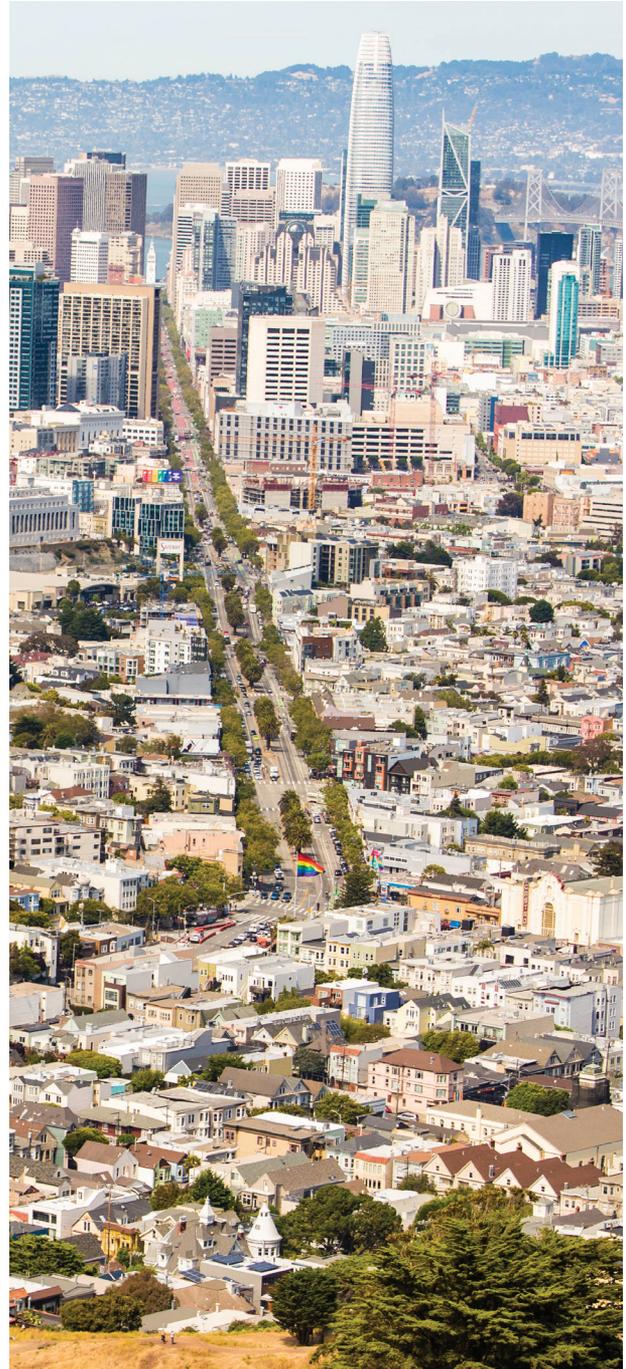
A surviving spouse or partner who is not enrolled on the deceased member's health plan at the time of the member's death may be eligible for coverage but must wait to enroll during the next Open Enrollment period.

Changing FSA Contributions

Per IRS regulations, some qualifying events may allow you to initiate or modify your Flexible Spending Account (FSA) contributions. Contact SFHSS at **(628) 652-4700** for more information.

Responsibility for Premium Contributions

Changes in coverage due to a qualifying event may change premium contributions. **Review your paycheck to make sure premium deductions are correct. If your premium deduction is incorrect, contact SFHSS.** You must pay any premiums that are owed. Unpaid premium contributions will result in termination of coverage.



Failure to notify SFHSS of your dependent(s) ineligibility can result in significant financial penalties equal to the total cost of benefits and services provided to ineligible dependent(s).



Medical Plan Options

These medical plan options are available to 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, access service through your Primary Care Physician (PCP) or an affiliated urgent care center. There is no deductible before accessing your benefits. Most services are available for a fixed dollar amount (co-payment). SFHSS offers the following HMO medical plans:

- Trio HMO - Blue Shield of California
- Access+ HMO - Blue Shield of California
- 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 however, out-of-network providers cost more. You are not assigned to a Primary Care Physician (PCP), giving you more responsibility for coordinating your care.

Compared to an HMO, enrolling in a PPO usually results in higher out-of-pocket costs. Like HMO plans, PPOs have maximum out-of-pocket expenses. You must pay a plan year deductible and a coinsurance percentage each time you access service.

Because UnitedHealthcare PPO (City Plan) 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:

- UnitedHealthcare PPO (City Plan)
 - UnitedHealthcare Select Plus
for *California Members*
 - UnitedHealthcare Choice Plus
for *non-California Members*

How To Enroll In Medical Benefits

Eligible full-time employees must enroll in an SFHSS medical plan **within 30 calendar days** of their work start date. Submit a completed **Municipal Executive Enrollment Application Form** and required eligibility documentation to SFHSS.

If you do not enroll by the required deadline, you will only be able to enroll in benefits during the next Open Enrollment period or in the event of a **qualifying event** (see pages 6-7).

Coverage will start the first day of the coverage period after eligibility is approved. Once enrolled, you must pay all required employee premium contributions.

SFHSS does not guarantee the continued participation of any particular doctor, hospital or medical group in any medical plan.

You cannot change your benefit elections because a doctor, hospital or medical group chooses not to participate. You will be assigned or must select another provider (individuals with End Stage Renal Disease may be prohibited from changing plans).



Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions in effect during the plan year.



If there are any discrepancies between the information provided in this Guide and the plan's EOC, the plan's EOC shall prevail. Download EOCs at sfhss.org.

Medical Plan Service Areas

County	Kaiser Permanente HMO	Trio HMO (Blue Shield of CA)	Access+ HMO (Blue Shield of CA)	UHC PPO (City Plan)
Alameda	■	■	■	■
Contra Costa	■	■	■	■
Marin	■	○	■	■
Napa	○			■
Sacramento	■	○	■	■
San Francisco	■	■	■	■
San Joaquin	■	■	■	■
San Mateo	■	■	■	■
Santa Clara	○	■	■	■
Santa Cruz	■	■	■	■
Solano	■	○	■	■
Sonoma	○		■	■
Stanislaus	■	○	■	■
Tuolumne				■
Outside of California	Urgent/ER Care Only	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 HMO and Kaiser Permanente HMO: 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 of California’s **Trio HMO**, call **(855) 747-5800**. For Blue Shield of California’s **Access+ HMO**, call **(855) 256-9404**. For **Kaiser Permanente HMO**, call **(800) 464-4000**.

UnitedHealthcare PPO (City Plan): No Service Area Limits

UnitedHealthcare PPO (City Plan), does not have any service area requirements. If you have questions, contact **UHC** at **(866) 282-0125**.

UnitedHealthcare PPO

Members who lack geographic access to other medical plans offered by SFHSS (e.g. Blue Shield of California’s Trio HMO, Access+ HMO or Kaiser Permanente HMO) are eligible to enroll in **UnitedHealthcare PPO** with lower premiums.



