SAN FRANCISCO
HEALTH SERVICE SYSTEM
Affordable, Quality Benefits & Well-Being

GOVERNANCE POLICIES
AND
TERMS OF REFERENCE

Revised December 2024

SAN FRANCISCO
HEALTH SERVICE SYSTEM
Affordable, Quality Benefits & Well-Being

Health Service Board Governance Manual

Terms of Reference #	Tab #	Page #	Description	Originally Adopted	Date of Review & Amendment	Date of Review & Amendment
101	2	3	Health Service Board Terms of Reference	2/22/2007	02/14/2019	2/10/2022
102	3	10	President of Health Service Board Terms of Reference	2/22/2007	02/14/2019	2/10/2022
103	4	12	Vice President of Health Service Board Terms ofReference	2/22/2007	02/14/2019	2/10/2022
104	5	13	Executive Director Terms of Reference	2/22/2007	02/14/2019	2/10/2022
105	6	16	Budget and Finance Committee Terms of Reference	2/22/2007	02/14/2019	2/10/2022
106	7	18	Governance Committee Terms of Reference	2/22/2007	02/14/2019	2/10/2022

Policy #	Tab #	Page #	Description	Originally Adopted	Date of Review & Amendment	Date of Review & Amendment
201	8	20	Board Operations Policy	2/22/2007	02/14/2019	2/10/2022
202	9	27	Board Education Policy	2/22/2007	02/14/2019	2/10/2022
203	10	38	Board Performance Evaluation Policy	2/22/2007	02/14/2019	2/10/2022
204	11	40	Executive Director Performance Evaluation Policy	2/22/2007	02/14/2019	2/10/2022
205	12	42	Monitoring and Reporting Policy	2/22/2007	02/14/2019	2/10/2022
206	13	44	Board Communications Policy	2/22/2007	02/14/2019	2/10/2022
207	14	47	Service Provider and Vendor Selection Policy	2/22/2007	02/14/2019	2/10/2022
208	15	51	Strategic Planning Policy	2/22/2007	02/14/2019	2/10/2022
209	16	54	Investment Policy	1/5/2017	1/5/2020	2/10/2022
210	17	60	Contingency Reserve Policy and Methodology	3/8/2008	3/14/2013	12/12/2024
211	18	62	Self-Funded Plans' Rate Stabilization Policy	3/8/2008	1/8/2015	2/10/2022
212	19	66	IBNR Reserve Policy and Methodology	3/14/2013	3/14/2019	2/10/2022
213	20	68	Legal Settlement Policy	1/12/2023		

Reference Documents	Tab #		Description			Updated
	20		San Francisco Administrative Charter & Admin Codes			2/10/2022
	21		SFHSS Membership Rules and Cafeteria Plan 2025			12/12/2024

101: HEALTH SERVICE BOARD TERMS OF REFERENCE

Introduction

1) The San Francisco Health Service System ("SFHSS") is dedicated to providing outstanding health and other employee benefits to its members while adhering to the highest standards of customer service.

2) To carry out its mission and the responsibilities of the SFHSS, as set out in the City Charter ("Charter") and San Francisco Administrative Code ("Administrative Code"), the Health Service Board ("Board") has established clear roles and responsibilities for itself, and the other parties involved in the governance and management of the SFHSS.

3) The Board has established these terms of reference to confirm and build upon the Board's statutory duties. In the event of a conflict between the City Charter or the Administrative Code and the terms of reference or governance policies adopted by the Board, the City Charter and Administrative Code will prevail.

Duties and Responsibilities
General Duties

4) Consistent with Charter section 12.201, the Board and each committee of the Board shall confine its activities to policy matters and matters coming before it as an appeals Board.

5) The Board's duties fall into two broad categories:

    a) Designing benefit plans and benefit changes and determining rates under Charter section A8.422 subject to final approval by the Board of Supervisors; and

    b) Health and welfare plan and fund administration in connection with:

        i) The Health SFHSS Trust Fund, under Charter section 12.203;

        ii) Benefit plans adopted under Charter section A8.422; and

        iii) Benefit plans are administered by the Board under Charter section 4.102.

Plan Adoption and Benefit Design

6) Under Charter section A8.422, the Board has an important role to play in designing health benefit plans and amendments thereto for adoption by the Board of Supervisors:

    a) The Board shall have power, and it shall be its duty by a majority vote of the entire membership of the Board, to adopt a plan or plans for rendering medical care to SFHSS members, or for obtaining and carrying insurance against such costs or for such care. Such plan or plans as may be adopted shall not become effective until approved by ordinance of the Board of Supervisors, adopted by three-fourths of its members (Charter § A8.422); and

b) Consistent with the plan year set by the Board, at a public meeting, the Board shall review and determine the adequacy of health care provided for SFHSS members and the adequacy of rates and benefits and the compensation paid for all services rendered, and it may make such plan revisions as it deems equitable, however, such revisions shall not become effective until approved by ordinance of the Board of Supervisors adopted by three- fourths of its members.

7) To facilitate carrying out the duties set out in paragraph 6 above, the Board shall approve:

a) The annual benefit and rate-setting process; and

b) The Rates and Benefits Review cycle will guide the goals/objectives for the Board so that they can carry out the health care adequacy review as set forth in section 6) b).

Board Governance

8) The Board is responsible for ensuring effective governance practices in respect of the Board.

9) The Board shall approve, and amend, as necessary:

a) An Annual Statement of Purpose (Charter § 4.102);

b) Rules and regulations consistent with the Charter and Ordinances at least annually (Charter § 4.104(1));

c) Terms of reference describing the roles and responsibilities of the Board, Board committees, Board officers, the Executive Director, and, if applicable a Medical Director;

d) Any governance-related policies necessary to help ensure appropriate governance practices at SFHSS; and

e) A Board Education Plan.

10) The Board shall:

a) Elect a President and Vice-President of the Board on an annual basis;

b) Establish standing or ad hoc committees or task forces as necessary;

c) Upon the recommendation of the President, appoint Board members and a chair to each standing committee, ad hoc committee, and task force;

d) Ensure that a Board orientation and continuing education program is in place to assist Board members in securing the knowledge they require to properly execute their duties;

e) Annually conduct a Board performance evaluation, in which Board members may evaluate the performance and practices of the Board during the prior year and suggest opportunities for improvement;

f) When budget permits, approve travel requests by Board members for education or other business purposes pertaining to SFHSS; and

g) Ensure that a record of Board and Committee meeting proceedings is maintained as required under the *San Francisco Sunshine Ordinance*, Administrative Code, Chapter 67.

Benefit Administration

11) The Board shall ensure the administration of health and wellness plans adopted by the Board of Supervisors under Charter section A8.422, and health and welfare plans established by the Mayor and the Board of Supervisors under Charter section 4.102.

12) The Board shall ensure that SFHSS management implements benefit and administration policies to ensure the efficient and effective administration of all benefit plans it administers, addressing, for example, membership rules, the annual rates, and benefits setting process, service quality standards, member communications, open enrolment rules, the confidentiality of member data, and performance evaluation of vendors.

13) The Board shall establish and, at least annually, review and if necessary, amend the SFHSS Rules to comply with Internal Revenue Code section 125.

Investment Administration

14) The Board shall administer the SFHSS Trust Fund in accordance with the Charter solely for the benefit of the active and retired members of the SFHSS and their covered dependents. (Charter § 12.203)

15) The Board shall have control of the administration and investment of the SFHSS Trust Fund provided that all investments shall be of the character legal for insurance companies in California. (Charter § A8.429)

16) In keeping with its fiduciary duty to prudently administer the SFHSS Trust Fund, the Board shall be responsible for:

a) Approving a written investment policy statement, and reviewing, confirming, or amending such policy at least annually. The policy statement is outlined in the 209: SFHSS TRUST FUND INVESTMENT POLICY.

b) Ensuring qualified parties are appointed to manage SFHSS Trust Fund assets.

c) Ensuring regular compliance monitoring in regard to the investment policy statement.

d) Ensuring ongoing review of the investment performance of the Health Service Trust Fund.

Rates and Accounting

17) The Board shall adopt funding policies to ensure the financial health and integrity of each flex and self-funded plan, and shall be reviewed annually and, when necessary, amend said policies. The funding policy shall also address other reserves to be held in the SFHSS Trust Fund. The policy may address, among other things, appropriate contingency reserve targets for unanticipated needs and claims that are incurred but not reported (“IBNR”), the actuarial methodologies and assumptions to be used in determining reserves, and subsidies.

18) As outlined in the City Ordinance, prior to the second Monday in January in the year, or such time consistent with the plan year set by the Board, the Board shall ensure a survey is conducted of the 10 largest counties in California, other than the City and County of San Francisco, to determine the average contribution made by each employer of such county to health benefit coverage. Based on the survey, the Board shall determine the average contribution made with respect to each employee by the 10 counties toward the health care plans provided for their employees, and shall certify to the Board of Supervisors the amount of such average contribution. (Charter § A8.423)

19) The Board shall:

a) Ensure that management implements mechanisms to collect all required contributions to the Health SFHSS Trust Fund and to make all distributions in a timely manner;

b) Ensure historical records on rates and costs are maintained;

c) Ensure appropriate financial and operational controls are established by management;

d) Ensure funding is in place to provide for the annual independent financial audit;

e) Review with management significant accounting policy changes, as required; and

f) Review and accept the annual audited financial statements and external auditors' management letter and take corrective action if required.

Organizational Planning & Risk Management

20) The Board shall annually approve:

a) A strategic plan, which may include a mission statement for the SFHSS, the broad direction and goals of the SFHSS, and the specific projects that must be completed to fulfill SFHSS' direction and goals;

b) The SFHSS annual General Fund and the Healthcare Sustainability Fund Budget;

c) The basic SFHSS organizational structure; and

d) Outsourcing strategies with respect to cores SFHSS services, i.e., whether certain activities will be performed by an outside agent rather than SFHSS staff.

21) The Board shall ensure management develops, over time, on an ongoing system of operational risk management to include health plan audits and compliance plans that management reports to the Board at least annually on such system. This may be accomplished as part of the strategic planning process if deemed appropriate by SFHSS management and the Board.

Human Resources

22) The Board shall:

a) Appoint an Executive Director and determine the duties and responsibilities of the position;

b) Establish a process for evaluating the performance of the Executive Director, and annually evaluate the Executive Director accordingly;

c) Establish and annually review the compensation of the Executive Director within the ranges of the classification set for the position; and

d) Ensure the Executive Director documents the delineation of SFHSS managerial authority and responsibility in the event the Executive Director is absent or unavailable to perform the Executive Director's duties for an extended period, along with any related procedures to ensure continuity in SFHSS operations. The Executive Director shall review such documentation, and any updates thereto with the Board, from time to time, subject to open meeting law requirements.

Communications

23) The Board shall:

a) Ensure that an annual report describing its activities, and file such report with the Mayor and the Clerk of the Board of Supervisors; (Charter §4.103)

b) Hold meetings open to the public and encourage the participation of interested persons; (Charter § 4.104.2)

c) Conduct meetings in accordance with the *San Francisco Sunshine Ordinance* (San Francisco Administrative Code, Chapter 67), and the *Ralph M. Brown Act* (California Government Code, Section 54950 et seq.);

d) Ensure that information is obtained and disseminated to the members of the SFHSS with regard to plan benefits and costs thereof; (Charter § A8.423) and

e) Work with the Executive Director to ensure other mechanisms and procedures are in place to enable accurate, coordinated, and effective communication between the SFHSS and its stakeholders, including plan members, the City, other participating SFHSS employers, and employee groups.

Legislation and Litigation

24) The Board may, in closed session, consider and approve recommendations made by the Executive Director or legal counsel concerning settlements or other legal actions involving SFHSS.

Selection of Vendors

25) The Board shall establish policies to help ensure effective and prudent selection of service providers.

26) The Board recognizes that it is neither effective nor efficient for the Board to be involved in the selection of all service providers. Accordingly, the Board shall be responsible for approving the awarding of final contracts for the following primary service providers named below:

a) Actuaries;

b) Plan Administrators;

c) Hearing officers or firms providing the services of hearing officers;

d) Third-party administrators retained for services in connection with non-Charter benefits and with contract values in excess of $500,000 annually;

e) External information technology consultants retained for services with contract values in excess of $500,000;

f) Services of a Medical Director;

g) Investment managers or advisors; and

h) Other service providers, as may be determined by the Board.

27) It is recognized and understood that the following services are provided or coordinated by various departments within the City:

a) Financial and operational audit services;

b) Custody services;

c) Legal services;

d) Investment management and advisory services; and

e) Information technology services.

28) The Board shall communicate to the Executive Director regarding secondary service providers or classes of services providers, which the Executive Director shall be authorized to select, and the Board shall determine the controls to be put in place with respect to such authority; such as, for example, dollar limits on expenditure authority.

Monitoring

29) The Board shall ensure that appropriate monitoring and reporting practices are established and documented within SFHSS.

30) The Board shall periodically review compliance with, and the continued appropriateness of, any policies adopted by the Board including, but not limited to, policies in the following areas:

a) Governance policies and terms of reference;

b) Benefit design policy;

c) Funding policies:

i) Rate Stabilization Reserve policy;

ii) Incurred But Not Reported ("IBNR") policy; and

iii) Contingency Reserves policy.

d) Investment policy;

e) Health Service System rules;

f) Communication policy; and

g) Accounting policy.

31) The Board shall monitor periodically:

a) The levels of the reserves (on not less than a quarterly basis);

b) The adequacy of rates, including a retrospective review of rate-setting; and

c) The investment performance and costs of the Health System Trust Fund.

32) The Board shall ensure periodic performance reviews of key service providers including, but not limited to, insurance carriers and third-party administrators relative to pre-established performance criteria.

33) The Board shall ensure the periodic monitoring of usage and participation levels by members within SFHSS health plans, and the general affordability of the plans it administers.

34) The Board shall monitor the levels of service quality provided by the SFHSS health plans, and other benefit plans sponsored by the SFHSS, developing over time the methodologies necessary to do so.

35) The Board shall monitor:

a) Implementation of the Strategic Plan; and

b) Compliance with the SFHSS Operating Budget.

36) At least annually, the Board shall review the performance of:

a) The Executive Director; and

b) The Board itself.

Review

37) The Board shall review these terms of reference at least every three years.

History

38) These terms of reference were adopted by the Board on February 22, 2007; amended on April 9, 2015, February 14, 2019, February 10, 2022, and January 12, 2023.

102: PRESIDENT OF THE HEALTH SERVICE BOARD TERMS OF REFERENCE

Introduction

1) Unless otherwise agreed by the Board, at its regular meeting in June of each year, the Board shall elect one Board member to serve as President. The President shall take office at the regular July meeting in July immediately following the election and the President's term shall continue until the assumption of office by the next President at the regular meeting in the following July.

Duties and Responsibilities

2) The President shall exercise the powers and shall perform the duties and functions as specified herein:

    a) Preside at all Board meetings, ensuring that such meetings are conducted efficiently and in accordance with the *San Francisco Sunshine Ordinance* (Administrative Code, Chapter 67), the *Ralph M. Brown Act* (California Government Code, section 54950 et seq.), and the policies of the Board;

    b) Recommend to the Board the creation of task forces or ad hoc committees of the Board, and theappointment of members and a chair to each standing committee, ad hoc committee, and task force. Recommendations concerning membership and chairs of standing committees are generally to be made by the President at the Board meeting following the meeting at which the President is elected;

    c) Authenticate by his or her signature when necessary, or when required by law, all documents authorized by the Board;

    d) Call special meetings. Special meetings may be called by the President; however, they must be called by the President upon the written request of a majority of the members of the Board or authorization by a majority of the Board at a prior meeting. This provision must be implemented in amanner consistent with applicable open meeting laws;

    e) In situations that call for a spokesperson to speak on behalf of the SFHSS, the President shall consult with the Executive Director and determine whether the President, Executive Director or another individual should serve as a spokesperson in the situation in question;

    f) Review the agenda of each Board meeting with the Executive Director prior to the meeting;

    g) Be available to assist committee chairs in carrying out their duties; and

    h) Be available to assist the Executive Director in the orientation process for new Board members.

Review

3) The Board shall review these terms of reference at least every three years.

History

4) These terms of reference were adopted by the Board on February 22, 2007; amended on April 9, 2015, February 14, 2019, and February 10, 2022.

103: SFHSS VICE PRESIDENT OF THE BOARD TERMS OF REFERENCE

Introduction

1) Unless otherwise agreed by the Board, at its regular meeting in June of each year, the Board shall elect one Board member to serve as Vice President. The Vice President so elected shall take office at the regular meeting in July immediately following the election and the Vice President's term shall continue until the assumption of office by the next Vice President at the regular meeting in the following July.

Duties and Responsibilities

2) The Vice-President shall assume the duties of the President when the President is absent, or when the President shall designate the Vice-President to act. In the event of death, resignation, removal from office, or permanent disability of the President, the Vice-President shall temporarily act for the President until such time as an election can be held to elect a new President.

Review

3) These terms of reference shall be reviewed by the Board at least every three years.

History

4) These terms of reference were adopted by the Board on February 22, 2007; amended on April 9, 2015, February 14, 2019, and February 10, 2022.