Change of Address? Contact SFHSS (628) 652-4700

If you move out of the service area covered by your plan, you must enroll in a medical plan that provides coverage in your new area. Failure to change your elections to reflect this may result in non-payment of claims for services rendered.



Medical Plans

This chart provides a summary of benefits only. In any instance where information in this chart or Guide conflicts with the plan's Evidence of Coverage (EOC), the plan's EOC shall prevail. For a detailed description of benefits and exclusions, please review your plan's EOC. EOCs are available for download at sfhss.org.

	BLUE SHIELD of CA HMO		KAISER PERMANENTE HMO	UNITEDHEALTHCARE PPO (City Plan)	
	TRIO HMO	ACCESS+ HMO	TRADITIONAL HMO	UNITEDHEALTHCARE PPO	
Choice of Physician	Primary Care Physician assignment required.	Primary Care Physician assignment required.	KP 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	OUT-OF-NETWORK
				\$250 employee only \$500 +1 \$750 +2 or more	\$500 employee only \$1,000 +1 \$1,500 +2 or more
Out-of-Pocket Maximum does not include premium contributions	\$2,000 per individual \$4,000 per family		\$1,500 per individual \$3,000 per family	\$3,750 per individual \$7,500 per family	\$7,500 per individual
General Care and Urgent Care					
Annual Physical; Well Woman Exam	No charge		No charge	100% covered no deductible	50% covered after deductible
Doctor 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	\$10 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	\$25 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	\$50 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	\$20 co-pay 90-day supply	Not covered
Mail Order: Brand-Name	\$50 co-pay 90-day supply		\$30 co-pay 100-day supply	\$50 co-pay 90-day supply	Not covered
Mail Order: Non-Formulary	\$100 co-pay 90-day supply		Physician authorized only	\$100 co-pay 90-day supply	Not covered
Specialty	20% up to \$100 co-pay 30-day supply		20% up to \$100 co-pay 30-day supply	Same as 30-day above limitations apply; see EOC	Same as 30-day above limitations apply; see EOC

	BLUE SHIELD HMO		KAISER PERMANENTE HMO	UNITEDHEALTHCARE PPO (City Plan)	
	TRIO HMO	ACCESS+ HMO	TRADITIONAL HMO IN-NETWORK ONLY	IN-NETWORK AND OUT-OF-AREA	OUT-OF-NETWORK
Hospital Outpatient and Inpatient					
Hospital Outpatient	\$100 co-pay per surgery		\$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

Municipal Executives

2020 Medical Premium Contribution Rates (Biweekly)

EMPLOYEE ONLY	BLUE SHIELD OF CA TRIO HMO		BLUE SHIELD OF CA ACCESS+ HMO		KAISER PERMANENTE HMO		UHC PPO (City Plan)	
CITY AND COUNTY OF SAN FRANCISCO	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay
Municipal Executives MEA Miscellaneous Unrepresented Managers Unrepresented Employees Elected Officials Municipal Executives MEA – Fire Municipal Executives MEA – Police	\$325.81	\$22.03	\$325.81	\$85.82	\$298.02	\$0	\$325.81	\$221.16
MUNICIPAL TRANSPORTATION AGENCY	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay
Municipal Executives MEA MTA Unrepresented Managers	\$325.81	\$22.03	\$325.81	\$85.82	\$298.02	\$0	\$325.81	\$221.16
SUPERIOR COURT	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay
Municipal Executives MEA Unrepresented Managers Court Duty Officer Courts Commissioners' Association	\$0	\$347.84	\$0	\$411.63	\$0	\$298.02	\$0	\$546.97
EMPLOYEE +1	BLUE SHIELD OF CA TRIO HMO		BLUE SHIELD OF CA ACCESS+ HMO		KAISER PERMANENTE HMO		UHC PPO (City Plan)	
CITY AND COUNTY OF SAN FRANCISCO	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay
Municipal Executives MEA Miscellaneous Unrepresented Managers Unrepresented Employees Elected Officials Municipal Executives MEA – Fire Municipal Executives MEA – Police	\$325.81	\$368.59	\$325.81	\$496.18	\$298.02	\$296.65	\$325.81	\$733.42
MUNICIPAL TRANSPORTATION AGENCY	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay
Municipal Executives MEA MTA Unrepresented Managers	\$325.81	\$368.59	\$325.81	\$496.18	\$298.02	\$296.65	\$325.81	\$733.42
SUPERIOR COURT	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay
Municipal Executives MEA Unrepresented Managers Court Duty Officer Courts Commissioners' Association	\$0	\$694.40	\$0	\$821.99	\$0	\$594.67	\$0	\$1,059.23
EMPLOYEE +2 OR MORE	BLUE SHIELD OF CA TRIO HMO		BLUE SHIELD OF CA ACCESS+ HMO		KAISER PERMANENTE HMO		UHC PPO (City Plan)	
CITY AND COUNTY OF SAN FRANCISCO	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay
Municipal Executives MEA Miscellaneous Unrepresented Managers Unrepresented Employees Elected Officials Municipal Executives MEA – Fire Municipal Executives MEA – Police	\$0	\$982.02	\$0	\$1,162.56	\$0	\$840.88	\$0	\$1,491.79
MUNICIPAL TRANSPORTATION AGENCY	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay
Municipal Executives MEA MTA Unrepresented Managers	\$0	\$982.02	\$0	\$1,162.56	\$0	\$840.88	\$0	\$1,491.79
SUPERIOR COURT	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay
Municipal Executives MEA Unrepresented Managers Court Duty Officer Courts Commissioners' Association	\$0	\$982.02	\$0	\$1,162.56	\$0	\$840.88	\$0	\$1,491.79



Vision Plans

Members and dependents enrolled in a medical plan are automatically enrolled in basic vision benefits.

Vision Plan Benefits

SFHSS members and dependents enrolled in a medical plan automatically receive vision coverage through VSP Vision Care. You may go to a VSP network or non-network provider. Visit vsp.com for a complete list of network providers.

Accessing Your Vision Benefits

No ID cards are issued for the vision plan. To receive services from a network provider, contact the provider and identify yourself as a VSP Vision Care member *before* your appointment. VSP Vision Care will provide benefit authorization directly to the provider. Services must be received prior to the benefit authorization expiration date.

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

Basic Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every other calendar year unless enrolled in the VSP Premier Plan. If examination reveals prescription change of 0.50 diopter or more after 12 months, replacement lenses are covered.
- Eligible dependent children are covered in full for polycarbonate prescription lenses.
- Cosmetic extras, including progressive, tinted or oversize lenses, cost more.