104: SFHSS EXECUTIVE DIRECTOR TERMS OF REFERENCE

Introduction

1) The Executive Director shall hold office at the pleasure of the Board and shall be responsible to the Board as a Board, but not to any individual member or committee thereof. (Charter §12.201)

2) The Executive Director shall provide leadership for the SFHSS in implementing programs necessary to achieve the mission, goals, and objectives established by the Board, and shall manage the day-to-day affairs of SFHSS in accordance with the Charter.

3) The Executive Director is the executive ultimately responsible for the entire operations of SFHSS. The Executive Director shall ensure proper delegation of duties to senior management and staff to maximize the efficiency and effectiveness of SFHSS resources.

4) The Executive Director shall provide support to the Board and its committees in establishing all policies of the Board including identifying and analyzing issues requiring Board policy and providing policy options and clear, well-supported policy recommendations for consideration by the Board or its committees.

5) In addition to having operational responsibility for SFHSS, the Executive Director is responsible for assisting and supporting the Board and its standing committees in carrying out the duties and responsibilities set out in their respective terms of reference.

Duties & Responsibilities
Governance

6) The Executive Director shall assist the Board in its governance functions by:

    a) Recommending terms of reference and other policies to ensure appropriate governance practices;

    b) Coordinating new Board member education and training and additional education within budget limitations in accordance with the Board Education Policy and Board Education Plan; and:

    c) Coordinating Board member travel within budget limitations.

Benefits Administration and Operations

7) The Executive Director shall direct and oversee all SFHSS administrative and operational activities including:

    a) Developing and implementing all policies necessary to ensure the effective administration of member benefits and reporting to the Board, and directing administrative staff involved in the delivery of service to plan members and in SFHSS operations;

    b) Developing and recommending a strategic plan to the Board;

c) Developing an annual operating budget, as well as applicable departmental budgets, and presenting them to the Board for approval as part of the City's budget process;

d) Ensuring a system of operational risk management is in place, which addresses, among other things, sound records, data management, and security;

e) Ensuring prudent fiscal management, oversight, and reporting of SFHSS operations;

f) Negotiating and executing agreements, and authorizing payments related to the administration of SFHSS and the appointment of all service providers, consistent with the operating budget and internal SFHSS controls;

g) Ensuring effective and timely communication with members and stakeholders on matters relating to SFHSS administration; and

h) Representing the SFHSS at the Board of Supervisors and other City departments on the budget and other matters affecting the SFHSS.

Human Resources

8) Consistent with the City's Administrative Code, applicable civil service rules, the operating budget, and collective bargaining agreements, the Executive Director shall hire, direct, supervise,and when appropriate, terminate senior executives of the SFHSS and shall oversee the hiring, management, and termination of staff. The Executive Director shall manage the employee grievance process relating to SFHSS staff in accordance with the City Charter, Administrative Code, and the collective bargaining agreements; and shall inform the Board of any issues as appropriate.

9) The Executive Director shall ensure ongoing assessment of SFHSS human resource needs and the development of appropriate human resource programs and procedures, including succession planning and coordination with other City departments as necessary.

Legislation and Litigation

10) The Executive Director shall carry out the following duties with the advice of legal counsel asnecessary:

a) Monitor trends regarding legislation that may have a significant impact on SFHSS;

b) Report to the Board on legislative proposals that could significantly affect the SFHSS, and recommend whether the Board should take any action;

c) Manage and coordinate, with legal counsel, all legal proceedings involving SFHSS;

d) Provide recommendations to the Board concerning member appeals, settlements, or other legal actions involving SFHSS;

e) Make recommendations or proposals to the Board on a proactive basis regarding Charter amendments that are consistent with the SFHSS' mission; and

f) Recommend to the Board that obsolete provisions of the Administrative Code be eliminated, or that various provisions of the Administrative Code be amended to reflect Charter amendments or new or revised State legislation.

Service Providers

11) The Executive Director shall:

a) Initiate and conduct the solicitations for contracts, and shall apprise the Board ofinformation regarding the selection process;

b) Negotiate and execute all serviceprovider/vendor agreements;

c) Appoint those service providers for which the Board has delegated appointing authority to the Executive Director, in accordance with the Service Provider/Vendor Selection Policy or other Board action; and

d) Regularly monitor the performance of all SFHSS service providers, and report regularly to theBoard on such monitoring efforts.

Monitoring and Reporting

12) The Executive Director shall ensure that monitoring and control mechanisms are in place to ensure that policies and procedures are properly implemented and that the operations of the SFHSS are effective.

13) The Executive Director shall provide the Board with relevant, appropriate, and timely information to enable it to properly carry out its oversight responsibilities. The Executive Director shall also apprise the Board in a timely manner of all significant issues, problems, or developments pertaining to SFHSS, and provide recommended courses of action as appropriate.

Review

14) The Board shall review these terms of reference at least every three years.

History

15) These terms of reference were adopted by the Board on February 22, 2007; amended on April 9, 2015, February 14, 2019, and February 10, 2022.

105: SFHSS BUDGET AND FINANCE COMMITTEE TERMS OF REFERENCE

Introduction

1) The Board has established the Budget and Finance Committee to assist the Board in the financial oversight of the SFHSS, including oversight of all audits of the SFHSS and the budgeting process. These financial oversight duties may be performed as a committee of the whole.

Composition

2) Upon the recommendation of the President, the Budget and Finance Committee shall be comprised of three Board members including the Committee Chair, all of whom shall be appointed by the Board.

3) The Executive Director shall designate a staff member to provide administrative support to the Budget and Finance Committee.

Operational Rules

4) The Budget and Finance Committee shall adhere to the following operational rules:

    a) The presence of a majority shall constitute a quorum;

    b) All actions of the Budget and Finance Committee shall be by a vote of the majority of the memberspresent at a meeting of the Finance Committee, provided a quorum is present;

    c) To be effective, all actions of the Budget and Finance Committee shall be approved by the Board;

    d) The Budget and Finance Committee shall meet at least annually, or more often if it deems necessary.

5) The Budget and Finance Committee may establish other operational rules, procedures, calendars, and agendas for the Committee, as necessary, provided they are consistent with the Charter and Cityordinances, and Board policies.

6) The Budget and Finance Committee shall periodically review its terms of reference and advise the Governance Committee with respect to modifications, as appropriate.

Duties and Responsibilities
Audits and Examinations

7) The Budget and Finance Committee shall:

    a) Provide clear direction to SFHSS that the independent financial auditor is accountable to share a report to the Board;

i. Budget and Finance Chair, in consultation with Board President, CFO, and Executive Director, will make a recommendation for the report to be submitted directly to the Committee or directly to the full Board for its review.

b) Receive presentations from SFHSS management or the external financial auditor regarding the annualaudited financial statements, review any responses by management, and recommend any appropriate actions to the Board;

c) Provide the appropriate forum to review and comment on finalized management letters submitted bythe financial auditor, review management's responses thereto, and provide recommendations to the Board, as appropriate; and

d) Provide the appropriate forum for handling all policy-related matters with respect to audits, examinations, and investigations or inquiries by local, state, or federal agencies in conjunction with the Executive Director and SFHSS staff.

Annual Budgeting Process

8) The Budget and Finance Committee shall:

a) Review the annual Administrative Budget and the Healthcare Sustainability Fund Budget of theSFHSS and all requested modifications and supplements thereto;

b) Recommend the Administrative Budget and the Healthcare Sustainability Fund Budgets to the Boardfor approval; and

c) Monitor SFHSS budget variance reports every quarter and recommend appropriate action to the Board and Executive Director, if necessary.

Other

9) The Budget and Finance Committee shall:

a) Review any significant changes in accounting practices or policies that may impact SFHSS' financial status;

b) Report regularly to the Board on its activities; and

c) Perform any other duties assigned by the Board.

Review

10) The Board shall review these terms of reference at least every three years.

History

11) These terms of reference were adopted by the Board on February 22, 2007; amended on April 9, 2015, February 14, 2019, and February 10, 2022.

106: SFHSS GOVERNANCE COMMITTEE TERMS OF REFERENCE

Introduction

1) The Board has established the Governance Committee to assist the Board in:
    a) Developing, overseeing, and implementing the governance policies and practices of the Board and its committees; and
    b) Coordinating the performance evaluations of the Board and the Executive Director
2) Upon the recommendation of the President, the Governance Committee shall be comprised of three Board members, including the committee chair, all of whom shall be appointed by the Board.
3) The Executive Director shall designate a staff member to provide administrative support to the Governance Committee.

Operational Rules

4) The Governance Committee shall adhere to the following operational rules:
    a) The presence of a majority shall constitute a quorum;
    b) All actions of the Governance Committee shall be by a vote of the majority of themembers present at a meeting of the Committee, provided a quorum is present;
    c) All actions of the Governance Committee shall be approved by the Board to be effective, unless otherwise provided herein; and
    d) The Governance Committee shall meet at least annually.
5) The Governance Committee shall establish other operational rules, procedures, calendars, and agendas for the Committee, as necessary, provided they are consistent with the Charter, City ordinances, and Board policies.

Duties and Responsibilities

6) The Governance Committee shall:
    a) In consultation with the Executive Director, develop and recommend to the Board terms of reference for the:
        i) Board;
        ii) Committees of the Board;
        iii) President and Vice President of the Board; and
        iv) Executive Director. Periodically recommend to the Board such amendments to the terms of reference as may benecessary or advisable;

b) Recommend to the Board any modifications to the committee structure of the Board, e.g., the addition or elimination of any committees;

c) Review, develop and recommend to the Board for approval, new governance policies as maybe necessary, and review existing governance policies in accordance with the schedule for review established within each policy;

d) Recommend to the Board a Board Education Plan and updates thereto;

e) Co-ordinate the implementation of the annual Board performance evaluation policy, includingapproving and amending as necessary any surveys or similar forms used in the evaluation;

f) Coordinate the implementation of the annual Executive Director performance evaluation policy. The Committee shall recommend to the Board the criteria to be used in evaluating theperformance of the Executive Director, and shall have the authority to approve minor amendments as necessary to any surveys or similar instruments used to perform the evaluation;

g) Monitor compliance with governance-related policies, rules, and legislation, and address any alleged violations;

h) Report regularly to the Board on its activities; and

i) At the request of the Board, undertake such other governance-related initiatives as may be necessary or desirable to contribute to the success of SFHSS.

Review

7) The Board shall review this policy at least every three years.

History

8) These terms of reference were adopted by the Board on February 22, 2007; amended on April 9, 2015, February 14, 2019, and February 10, 2022.

201: SFHSS BOARD OPERATIONS POLICY

Purpose

1) This Board Operations Policy is intended to set out the manner in which the Board shall conduct its business and includes guidelines addressing, among other things, the appointment of officers, the establishment of committees, and the conduct of meetings.

Board Composition

2) Under Charter Section 12.200, the Board consists of seven members:

    a) One member of the Board of Supervisors appointed by the President of the Board of Supervisors;

    b) Two members to be appointed by the Mayor. (The two members appointed by the Mayor shall be appointed in accordance with the requirements set forth in Charter section 3.100 and Charter sections 12.100 –12.103.)

    c) One member is appointed by the Controller. If the Board fails to calendar the Controller's nomination for consideration at a meeting to occur not later than 60 days after receipt of the Controller's written notice of nomination, the Controller's nominee shall be deemed approved.

    d) Three members elected from the active and retired members of the SFHSS from among their number.

3) The term of office of each member, except the member of the Board of Supervisors, shall be five years.

4) Vacancies on the Board:

    a) A vacancy on the Board appointed by the Mayor shall be filled by the Mayor.

    b) A vacancy in the Controller's appointed position shall be filled by the Controller and confirmed by the Board**.**

    c) A vacancy in an elected office on the Board shall be filled by a special election within 90 days after the vacancy occurs unless a regular election is to be held within six months after such vacancy shall have occurred. (Charter section 12.200).

Election of President and Vice President

5) There shall be a President and Vice President of the Board each of whom shall be a Board member. (SHFSS Rules and Regulations, A3)

6) At its regular meeting in June of each year, the Board shall elect one Board member to serveas President and one Board member to serve as Vice President. The President and Vice President shall take office at the regular meeting in the month of July immediately following the election and

their terms shall continue until the assumption of office by the next President and Vice President at the regular meeting in the following July. (SFHSS Membership Rules and Regulations, A3(a))

7) In electing a President and Vice-President, it is expected that, at a minimum, the followingcriteria will be considered:

    a) Demonstrated leadership abilities;

    b) Committee and committee chairperson experience; and

    c) Time availability.

8) If an officer vacates his office prior to the end of his term, an election shall be held at the next regular meeting of the Board to select a new officer who shall take office immediately upon election and shall hold office for the unexpired term. Notwithstanding the foregoing, so long as there is no President, the Vice President shall act as President until a new President is elected and takes office. (SFHSS Membership Rules and Regulations, A3(b))

9) Neither President nor Vice President may hold such office for more than two consecutive one-year terms. This two-term limit shall not include service for any unexpired term pursuant herein. (SFHSS Membership Rules and Regulations, A3(c))

Board Committees

10) Based on the recommendations of the President, the Board shall:

    a) Approve the establishment of standing and ad hoc committees; and

    b) Annually approve the members and chairs of standing and ad hoc committees.

11) The standing committees of the Board shall be as follows:

    a) Budget and Finance Committee

    b) Governance Committee

12) The Governance Committee shall be responsible for recommending to the Board terms of reference for each standing committee of the Board.

13) Committees shall be comprised of not more than three Board members, one of whom shall be the committee chair.

14) In the event of a vacancy on any standing or ad hoc committee, the President shall appoint a replacement to hold office for the balance of the unexpired term.

15) The term of office for chairs of standing committees shall be one year. No chair of a standing committee may hold such office for more than two consecutive one-year terms. This two-term limit shall not include service for any unexpired term as set forth above.

16) Members and chairs of ad hoc committees shall serve until the dissolution of the committee, or until the Board determines otherwise.

17) In the absence of a committee chair, the committee chair may designate in advance another committee member to act as chair for a particular meeting, failing which the remaining committee members shall designate one of themselves to act as chair for such meeting.

18) The Executive Director shall designate a staff member to provide administrative support toeach committee.

Meetings of the Board and Committees

19) The time and location of Board meetings shall be as follows:

a) Regular meetings of the Board shall be held at 1:00 p.m. on the second Thursday of the monthat City Hall Room 416, San Francisco, or at such other time or place as the Board, at a prior regular meeting, may designate. In the event this day is a holiday, the meeting shall be held on the third Thursday unless otherwise determined by the Board. (SFHSS Membership Rules and Regulations, A1(a))

b) Special meetings of the Board may be called at any time by the President or by a majority of the Board, however, special meetings of the Board for closed sessions with legal counsel may precede or follow the regular meeting of the Board. (SFHSS Membership Rules and Regulations, A1(b))

20) All meetings shall be open and public, and all persons shall be permitted to attend any meetings of the Board. Notwithstanding the foregoing, the Board may meet in closed sessionwhen authorized by the Ralph M. Brown Act of the State of California (the “Brown Act”), the San Francisco Sunshine Ordinance, Chapter 67 of the San Francisco Administrative Code, and Charter section 4.104(2). (SFHSS Membership Rules and Regulations, A1(c))

Committee Meetings

21) Standing committees shall meet at times and places agreed to by the committee. Ad hoc committees shall meet as required.

22) If possible, committee meetings shall take place at City Hall, San Francisco. To assist committee members in planning to attend meetings, each standing committee shall if feasible, establish an annual forward agenda or meeting schedule.

Teleconferencing

23) Board members may not participate by teleconference in Board or committee meetings except as may occur during a state of emergency and/or otherwise allowed under State and Local law.

24) Advisors and other vendors may participate by teleconference at Board and committee meetings to the extent permitted by law.

Calendar, Meeting Materials, Minutes

25) The agenda for Board and committee meetings shall be prepared by the Executive Director and, if time permits, reviewed and approved by the President or committee chair respectively.Board and committee members may request that the Executive Director, President, or committee chair calendar any item for a Board or committee meeting, and such requests maybe made at or outside a Board or committee meeting. The Executive Director, President, and committee chairs shall make a good faith effort to ensure all such requests are calendared within a reasonable period of time.

26) Consent agendas may be used to address items that staff considers to be routine and non-controversial. The consent agenda may be approved by one motion if no member of the Board or public wishes to comment or ask questions about any item on the consent agenda. If a comment or discussion on any item is desired by anyone, the item will be removed from the consent agenda and will be considered separately by the Board.

27) The Board shall receive an advance calendar and the related meeting materials no later than the Friday preceding the next scheduled meeting.

28) Only items that have been calendared will be heard by the Board at any meeting. The Board may consider emergency items provided they have been noticed in writing at least 24 hours inadvance of the Board meeting, consistent with the Ralph M. Brown Act.

29) A request that a calendared item be heard out of order shall be presented at the start of the meeting to the President. The President shall decide if the request shall be granted based onthe reason for the request.

30) All calendared matters to be postponed shall be announced at the start of the meeting. During a meeting, any Board member or any interested party may request postponement of an action. The President shall approve or reject any request to postpone an action being considered by the Board at its meeting, subject to the discretion of the full Board.

31) With respect to minutes:

a) The Secretary to the Board shall record in the minutes the time and place of each Board and committee meeting, the names of the Board members present, all official acts of the Board orcommittee, and the votes of the members; and

b) The minutes shall be written and presented for correction and approval within a reasonable time. The minutes, or a true copy thereof, shall be certified by the Board Secretary.

Resolutions

32) The term "resolution" shall mean any action of the Board which prescribes or defines inwritten form a Board policy or decision.