Expenses Not Covered by Plan

- Orthoptics (and any associated supplemental testing), plano (non-prescription) lenses or two pairs of glasses in lieu of a pair of bifocals.
- Replacement of lenses or frames furnished that are lost or broken (except at the contracted intervals).
- Medical or surgical eye treatment (except for limited Primary eye care as described on page 14).
- Corrective vision treatments such as, but not limited to, LASIK and PRK laser surgery. You may be eligible for discounts from a VSP doctor.

VSP Basic and Premier Vision Plans

You now have a choice. As a new hire or during Open Enrollment, you can remain in the VSP Basic Plan or enroll in the VSP Premier Plan for enhanced benefits. See page 14 for more details.

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, bifocal, and trifocal lenses.

VSP Vision Care Member Extras

VSP Vision Care offers exclusive special offers and discounts 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.



Vision Plan Benefits-at-a-Glance

Covered Services	VSP Basic ¹	VSP Premier
Well Vision Exam	\$10 co-pay every calendar year	\$10 co-pay every calendar year
Single Vision Lenses	\$25 co-pay every other calendar year ²	\$0 every calendar year
Lined Bifocal Lenses	\$25 co-pay every other calendar year ²	\$0 every calendar year
Lined Trifocal Lenses	\$25 co-pay every other calendar year ²	\$0 every calendar year
Standard Progressive Lenses	100% coverage every other calendar year	100% coverage every calendar year
Premium Progressive Lenses	\$95–\$105 co-pay every other calendar year	\$25 co-pay every calendar year
Custom Progressive Lenses	\$150–\$175 co-pay every other calendar year	\$25 co-pay every 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 (<i>instead of glasses</i>)	\$150 allowance every other calendar year ²	\$250 allowance every calendar year
Contact Lens Exam	Up to \$60 co-pay every other calendar year ²	Up to \$60 co-pay every calendar year
Primary Eye Care (<i>for the treatment of urgent or acute ocular conditions</i>)	\$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
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Vision Care Premium Rates

VSP Basic Plan

VSP Premier Contribution (Biweekly)

Included with your medical premium.

Employee Only \$4.58
Employee + 1 Dependent \$6.91
Employee + Family \$14.34

Your Coverage with Out-of-Network Providers

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

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

¹VSP Basic Plan coverage is included with your medical premium.

²Under the VSP Basic plan, new lenses may be covered the next year if Rx change is more than .50 diopters.

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



Dental Plans

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

PPO Dental Plans

A PPO dental plan allows you to visit any in-network or out-of-network dentist. The plan pays higher benefits (i.e. you pay less) when you go to an in-network PPO dentist.

SFHSS offers the following PPO dental plan:

- Delta Dental PPO

Save Money By Choosing PPO Dentists

Delta Dental PPO has two different networks. Ask your dentist if they are a Delta Dental PPO network or Premier network dentist. Both networks are held to the same quality standards. Choosing a PPO dentist will cost less.

You can also choose a dentist outside of the PPO and Premier networks. However, services may be covered at a lower percentage, so you pay more. Payment is based on reasonable and customary fees for the area.

Ask your Delta Dental dentist about costs *before* receiving services. You can request a pre-treatment estimate of costs before you receive care.

DHMO Dental Plans

Similar to medical HMOs, Dental Health Maintenance Organization (DHMO) plans require that you receive all of your dental care from within a network of participating dental offices. These networks are generally smaller than dental PPO networks.

Before you elect a DHMO plan, make sure that the plan's network includes the dentist of your choice.

Under these plans, services are covered either at no cost or a fixed co-pay. Out-of-pocket costs for these plans are generally lower than PPO plans.

SFHSS offers the following DHMO plans:

- DeltaCare USA DHMO
- UnitedHealthcare Dental DHMO

Delta Dental PPO SmileWay Program

Delta Dental PPO's **SmileWay** program features 100% coverage for one annual periodontal scaling and root planing procedure and an increased number of teeth cleaning or periodontal maintenance services for members with specific chronic conditions. To enroll, call Delta Dental PPO directly at **(888) 335-8227**.

Dental Plan Quick Comparison

	Delta Dental PPO	DeltaCare USA DHMO	UnitedHealthcare Dental DHMO
Can I receive service from any dentist?	Yes. You can use any dental provider. You pay less when you choose an in-network provider.	No. All services must be received from your assigned contracted network dentist.	No. All services must be received from a contracted network dentist.
Do I need a referral for specialty care?	No.	Yes.	Yes.
Will I pay a flat rate for most services?	No. You pay a percentage of allowed charges.	Yes.	Yes.
Do I need to live in the plan's service area to enroll?	No.	Yes. You must live in this plan's service area.	Yes. You must live in this plan's service area.



Dental Plan Benefits-at-a-Glance

	Delta Dental PPO			DeltaCare USA DHMO	UnitedHealthcare Dental DHMO
Choice of Dentist	You may choose any licensed dentist. You will receive a higher level of benefit and lower out-of-pocket costs with Delta Dental PPO network dentists.			DeltaCare USA network only	UHC Dental network only
Deductible	None			None	None
Plan Year Maximum	\$2,500 per person Per calendar year, excluding orthodontia benefits			None	None
Covered Services	PPO Dentists	Premier Dentists	Out-of-Network	In-Network Only	In-Network Only
Cleanings¹ and Exams	100% covered annual - 2x/yr.; pregnancy - 3x/yr.	100% covered annual - 2x/yr.; pregnancy - 3x/yr.	80% covered annual - 2x/yr.; pregnancy - 3x/yr.	100% covered 1 every 6 months	100% covered 1 every 6 months
X-rays	100% covered full mouth 1x/5 years; bitewing 2x/year to age 18; 1x/year over age 18	100% covered full mouth 1x/5 years; bitewing 2x/year to age 18; 1x/year over age 18	80% covered full mouth 1x/5 years; bitewing 2x/year to age 18; 1x/year over age 18	100% covered some limitations apply	100% covered
Extractions	90% covered	80% covered	60% covered	100% covered	100% covered
Fillings	90% covered	80% covered	60% covered	100% covered limitations apply to resin materials	100% covered limitations apply
Crowns	90% covered	80% covered	50% covered	100% covered limitations apply to resin materials	100% covered limitations apply
Dentures, Pontics, and Bridges	50% covered	50% covered	50% covered	100% covered full and partial dentures 1x/5yrs.; fixed bridgework, limitations apply	100% covered full and partial dentures 1x/5yrs.; fixed bridgework, limitations apply
Endodontic/ Root Canals	90% covered	80% covered	60% covered	100% covered excluding the final restoration	100% covered
Oral Surgery	90% covered	80% covered	60% covered	100% covered authorization required	100% covered
Implants	50% covered	50% covered	50% covered	Not covered	Covered Refer to co-pay schedule
Orthodontia	50% covered child \$2,500 lifetime max; adult \$2,500 lifetime max.	50% covered child \$2,000 lifetime max; adult \$2,000 lifetime max.	50% covered child \$1,500 lifetime max; adult \$1,500 lifetime max.	Employee pays: \$1,600/child \$1,800/adult \$350 startup fee; limitations apply	Employee pays: \$1,250/child \$1,250/adult \$350 startup fee; limitations apply
Night Guards	80% covered (1x3yr.)	80% covered (1x3yr.)	80% covered (1x3yr.)	\$100 co-pay	100% covered

¹Members with Chronic Conditions (diabetes, heart disease, HIV/AIDS, rheumatoid arthritis and stroke) may receive up to 4 cleanings per year. In any instance where information in this chart conflicts with a plan's Evidence of Coverage (EOC), the plan's EOC shall prevail.



Dental Premium Contribution Rates (Biweekly)

	DELTA DENTAL PPO		DELTACARE USA DHMO		UNITEDHEALTHCARE DENTAL DHMO	
	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay
CCSF & MTA MEA						
Employee Only	\$24.13	\$2.31	\$12.44	\$0	\$13.21	\$0
Employee +1 Dependent	\$50.89	\$4.62	\$20.52	\$0	\$21.82	\$0
Employee +2 or More Dependents	\$72.39	\$6.92	\$30.35	\$0	\$32.26	\$0
SUPERIOR COURT MEA						
Employee Only	\$26.44	\$0	\$12.44	\$0	\$13.21	\$0
Employee +1 Dependent	\$55.51	\$0	\$20.52	\$0	\$21.82	\$0
Employee +2 or More Dependents	\$79.31	\$0	\$30.35	\$0	\$32.26	\$0

Eligible MEA employees of the City and County of San Francisco and Superior Court of San Francisco may apply these Flex Credit dollars to a variety of benefit options, including payment of employee medical and dental premium contributions. The amount of Flex Credits for Employees +2 or more has been increased to reflect the City’s commitment to ensuring affordable health coverage for families. For more information about Flex Credits, see pages 18-19.





Flex Benefits

2020 Dollar Value of Flex Credits (Biweekly)

	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE +2 OR MORE			
			Blue Shield of California		Kaiser Permanente HMO	UHC PPO (City Plan)
			Trio HMO	Access+ HMO		
CITY AND COUNTY OF SAN FRANCISCO						
Municipal Executives MEA Miscellaneous Unrepresented Managers Unrepresented Employees MEA Fire and Police	\$352.86	\$407.14	\$815.08	\$964.93	\$697.93	\$964.93
MUNICIPAL TRANSPORTATION AGENCY (MTA)						
Municipal Executives MEA (MTA) Unrepresented Managers	\$352.86	\$407.14	\$815.08	\$964.93	\$697.93	\$964.93
SUPERIOR COURT OF SAN FRANCISCO						
Municipal Executives MEA Unrepresented Managers Court Duty Officer Courts Commissioners' Association	\$1,163.00	\$1,163.00	\$1,163.00	\$1,163.00	\$1,163.00	\$1,163.00

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

How Flex Benefits Work

The City and County of San Francisco provides qualifying employees with Flex Credits, which can be spent on a variety of *pre-tax and post-tax* benefit options, paid via payroll deduction. If the premium contributions for your benefit choices cost more than your flex credits, you pay the balance from salary. If your benefits choices cost less than flex credits, you will receive cash back as taxable, non-pensionable earnings in your paycheck.

\$50,000 Group Term-Life Insurance

A \$50,000 Group Term-Life Insurance policy is also provided at no cost to employees who are eligible for flex credit benefits. You are responsible for keeping your designated beneficiaries up-to-date.

New Hires

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

Open Enrollment

During Open Enrollment, Municipal Executives may change flex benefit elections, based on available *pre-tax and post-tax* options. Flex benefit changes are administered by **WORKTERRA** and must be completed during Open Enrollment. For questions, contact **WORKTERRA** at **(888) 392-7597**.

Flex Credit Benefit Options (Except FSAs) Will Roll Forward in 2020

If you are not making any changes to benefit selections, and you do not wish to fund an FSA (Flexible Spending Account), you do not need to contact **WORKTERRA** during Open Enrollment. Your current benefit elections (except FSAs) will roll forward in 2020. To continue making FSA contributions, or to change your benefit choices, you must contact **WORKTERRA** during Open Enrollment. Without re-enrollment, all FSA contributions will cease December 31, 2019.

Qualifying Event Changes

Members may reallocate flex credits outside of Open Enrollment if there is a qualifying event.

Leaves of Absence

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



Flex Benefits

Maximize Your Benefits

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

Pre-Tax Flex Benefit Options

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

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

Taxable Flex Benefit Options

	EOI Required
Accident Insurance Voya	No
Short-Term Disability Insurance Abacus	Up to \$700/wk - No Above \$700/wk - Yes
Long-Term Care Insurance John Hancock, MetLife, Mass Mutual, Mutual of Omaha	Yes
Pet Insurance Pets Best	No
Group Legal Plan LegalShield	No
Critical Illness Voya Financial	No
Supplemental Group Term-Life Insurance and Accidental Death & Disability Insurance (AD&D) The Hartford	Yes ²
LifeLock Identity Theft Protection LifeLock Benefit Solutions	No

Evidence of Insurability (EOI)

Some benefits require additional information from the applicant before enrollment is completed. This can include medical evidence. The insurer will contact you if specific records are required. It is your responsibility to provide all requested documentation. Enrollment may be denied by the insurer. In 2020, no payroll deductions will be taken until enrollment is approved by each insurer. If approved, there may be a catch-up payroll deduction retroactive to the effective date of your policy. If denied coverage, no premiums for that benefit will be deducted from your paycheck.

To enroll online, go to workterra.net. If you set up your password during the last enrollment period, use the login instructions below along with your current password to login. Your **user name** is your 6-digit **DSW number** (add a "0" in front 5-digit numbers). The **password** is the **first four letters** of your **last name** (the system will also accept last names with 3 letters or less) **AND** the **first four** of your **Social Security number**. The **company name** is **ccsf**.

¹ Evidence of Coverage (EOC) is not required for new hires or newly eligible employees. ² Evidence of Coverage (EOC) is not required for new hires or newly eligible employees, for up to \$100,000 life/AD&D insurance.



Flexible Spending Accounts (FSAs)

An FSA account allows you to be reimbursed for qualifying expenses incurred by you, your legal spouse, or a qualifying child or relative (as defined in Internal Revenue Code Section 125) with *pre-tax* dollars. FSAs are administered by the P&A Group.

You must re-enroll in Flexible Spending Account(s) during Open Enrollment if you want to continue this benefit for the next plan year. If you do not re-enroll, your FSA will terminate at the end of the plan year. If you are enrolled in an FSA and go on a leave of absence, you must contact SFHSS to arrange for payments to be made directly to SFHSS. A leave of absence will affect your FSA contributions and reimbursement periods.