33) The Board shall enact and adopt resolutions as follows:

a) At any regular or special Board meeting, any Board member may move for the adoption of a resolution which may be stated orally or in writing;

b) The Executive Director shall be responsible for performing, or causing to be performed, all necessary research and analysis to support resolutions prior to their adoption by the Board;

c) Prior to adoption, the proposed resolution shall be prepared by the Executive Director in proper format and the Executive Director may, if necessary, forward the resolution to the City Attorney's Office for approval as to format and legality. The proposed resolution shall thereafter be presented to the Board for action; and

d) An adopted resolution shall be signed and dated by the President and the Executive Director.

34) All adopted resolutions shall be numbered in an orderly sequence and shall be retained in the office of the Executive Director. The resolutions shall be readily accessible to members of the SFHSS and the public at large.

35) The Executive Director shall notify the Board of any legislative or court action which would require the rescinding, amending, or modifying a Board resolution.

Quorum, Rules of Order, and Voting

36) The presence of a majority of the members of an appointive Board, commission, or other units of government shall constitute a quorum for the transaction of business by such body. Unless otherwise required by the Charter, the affirmative vote of a majority of the members shall be required for the approval of any matter, except that the Operations Policy or Membership Rules may provide that, with respect to matters of procedure, the body may act by the affirmative vote of a majority of the members present, so long as the members present constitute a quorum. (Charter section 4.104)

37) The majority of the members of each committee shall constitute a quorum, and committees may act by a majority of the members present at a committee meeting provided, however, that a quorum is in attendance.

38) Board and committee members may not vote by proxy and must be present at a meeting in order to vote.

39) Except as otherwise provided in this Operations Policy, Robert's Rules of Order in its latest revision shall guide the Board as to rules of order in the event of a dispute among Board members.

40) When a Board member desires to address the Board, the member shall seek recognition by addressing the presiding officer. When recognized, the Board member shall proceed to speak, confining his remarks to the question before the Board. No discussion shall take place until a resolution or motion has been moved and seconded, or until a calendared item has been introduced. (SFHSS Membership Rules and Regulations, A6)

41) The Board may take action only upon a motion by a Board member, seconded by another Board member.

42) Each member of the Board present at a regular or special meeting must vote “yes” or “no” when a question is put unless excused from voting by a motion adopted by a majority of themembers present. (Charter section 4.104)

43) Tie votes shall be handled as follows:

a) A tie vote on an affirmative motion shall be deemed to be a failure to adopt such motion, and the matter or request before the Board is denied; and

b) A tie vote on a negative motion shall be deemed to be a failure to adopt such motion, but the matter or request remains before the Board for action.

44) Nothing in this policy shall prohibit the President or a committee chair from making or seconding a motion, voting on a motion, and otherwise participating as a Board member.

45) A motion to reconsider a Board action can only be proposed by a Board member who voted with the prevailing side, however, a Board member who is not eligible to move to reconsider may briefly state their reasons for reconsideration. If the Board does not consent to hear the matter, the request is denied, and the previous action is final.

46) Requests for rulings on moot or hypothetical questions will not be permitted by the Board.

Attendance

47) Except in the event of a notified absence (defined below), each member of the Board is expected to attend each regular or special meetings of the Board and each meeting of any committees on which they serve. The Commission Secretary shall maintain a record of members' attendance.

48) A Board member’s absence shall constitute a notified absence where the Board member, in advance of the meeting, informs the Commission Secretary that the member will be absent. An absence due to unforeseen circumstances such as illness or emergency shall also qualify as a notified absence where the member reports such absence to one of the above-mentioned parties as soon as reasonably possible. The Commission Secretary shall record as non-notified all absences involving neither advance notice nor unforeseen circumstances.

49) The Commission Secretary shall report all instances of non-notified absences as well as any instance of three consecutive absences of a member from Board or committee meetings in a fiscal year to the member’s appointing authority.

50) At the end of each fiscal year, the Commission Secretary shall submit a written report to the appointing authorities of the Board detailing each Board member's attendance at all meetings of the Board and its committees for that fiscal year.

Public Comment

51) Before taking a vote on any action item, the Board shall ask for public comment. Each speaker shall be limited to three (3) minutes of comments with respect to each action item. This rule may be waived at the discretion of the presiding officer, or by a vote of a majority of the Board members present. The Board Secretary may be asked to time each speaker and to notify such speaker when the time limit has expired. Notwithstanding the foregoing, when a large number of speakers wish to comment on a particular action item, a reasonable overall time limit may be placed on public comment for such action item, and each speaker may thereby be limited to a period of comment that is less than three minutes. (SFHSS Membership Rules and Regulations, A5)

52) Speakers who wish to make public comment may be requested to fill out speaker cards in advance provided, however, that a speaker may nevertheless choose to remain anonymous. (SFHSS Membership Rules and Regulations, A5)

53) Each speaker's comments must be pertinent to the item under consideration by the Board. The presiding officer of the meeting shall be the sole judge of such pertinence and may limit comments to the extent they do not pertain to the item under consideration or are duplicative of points made by previous speakers. Members of the Board need not respond after each speaker's comments. (SFHSS Membership Rules and Regulations, A5)

54) Members of the public may address the Board on any matter within the Board's jurisdiction during the "Other Business" item on the agenda. No formal action shall be taken on any matter raised during such agenda item unless such action is permitted under the Brown Actand the Sunshine Ordinance. (SFHSS Membership Rules and Regulations, A5)

55) If an agenda item is continued from one meeting to another, any member of the public who commented on such item at the initial meeting need not be permitted to comment on such item at the next meeting. This rule shall not apply, however, if the agenda item is modified in any manner after the initial meeting. (SFHSS Membership Rules and Regulations, A5)

56) Members of the public who disrupt a meeting by making noise, speaking out of turn, or otherwise refusing to comply with these Rules shall be given a warning and an opportunity to correct their behavior. Thereafter, the Board may take action to have any such member(s) removed from the meeting. (SFHSS Membership Rules and Regulations, A5)

Review

57) The Board shall review this policy at least every three years.

History

58) This policy was adopted by the Board on February 22, 2007, and amended on April 9, 2015. February 14, 2019, and February 10, 2022.

202: SFHSS BOARD EDUCATION POLICY

Policy Objectives

1) The Board recognizes that Board members come to the Board with varying levels of knowledge and experience in the health and other employee benefits areas and that all Board members can benefit from a formal Board education program. Furthermore, a well-designed Board education program will benefit SFHSS and its members and therefore justifies prudent budgeting for, and expenditure of SFHSS administrative funds and resources.

2) The objectives of this policy are to establish policy guidelines to help ensure:

    a) Board members have an adequate opportunity and assistance to acquire the knowledge they need to effectively carry out their SFHSS Board member duties; and

    b) Any expenditure of SFHSS funds or resources is prudent, cost-effective, and consistentwith the best interests of the Board, SFHSS, and its beneficiaries.

Assumptions

3) This policy sets out various expectations concerning the efforts Board members should make to educate themselves on matters pertaining to health and other employee benefits. It is understood that any actual efforts undertaken by the Board or individual Board members shall be contingent on the availability of budget resources.

4) Though there may be limited resources available to fund attendance at educational conferences, a Board education policy is nevertheless necessary to define and guide other approaches to education available to the Board.

5) No single method of educating Board members is optimal – therefore, a Board education program should include a variety of educational methods and tools.

General Provisions

6) As fiduciaries, Board members are required to be knowledgeable of all matters concerning health and employee benefits policy and oversight. Accordingly, and within the constraints of available resources:

    a) Board members agree to develop and maintain an adequate level of knowledge and understanding of relevant issues pertaining to SFHSS oversight and policy-setting throughouttheir terms on the Board; and

    b) Board members agree to pursue appropriate education across a range of employee-benefitrelated areas, including:

        i) Governance and fiduciary duty;

        ii) Health and welfare plan design; Funding of health and welfare plans;

iii) Actuarial science;

iv) Benefits administration; and

v) The regulatory and legal environment in which SFHSS operates.

7) In addition to technical knowledge, the Board recognizes that the Board training program should provide Board members with an understanding of the environment in which SFHSS operates, including the SFHSS's relationship to the Board of Supervisors, SFHSS participating employers, and other City departments.

8) The Board considers the following types of vehicles to be appropriate for training its Board members and encourages Board members to take advantage of them, where budget resources permit:

   a) External conferences, seminars, workshops, roundtables, and similar events (collectively "conferences");

   b) Meetings of associations or other similar bodies within the health and welfare industry;

   c) In-house educational seminars or briefings by staff, City Administration, Board serviceproviders, or other special advisors;

   d) Relevant periodicals, journals, textbooks, or similar materials; and

   e) Electronic media including webinars and podcasts.

9) Where budget resources permit, the Executive Director shall, on an ongoing basis, identify appropriate educational opportunities and include details of such through electronic means to Board members and in Board meeting packages for Board members' consideration. Board members are also encouraged to suggest educational programs that may provide value to the Board. Conferences requiring overnight lodging or other significant travel-related expenses should include an average of at least 5 hours of substantive educational content per day.

10) Board members shall attempt to meet the following minimum goals, provided sufficient budget resources are available:

   a) To secure, over time, a useful level of understanding in each of the topic areas listed in paragraph 6b above;

   b) To attend at least one conference annually, which includes at least 5 hours of substantive educational content per day of the conference; (Recommended conferences are listed in Appendix 1 of this policy)

   c) Regularly attend online educational events, e.g., webinars identified as relevant to the Board; and

d) Participate in in-house educational seminars or briefings that may be organized from time to time.

11) Board members shall annually complete the City training program on the Sunshine Ordinance and any other training programs mandated by the City. Attendance at such programs will be documented and reported to the Board Secretary on an annual basis.

Education Plan

12) The Board shall adopt a Board Education Plan covering a 1-3-year period and shall update the Plan as necessary.

13) The Board Education Plan may set out the educational goals of the Board, with key topics to be covered over time by the Board and individual board members, and shall cover both external and in-house education efforts. The Plan shall include a tentative schedule of topics to be addressed and associated timing.

Orientation Program

14) A formal orientation program, covering the general topic areas outlined in paragraphs 6b and 7 above will be developed by the Executive Director for new Board members. The orientation program will aim to ensure that new Board members are in a position to contribute fully to Board and committee deliberations, and effectively carry out their duties as soon as possible after joining the Board.

15) As part of the orientation process, new Board members shall, within 45 days of their election or appointment to the Board, be provided one or more general orientation sessions during which they shall be:

a) Briefed by the Executive Director on the history, background, and structure of SFHSS;

b) Oriented by the Executive Director and President on current issues before the Board;

c) Provided an overview of the current health plans and benefits, the benefit and funding policies of the Board, and how all such plans, benefits, and policies have evolved;

d) Introduced to members of senior management;

e) Provided a tour of SFHSS offices;

f) Briefed on their fiduciary duties, conflict of interest guidelines, *The Brown Act*, the *Sunshine Ordinance* and other pertinent legislation;

g) Provided with:

i. A Board Member Reference Manual (the contents of which are listed in Appendix 2 of this policy);

ii. A listing of recommended educational programs; and

iii. Other relevant information and documentation are deemed appropriate by the Executive Director.

16) Within 30 days of being appointed or elected to the Board or leaving the Board, Board members must complete a *Statement of Economic Interest and any other disclosure forms required by law*. The Board Secretary shall provide new Board members with any necessary assistance. Thereafter, Board members shall complete, and file said disclosure forms on an annual basis, or consistent with the requirements of applicable laws.

17) As part of the orientation process, the Executive Director shall also make available a series of in-house education seminars for the benefit of new Board members, generally within four (4) months of their election or appointment to the Board. Seminars will be designed and scheduled in consultation with the Board member(s) in question. Although intended for new Board members, any Board member may attend. The seminars will cover, at a minimum, basic health, and welfare-related topics including health plan design, actuarial topics, SFHSS operations, legislation, and trust/fiduciary law.

18) The Executive Director shall review and update the Board Reference Manual as needed. A master copy of the Board Member Reference Manual will be available for use by Board members at the SFHSS offices.

Continuing Education – In-House Education Seminars

19) Annually, the Executive Director shall, after seeking Board input, identify at least two (2) topics of relevance to the Board, and shall organize one or more in-house educational sessions on these topics. Such sessions may be appended to regular Board or committee meetings or be organizedas stand-alone sessions.

Attendance at Conferences & Association Meetings

20) Approval for attendance and reimbursement of travel expenses in connection with educational conferences or association meetings will be in accordance with the provisions set out in the SFHSS Board Travel Policy.

Reporting

21) Board members shall inform the Executive Director, for information purposes, of all health and welfare-related conferences attended, whether funded by SFHSS or not.

22) Attendees shall complete a brief written assessment of the quality and relevance of each conference attended (see Conference Attendance Form). The Executive Director shall review these assessments and update the list of recommended conferences as appropriate.

23) Upon returning from a conference, attendees may report to the Board on information or knowledge attained at the conference for the benefit of Board members who did not attend.

24) On an annual basis, the Board Secretary shall submit a report to the Board on the educational activities of the Board completed in the prior year. At a minimum, the report will summarize the implementation of the Board Education Plan including for example:

a) Attendance by Board members at conferences during the year;

b) Webinars made available to Board members;

c) Education sessions held during Board meetings;

d) Special in-house educational sessions held during the year; and

e) Other educational activities undertaken during the year.

Review

25) The Board shall review this policy at least every year.

History

26) The Board adopted this policy on February 22, 2007, amended it on April 9, 2015, February 14, 2019, and further amended it on February 10, 2022.

APPENDIX

Suggested Conferences, Seminars, and Webinars

The following associations or conference organizers have been found to provide informative educational conferences and webinars. Conferences typically also contain five (5) hours of substantive educational content per day, as required by the Board's travel policy. Board members are encouraged to visit their websites as a first step in identifying potential conferences to attend.

International Foundation of Employee Benefit Plans

Organizes an annual conference and other conferences and seminars throughout the year

Contact:
P.O. Box 69
Brookfield, WI 53008-0069
(888) 334-3327

APPENDIX

Board Member Reference Manual

A Board Member Reference Manual shall include the following materials

1) Most recent plan descriptions or member handbooks
2) Most recent Annual Report
3) Organizational chart
4) Contact information for the Executive Director and Board members
5) Listing of current committee assignments
6) Relevant City Charter and Administrative Code provisions
7) Terms of reference and Board policies
8) Glossary of key health and welfare administration terms and definitions
9) SFHSS Membership Rules and Regulations

APPENDIX

Travel Policy

Travel Authorization

1) Each Board member is generally limited to one seminar or conference requiring travel outside of San Francisco County and/or overnight lodging per fiscal year. No more than one conference per year mayinvolve travel to a destination outside the United States.

2) As a general rule, Board members should incur only those expenses that a reasonable and prudent personwould incur when traveling on official business.

3) Attendance by Board members at seminars and conferences requiring travel outside of San Francisco County and/or overnight lodging requires prior approval of the Board and is subject to the limits set out inparagraph 1.

4) Attendance by Board members at association meetings, due diligence visits, or other Board business requiring travel outside of San Francisco County and/or overnight lodging also requires prior Board approval.

5) All requests for business travel require approval in advance by the Board. A travel authorization form mustbe completed by the requestor and signed by the President of the Board or designee.

    a) Information required for authorization includes:

        i. Dates of travel and location

        ii. The business purpose of travel/training/conference

        iii. Estimated expenses including, but not limited to, when applicable, registration fee, cost of airticket, other transportation costs, and lodging must be itemized with details or any changes made by the Controller.

    b) The authorization form must be forwarded to Chief Financial Officer (“CFO”) to approve the useof funds and confirm all City requirements are met.

    c) The CFO shall forward the authorization form to the Executive Director for final preauthorization approval.

6) The acceptance of any gifts which enable Board members to attend seminars and conferences requires prior approval of the Board in strict compliance with Fair Political Practices Commission Regulations, section 18944.2.

7) Review and approval of educational travel will depend on the cost, substance, and quality of the seminar or conference. As a general rule, travel to a conference or seminar outside of San Francisco County and/or requiring overnight lodging should only be approved if the conference/seminar agenda contains an averageof five (5) hours of substantive educational

content per day. The Board may waive this requirement if the best interests of SFHSS would be served by such a waiver.

8) The Board recognizes that Board members are often considered experts in their professional fields or ashaving considerable experience as a Board member. As such, they may often be asked to speak at conferences. While SFHSS encourages the exchange of professional information, it must be evident that such speaking engagements would provide value to SFHSS before attendance is authorized on SFHSS' behalf.

Cost of Administration

9) Travel expenses of Board members shall be direct costs of administration to SFHSS and may not be paid through third-party contracts without the express approval of the Board or the Executive Director. Board members shall comply with applicable requirements for expenses paid or reimbursed by third parties.

Authorized Expenses

10) Authorized travel expenses include lodging, transportation costs, registration or attendance fees, meals, and other costs reasonably and necessarily incurred when the Board member is required to travel on official SFHSS Board business.

Limitation on Allowance of Time and Expenses

11) Allowance for time and expense shall not exceed that which is usual and reasonable as claimed by others to that precise destination. Normally, travel and arrival the evening before is authorized when meeting, conference, or seminar agendas calendar substantive content prior to 9:30 a.m. When substantive content continues after 5:00 p.m., lodging for that night is authorized. Reasonable additional expenses, e.g., lodging and per diem for extra days either before or after a conference, will be reimbursed if such extension results in lower overall trip costs.