Healthcare FSA and Carryovers

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

For a complete list of eligible healthcare expenses, visit padmin.com.

- Start by designating between \$250 and \$2,700 pre-tax dollars for the plan year. Deductions between \$10 and \$108 and will be taken biweekly from your paycheck in 2020.
- P&A will issue a debit card for you to use to make spending your FSA easier or you can submit a claim by mail, online or smartphone app.
- SFHSS administers a **Carryover minimum** of \$10 and maximum of \$500. 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 become available for any claims incurred as of the first day of the new plan year. **Carryover funds** can only be accessed for one plan year. After one plan year, remaining **Carryover funds** will be forfeited. **There are no exceptions.**¹

Childcare/Eldercare Dependent Care FSA

Dependent Care FSAs help pay for qualifying child care and elder care expenses, such as certified children's day care, pre-school, day camp, before/after school programs, as well as adult day care for elders. Dependent care expenses must be incurred to enable you (and, if married, your spouse) to work. Children must be under age 13.

For a complete list of eligible dependent care expenses, visit padmin.com.

- Set aside between \$250 and \$5,000 pre-tax per household for the plan year (\$2,500 each if you are married filing separate federal tax returns). Deductions between \$10 and \$200 will be taken biweekly from your paycheck in 2020.
- Funds for a Dependent Care FSA **cannot be used for dependent medical, dental, or vision expenses.** If you have a stay-at-home spouse, you cannot enroll in a Dependent Care FSA.
- You can submit reimbursement claims to P&A Group by mail, online, or smartphone app for eligible out-of-pocket expenses.
- Funds for a Dependent Care FSAs are available after being deducted from your paycheck and received by P&A Group. The entire annual amount is not available on January 1, 2020.
- **Unlike a Healthcare FSA, there is no Carryover option.** Funds for a Dependent Care FSA must be used during the plan year or be forfeited. **There are no exceptions.**¹



¹ **FSA expenses for the 2020 plan year must be spent in 2020 and reimbursement claims must be received by P&A no later than 3/31/21.** Per IRS rules, you forfeit all funds remaining in an FSA by the end of the claim filing period unless covered by the Healthcare FSA Carryover provision. **There are no exceptions.**



Preventive Care: Staying Healthy for FREE

Most of the top causes of death in the U.S. are potentially preventable through lifestyle changes and *proactive* healthcare services.¹



Preventive Care services are 100% covered, no co-pays or deductibles.

Get the recommended *preventive care* services. Make healthy lifestyle choices for good health and well-being to prevent disease, illnesses, and other health concerns.

For more information about your benefits, contact **SFHSS** at **(628) 652-4700** or toll-free at **(800) 542-2266**.

Getting Started – Schedule Your Appointment Today

<p>Vaccinations</p> <ul style="list-style-type: none"> ■ Flu ■ Measles ■ Shingles ■ Hepatitis B ■ Pneumonia ■ Polio ■ Chicken Pox 	<p>Annual/ As Per Physicians Recommendation</p>	<p>Kaiser Permanente HMO: (800) 464-4000</p> <p>Blue Shield of California</p> <ul style="list-style-type: none"> ■ Trio HMO: (855) 747-5800 ■ Access+ HMO: (855) 256-9404 <p>UnitedHealthcare PPO (City Plan): (866) 282-0125</p>
<p>Wellness Checks</p> <ul style="list-style-type: none"> ■ Blood Pressure ■ Diabetes ■ Cholesterol ■ Well-Women ■ Well-Men ■ Well-Baby ■ Well-Child 		
<p>Cancer Screenings</p> <ul style="list-style-type: none"> ■ Mammograms ■ Colonoscopy 		
<p>Eye Exam</p>	<p>Annual</p>	<p>VSP Vision Care: (800) 877-7195</p>
<p>Dental Exam and Cleaning</p>	<p>Every 6 Months</p>	<p>Delta Dental PPO: (888) 335-8227 DeltaCare USA DHMO: (800) 422-4234 UnitedHealthcare Dental DHMO: (800) 999-3367</p>

¹<https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>



Mental Health and Substance Abuse Benefits

Health Plans: Mental Health, Well-Being and Substance Abuse Benefits¹

Kaiser Permanente HMO	Blue Shield of California HMO	UnitedHealthcare PPO (City Plan)
Mental Health and Substance Abuse		
Call (800) 464-4000 to make an appointment. You don't need a referral from your Primary Care Physician (PCP) to see a therapist.	Call (877) 263-9952 to find a provider and schedule an appointment.	Call (866) 282-0125 to make an appointment. To find providers online go to liveandworkwell.com or welcometouhc.com/sfhss Telemental Health: Services are available with participating partners.
Mental Well-Being Services		
<p>Classes and Support Groups: Contact your local Kaiser Permanente facility for a calendar or visit kp.org/mentalhealth for more information.</p> <p>Health/Wellness Coaching: Call (866) 862-4295 to make an appointment for a Wellness Coach to contact you.</p>	<p>Counseling and Consultation: <i>LifeReferrals</i> is available with no co-pay for up to three sessions. Topics include relationship problems, stress, grief, legal or financial issues, and community referrals.</p>	Call the Confidential 24/7 Helpline at (866) 282-0125 .

Employee Assistance Program (EAP)

EAP, staffed by licensed therapists, provides confidential, voluntary and free mental health services to all employees and immediate adult family members. **Please contact EAP if you have a difficulty accessing Mental Health or Substance Abuse services.** Visit us at sfhss.org/eap.

Individual Services	Organizational Services
<ul style="list-style-type: none"> ■ Short Term solution focused counseling for individuals and couples ■ Assessments and referrals ■ Consultations and coaching 	<ul style="list-style-type: none"> ■ Management Consultation and Coaching ■ Mediation and Conflict Resolution ■ Critical Incident Response ■ Non-Violent Crisis Intervention Training ■ Workshops and Training

EAP Appointments are available Monday through Friday 8:00am-5:00pm. Call (628) 652-4600 or toll-free (800) 795-2351 to schedule an appointment.

¹As a result of mental health parity law, there is no yearly, or lifetime dollar amounts for mental health benefits. Please contact EAP if you have difficulty accessing mental health or substance abuse services through your health plan.



Long-Term Disability Insurance (LTD)

LTD can replace lost income if you become injured or ill.

Long-Term Disability Insurance

Employees represented by the Municipal Executives Association (MEA) who have families enrolled in medical coverage receive employer-sponsored LTD. Other MEA employees may apply to purchase LTD with flex credits through WORKTERRA.

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

Plan benefits include:

- 66.667% of monthly base earnings (as defined by The Hartford)
- \$7,500 monthly maximum
- 90-180 day monthly elimination period
- There may be a waiting period based on your start work date.

If You Become Disabled

Notify The Hartford of your disability as soon as possible by calling **(888) 301-5614**. Within **30 days** after the date of your disability you should begin filing a long-term disability insurance claim with The Hartford.

The Hartford will work with your doctor to certify that your illness or injury will prevent you from working.

The Hartford may request authorization to obtain additional medical information from your healthcare providers. You may also be asked to provide non-medical information to support your claim.

For more information about LTD Insurance, visit sfhss.org/long-term-disability-insurance.

Absence from Work and LTD Coverage

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

If you are not actively at work due to non-medical reasons, including temporary lay-off, personal leave, family care leave, or administrative leave, LTD coverage will terminate at the end of the month following the month your absence began. Call SFHSS at **(628) 652-4700** for more information about a leave of absence and long-term disability coverage.

Returning To Work

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

Bargaining Units Covered by LTD

90-day elimination period; up to 66.6667% of monthly base earnings; \$7,500 monthly maximum:

You will be eligible for employer-sponsored LTD if you are represented in collective bargaining by the Municipal Executives Association (MEA), you have at least two dependents enrolled on your medical coverage, and you are actively at work more than 20 hours per week at the time of your disability. Other individuals represented by MEA may apply to purchase LTD with Flex Credits. See page 18-19.

This is a general summary. For LTD coverage details, see plan documents at sfhss.org or call The Hartford at **(888) 301-5614**.



Group Life Insurance

MEA union contract provides for 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; and
- 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 dies.

It is your responsibility to keep your beneficiary designations current. You may designate multiple beneficiaries.

To update your beneficiary designations, go to sfhss.org/group-life-insurance, to download the Life Insurance Beneficiary Form, and return to SFHSS.

Leaves of Absence

If you are not actively at work due to a temporary layoff, personal leave, family care leave, or administrative leave (for 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 The Hartford with a written notice of claim for this extended benefit within the 18-month coverage period. Call SFHSS at **(628) 652-4700** for information about how a leave of absence (pages 25-26) can impact your life insurance coverage.

This is a general summary. For a complete list of bargaining units with Group Life benefits and to view plan documents, visit sfhss.org/group-life-insurance or call The Hartford at **(888) 563-1124** or **(888) 755-1503**.

Outline of Life Insurance Plan Basics

Bargaining Unit ¹	Coverage
Municipal Executives (except Fire and Police)	\$50,000

¹Fire and police employees represented by MEA have other life insurance benefits

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. The Hartford Life Essentials offers no cost legal assistance for preparation of a living will or power of attorney, funeral planning and phone counseling with a licensed social worker.

Visit thehartford.com/employee-benefits/value-added-services.

Portability

If you leave your job or otherwise lose eligibility, you may be able to continue your Group Life Insurance to an individual policy, with premiums paid by you. Please review your plan documents for information on portability.



Leave of Absence

You must immediately notify SFHSS of any leave of absence.

Type of Leave	Health Benefits Eligibility
<p>Family and Medical Leave (FMLA)</p> <p>Workers' Compensation Leave</p> <p>Family Care Leave</p> <p>Military Leave</p>	<p>You must notify 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. You must notify SFHSS immediately upon return to work in order to avoid a break in coverage.</p>
<p>Personal Leave following Family Care Leave</p>	<p>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. You must notify SFHSS immediately upon return to work in order to avoid a break in coverage.</p>
<p>Educational Leave</p> <p>Personal Leave</p> <p>Leave for Employment as an Employee Organization Officer or Representative</p>	<p>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. If your leave lasts beyond 12 weeks, you must pay the <i>total cost</i> of health coverage for yourself and enrolled dependents. Total cost is your premium contribution plus your employer's premium contribution. Contact SFHSS for details. You must notify SFHSS immediately upon return to work in order to avoid a break in coverage.</p>

Your Responsibilities

1. 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 SFHSS for details.

2. 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.

3. When leave ends, contact SFHSS 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 Leave of Absence

Medical, Vision and Dental

While you are on an unpaid leave, premiums for health coverage can no longer be deducted from your paycheck. **To maintain coverage, you must pay premium contributions directly to SFHSS.**

You must 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 health benefits, which may not be reinstated until you return to work or during Open Enrollment.**

When you return to work, contact SFHSS **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, contact SFHSS within 30 days of when leave begins to arrange for your FSA contribution payments.

You may suspend your **Healthcare FSA** if you notify SFHSS at the start of your leave. Accounts that remain unpaid for two 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 any missed contributions 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.

You may reinstate at the original biweekly FSA deduction amount, or you can increase biweekly 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 2020, a suspended Healthcare or Dependent Care FSA from the 2020 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 a leave of absence.

Questions? Contact us at **(628) 652-4700**.



Transitioning to Retirement

Enrollment in Retiree Benefits Does Not Happen Automatically

If eligible, you must elect to continue retiree health coverage by submitting a **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 an SFHSS member at some time during their active employment to be eligible for retiree health benefits (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 **(628) 652-4700** to review your options before selecting a 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 your monthly premium contributions are greater than your pension check, you must contact SFHSS to make payment arrangements.**

Lump-Sum Pension Distribution Will Affect Retiree Premium Contributions

If you 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.

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 Medicare and you will be enrolled in UnitedHealthcare PPO (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 the employee retires. A Medicare-eligible spouse must be 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 Employee Assistance Program (EAP)

Before you select your retirement date, make an appointment with EAP to help you plan for a meaningful retirement. Address any personal or life changes to ensure that your retirement years are the best they can be. Contact EAP at **(628) 652-4600**.



Start Planning Before Your 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 and County of San Francisco, San Francisco Unified School District, City College of San Francisco or Superior Court of San Francisco. 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 a City employer.

Different premium contribution rates apply for employees hired *after* January 9, 2009, based on eligibility and years of credited service with 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 total employer premium contribution.
- **With at least 15 years** but *less than 20 years* of credited service, the retiree will receive 75% of the total employer premium contribution.
- **With 20 or more years of credited service**, or disability retirement, the retiree will receive 100% of the total employer premium contribution.

Getting Ready to Retire? Start by Making an Informed Decision.

(1) Confirm years of credited service with your retirement system: SFERS, CalPERS, CalSTRS or PARS. There is no reciprocity with other public retirement systems under Proposition B for health benefits. (2) Contact SFHSS. Our Benefits Analysts will review your service credits, eligibility, plan options and premium contributions so you can make an informed decision that is best for you and your family.



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 **(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 employee ineligible for employer health coverage

Covered spouses or domestic partners may also elect to be covered under COBRA if coverage loss 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 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.