Limitation on Car Rental

12) Normally, Board members shall be expected to use an airport shuttle service to metropolitan destinations unless it is more economical to rent a car, pay for parking, fuel. etc. Reimbursement of alternative modes oftransportation will be limited to the cost of the airport shuttle service unless otherwise justified, e.g., for reasons of personal safety or scheduling conflicts. As the City is self-insured, auto insurance is not reimbursable.

Cancellation of Travel and Lodging Arrangements

13) Normally, Board members are responsible for the timely cancellation of travel and lodging arrangements madeon their behalf so that no costs will be incurred by SFHSS.

Transportation Expense In Lieu Of Airfare

14) Airfare should be booked for economy/coach class only. Air tickets must be purchased in advance to takeadvantage of the most economical fares available. If the airline charges for checked luggage, only the cost ofthe first checked bag may be reimbursed.

15) Board members have the option of purchasing air tickets from a City-approved vendor or online directly. If Board members choose to purchase air travel online directly, they must document and demonstrate this option is the most economical by obtaining a comparative quote from a City vendor for the travel dates.

Lodging Expense

16) The most economical and practical accommodations available considering the purpose of the meeting, andother relevant factors will be reimbursed. For travel within the United States, the maximum reimbursement is the Federal per-diem General Services Administration ("GSA") rate for lodging. To stay within the maximum rates, conference discount rates and "government rates" should be used whenever possible.

17) In situations where lodging at GSA rates are not available, or business circumstances require the Board members to stay in a hotel that exceeds the federal per diem rate, reimbursement will be allowed if justifiedby business need, the most economical and practical lodging rates can be demonstrated, and pre-approvalby the President of the Board is obtained.

Filing Claims

18) Claims for reimbursement of travel expenses shall be submitted to SFHSS Finance staff within 30 days following completion of the travel for which such expenses are claimed.

19) Supporting documentation including, but not limited to, approved travel authorization forms, air or other itinerary, conference/meeting/workshop schedules and agendas, original itemized receipts, and proof of payment documents, must be submitted and itemized when filing travel claims.

Cash Advances

20) Cash advances will not be allowed unless specifically approved by the Board.

Expenses for Spouses

21) Expenses of travel companions, including spouses, are not reimbursable by SFHSS.

SAN FRANCISCO
HEALTH SERVICE SYSTEM
Affordable, Quality Benefits & Well-Being

APPENDIX 4

Education Resource Page

1) California Health Care Foundation
   - Events
   - Media
   - Topics
   - Projects
   - Collections
   - Investment

2) America's Health Insurance Plans
   - Issues
   - Research
   - News
   - Resources
   - Events

3) Kaiser Family Foundation
   - Newsroom
   - Perspectives

4) California Healthline
   - Spotlight
   - Daily Addition
   - Innovations

5) Employee Benefit News
   - Retirement
   - Employer Strategies
   - Regulation

6) International Foundation for Employee Benefits Health Service Board members are provided with membership
   - Trustee Resources
   - Annual conferences
   - Virtual Education and CEBS Learning Center.
   - News – log into your account to sign up for the daily newsletter.

7) Catalyst for Payment Reform
   - The Latest
   - Resource Library
   - Upcoming Events
   - Newsletter

8) Pacific Business Group on Health
   - Key Strategies
   - Programs
   - Publications

9) Integrated Healthcare Association

10) Employee Benefits Research Institute

203: SFHSS BOARD PERFORMANCE EVALUATION POLICY

Objectives

1) The Board recognizes that annual Board evaluations have become an accepted best practice in the area of Board governance. Accordingly, in keeping with the Board's desire to reflect best practices in all of its operations, the Board has adopted this Board Performance Evaluation Policy.

2) The objective of this policy is to set out a process by which the Board may engage in periodic self-assessment to continuously develop and improve its effectiveness as agoverning body.

Principles

3) The Board performance evaluation process should include the participation of all Board members and beconsistent with the provisions of *The Sunshine Ordinance* and *The Brown Act,* California Government Code sections 54950.

4) Management input into the Board's performance may be highly beneficial to the evaluation process, provided SFHSS management is given whatever level of anonymity it desires in the process.

5) The scope of the Board performance evaluation and any resulting actions should be limited to the activitiesand decision-making practices of the Board and Board members. Separate policies or practices will be used to evaluate the performance of the Executive Director.

Roles & Responsibilities

6) The Governance Committee shall be responsible for coordinating the implementation of this policy, including the approval of any survey forms or similar instruments to be used in the evaluation process, and the making of recommendations to the Board for addressing issues arising out of the evaluation.

Board Member Surveys

7) In about the fourth quarter of each fiscal year, the Governance Committee shall review any survey tools to be used in the evaluation process and make modifications as appropriate. Due to cost considerations, it isexpected that the evaluation will normally be administered using a survey.

8) The purpose of any Board survey instrument shall be to provide Board members with a framework for reviewing the performance of the Board and for raising, in an anonymous manner if desired, any concerns or suggestions Board members may have to improve the Board's performance. Survey forms may take anyformat deemed appropriate by the Governance Committee but must provide an opportunity for Board members to provide written comments or suggestions.

9) In about the fourth quarter of each year, copies of any Board surveys to be used will be distributed to each Board member with instructions for completing and submitting the survey.

10) Board members are required to complete and submit the survey within 14 days of receiving it. The Governance Committee shall determine the method for distributing, submitting, and tabulating the Survey, e.g., mail, internet, etc. Any summary report of findings will display the findings in a confidential manner.

Management Input

11) The Executive Director shall have the option of providing input on the Board's performance from members of SFHSS management or staff using the same survey instrument used by Board members. Alternatively, the Executive Director may develop a separate survey tailored for use by management and staff and shallreview the survey with the Governance Committee. Any such surveys shall provide an opportunity for written comments and suggestions.

12) The Executive Director shall determine which members of SFHSS management or staff shall be invited to complete a Board evaluation survey. Such surveys shall be completed and tabulated in a manner that ensures anonymity. To that end, the Executive Director shall invite as many members of management and staff as is reasonable and appropriate.

13) The Executive Director shall approve the summary of management's survey results prior to the results being shared with any member of the Board.

Reporting

14) Board and management survey results shall be summarized by an independent party, be determined bythe Governance Committee, and reviewed by the Governance Committee. Based on the results, the Governance Committee shall develop Committee recommendations for the Board's consideration.

15) The Governance Committee Chair shall report to the Board on the discussions, conclusions, and any recommendations of the Governance Committee.

16) The Board's discussions and any actions arising out of the evaluation shall be summarized in the Boardminutes.

Interviews

17) The Governance Committee may recommend to the Board that in certain years the above surveys be replaced or supplemented with personal interviews of Board members and management by an independent party to obtain more detailed or robust results.

Review

18) The Board shall review this policy at least once every three years.

History

19) The Board adopted this policy on February 22, 2007; amended it on April 9, 2015, February 14, 20219, and February 10, 2022.

204: SFHSS EXECUTIVE DIRECTOR PERFORMANCE EVALUATION POLICY

Background and Purpose

1) The Board believes that selecting, directing, and evaluating the SFHSS Executive Director is one of its most important responsibilities. In keeping with this responsibility, the Board has adopted this policy, which sets out an annual process to be followed in assessing the Executive Director's performance and communicating the results to the Executive Director.

Policy Guidelines

2) The Governance Committee shall be responsible for coordinating the Executive Director's performance evaluation process.

3) The Governance Committee, in consultation with the Executive Director, shall develop the criteriato be used in performing the evaluation. Quantitative criteria shall weigh 65% within the overall evaluation and qualitative criteria shall weigh 35%.

Qualitative Criteria

4) Qualitative criteria will generally be evaluated using a survey instrument or similar tool, to be developed by the Governance Committee and refined over time, with input from the Board as appropriate. Assessments of qualitative criteria by Board members that correspond to above or below "Satisfactory Performance" must be accompanied by examples and comments or they will not be considered. In cases where such assessments were not accompanied by examples or comments, the party responsible for administering the survey shall follow up with Board members and encourage them to provide such commentary.

5) All members of the Board are expected to complete the survey instruments or tools developed bythe Governance Committee as part of the Executive Director's evaluation.

Quantitative Criteria

6) Quantitative criteria shall reflect the strategic plan and shall be developed and refined over time as SFHSS develops methods for obtaining any necessary data and developing meaningful measures of performance.

7) To the extent possible, the Governance Committee shall obtain the necessary information or data to assess the quantitative criteria from independent sources, e.g., from the financial auditor.

Timing & Process

8) In the fourth quarter of each calendar year, Board members shall be provided copies of an evaluation survey addressing qualitative criteria and will have two weeks to complete and return them. Accompanying the survey will be a report from the Executive Director containing the Executive Director's assessment and any supporting information and documentation the Executive Director believes may be of value to the Board members in completing the survey.

9) The Chair of the Governance Committee shall work with the Executive Director and other partiesas necessary to gather and synthesize any data and information necessary to assess the objective criteria.

10) The Chair of the Governance Committee, with the assistance of the Board Secretary, shall ensure that all the information necessary to facilitate the evaluation of the Executive Director (quantitative and qualitative) is tabulated and summarized in a report, and will review the results with the Governance Committee. Any Board member input provided shall not be anonymous.

11) In a closed session, the Chair of the Governance Committee shall present to the Board a summary of the evaluation results along with the Committee's findings and recommendations for Board discussion and approval. A summary of the evaluation will be placed in the Executive Director's personnel file.

12) The Executive Director shall be allowed to attend any meetings of the Board or its committees at which the Executive Director's performance is to be reviewed and discussed and the Executive Director shall have an opportunity to respond to any of the Board's findings prior to the Board completing its evaluation. Such meetings will be held in closed sessions, as provided for by applicable open meeting laws. If the Executive Director chooses not to attend the Board meeting at which the Board finalizes the Executive Director's performance evaluation, the Chair of the Governance Committee and the President of the Board shall subsequently meet with the Executive Director to review the Executive Director's evaluation.

13) Minor changes to the Executive Director Evaluation Survey may be made by the Governance Committee provided, however, the survey continues to reflect the subjective evaluation criteria approved by the Board. Material changes to the Survey shall be reviewed with the Board.

14) The Governance Committee shall generally hold a mid-year review with the Executive Director to assess progress, adjust goals and objectives if necessary, and identify potential issues or concerns. The Governance Committee shall report the results of the mid-year review to the Board along with any recommended adjustments to the evaluation criteria.

Compensation and Bonuses

15) The Board annually shall review the Executive Director's compensation and consider changes that may be feasible under existing City policies or programs.

Review

16) The Board shall review this policy at least every three years.

History

17) This policy was adopted by the Board on February 22, 2007, and amended on April 9, 2015, February 14, 2019, and February 10, 2022.

SAN FRANCISCO
HEALTH SERVICE SYSTEM
Affordable, Quality Benefits & Well-Being

205: SFHSS MONITORING AND REPORTING POLICY

Introduction

1) In carrying out its responsibility to monitor and oversee the operations of the SFHSS, the Board receives numerous reports on various topics, from different parties, and with different frequencies. While some of the reports are ad hoc in nature, many are routine. The Board has adopted this policy to help ensure that the system of routine reporting is clear and systematic and will evolve over time to continue to meet Board needs.

Policy Guidelines

2) The Board shall be provided the routine reports including, but not limited to, those outlined in Appendix 1 of this policy with the frequency set out in Appendix 1.

3) Requests by Board members for additional routine reports shall require Board approval and an amendment to Appendix 1 of this policy.

Review

4) The Board shall review this policy at least every three years.

History

5) The Board adopted this policy on February 22, 2007, amended it on April 9, 2015, February 14, 2019, and February 10, 2022

APPENDIX 1

Scheduled Board Reports

#	Report Name	Frequency of Report	Prepared By	Presented By	Description/Purpose
Governance Reports					
1	Report to Mayor	Annually	Executive Director	Executive Director	Charter Section 4.103 requires the Board to file an annual report of activities with the Mayor's Office & Clerk of the Board of Supervisors
2	Board Education Plan	Annually	Governance Committee	Chair of Governance Committee	Summarizes the Board education goals and tentative schedule/timing of selected topics
3	Board Education Report	Annually	Governance Committee	Chair of Governance Committee	Summarizes Board training and educational activities (both internal and external) and individual Board members.
4	Board Performance Report	Annually	Governance Committee	Chair of Governance Committee	Summarizes the results of the Board self-evaluation process, including follow-up actions.
5	Executive Director Evaluation Report	Annually	Governance Committee	Chair of Governance Committee	Summarizes the results of the Executive Direction evaluation process.
Investment Reports					
6	Investment Policy Compliance Report	Annually	CFO	TBD	An assessment of the extent to which the Board's investment policy statement was compiled during the year.
7	Investment Performance	Annually	CFO	TBD	Summarizes investment performance of Health Service Trust Fund in the past year
Benefits Administration and Member services Reports					
8	Member Services Review	Annually	COO	TBD	Assessment of the adequacy of health care provided for members, fee schedules, compensation paid for all services rendered, and the general affordability of administered plans
9	Demographics Report	Annually	ESA	TBD	Review of the member participation levels with the health plans
10	10-County Report	Annually	Finance	TBD	Summarizes results from a survey of the 10 largest counties in California that assessed the average contribution made by county employees' health benefit coverage
Funding and Accounting Reports					
11	Audit Report	Annually	External Auditor	External Auditor	Review of annual audited financial statements and external auditor's management letter.
12	Report of Reserves	Quarterly	CFO	CFO	Summarizes the levels of the reserves.
Operations and Risk Management Reports					
13	Service Provider Review	Annually	Executive Director	Executive Director	Assessment of the performance of key service providers, including but not limited to insurance carriers and third-party administrators, relative to pre-established performance criteria
14	Risk Management Report	Annually	Executive Director	Executive Director	Summarizes ongoing system of operational risk management

206: SFHSS BOARD COMMUNICATIONS POLICY

Introduction & Objectives

1) Effective, coordinated, and accurate communication by the Board and Board members is essential to ensuring compliance with fiduciary obligations and to achieving operational effectiveness. To help achieve this, the Board has adopted this policy to guide Board membercommunications. The policy is intended to:

    a) Ensure efficient and effective communications among Board members, staff, service providers,and stakeholders;

    b) Serve and protect the interests of plan members and beneficiaries through consistent and accurate communication; and

    c) Maintain a reputation of professionalism and integrity.

Principles

2) The Board is most effective when it communicates as one body with a single voice.

Definitions

3) Throughout this policy, the term “communication” shall refer to all forms of communication including written, oral, or electronic communications.

Guidelines
Communication with Board Members and Staff

4) Board members shall communicate in a respectful, honest, and constructive manner during all Board and committee meetings, and in all interactions with staff, service providers, and the public at large.

5) Only the Board or a committee may request information from staff or assign work to the Executive Director.

Public Communications

6) Public communications on the part of the Board or SFHSS shall generally occur through a spokesperson designated by the Board or the Executive Director respectively. The designated spokesperson for the Board shall normally be the President or the Executive Director. The Board expects that the President and Executive Director shall confer to determine which of them shall act as spokesperson on a case-by-case basis.

7) In carrying out their duties, spokesperson(s) shall:

    a) Confer with the Executive Director, President, the Board, or City Attorney as appropriate prior to engaging in official communications;

b) Communicate only official positions of the Board and not make unilateral commitments on thepart of the Board; and

c) Report back to the Board on any communications undertaken in their capacity as a spokesperson.

8) Board members who are not designated spokespersons, and who nevertheless wish to communicate publicly on matters relating to the SFHSS, shall take all reasonable steps to ensure that they communicate the policies, positions, and deliberations of the Board clearly and accurately.

9) As a courtesy, Board members are encouraged to appraise the President and the Executive Director of any public communications they may have concerning the SFHSS. At a minimum, however, Board members shall inform the Executive Director and the President or Vice-President of any communication they engage in that might reasonably be expected to result in media exposure for the SFHSS.

10) Board members are strongly advised to review in advance with the President and the Executive Director any communications they intend to make or release publicly, and to make any modifications recommended by them regarding the accuracy of such communications.

11) If any Board member publicly communicates a personal opinion that is inconsistent with a policy or decision of the Board, they shall disclose to their audience that they are expressing a personal opinion and that such opinion does not reflect the policies or decisions of the Board.

12) If a Board member votes with the losing side on an issue, the member is expected to nevertheless respect and support the decision of the majority. Reconsideration of Board actions may occur consistent with the Board Operations Policy. The Board recognizes that some Board members must function in capacities other than that of a Board member and, as such, may believe they must express publicly their disagreement with a decision of the Board. In such instances, the Board expects that they shall do so in an open, constructive, and professional manner.

Communication with Members and Beneficiaries

13) The Board does not intend to unduly restrain communications by Board members with plan members and beneficiaries. The Board also recognizes that Board members are generally not qualified to communicate technical details concerning the SFHSS and its numerous benefit plans and that providing inaccurate or incomplete information to members may cause confusion or harm.