2020 Monthly COBRA Premium Rates

Blue Shield of California Trio HMO

Employee Only	\$768.73
Employee +1	\$1,534.62
Employee +2 or More	\$2,170.27

Blue Shield of California Access+ HMO

Employee Only	\$909.72
Employee +1	\$1,816.60
Employee +2 or More	\$2,569.27

Kaiser Permanente HMO

Employee Only	\$658.62
Employee +1	\$1,314.22
Employee +2 or More	\$1,858.34

UnitedHealthcare PPO (City Plan)

Employee Only	\$1,208.81
Employee +1	\$2,340.91
Employee +2 or More	\$3,296.85

Delta Dental PPO

Employee Only	\$58.43
Employee +1	\$122.69
Employee +2 or More	\$175.27

DeltaCare USA DHMO

Employee Only	\$27.49
Employee +1	\$45.35
Employee +2 or More	\$67.08

UnitedHealthcare Dental DHMO

Employee Only	\$29.20
Employee +1	\$48.23
Employee +2 or More	\$71.30

VSP Premier

Employee Only	\$10.13
Employee +1	\$15.28
Employee +2 or More	\$31.68

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 biweekly contribution plus a 2% administrative charge. COBRA Flexible Spending Account contributions are 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 **(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:

1. Employees must certify annually that they are unable to obtain other health coverage.
2. Holdover premium contributions must be paid by the due date listed on the 2020 Health Coverage Calendar see page 33. Rates may increase each plan year.



Health Service Board Achievements



Karen Breslin
President
Elected Retiree



Stephen Follansbee, M.D.
VP, Appointed by
Former Mayor Lee



Chris Canning
Elected by SFHSS
Membership



Mary Hao
Appointed by
Mayor Breed



Wilfredo Lim
Elected by SFHSS
Membership



Randy Scott
Appointed by
Controller's Office

Health Service Board Elections

The Board Secretary and the SFHSS Leadership team planned an election for two Board Commission Seats throughout the months of October-March. By March 27, three of the five eligible nominated candidates officially withdrew their names from the Election – leaving two viable candidates. Under Administrative Code Section 16.553, if there are no competing candidates for an open seat, then the Department of Elections is no longer required to hold an election, and the eligible candidate will be declared to be a member of the Board. Two viable candidates assumed the two open seats on May 15, 2019: Commissioner Karen Breslin, a Health Service Board Commissioner incumbent and active SFHSS member, Chris Canning.

Health Service Board Commissioner Appointment

At the June 13th Health Service Board meeting, the Health Service Board had the full Board seated. Commissioner Mary Hao was appointed to the Board by Mayor Breed to serve a five-year term and attended her first meeting in May 2019. Commissioner Chris Canning, elected by SFHSS membership, assumed his Board seat to serve his five-year term beginning May 2019. SFHSS Leadership conducted a new Commissioner orientation in April 2019. This comprehensive on-boarding process introduced the newly seated members to SFHSS departments and roles, the Health Service Board Commissioner role as a governing body, the Rates and Benefits Cycle, over all Board responsibilities, and reviewed member benefits.

Health Service Board Education

The Health Service Board completed a Special Meeting in July 2019 focusing on the Healthcare Marketplace. The presentation covered a wide range of health benefit design and contracting strategies. The Board reviewed different health system models and discussed possible options of health system models for future health care plans. The education session covered the current pharmacy landscape and trends during the April meeting. At the July meeting, the Board reviewed developments in prescription drug tiering, generic drug pricing shifts, and pharmacy benefit managers' impact on current drug re-tiering practices.

Board Approval on Benefit and Plan Enhancements: Blue Shield of California Trio and Access+ HMO Plans

Approved access for Blue Shield members to receive an array of vaccines from participating pharmacies without a prescription from their primary care providers. Approved access for Blue Shield members to receive nutritional counseling sessions without a medical diagnosis.

Kaiser Permanente Medicare Advantage Plan

Approved a transportation benefit for members that will be available utilizing these provisions: non-medical transportation, up to 24 one-way trips for routine or post-discharge needs (50 mile distance limit per trip).

VSP Basic & Premier Vision Plans

Approved 0% rate increase for the Basic plan.

Delta Dental PPO

Approved a 5.3% rate decrease for self-funded plan.

Delta Dental PPO for Retirees

Approved a PPO network design change to increase plan-paid coinsurance, for services provided by Delta Dental PPO providers, currently covered at 50%, to 60%—including crown, denture, pontic, bridge, and endodontic/root canal services. For Premier and out-of-network providers, the co-insurance coverage shall remain unchanged at 50%. Approved the Premier network and out-of-network design change to increase individual member deductible for services (excluding diagnostic and preventive care) from \$50 to \$75 annually. No change to the family deductible of \$150.

UHC PPO (City Plan)

Approved a reduction of in-network Family Out-of-Pocket Maximum from \$12,700, to twice the amount of the individual in-network Out-of-Pocket Maximum, \$7,500.

Life Insurance and Long-Term Disability

Approved an aggregate 12% rate decrease for Basic Life, LTD, and Supplemental Life Insurance. Approved 0% rate increase for Child Life Insurance, AD&D insurance.



Legal Notices

Summary of Benefits and Coverage (SBCs)

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

Women's Health and Cancer Rights Notice

The Women's Health and Cancer Rights Act of 1998 requires that your medical plan provide benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Contact your medical plan for details.

Use and Disclosure of Your Personal Health Information

SFHSS maintains policies to protect your personal health information in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA).

Other than the uses listed below, SFHSS will not disclose your health information without your written authorization:

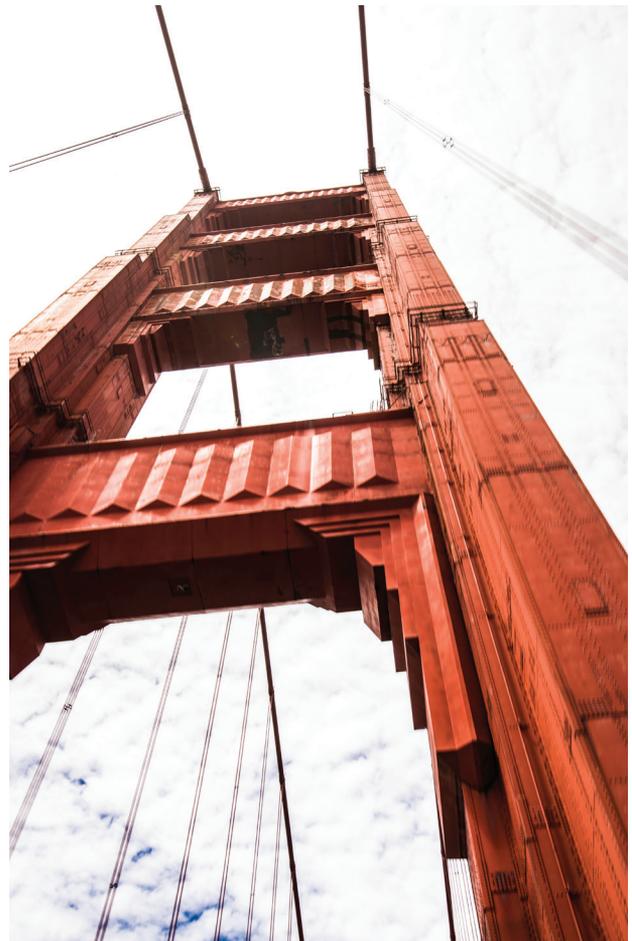
- To make or obtain payments from plan vendors contracted with SFHSS
- To facilitate administration of health insurance coverage and services for SFHSS members
- To assist actuaries in making projections and soliciting premium bids from health plans
- To provide you with information about health benefits and services
- When legally required to disclose information by federal, state, or local law (including Worker's Compensation regulations), law enforcement investigating a crime, and a court order or subpoena
- To prevent a serious or imminent threat to individual or public health and safety

If you authorize SFHSS to disclose your health information, you may revoke that authorization in writing at any time.