Accordingly, Board members shall exercise judgment and discretion whenever communicating with plan members and beneficiaries, and shall be aware of and comply with the following guidelines to protect the SFHSS, Board members, and, most importantly, plan members and beneficiaries:

a) Board members may communicate general information or simple, factual, information to members and beneficiaries only where there is no risk of communicating inaccurate or conflicting information;

b) Board members may not provide plan members or beneficiaries with education, advice, or technical information pertaining to the benefit provisions of SFHSS. Instead, Board members should refer such members or beneficiaries to the SFHSS website, the SFHSS Member Services Department, or the Executive Director, as appropriate;

c) Board members who, in their capacity as members of the Board, wish to meet with groups ofplan members, beneficiaries, or stakeholders, for the purposes of conducting a meeting, presentation, or similar exchange shall exercise discretion and may:

   i. Dates Inform the Executive Director and, when possible, arrange for an SFHSS staff person to be present at the meeting to help ensure all communications accurately reflect the policies, positions, or benefit provisions of SFHSS; or

   ii. Provide the Executive Director copies of the written materials the Board member intends to distribute at the meeting.

External Communications – Service Providers

14) Board members agree to abide by the black-out period provisions pertaining to service providers as specified in the Service Provider Selection Policy.

15) Individual Board members shall not direct or otherwise assign work to service providers. Instead, all direction or requests to service providers shall occur at a Board, or committee meeting, or be channeled through the Executive Director. Furthermore, Board members shall not direct plan members to contact service providers directly. They should be directed to contact SFHSS staff.

Review

16) This policy shall be reviewed at least every three years.

History

17) This policy was adopted by the Board on February 22, 2007, and amended on April 9, 2015, February 14, 2019, and February 10, 2022.

207: SFHSS SERVICE PROVIDER AND VENDOR SELECTION POLICY

Purpose

1) The Service Provider/Vendor Selection Policy is intended to establish general guidelines by which service providers will be selected, evaluated, or terminated by SFHSS.

Roles and Responsibilities

2) The role of the Board with respect to the selection of service providers is to:

    a) Establish appropriate policies to help ensure prudent and sound selection decisions are made including, but not limited to, providing input to management about broad policy directions or specific goals and guidelines, prior to the drafting of a Request for Proposals ("RFP");

    b) Monitor compliance with such policies;

    c) Approve the award of a contract with the following primary service providers:

        i. Actuary;

        ii. Plan Administrators;

        iii. Hearing officers or firms providing the services of hearing officers;

        iv. Third-party administrators retained for services in connection with non-charterbenefits and with contract values in excess of $500,000 annually;

        v. Information technology consultants retained for services with contract values in excess of $500,000;

        vi. Medical Director; and

        vii. Other service providers, as may be determined by the Board.

3) The Executive Director shall be responsible for selecting service providers/vendors other than the above primary service providers, consistent with the operating budget and other applicable policies of the Board and the City and County of San Francisco, and for keeping the Board apprised of such appointments when material.

4) Notwithstanding paragraph 3 above, if the Executive Director determines that specific circumstances suggest that it would be prudent for the Board to approve the award of a contract to a particular service provider that is not a primary service provider, the Executive Director may elect to submit a selected service provider to the Board for its approval.

5) The Executive Director and department personnel shall initiate and conduct the solicitation for contracts and shall apprise the SFHSS Board about the selection process.

6) It is recognized and understood that the following services are provided or coordinated by various departments within the City:

    a) Financial and operational audit services;

    b) Custody services;

    c) Legal services;

    d) Investment management and advisory services; and

    e) Information technology services.

7) The Executive Director shall be responsible for ensuring that all necessary search and due diligence activities are carried out, with assistance from external advisors or experts as required.

The Search Process
General Guidelines

8) The selection of all service providers shall be made in the best interests of SFHSS members and beneficiaries in keeping with the fiduciary responsibilities of the Board and staff and will be consistent with the SFHSS and City policies.

9) The Board and the Executive Director shall make a good faith effort to retain and utilize the services of disadvantaged business enterprises, on a primary or sub-contract basis, when those services or products are provided consistent with the fiduciary responsibilities of the Board and staff.

Black-Out Periods

10) The Board shall initiate a “black-out period” when notified that SFHSS will initiate a search process resulting in the release of an RFP, Request for Qualifications (“RFQ”), other formal solicitations for the selection of a primary service provider, or the expansion of a relationship with an existing primary service provider.

11) Black-out periods will be instituted at a Board or committee meeting. Written notification will be issued to all Board members that are not present at said meeting. A black-out period may also be instituted between Board meetings at the discretion of a Board acting as a committee of the whole. The Executive Director shall provide written notification to all Board members of all black-out periods instituted between Board or committee meetings as soon as possible. Board members shall comply with the black-out period restrictions upon receipt of the Executive Director’s notification.

12) The initiation of a black-out period, and the types of providers to which it applies, will be specified in the minutes of the Board meeting at which it was approved or ratified by the Board. Where it is not possible to specifically define the types of service providers to which a black-out period applies, Board members shall make good faith efforts to comply with the intent of the black-out period provisions by

taking all reasonable efforts to determine if service providers they may communicate with are potential candidates in an SFHSS process.

13) During black-out periods, Board members shall not communicate with service providers who may provide the types of services for which the solicitation is being issued, except during Boardor committee meetings. Board members who need to communicate with such service providers for reasons unrelated to SFHSS business agree to disclose such needs in writing to the Executive Director and the Board prior to undertaking such communications. Disclosure to the Board shall be made at a meeting of the Board. If time does not permit timely disclosure to the Board, the Board member shall then provide written disclosure of the intended communication to the President, or the Vice President if the Board member in question is the President.

14) During black-out periods, service providers participating in or considering participating in an SFHSS search process shall not communicate with Board members except during Board or committee meetings. This requirement shall be included in all RFPs and RFQs issued by SFHSS. Any service provider found to violate the black-out provision may be subject to disqualification from the search process by the Board.

15) Board members found to have knowingly violated the black-out provisions may be subject to any penalties or other actions of the Board as set out in the SFHSS Statement of Incompatible Activities or the Code of Conduct.

16) For black-out period provisions, communications include telephone conversations, letters, and e-mail.

17) A black-out period will cease when a successful bidder has been selected to a contract or agreement with SFHSS, enters signs into a contractual arrangement with HSS or the City and County of San Francisco, or the search process is otherwise ended by the Board.

Contracts

18) The Executive Director shall negotiate and execute all agreements approved in connection with service providers. In negotiating contracts or contract renewals, the Executive Director may seek the assistance of Board members as appropriate.

19) All contracts and similar arrangements for the engagement of service providers shall comply with applicable laws and regulations.

20) Annually, the Executive Director shall provide the Board a two-year budget which provides details on the types of services that SFHSS will be issuing solicitations for during that time period. The notice of the “black-out” will serve as a notification that SFHSS has created an RFP or RFQ. The Board shall approve the award of the contract.

Monitoring and Reporting

21) All service providers shall be subject to regular monitoring of performance and expenditures and periodic reviews, as appropriate, throughout the term of their contract. Criteria for review may

include performance, staff satisfaction, the competitiveness of fees, quality of reporting, the accuracy of assumptions and forecasts, and adherence to budget.

22) The Executive Director shall report regularly to the Board on all monitoring efforts involving service providers, identifying any material issues or actions taken in a timely fashion.

23) All monitoring and reporting provisions contained in this policy serve as minimum requirements. If more stringent requirements are established within other policies of SFHSS, such requirements will prevail.

24) The Executive Director shall report to the Board any material failures by named service providers to comply with the terms of their contract.

Review

25) The Board shall review this policy at least every three years.

History

26) The Board adopted this policy on February 22, 2007, and amended it on April 9, 2015, February 14, 2019, and February 10, 2022.

208: SFHSS STRATEGIC PLANNING POLICY

Introduction

1) Like every complex organization, SFHSS continually faces new challenges and opportunities and has limited resources with which to address them. Organizational success requires that SFHSS have an effective planning process to set SFHSS' strategic direction, identify specific business priorities, effectively allocate resources to such priorities, and plan for their successful completion. The Board has established this Strategic Planning Policy to provide guidance to the SFHSS's planning process.

Objectives

2) The objectives of the Strategic Planning Policy are to:

    a) Ensure SFHSS actively and systematically plans for the future needs of the SFHSS;and

    b) Facilitate consensus by the Board and the Executive Director on the direction, needs,and priorities of the SFHSS.

Principles

3) An effective planning process should strike an appropriate balance between ensuring a systematic approach to planning, encouraging creativity in identifying business issues andsolutions, and ensuring sufficient flexibility to respond to changing circumstances.

Policy Guidelines
Roles and Responsibilities

4) The Executive Director shall be responsible for:

    a) Identifying risks, opportunities, and needs of the SFHSS;

    b) Identifying and prioritizing business initiatives; and

    c) Recommending a Strategic Plan to the Board for its consideration.

5) The Board shall be responsible for playing a policy and oversight role in the planning process which will include:

    a) Approving the Strategic Planning Policy and any amendments thereto;

    b) Providing the Executive Director with input into the broad direction of the SFHSS and possible initiatives to be included in the Strategic Plan;

    c) Approving the Strategic Plan and ensuring adequate resources are in place tosuccessfully implement it; and

    d) Monitoring the implementation of the Strategic Plan.

The Annual Planning Process

6) In approximately the fourth quarter of each calendar year, the Executive Director shall present and discuss the following issues with the Board:

    a) The status of the current year's Strategic Plan which can be in the form of the draft annual report;

    b) Current business needs, risks, or opportunities of the SFHSS; and

    c) A prioritized list of proposed business initiatives with supporting rationale.

7) Based on the above review and discussions, the Executive Director with input from senior staff shall prepare a draft Strategic Plan. The Executive Director shall have discretion in determining the most effective or appropriate format for the Strategic Plan, however, it is expected that the plan will generally include the following components:

    a) The SFHSS mission statement including any necessary detail or elaboration;

    b) A discussion of current business needs, risks, and opportunities;

    c) Proposed business initiatives accompanied by rationale and appropriate analysis, data,and parameters including for example:

        i. Expected outcomes of each initiative;

        ii. Timelines for completion;

        iii. Assignment of responsibilities for implementation;

        iv. Resource implications;

        v. Risk analysis; and

        vi. Criteria for assessing the success of the initiative.

8) In the first quarter of each year, the Executive Director shall present the draft Strategic Plan tothe Board for its consideration and approval.

9) Should the Executive Director determine that changing circumstances will not allow the Executive Director to meet a particular parameter associated with a Strategic Plan initiative, the Board shall be informed in a timely manner.

Review of Strategic Plan Status

10) The Executive Director shall review the status of each initiative in the Strategic Plan mid-year.

Strategic Session

11) As a separate but complementary element of the SFHSS's strategic planning process, the Board shall strive to organize at least one strategic session annually to engage in informal strategic discussions and related education or information-sharing. The focus of such sessions may vary each year but should be a forward-looking attempt to identify and understand trendsor issues that may affect the future of health care. The session should allow for more informal interaction among board members, senior staff, and potentially service providers or stakeholders. The strategic session may, but need not, result in specific initiatives for inclusionin the strategic plan.

Review

12) The Board shall review this policy at least every three years.

History

13) The Board adopted this policy on February 22, 2007, and amended it on April 9, 2015, February 14, 2019, and February 10, 2022

209: SFHSS TRUST FUND INVESTMENT POLICY

Background and Purposes

1) The SFHSS was established through a City Charter amendment in 1937. (Charter section A8.420.) Charter Section 12.203 established the Health Service System Fund ("SFHSS Trust Fund") and provides:

    a) The Health Service System fund shall be a trust fund administered by the HealthService Board in accordance with the provisions of this Charter solely for the benefit of the active and retired members of the Health Service System and the covered dependents. The City and County, School District, and Community College District shall each contribute to the Health Service System Fund amountssufficient to efficiently administer the Health Service System.

The SFHSS Trust Fund was established to facilitate the contributions and disbursements of the System, while also providing a funding source to ensure payments could be made if disbursements exceeded contributions for a period of time. See also Charter section A8.429, which provides that:

    b) The health service board shall determine and certify to the controller the amount to be paid monthly by the members of the system to the health service system fund for the purposes of the system hereby created. The controller shall deduct said sums from the compensation of the members and shall deposit the same with the treasurer of the City and County to the credit of the health service system fund. Such deductions shall not be deemed to be a reduction of compensation under any provision of this Charter.

    c) The health service board shall have control of the administration and investment of the health service system fund, provided that all investments shall be of the character legal for insurance companies in California. Disbursements from the fund shall be made only upon audit by the controller and the controller shall have and exercise the accounting and auditing powers over the health service system fund which are vested in him by this Charter with respect to all other municipal boards, officers, and commissions

The purpose of this Investment Policy Statement is to set forth the objectives andconstraints on the Fund and to establish appropriate guidelines and options for investing Fund assets. This statement is intended to incorporate sufficient flexibility to accommodate current and future economic and market conditions, as well as any changes in applicable statutory and regulatoryrequirements.

Definitions

2) Please use the following definitions.

    a) Recordkeeper: The term "Recordkeeper" shall mean the individual, entity, or organization responsible for maintaining and updating the information regarding the Fund balance, reserves, and other duties necessary to maintain the proper accounting of the Fund.

b) Custodian: The term "Custodian" shall mean the custodian bank which holds the assetsof the Fund.

c) Investment Advisor: The term "Investment Advisor" shall mean a registered investment advisor who the Board may, but is not required to, retain to provide advice or other assistance to the Board with respect to the Fund investments and administration.

Statement of Investment Goals and Objectives

3) The purchase and administration of health and other benefits necessitate significant cash inflows and outflows in the Fund. Therefore, the primary objective of the Fund is to act as a temporary repository of assets before such assets are disbursed. The Fund's investment objectives include the following:

a) Safety: To maintain the safety of the principal and ensure that investment of the Fund assets are undertaken in a manner that seeks to preserve capital while complying with relevant statutory requirements;

b) Liquidity: To maintain sufficient liquidity to enable HSS to meet all obligations when due;

c) Cost Control: To control costs of administering the Fund and managing Fund Assets while assuring sufficient flexibility to meet future needs; and

d) Return on Investment: To enable the Fund to maximize return within reasonable and prudent levels of risk consistent with investment objectives with low-risk assets.

Fiduciary Standards

4) The Board is the fiduciary for the SFHSS Trust Fund and is charged with governing the Fund. As Trustees of the Fund, Board members are fiduciaries. As fiduciaries, the Board members must comply with applicable fiduciary standards including, but not limited to, the prudent person standard set forth in California Constitution Article 16, Section 17(c); the California Uniform Prudent Investor Act ("UPIA"); and California Government Code Section 53600.3.

In addition, the SFHSS Board Governance Manual requires that the Board shall be responsible for approval and subsequent review of a written policy statement, ensuring responsible management thereof, compliance with the policy, and ongoing review of investment performance.

Use of Investment Advisor and Other Professionals

5) The Board may retain a registered investment advisor ("Investment Advisor") to provide adviceand other assistance to the Board to help it fulfill its obligations with respect to the Fund investments and administration. The Investment Advisor's services and the fees charged for those services must be set out in a written agreement with the Board under which the Investment Advisor acknowledges that it is a co-fiduciary with respect to the SFHSS Trust Fund.

6) **Allocation of Responsibilities**

a) **Board's Responsibilities:** As set forth in Charter section A8.429, the Board "shall have control of the administration andinvestment of the health service system fund, provided that all investments shall be of the character legal for insurance companies in California." (Charter Section A8.429; see also California Insurance Code sections 1170-1202 and Government Code sections 53600 et seq.) In performing this function, the Board shall:

i. Prepare and maintain a written investment policy statement (e.g., this Statement), review the statement periodically, and make changes to such statement, as appropriate from time to time;

ii. Designate certain investments that may be made under the SFHSS Trust Fund;

iii. Establish and implement a disciplined process for selecting, monitoring, and retaining or terminating investments;

iv. Take appropriate action if investment objectives are not met or investment policies or guidelines are not followed.

The Board shall also:

v. Select and monitor the performance and fees of the Investment Advisor, if retained, a Recordkeeper and other providers for the SFHSS Trust Fund as it deems appropriate; and

vi. Review all agreements between the SFHSS Trust Fund and service providers to ensure adherence to statutory requirements.

b) **Controller Responsibilities:** The Controller shall have the responsibilities set out by law, which shall include:

i. Deducting the requisite amounts, as determined by the Board, from the members' compensation;

ii. Depositing such amounts with the Treasurer; and

iii. Exercising accounting and auditing powers over the SFHSS Trust Fund.

c) **Custodian's Responsibilities:** The Custodian is responsible for safekeeping the SFHSS Trust Fund's assets. The duties and responsibilities of the Custodian include:

i. Maintaining possession of the SFHSS Trust Fund assets (directly or through a sub-custodian);

ii. Collecting all income and dividends owed to the SFHSS Trust Fund;

iii. Settling all transactions (buy-sell orders);

iv. Valuing the SFHSS Trust Fund's holdings; and

v. Providing monthly reports that detail transactions, cash flows, securities held, their current value, and other portfolio statistics in accordance with the California Government Code.

d) **Investment Advisor's Responsibilities:** The Investment Advisor, if retained shall provide investment advice to the Board concerning the investment of Fund assets consistent with the investment objectives, policies, and constraints included in the Investment Policy Statement, as amended from time to time. The investment Advisor's responsibilities include:

i. Assisting in the creation, review, and revision of a written investment policy statement;

ii. Assisting in the establishment and implementation of a disciplined process for selecting,monitoring, and retaining or terminating investments;

iii. Providing independent and unbiased information;

iv. Assisting in investment option mapping where deemed appropriate;

v. Assisting in the control of investment expenses, including helping to negotiate investment, record keeper, and other service provider fees;

vi. Reporting annual investment performance results to enable the Board to evaluate investment performance in light of existing goals and objectives;

vii. Performing such other services for the SFHSS Trust Fund as agreed to by the Board and the Investment Advisor from time to time.

e) **Treasurer's Responsibilities:** The Treasurer shall be responsible for those funds required for daily cash flow and all additional funds delegated to the Treasurer for investment that exceeds the amounts for daily cash flows and reserves.

Investment Options

7) The Board, with the assistance of the Investment Advisor, if retained, shall consider several factors when determining the most prudent course of investing the SFHSS Trust Fund's assets in excess of the amount needed for daily cash flow and reserves, including:

a) The goals and constraints of the SFHSS Trust Fund (see Section 3.0 Statement of Objectives above);

b) The investment's track record;

c) The performance as compared to an appropriate benchmark;

d) The investment risk;

e) The vestment strategy, any changes investment strategy, and adherence to stated strategy over time;

f) The fees and expenses associated with the investment;

g) Qualitative characteristics, including, but not limited to, management strategy, the strategy of assets under management, turnover, and recent portfolio activity in view of the current market conditions; and

h) Qualitative characteristics, including, but not limited to, management strategy, the strategy of assets under management, turnover, and recent portfolio activity in view of the current market conditions; and

i) Such other information as the Board and Investment Advisor deems appropriate. In selecting investment options for the SFHSS Trust Fund, the Board shall comply with California Government Code, Section 53600, and may not invest in any investments not specifically authorized by California Code, Section 53600. In general, Section 54600 limits local agency investment funds to high-quality, fixed-income securities with maturities of less than five years. Securities with a maturity of greater than five years require approval by the Board of Supervisors. For example, permitted securities include:

    i. Obligations of the United States Government (“Treasuries”), federal agencies, municipalities, and negotiable Certificates of Deposits (“CD”) are allowed with a maximum maturity of five years;

    ii. Medium-term corporate bonds (“A” or better) and asset-backed securities with a maximum maturity of five years;

    iii. Repurchase agreements with a maximum maturity of one year;

    iv. Commercial paper with a maximum maturity of 280 days;

    v. Bankers’ acceptance notes with a maximum maturity of 180 days. Prohibited securities include, but are not limited to, Commercial Mortgage-Backed Securities, high yield bonds, convertibles, non-United States denominated investment-grade bonds, emerging market debt, equities, commodities, real estate, hedge funds, and private equity. Additional guidelines on permissible and prohibited investments are set forth in Government Code sections 536001 to 53610 attached hereto.

j) The following options currently satisfy the above factors:

    i. Investment assets in the City of San Francisco’s Treasury Pool (which complies with California Government Code 53600). Investment in the City and County of San Francisco’s Treasury Pool also meets Section 16 of the Health Service Board’s Governance Manual (reference above). If adopted, the Board shall receive quarterly written updates on the performance of the Treasury Pool and annual updates from

Treasurer and Tax Collector staff;

ii. Investing assets with external investment managers to run a portfolio that will comply with the California Government Code; or

iii. Making direct purchase of investment assets. Investment options #2 and #3 above are limited to investing the funds balance less: (i) obligations (funds required for daily cash flow); and (ii) reserves.

Monitoring of Investments

8) The Board shall decide the most appropriate options for investment of the SFHSS Trust Fund, and shall monitor the investment options on an ongoing quarterly basis. No less than every three years the Board shall review the SFHSS Trust Funds' performance in detail. Material changes in market conditions or changes to the investment team managing the Fund assets or the team's strategy would require a timelier review.

Review

9) The Board shall review this Investment Policy Statement periodically, but not less than every three years, to determine whether the investment objectives are still relevant. It is not expected that this Statement will change frequently. In particular, short-term changes in the financial markets should not require adjustments to this Investment Policy Statement.

10) This Investment Policy Statement acknowledges that Section 53600 of the Government Code is more restrictive than the California Insurance Code, however, both must be considered when investing Fund assets.

11) The City and County of San Francisco's Treasury Pool's investment priorities of safety, liquidity, and return should align with the objectives of the SFHSS Trust Fund. The Treasury Pool's Investment Policy is reviewed and monitored by the Treasury Oversight Committee pursuant to City and County Administrative Code Section 10.80-1.

Effective Date

12) The policy is effective immediately upon Board approval. This Investment Policy Statement shall guide the Board and the Investment Advisor, if retained, shall remain in effect until amended by the Board. Nothing contained in this Statement shall provide to any participant or beneficiary the right to challenge the terms of this Investment Policy Statement. Subject to relevant statutory requirements, the Board shall have full discretion as to how it selects and monitors the investments and the application of this Investment Policy Statement to any specific situation.

210: SFHSS CONTINGENCY RESERVE POLICY

Policy Objectives

1) It is prudent for an administrator of a self-funded and flex-funded benefit programs to establish a Contingency Reserve, otherwise known as excess loss reserve, to absorb financial strain brought about by adverse claims experience. A Contingency Reserve is funding reserve to cover the risk of claims in excess of the expected claims target used in the underwriting rate setting process.

2) Independent of the ability of a self-funded benefit plan to access external dollars to fund adverse experiences, it is prudent and sound to consider implementing a Contingency Reserve. It allows the Plan Sponsor to establish a budget based on a predetermined funding level and maintain that structure regardless of claims experience level.

3) Establishment of the Contingency Reserve serves the same purpose as external stop loss insurance, and therefore external stop loss insurance will not be purchased except where required by the health plan.

Contingency Reserve Policy

1) This policy standardizes the SFHSS ***Contingency Reserve*** setting methodology for self-funded health plans. The purpose of the Contingency Reserve is to establish reserve funds that are available in the event claims are in excess of target costs. The Contingency Reserve policy is specific to SFHSS' flex and self-funded medical and prescription drug plans:

    a) Flex-Funded Medical/Rx HMO Plans (non-capitated costs) and

    b) Self-Funded PPO Medical/Rx PPO Plan(s)

The methods specified in this document will be applied for Contingency Reserve estimation as of at the end of each fiscal year.

Definitions

2) *Contingency Reserve*: Any actuarial estimate is based upon the information available at a point in time and is subject to unforeseen and random events. At any point in time, estimated reserves may be higher or lower than required. Future funding projections will generate revenue that may be higher or lower than actual experience. Multiple factors impact the eventual experience of the self-funded and flex funded health plans. The range of plausible results around the best estimate rates would consider:

    a) Random variation from expected claims;

    b) Credibility of the experience;

    c) Fluctuations in large claims experience;

    d) Vendor processing stability;

e) Changes in COBRA enrollment; and

f) Catastrophic events and whether to make allowance or not.

The Contingency Reserve is intended to immunize against such adverse experience. *Large Claims Reserve*: a subset of the Contingency Reserve. The Contingency Reserve accounts for all claims over the projected claims target level. The Large Claims Reserve accounts for all large claims over a certain threshold. Since all large claims over the threshold are also over the projected claims target level, they are already being accounted for in the Contingency Reserve.

Contingency Reserve Methodology

3) To establish the Contingency Reserve(s), linear regression is used, specifically:

   a) The City and County of San Francisco's third-party administrator(s) provide either 36 or48 months of claim data which the actuarial consultant firm summarizes by incurred and paid period. This data is separate for medical/prescription drugs for each plan.

   b) These amounts are converted to a per employee per month ("PEPM") basis and linear regression is performed on the monthly PEPM values.

   c) The regression data is used to determine the predicted monthly values and the corresponding monthly variances, as well as the predicted annual claims per employee per year ("PEPY") and corresponding variance PEPY.

   d) Using the predicted claims PEPY and variance PEPY, the expected value is calculated at a particular level of confidence. This is done by using the normal distribution. For our analysis, we use three levels of potential excess cost; confidence levels of 95%, 97%, and99%.

   e) The gross Contingency Reserve is the difference between the cost at a particular confidence level and the projected PEPY costs times the anticipated enrollment, plus a margin between 0% and 10%.

   f) The actuarial consultant firm presents the analysis at the three levels of confidence (95%, 97%, and 99%) to the HS Board for final determination of the approved contingency reserve amount for each plan

Review

4) The Board shall review this policy at least every three years.

Policy History

5) The Board adopted this policy on March 12, 2008, and amended it on March 14, 2013, February 13, 2014, February 10, 2022, January 12, 2023, and December 12, 2024.

211: SFHSS SELF-FUNDED PLANS' RATE STABILIZATION POLICY

Policy Objectives

1) The objective of a stabilization reserve is to spread any underwriting surpluses or shortfalls into the future year's premium calculation in an even-handed manner such that the Employers and membership are not subject to volatile year-over-year changes in premium.

Rate Stabilization Policy

2) This policy standardizes the methodology that will be used to incorporate the impact of prior year revenue surpluses and shortfalls against projected expense in future self-funded plans' premium rate requirements. The purpose of a Stabilization Policy is to even out the premiumfluctuations year-to-year.

3) The SFHSS flex and self-funded health plans covered by this policy include:

    a) Flex-Funded/Self-Funded HMO Plan(s)

    b) Self-Funded PPO Plan

    c) Self-Funded Dental PPO (for Actives only)

4) As described in the Methodology section below, a rolling three-year period will be used to reflect prior year revenue surpluses and shortfalls against projected expense in the flex or self-funded plan.

5) The methods specified in this document will be applied annually during the rate-setting processto plan year premium rates using the revenue excess or shortfall experienced during the prior plan years.

6) The actuarial consultant firm presents the recommendation and supporting analysis to the Board for approval of the stabilization reserve calculation each year during the rate-setting process.

Definitions

7) Contingency Reserve: Any actuarial estimate is based upon the information available at a pointin time and is subject to unforeseen and random events. At any point in time, estimated reserves may be higher or lower than required. Future funding projections will generate revenue that may be higher or lower than actual experience.

8) Multiple factors impact the eventual experience of the self-funded health plans.The range of plausible results around the best estimate rates would consider:

    a) Random variation from expected claims;

    b) Credibility of the experience;

    c) Fluctuations in large claims experience;

d) Vendor processing stability;

e) Changes in COBRA enrollment; and

f) Catastrophic events and whether to make allowance or not.

Methodology

9) The flex or self-funded plans' premium rates for plan year X will consist of the following five components:

   a) Estimated incurred claims cost for plan year X

   b) Estimated cost of administering the claims over plan year X

   c) Estimated cost of any fixed component (e.g. capitation to medical groups or pooling charges) over plan year X

   d) Estimated change in the Contingency Reserve over plan year X

   e) Factor reflecting revenue surplus or shortfall experience from prior plan yearsadministrative costs, and, if applicable, any other fixed components) are common to the in-force premium rates. Unlike the change in IBNR (Incurred but not reported), which is implicitly included in the projection of incurred claims, the Contingency Reserve is added as a component of each plan's targeted year-end funding level. The anticipated change in the Contingency Reserve is factored into the rate requirements as the fourth component of the self-funded plans' premium rates.

   The first three components of the self-funded plans' premium rates (incurred claims, administrative costs, and, if applicable, any other fixed components) are common to the in-force premium rates. Unlike the change in Incurred But Not Reported ("IBNR") claims, which are implicitly included in the projection of incurred claims, the Contingency Reserve is added as a component of each plan's targeted year-end funding level. The anticipated change in the Contingency Reserve is factored into the rate requirements as the fourth component of the self-funded plans' premium rates.

   The fifth component of flex or self-funded plans' premium rates "Factor reflecting revenue excess or shortfall experience from prior plan years", is the focus of this policy.

   The methodology used to determine the "Factor reflecting revenue excess or shortfall experience from prior plan years" varies by plan. The revenue excess or shortfall in any plan year will be determined by comparing the following two amounts:

   a) Expected Revenue = Expected incurred claims + Expected administration costs + Expected fixed component(s) (if applicable) + Expected change in Contingency Reserve. The expected revenue amount will be based on the per capita estimates for the plan year aggregated using the actual plan year enrollment.

b) Actual Revenue = Actual incurred claims + Actual administration costs + Actual fixed component(s) (if applicable) + Actual change in Contingency Reserve

Example:

The self-insured PPO
For plan year X, this component equates to one-third of the cumulative difference between prior years' revenue and expense less prior years' release of this amount.

Revenue excess in year X-2 = $90
Premium rates for plan year X includes an offset of $30, i.e. one-third of $90, thus leaving abalance of $60

Revenue excess in year X-1 = $90
Premium rates for plan year X+1 includes an offset of $50, i.e. one-third of the accumulation of $150 (($90 - $30) + $90 = $150), thus leaving a balance of $100

Revenue shortfall in year X = -$70
Premium rates for plan year X+2 includes an offset of $10, i.e. one-third of the accumulation of $30 (($90 - $30) + ($90 - $50) - $70 = $30), thus leaving a balance of $20

Allocation of cumulative revenue surplus or shortfall across categories of membership. To develop the premium rate factor, allocation of the cumulative revenue surplus or shortfall across categories of membership (employees/non-Medicare retirees) is proportional and is based on the aggregate of the projected claims costs, administration costs,fixed component(s) costs (if applicable), and Contingency Reserve increase/decrease over the plan year in question.

An illustration is provided below:

The projected claims costs, administration costs, fixed component(s) costs (if applicable), and Contingency Reserve increase/decrease over the plan year for the self-funded PPO in year X are expected to be $60 million and this is split across membership categories as follows:

Employees: $20 million
Non-Medicare Retirees: $10 million
There is also a cumulative revenue excess amount of $6 million to be allocated across membership categories, the allocation in the calculation of premiums for plan year X would beas follows:

Employees: $4 million
Non-Medicare Retirees: $2 million

Review

10) The Board shall review this policy and methodology at least every three years.

Policy History

11) The Board adopted this policy on March 12, 2008, amended it on March 14, 2013, February 13, 2014, January 8, 2015, and February 10, 2022.

12) This policy has been applied to City Plan (now referred to as the self-funded PPO) annually since 2007.

212: SFHSS IBNR Reserve Policy and Methodology

Policy Objectives

1) There is a lag between the time period when a medical service is rendered to the time that a claim is submitted and fully settled in payment. It is prudent for a flex or self-funded plan to set aside funds for IBNR reserves. An IBNR reserve, otherwise known as an operating reserve, is an estimate of the unpaid claims liability for run-out claims. To accurately project the self-funded plan's outstanding claims liability, the Board actuary will estimate the cost of the claims rendered but not paid based on experience.

IBNR Reserve Policy

2) This policy standardizes the ***IBNR Reserve*** setting methodology for the SFHSS self-funded plans. The IBNR Reserve policy is specific to the self-funded plans for which SFHSS maintains reserves, i.e., the following plans:

    a) Flex-Funded HMO Plans (non-capitated costs)

    b) Self-Funded PPO Plan

    c) Self-Funded Dental PPO Plan (for Actives only)

3) The methods specified in this document will be applied for IBNR Reserve estimation as of June 30th of each year at the end of each fiscal year.

Definitions

4) Please use the following definitions.

    a) *IBNR Reserve:* Reserve(s) calculated to pay for the outstanding liability of estimated run-out claim costs that have been incurred before a given date but have not paid as of the given date.

    b) *Developmental Method:* The method by which the IBNR liability is estimated based on claim run-out patterns which are assumed to remain stable over time.

    c) *Projection Method:* The IBNR liability estimate produced by the Developmental Method is adjusted for months where data is considered non-credible using the Projection Method based on the change in costs per exposure unit over time. The IBNR liability is further adjusted to reflect actuarial assumptions related to a number of factors/contingencies which could impact reserve adequacy. Such factors/contingencies include: change in claim payment cycles, plan design, insurance carriers, large dollar claims, emerging claim trends, provider contract changes, seasonality, and other factors.

IBNR Reserve Methodology

5) The reserves at the end of each plan year will equate to the sum of the estimated future cost of IBNR claims as that date of the estimated cost of administering these claims.

The IBNR reserves will be based on the historical claims experience of each plan. Actuarial analysis of this experience will be completed to develop factors that are applied to paid claims data to estimate the potential run-out of the claims post-fiscal year-end. Where plan-specific claims data is deemed less than fully credible, additional normative claims data can be utilized to supplement the analysis performed. The Board's actuarial consultant firm applies the Developmental Method and Projection Method to set the IBNR reserves.

The estimated cost of administering the run-out claims will reflect the terms and conditions of the plan administrator responsible for setting the relevant plan's claims. The Actuarial consultant firm presents IBNR Reserve recommendations and supporting analysis to the Board for approval.

Review

6) The Board shall review this policy at least every three years.

History

7) The Board adopted this policy on March 12, 2008, and amended it on March 14, 2013, February 13, 2014, and February 10, 2022.

213: LEGAL SETTLEMENT POLICY

Policy Objectives

SFHSS manages self-funded and flex-funded plans and may participate n legal claims to resolve disputes with providers. The resolution of the dispute may involve payments to SFHSS. This policy describes the acceptance and use of these settlements.

Settlement Policy

1) The settlement funds will be accepted and deposited in the medical trust fund for the health plan that most closely matches the claim.
2) The funds will be used in the underwriting rate setting process to set applicable health plan future rates, employer contributions and member contributions.
3) The underwriting rate setting process will consider the stability of the rates in determining the number of years for which rates will be adjusted.

Review

4) The Board shall review this policy at least every three years.

Policy History

5) The Board adopted this policy on January 12, 2023.