You have the right to express complaints to SFHSS and the Federal Health and Human Services Agency if you feel your privacy rights have been violated. Any privacy complaints made to SFHSS should be made in writing.

This is a summary of a legal notice that details SFHSS privacy policy. The full legal notice of our privacy policy is available at sfhss.org/sfhss-privacy-policy-and-forms.

You may also contact SFHSS to request a written copy of the full legal notice.





2020 Health Coverage Calendar

Work Dates	Pay Date	Coverage Period
December 28, 2019–January 10, 2020	January 21, 2020	December 28, 2019–January 10, 2020
January 11, 2020–January 24, 2020	February 4, 2020	January 11, 2020–January 24, 2020
January 25, 2020–February 7, 2020	February 18, 2020	January 25, 2020–February 7, 2020
February 8, 2020–February 21, 2020	March 3, 2020	February 8, 2020–February 21, 2020
February 22, 2020–March 6, 2020	March 17, 2020	February 22, 2020–March 6, 2020
March 7, 2020–March 20, 2020	March 31, 2020	March 7, 2020–March 20, 2020
March 21, 2020–April 3, 2020	April 14, 2020	March 21, 2020–April 3, 2020
April 4, 2020–April 17, 2020	April 28, 2020	April 4, 2020–April 17, 2020
April 18, 2020–May 1, 2020	May 12, 2020	April 18, 2020–May 1, 2020
May 2, 2020–May 15, 2020	May 26, 2020	May 2, 2020–May 15, 2020
May 16, 2020–May 29, 2020	June 9, 2020	May 16, 2020–May 29, 2020
May 30, 2020–June 12, 2020	June 23, 2020	May 30, 2020–June 12, 2020
June 13, 2020–June 26, 2020	July 7, 2020	June 13, 2020–June 26, 2020
June 27, 2020–July 10, 2020	July 21, 2020	June 27, 2020–July 10, 2020
July 11, 2020–July 24, 2020	August 4, 2020	July 11, 2020–July 24, 2020
July 25, 2020–August 7, 2020	August 18, 2020	July 25, 2020–August 7, 2020
August 8, 2020–August 21, 2020	September 1, 2020	August 8, 2020–August 21, 2020
August 22, 2020–September 4, 2020	September 15, 2020	August 22, 2020–September 4, 2020
September 5, 2020–September 18, 2020	September 29, 2020	September 5, 2020–September 18, 2020
September 19, 2020–October 2, 2020	October 13, 2020	September 19, 2020–October 2, 2020
October 3, 2020–October 16, 2020	October 27, 2020	October 3, 2020–October 16, 2020
October 17, 2020–October 30, 2020	November 10, 2020	October 17, 2020–October 30, 2020
October 31, 2020–November 13, 2020	November 24, 2020	October 31, 2020–November 13, 2020
November 14, 2020–November 27, 2020	December 8, 2020	November 14, 2020–November 27, 2020
November 28, 2020–December 11, 2020	December 22, 2020	November 28, 2020–December 11, 2020
December 12, 2020–December 25, 2020	January 5, 2021	December 12, 2020–December 25, 2020



New Hires: Health Coverage Does Not Begin On Work Start Date

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

Employee premium contributions are deducted from paychecks biweekly and are paid concurrent with the coverage period. Flexible Spending Account (FSA) deductions only occur on pay dates during the 2020 tax year.

If you take an approved unpaid Leave of Absence (see pages 25-26), you must arrange to make premium payments that were previously deducted from your paycheck, directly to SFHSS. Employee premium contributions are due no later than the pay date of the benefits coverage periods above.



Nurseline, Urgent Care, Telemedicine, and Online Services

24/7 Nurse Line

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

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 or inconvenient to see your regular provider and you need prompt attention for an illness or injury that is not life-threatening. Urgent care centers offer the convenience of same-day appointments and walk-in service.

Telemedicine

- ### UnitedHealthcare PPO (City Plan) Members

A video or virtual visit is an appointment with a telemedicine doctor that is done using the camera on your mobile device or computer.

- ### Blue Shield of California Members (Trio HMO and Access+ HMO)

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

- ### Kaiser Permanente HMO

Access services by video through: mydoctor.kaiserpermanente.org/ncal/videovisit/#

Go Online

Email your doctor, access your records, and renew your prescriptions.

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

Key Contacts

SFHSS

1145 Market Street, 3rd Floor
San Francisco, CA 94103

Tel: (628) 652-4700
Toll Free: (800) 541-2266
Fax: (628) 652-4701
sfhss.org

Hours: Mondays, Tuesdays,
Wednesdays and Fridays from
9am to 12pm and 1pm to 5pm
and Thursdays from 10:00am to
12pm and 1pm to 5pm-5:00pm

Well-Being

Catherine Dodd Wellness Center
1145 Market Street, 1st Floor
San Francisco, CA 94103
Tel: (628) 652-4650
wellbeing@sfgov.org
sfhss.org/well-being

Employee Assistance Program

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

Health Service Board

Attn. Board Secretary
1145 Market Street, 3rd Floor
San Francisco, CA 94103
Tel: (628) 652-4719
Fax: (628) 652-4702
health.service.board@sfgov.org
sfhss.org

MEDICAL PLANS

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

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

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

UnitedHealthcare PPO (City Plan)
(866) 282-0125
welcometouhc.com/sfhss
Group 752103

DENTAL & VISION PLANS

Delta Dental PPO
(888) 335-8227
deltadentalins.com/ccsf
Group 09502-0003

DeltaCare USA DHMO
(800) 422-4234
deltadentalins.com/ccsf
Group 71797-0001

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

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

FSA's & COBRA

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

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

VOLUNTARY BENEFITS

WORKTERRA
(888) 392-7597
workterra.net

LTD & GROUP LIFE INS.

The Hartford Long-Term Disability
(888) 301-5614
abilityadvantage.thehartford.com
NEW: Group 804927

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

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

OTHER AGENCIES

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

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

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

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



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