SAN FRANCISCO

CHARTER AND ADMINISTRATIVE

CODE SECTIONS

APPLICABLE TO

THE SAN FRANCISCO

HEALTH SERVICE SYSTEM

Updated 2/10/2022

TABLE OF CONTENTS

CHARTER SECTIONS

1. CHARTER SECTION 3.100 –EXECUTIVE BRANCH MAYOR – POWERS AND DUTIES.

The Mayor shall be the chief executive officer and the official representative of the City and County, and shall serve full time in that capacity. The Mayor shall devote his or her entire time and attention to the duties of the office, and shall not devote time or attention to any other occupation or business activity. The Mayor shall enforce all laws relating to the City and County, and accept service of process on its behalf.

The Mayor shall have responsibility for:

1) General administration and oversight of all departments and governmental units in the executive branch of the City and County:
2) Coordination of all intergovernmental activities of the City and County;
3) Receipt and examination of complaints relating to the administration of the affairs of the City and County, and timely delivery of notice to the complainant of findings and actions taken;
4) Assurance that appointees to various governmental positions with the City and County are qualified and are as representative of the communities of interest and diverse population of the City and County as is reasonably practicable, and are representative of both sexes;
5) Submission of ordinances and resolutions by the executive branch for consideration by the Board of Supervisors;
6) Presentation before the Board of Supervisors of a policies and priorities statement setting forth the Mayor's policies and budget priorities for the City and County for the ensuing fiscal year;
7) Appearance, in person, at one regularly-scheduled meeting of the Board of Supervisors each month to engage in formal policy discussions with members of the Board;
8) Introduction before the Board of Supervisors of the annual proposed budget or multi-year budget which shall be initiated and prepared by the Mayor. The Mayor shall seek comments and recommendations on the proposed budget from the various commissions, officers and departments; and
9) Preparation of and introduction to the Board of Supervisors of supplemental appropriations.

The Mayor shall have the power to:

10) Speak and be heard with respect to any matter at any meeting of the Board of Supervisors or any of its committees, and shall have a seat but no vote on all boards and commissions appointed by the Mayor;
11) As provided in Section 3.103 of this Charter, veto any ordinance or resolution passed by the Board of Supervisors;
12) Subject to the fiscal provisions of this Charter and budgetary approval by the Board of Supervisors, appoint such staff as may be needed to perform the duties and carry out

the responsibilities of the Mayor's office, provided that no member of the staff shall receive a salary in excess of seventy percent of that paid the Mayor. For purposes of this provision, staff does not include the City Administrator, department heads or employees of departments placed under his or her direction by Section 3.104. Notwithstanding any other provisions or limitations of this Charter to the contrary, the Mayor may not designate nor may the City and County employ on the Mayor's behalf any person to act as deputy to the Mayor or any similar employment classification, regardless of title, whose responsibilities include but are not necessarily limited to supervision of the administration of any department for which the City Administrator, an elected official other than the Mayor or an appointed board or commission is assigned responsibility elsewhere in this Charter;

13) Designate a member of the Board of Supervisors to act as Mayor in the Mayor's absence from the state or during a period of temporary disability;

14) In the case of an emergency threatening the lives, property or welfare of the City and County or its citizens, the Mayor may direct the personnel and resources of any department, command the aid of other persons, and do whatever else the Mayor may deem necessary to meet the emergency;

In meeting an emergency, the Mayor shall act only with the concurrence of the Board of Supervisors, or a majority of its members immediately available if the emergency causes any member of the Board to be absent. The Mayor shall seek the Board's concurrence as soon as is reasonably possible in both the declaration of an emergency and in the action taken to meet the emergency. Normal notice, posting and agenda requirements of the Board of Supervisors shall not be applicable to the Board's actions pursuant to these provisions;

15) Make an appointment to fill any vacancy in an elective office of the City and County until a successor shall have been elected;

16) Subject to the provisions of Charter Section 2.113, submit to the voters a declaration of policy or ordinance on any matter on which the Board of Supervisors is empowered to pass;

17) Have and exercise such other powers as are provided by this Charter or by law for the chief executive officer of a City and County;

18) Unless otherwise specifically provided, make appointments to boards and commissions which shall be effective immediately and remain so, unless rejected by a two-thirds vote of the Board of Supervisors within 30 days following transmittal of Notice of Appointment. The Notice of Appointment shall include the appointee's qualifications to serve and a statement how the appointment represents the communities of interest, neighborhoods and diverse populations of the City and County;

19) Appoint department heads subject to the provisions of this Charter; and

20) Prepare and submit schedule of rates, fees and other similar charges to the Board of Supervisors.

(Amended by Proposition C, Approved 11/6/2007; Proposition C, Approved 11/2/2010)

2. CHARTER SECTION 4.102 -BOARDS AND COMMISSIONS – POWERS AND DUTIES.

Unless otherwise provided in this Charter, each appointive board, commission or other unit of government of the executive branch of the City and County shall:

1) Formulate, evaluate and approve goals, objectives, plans and programsand set policies consistent with the overall objectives of the City and County, as established by the Mayor and the Board of Supervisors through the adoption of City legislation;
2) Develop and keep current an Annual Statement of Purpose outlining its areas of jurisdiction, authorities, purpose and goals, subject to review and approval bythe Mayor and the Board of Supervisors;
3) After public hearing, approve applicable departmental budgets or any budget modifications or fund transfers requiring the approval of the Board of Supervisors, subject to the Mayor's final authority to initiate, prepare and submit theannual proposed budget on behalf of the executive branch and the Board of Supervisors' authority under Section 9.103;
4) Recommend to the Mayor for submission to the Board of Supervisors rates, fees and similar charges with respect to appropriate items coming within theirrespective jurisdictions;
5) Unless otherwise specifically provided, submit to the Mayor at least threequalified applicants, and if rejected, to make additional nominations in the same manner, for the position of department head, subject to appointment by the Mayor;
6) Remove a department head; the Mayor may recommend removal of a department head to the commission, and it shall be the commission's duty to act on theMayor's recommendation by removing or retaining the department head within 30 days; failure to act on the Mayor's recommendation shall constitute official misconduct;
7) Conduct investigations into any aspect of governmental operations within its jurisdiction through the power of inquiry, and make recommendations to the Mayor orthe Board of Supervisors;
8) Exercise such other powers and duties as shall be prescribed by theBoard of Supervisors; and
9) Appoint an executive secretary to manage the affairs and operations of the board or commission.

In furtherance of the discharge of its responsibilities, an appointive board,commission or other unit of government may:

10) Hold hearings and take testimony; and
11) Retain temporary counsel for specific purposes, subject to the consent ofthe Mayor and the City Attorney.

Each board or commission, relative to the affairs of its own department, shall deal with administrative matters solely through the department head or his or her designees, and any dictation, suggestion or interference herein prohibited on the part ofany member of a board or commission shall constitute official misconduct; provided, however, that nothing herein contained shall restrict the board or commission's powers of hearing and inquiry as provided in this Charter.

3. CHARTER SECTION 4.103 -BOARDS AND COMMISSIONS – ANNUAL REPORT.

As of the operative date of this Charter and until this requirement is changed by the Board of Supervisors, each board and commission of the City and County shall be required by ordinance to prepare an annual report describing its activities, and shall filesuch report with the Mayor and the Clerk of the Board of Supervisors. The Annual Report can be included in the Annual Statement of Purpose as provided for in Section 4.102(2).

4. CHARTER SECTION 4.104 -BOARDS AND COMMISSIONS – RULES AND REGULATIONS.

a) Unless otherwise provided in this Charter, each appointive board, commission or other unit of government of the executive branch of the City and Countyshall:
   1) Adopt rules and regulations consistent with this Charter and ordinances of the City and County. No rule or regulation shall be adopted, amended or repealed, without a public hearing. At least ten days' public notice shall be given for such public hearing. All such rules and regulations shall be filed with the Clerk of the Board of Supervisors.
   2) Hold meetings open to the public and encourage the participation ofinterested persons. Except for the actions taken at closed sessions, any action taken at other than a public meeting shall be void. Closed sessions may be held in accordance with applicable state statutes and ordinances of the Board of Supervisors.
   3) Keep a record of the proceedings of each regular or special meeting. Such record shall indicate how each member voted on each question. These records, except as may be limited by state law or ordinance, shall be available for publicinspection.

b) The presence of a majority of the members of an appointive board, commission or other unit of government shall constitute a quorum for the transaction ofbusiness by such body. The term "presence" shall include participation by teleconferencing or other electronic means as authorized by Government Code Section54953(b) or any successor legislation after the Board of Supervisors has adopted an ordinance pursuant to subsection (c) allowing such participation when the member is physically unable to attend in person, as certified by a health care provider, due to the member's pregnancy, childbirth, or related condition. The Board of Supervisors may also, as part of a parental leave policy adopted pursuant to subsection (c), authorize a member of a board or commission to participate in meetings by teleconferencing or other electronic means when the member is absent to care for his or her child after birth of the child, or after placement of the child with the member or the member's immediate family for adoption or foster care. Unless otherwise required by this Charter, the affirmative vote of a majority of the members shall be required for the approval of any matter, except that the rules and regulations of the body may provide that, with respect to matters of procedure the body may act by the affirmative vote of a majority of the members present, so long as the members present constitute a quorum. All appointive boards, commissions or other units of government shall act by a majority, two-thirds, three-fourths or other vote of all members. Each member present at a regular or specialmeeting shall vote "yes" or "no" when a question is put,

unless excused from voting by amotion adopted by a majority of the members present.

c) Notwithstanding the provisions of Charter Section 10.101, the Board of Supervisors shall provide by ordinance for parental leave policies for members of appointive boards, commissions or other units of government, including, but not limitedto, authorization to participate in meetings by teleconferencing or other electronic means pursuant to subsection (b) and subject to the restrictions listed in that subsection.

(Amended by Proposition B, Approved 11/7/2006)

5. CHARTER SECTION 12.200 -HEALTH SERVICE BOARD.

There shall be a Health Service Board which shall consist of seven members as follows: one member of the Board of Supervisors, to be appointed by the President of the Board of Supervisors; two members appointed by the Mayor pursuant to Section 3.100, one of whom shall be an individual who regularly consults in the health care field,and the other a doctor of medicine; one member nominated by the Controller and three members elected from the active and retired members of the System from among their number. Elections shall be conducted by the Director of Elections in a manner prescribed by ordinance. Elected members need not reside within the City and County.

Not later than April 1, 2013 the Controller shall nominate a candidate for appointment to the Health Services Board for a two-year term commencing on May 15, 2013. The Controller shall transmit a written notice of nomination to the Health ServicesBoard. The Controller's nominee shall be subject to the approval of the Health ServicesBoard. If the Health Services Board fails to calendar the Controller's nomination for consideration at a meeting to occur not later than 60 days after receipt of the Controller's written notice of nomination, the Controller's nominee shall be deemed approved. All subsequent appointments of Controller's nominees shall be for a five-yearterm and be subject to the same procedure. The Controller's nominee may not vote on his or her successor.

The terms of Health Service Board members, other than the ex officio members,shall be five years, and shall expire on May 15 of each year, with the exception that theterm of the Board member that begins in May 2011 shall be three (3) years, and shall expire in May 2014, and the term of the Board member that begins in May 2013 term shall be two (2) years, and shall expire in May 2015.

The appointee nominated by the Controller shall succeed the elected member whose term expires at 12:00 noon on May 15, 2013. In the event the elected member whose term expires on May 15, 2013, leaves the Board prior to that date, the Controllershall nominate a successor to fill the unexpired term according to the procedures set forth above.

A vacancy on the Board appointed by the Mayor shall be filled by the Mayor. A vacancy on the Board of an appointee nominated by the Controller shall be filled for the unexpired term

according to the procedures set forth above for Controller's nominees. Avacancy in an elective office on the Board shall be filled by a special election within 90 days after the vacancy occurs unless a regular election is to be held within six monthsafter such vacancy shall have occurred.

The Health Service Board shall:

1) Establish and maintain detailed historical costs for medical andhospital care and conduct an annual review of such costs;
2) Apply benefits without special favor or privilege;
3) Put such plans as provided for in Section A8.422 into effect and Conduct and administer the same and contract therefor and use the funds of the System;
4) Make rules and regulations for the administration of business of theHealth Service System, the granting of exemptions and the admission to the System of persons who are hereby made members, and such other officers and employees as may voluntarily become members with the approval of the Board; and
5) Receive, consider and, within 60 days after receipt, act upon anymatter pertaining to the policies of, or appeals from, the Health Service System submitted to it in writing by any member or any person who has contracted to render medical care to the members.

Except as otherwise specifically provided, the Health Service Board shall have the powers and duties and shall be subject to the limitations of Charter Sections 4.102, 4.103 and 4.104.

Subject to the requirements of state law and the budgetary and fiscal provisionsof the Charter, the Health Service Board may make provision for heath or dental benefits for residents of the City and County of San Francisco as provided in Section A8.421.

(Amended November 2004; Proposition F, Approved 11/2/2010; Proposition C,Approved 11/8/2011)

6. CHARTER SECTION 12.201 -MEDICAL DIRECTOR AND HEALTH SERVICES ADMINISTRATOR.

The Health Service Board may appoint a full-time or part-time medical director. He or she shall hold office at its pleasure. The medical director shall be responsible to the Board as a board, but not to any individual member or committee thereof. The Health Service Board shall appoint a full-time administrator with experience in administering health plans or in comparable work, who shall hold office at the Health Service Board's pleasure. The Health Services administrator shall administer the HealthService System in accordance with the provisions of this Charter and the rules, regulations and policies of the Health Service Board. The Board and each committee ofthe Board shall confine its activities to policy matters and to matters coming before it asan appeals board. The Board shall prepare its rules, regulations and policies so that they are clear, definite and complete and so that they can be readily administered by the Health Services administrator.

(Amended November 2004)

7. CHARTER SECTION 12.202 -MEMBERSHIP IN HEALTH SERVICES YSTEM.

The members of the System shall consist of all officers and permanent employees of the City and County, the Unified School District, the Community CollegeDistrict, and such other officers, employees, dependents and retirees as provided by ordinance.

8. CHARTER SECTION 12.203 -HEALTH SERVICE SYSTEM FUND.

The Health Service System fund shall be a trust fund administered by the HealthService Board in accordance with the provisions of this Charter solely for the benefit of the active and retired members of the Health Service System and their covered dependents. The City and County, School District and Community College District shall each contribute to the Health Service System Fund amounts sufficient to efficientlyadminister the Health Service System.

9. CHARTER SECTION A8.420 -ESTABLISHMENT OF AND MEMBERSHIP IN HEALTH SERVICE SYSTEM.

A health service system is hereby established. Said system shall be administeredby the human resources department subject to the approval of the health service board.The members of the system shall consist of all permanent employees, which shall include officers of the City and County, of the San Francisco Unified School District, and of the Parking Authority of the City and County of San Francisco and such other employees as may be determined by ordinance, subject to such conditions and qualifications as the Board of Supervisors may impose, and such employees as may be determined by collective bargaining agreement. Any employee who adheres to the faith or teachings of any recognized religious sect, denomination or organization and, in accordance with its creed, tenets or principles, depends for healing upon prayers in the practice of religion shall be exempt from the system upon filing annually with the human resources department an affidavit stating such adherence and dependence and disclaiming any benefits under the system. The human resources department shall havethe power to exempt any person whose compensation exceeds the amount deemed sufficient for self-coverage and any person who otherwise has provided for adequate medical care. Any claim or request for exemption denied by the human resources department may be appealed to the health services board.

10. CHARTER SECTION A8.421 -ADOPTION OF PLANS FOR RESIDENTS.

Subject to the requirements of state law and the budgetary and fiscal provisionsof the Charter, the Health Service Board is authorized by a two-thirds vote of the entiremembership of the Health Service Board to adopt a plan or plans or make other provisions for health or dental benefits for residents of the City and County of San Francisco. Such plan or plans shall not

become effective until approved by an ordinanceof the Board of Supervisors adopted by three-fourths of its members. Residents shall not by virtue of enrolling in such plan or plans become members of the Health Service System. The Health Service System Fund shall not be used to provide any benefits under this section. The Health Service Board shall adopt rules and regulations to administer this section.

The determinations made under this section, including but not limited to whetherto adopt a plan or plans, what benefits to offer, determination of eligibility, and the fixingand allocation of the cost of any plan or plans, are within the sole discretion of the City and County and its officials.

(Amended November 2004)

11. CHARTER SECTION A8.422 -ADOPTION OF PLANS FOR MEMBERS.

The board shall have power and it shall be its duty by a majority vote of the entire membership of the health service board to adopt a plan or plans for rendering medical care to members of the system, or for the indemnification of the cost of said care, or for obtaining and carrying insurance against such costs or for such care.

Such plan or plans as may be adopted, shall not become effective until approved by ordinance of the Board of Supervisors, adopted by three-fourths of its members.

The Board of Supervisors shall secure an actuarial report of the costs and effort of any proposed change in the benefits of the health service system or rates of contribution before enacting an ordinance or before voting to submit any proposed Charter amendment providing for such change.

(Amended November 2004; Proposition C, Approved 11/8/2011)

12. CHARTER SECTION A8.423 -REVISION OF SCHEDULES AND COMPENSATION.

In January of each year, or at such other time consistent with the Plan Year set by the Health Service Board, or at such other time consistent with the Plan Year set by the Health Service Board, at a public hearing, the Health Service Board shall review and determine the adequacy of medical care provided for members of the system and the adequacy of fee schedules and the compensation paid for all services rendered and it may make such revisions therein as it deems equitable but such revisions shall not become effective until approved by ordinance of the Board of Supervisors adopted by three-fourths of its members.

Commencing in 1973, the Health Service Board shall, prior to the second Monday in January in each year, or at such other time consistent with the Plan Year set by the Health Service Board, conduct a survey of the 10 counties in the State of California, other than the City and County of San Francisco, having the largest populations to determine the average contribution made by each such county toward the providing of health care plans, exclusive

of dental care, for each employee of such county. The Health Service Board may promulgate rules and regulations for the surveyto allow for unavoidable gaps in survey data and to insure a consistent methodology from year to year. In accordance with said survey, the Health Service Board shall determine the average contribution made with respect to each employee by said 10 counties toward the health care plans provided for their employees and on or before thesecond Monday in January of each year, or at such other time consistent with the Plan Year set by the Health Service Board, the Health Service Board shall certify to the Board of Supervisors the amount of such average contribution. For the purposes of Section A8.428, the amount of such average contribution shall be "the average contribution."

The Health Service Board shall have the responsibility to obtain and disseminate information to its members with regard to plan benefits and costs thereof. All expenses in connection with obtaining and disseminating said information, the investment of such fund or funds as may be established, including travel and transportation costs, member wellness programs, actuarial expenses and expenses incurred to reduce health care costs, shall be borne by the system from reserves in the health service fund but only upon adoption of a resolution by the Health Service Board approving such expenses.

(Amended November 2004; Proposition C, Approved 11/8/2011)

13. CHARTER SECTION A8.424 -SPECIFICITY REQUIRED.

Each plan for medical care shall make detailed and specific provision for the benefits to be provided there under and for the rates of contribution required to support the plan.

14. CHARTER SECTION A8.425 -PERSONS COVERED.

Each plan may make provision for the participation in the benefits of the system by the dependents of members, retired City and County employees, temporary City and County employees, such other dependents of deceased and retired City and County employees as the Board of Supervisors may authorize by ordinance, teachers and otheremployees of the San Francisco Unified School District retired under the San Francisco City and County Employees' Retirement System and resigned employees of the City and County and resigned teachers and employees of the school district whose resignations occur after June 15, 1955, and within 30 days immediately prior to the dateon which, but for their resignations, they would have become retired members of the said Retirement System, on whose relinquishment of retirement allowances as permitted by the Charter occurs after such date and resigned employees of the San Francisco Unified School District not otherwise included. A resigned employee or teacher is one whose employment has terminated other than by retirement, discharge or death or who has relinquished retirement allowances. The purpose of empowering the health service board to make provision for the participation in the benefits of the system to the afore mentioned resigned teachers and employees of the San Francisco Unified School District is to enable them, subject to the health service board's exerciseof its power, to participate in the benefits of the system after

transferring to the State Teachers' Retirement System from the San Francisco City and County Employees' Retirement System. The purpose of empowering the health service board to make provision for participation in the benefits of the system by the afore mentioned resignedemployees of the City and County and other resigned employees of San Francisco Unified School District is to permit the health service board to have power to treat themthe same as it treats resigned teachers and employees of the San Francisco Unified School District.

As used in this section, and for the purpose of this section, the terms "City and County employees" and "employees of the City and County" shall include officers and employees of the Parking Authority of the City and County of San Francisco.

In addition to "the average contributions" in Subsection (b) of Section A8.428, the Board of Supervisors may provide by ordinance for additional funds from the City and County to pay the full cost of any plan for medical benefits adopted under Sections A8.422 or A8.423 for current members of the Board of Supervisors. The Board of Supervisors may also provide by ordinance for the continuation in any plan by former supervisors who agree to and do pay the full cost of such benefit.

(Amended March 2000)

15. CHARTER SECTION A8.426 -RIGHT OF SELECTION.

No member of the health service system shall be required to accept the servicesor medical supplies of any physician (physician includes physicians and surgeons, optometrists, dentists, chiropodists and osteopathic and chiropractic practitioners licensed by California State Law and within the scope of their practice as defined by California State Law), person licensed to treat human diseases without the use of drugs,nurse, pharmacist or hospital selected by the health service board, but, subject to rules and regulations of that board, every member shall have the right to select, of his or her own choice, a duly licensed physician, as defined herein, person licensed to treat human diseases without the use of drugs, nurse, pharmacist, hospital or other agency of medical care as herein defined, who or which is made available through health service system plans; and the health service board shall make provision for the exerciseof such selection; and is hereby expressly prohibited from entering into any exclusive contract for the rendering of said service.

A duly licensed physician, as defined herein, person licensed to treat human diseases without the use of drugs, nurse, pharmacist, hospital, or other agency of medical care shall have the right to furnish such services or medical supplies at uniformrates of compensation to be fixed by the health service board.

(Amended by Proposition C, Approved 11/8/2011)

16. CHARTER SECTION A8.427 -EFFECT OF OTHER CHARTER PROVISIONS.

Except as otherwise specifically provided herein, all provisions of the Charter shall be fully applicable to the health service board, the health service system and its administrator, medical director and employees in the same manner that they apply toother boards, commissions, and departments of the City and County.

(Amended November 2004)

17. CHARTER SECTION A8.428 -HEALTH SERVICE SYSTEM TRUST FUND.

There is hereby created a health service system trust fund. The costs of the health service system shall be borne by the members of the system and Retired Persons, the City and County of San Francisco because of its members and Retired Persons, the Parking Authority of the City and County of San Francisco because of its members and Retired Persons, the San Francisco Unified School District because of itsmembers and Retired Persons and the San Francisco Community College District because of its members and Retired Persons.

a) **Definitions.**

"Credited Service" means years of employment with the Employers or the former Redevelopment Agency of the City and County of San Francisco (the "Redevelopment Agency") or the Successor Agency to the Redevelopment Agency of the City and County of San Francisco (the "Successor Agency"), provided that for any employee of the Redevelopment Agency or Successor Agency, the employee became an employee of the Redevelopment Agency before September 1, 2010 and became anemployee of the City and County without a break in service after January 31, 2012 andbefore March 1, 2015.

"Employers" as used in this section means the City and County of San Francisco ("City and County"), the San Francisco Unified School District ("School District") and/or the San Francisco Community College District ("Community College District"). Employers shall also include the Superior Court of California, County of San Francisco ("Superior Court"), to the extent the Superior Court participates in the City's Health Service System, under Section A8.428(e).

"Hired on or Before January 9, 2009" as used in this section means employees hired on or before January 9, 2009, by the City and County, the School District, the Community College District, or the Redevelopment Agency, excluding the following categories of employees: (1) as-needed employees who have never earned 1,040 or more hours of compensation during any 12-month period ending on or before January 9, 2009; (2) employees who have separated from employment with the Employers or the Redevelopment Agency on or before January 9, 2009, and have less than 5 years of Credited Service with the Employers or the Redevelopment Agency; (3) former employees of the Redevelopment Agency who became employees of the City and County after February 28, 2015; (4) former employees of

the Redevelopment Agency who left employment with the Redevelopment Agency and became employees of the City and County before February 1, 2012; and (5) former employees of the Redevelopment Agency who have received retiree health care coverage under the Public Employees Medical and Hospital Care Act (PEMCHA) on or before February 28,2015.

"PERS" as used in this section shall mean the Public Employees' Retirement System of the State of California.

"Plan Year" as used in section A8.423 shall mean the twelve month period beginning on each July 1 and ending on June 30, or such other 12 month period as maybe determined by the Health Service Board.

"Registered as Domestic Partners" as used in this section means persons who have established a domestic partnership according to the provisions of Chapter 62 of the San Francisco Administrative Code, or California state law, as amended from time to time, or the law of the city or county in which they reside or of the state outside of California in which they reside. Persons who live in a state, city, or county that does not recognize domestic partnership who submit a completed and notarized City and County Health Service System Declaration of Domestic Partnership Form to the Health Service System shall also be considered domestic partners under this section. Domestic partners who have formed their domestic partnership only by notarization of a declaration of Domestic Partnership as provided in Chapter 62 of the San Francisco Administrative Code shall not be recognized or treated as a domestic partnership under this Section unless and until the domestic partnership is registered or certified.

"Retirement System" as used in this section shall mean the San Francisco City and County Employees' Retirement System.

"Retired under the San Francisco City and County Employees' Retirement System" as used in this section includes persons who retire for service; retire for disability; or who receive a retirement or vesting allowance from the Retirement System.

A **"Retired Person"** as used in this section means:

1) A former member of the health service system, Hired on or Before January 9, 2009, retired under the Retirement System and/or PERS (hereinafter,"Retired Employee who was Hired on or Before January 9, 2009");
2) The surviving spouse or surviving domestic partner of an active employeeof the Employers Hired on or Before January 9, 2009, provided that the surviving spouse or surviving domestic partner and the active employee have been married or Registered as Domestic Partners for a period of at least one year prior to the death of the active employee;

3) The surviving spouse or surviving domestic partner of a Retired Employeewho was Hired on or Before January 9, 2009, provided that the surviving spouse or surviving domestic partner and the Retired Employee who was Hired on or Before January 9, 2009 have been married or Registered as Domestic Partners for a period of at least one year prior to the death of the Retired Employee who was Hired on or BeforeJanuary 9, 2009;
4) A former member of the health service system, hired by the Employers onor after January 10, 2009, and retired under the Retirement System and/or PERS for disability, or retired under the Retirement System or PERS: (i) within 180 days of separation from employment from the Employers; and (ii) with 10 or more years of Credited Service with the Employers (hereinafter, "Retired Employee who was Hired onor After January 10, 2009");
5) The surviving spouse or surviving domestic partner of an active employeeof the Employers hired by the Employers on or after January 10, 2009, with 10 or more years of Credited Service with the Employers, who died in the line of duty where the surviving spouse or surviving domestic partner is entitled to a death allowance from theRetirement System as a result of the death in the line of duty, provided that the surviving spouse or surviving domestic partner and the active employee have been married or Registered as Domestic Partners for a period of at least one year prior to thedeath of the active employee; or
6) The surviving spouse or surviving domestic partner of a Retired Employeewho was Hired on or After January 10, 2009, provided that the surviving spouse or surviving domestic partner and the Retired Employee who was Hired on or After January 10, 2009, have been married or Registered as Domestic Partners for a period of at least one year prior to the death of the Retired Employee who was Hired on or

After January 10, 2009.

b) **Employer Contributions.**
The City and County, the School District and the Community College Districtshall each contribute to the health service fund amounts sufficient for the following purposes, and subject to the following limitations:

1) All funds necessary to efficiently administer the health service system.
2) The City and County, the School, District and the Community College District shall contribute to the health service system fund with respect to each of their members an amount equal to the lesser of "the average contribution," as certified by the health service board in accordance with the provisions of Section A8.423, or the cost of the plan selected by the member.
3) **Retired Employees Who Were Hired on or Before January 9, 2009.**

For Retired Persons identified in A8.428 Subsections (a)(1), (a)(2) and (a)(3), the Employers shall contribute to the health service fund, amounts subject to the following limitations: Monthly contributions required from Retired Persons and the surviving spouses and surviving domestic partners of active employees and

Retired Persons participating in the system shall be equal to the monthly contributions required from members in the system for health coverage excluding health coverage or subsidies for health coverage paid for active employees as a result of collective bargaining, with the following modifications:

(i) the total contributions required from Retired Persons who are also covered under Medicare shall be reduced by an amount equal to the amount contributed monthly by such persons to Medicare;
(ii) because the monthly cost of health coverage for Retired Persons may be higher than the monthly cost of health coverage for active employees, the City and County, the School District and the Community College District shall contribute funds sufficient to defray the difference in cost to the system in providing the same health coverage to Retired Persons and the surviving spouses and surviving domestic partnersof active employees and Retired Persons as is provided for active employee members excluding health coverage or subsidies for health coverage paid for active employees as a result of collective bargaining;
(iii) after application of Subsections (3), (3)(i) and (3)(ii), the City and County,the School District and the Community College District shall contribute 50% of Retired Persons' remaining monthly contributions.

4) **Retired Employees Who Were Hired on or After January 10, 2009 - Categories of Employees Eligible for 100% Employer Contribution**.

For Retired Persons identified in A8.428 Subsections (a)(4), (a)(5) and (a)(6), the Employers shall contribute 100% of the employer contribution established in A8.428 Subsection (b)(3) for:

(i) A Retired Employee who was Hired on or After January 10, 2009, with 20or more years of Credited Service with the Employers; and their surviving spouses or surviving domestic partners:
(ii) The surviving spouses or surviving domestic partners of active employees hired on or after January 10, 2009, with 20 or more years of Credited Service with the Employers;
(iii) Retired Persons who retired for disability; and their surviving spouses or surviving domestic partners; and
(iv) The surviving spouses or surviving domestic partners of active employees who died in the line of duty where the surviving spouse or surviving domestic partner is entitled to a death allowance as a result of the death in the line of duty.
(v)

5) **Retired Employees Who Were Hired on or After January 10, 2009 - Categories of Employees Eligible for 50%-75% Employer Contribution.**

For Retired Persons identified in A8.428 Subsections (a)(4), (a)(5) and (a)(6), the

Employers shall contribute:

(i) 50% percent of the employer contribution established in A8.428 Subsection (b)(3) for a Retired Employee who was Hired on or After January 10, 2009, with, at least 10 but less than 15 years of Credited Service with the Employers: their surviving spouses or surviving domestic partners: and the surviving spouses or surviving domestic partners of active employees hired on or after January 10, 2009, withat least 10 but less than 15 years of Credited Service with the Employers; and

(ii) 75% percent of the employer contribution established in A8.428 Subsection (b)(3) for a Retired Employee who was Hired on or After January 10, 2009, with at least 15 but less than 20 years of Credited Service with the Employers; their surviving spouses or surviving domestic partners; and the surviving spouses or surviving domestic partners of active employees hired, on or after January 10, 2009, with at least 15 but less than 20 years of Credited Service with the Employers.

6) **Retired Employees Who Were Hired on or After January 10, 2009 - Categories of Employees Eligible for Access to Retiree Medical Benefits Coverage.**
An employee hired on or after January 10, 2009, and retired under the Retirement System or PERS with five (5) or more years Credited Service with the Employers, shall be eligible to receive health benefits as a member of the health service system, provided that he or she makes monthly contributions equal to one hundred percent, (100%) of the total premiums for health coverage as established by the Health,Service Board, including the total cost for dependent coverage. At such time as he or she becomes eligible to receive benefits under A8.428 Subsection (a)(4), the Employersshall contribute the amounts established in A8.428 Subsections (b)(4), (b)(5), and (c), as applicable.

7) **Chart Summarizing Employer Contributions Under A8.428 Subsections (b)(4), (b)(5) and (b)(6) For Employees Hired on or AfterJanuary 10, 2009.**

Years of Credited Service At Retirement	**Percentage of Employer Contribution Established in A8.428 Subsection (b)(3)**
1. Less than 5 years of Credited Servicewith the Employers (except for the surviving spouses or surviving domestic partners of active employees who died in the line of duty)	No Retiree Medical Benefits Coverage
2. At least 5 but less than 10 years of Credited Service with the Employers;or greater than 10 years of Credited Service with the Employers but not eligible to receive benefits under Subsections (a)(4), (b)(4) and (b)(5) **(A8.428 Subsection (b)(6))**	0% Access to Retiree Medical Benefits Coverage, Including Access to DependentCoverage, But No Employer Contribution; Employee Pays Health Insurance Premium

3. At least 10 but less than 15 years of Credited Service with the Employers **(A8.428 Subsection (b)(5))**	50%
4. At least 15 but less than 20 years of Credited Service with the Employers **(A8.428 Subsection (b)(5))**	75%
5. At least 20 years of Credited Service with the Employers; Retired Persons who retired for disability; surviving spouses or surviving domestic partnersof active employees who died in the line of duty **(A8.428 Subsection (b)(4))**	100%

The above chart is a simplified summary of Employer contributions under A8.428 Subsections (b)(4), (b)(5) and (b)(6) for employees hired on or after January 10, 2009. The express language of Subsections (b)(4), (b)(5) and (b)(6), and not the summary chart or its content, shall determine Employer contributions.

8) **Employees Who Separated From Employment on or Before June 30,2001, and Who Retired on or After January 7, 2012.**

Notwithstanding any other provisions of A8.428 for Retired Persons who separated from employment on or before June 30, 2001, and who retired on or after January 7, 2012, the monthly contributions required from such Retired Persons, and thesurviving spouses and surviving domestic partners of active employees and such Retired Persons participating in the system, shall be equal to the monthly contributions required from members in the system for health coverage, excluding health coverage orsubsidies for health coverage paid for employees as a result of collective bargaining, with the following modifications:

(i) the total contributions required from Retired Persons who are also coveredunder Medicare shall be reduced by an amount equal to the amount contributed monthly by such persons to Medicare; and

(ii) because the monthly cost of health coverage for Retired Persons may be higher than the monthly cost of health coverage for active employees, the City and County, the School District and the Community College District shall contribute funds sufficient to defray the difference in cost to the system in providing the same health coverage to Retired Persons and the surviving spouses and surviving domestic partnersof active employees

and Retired Persons as is provided for active employee members excluding health coverage or subsidies for health coverage paid for active employees as a result of collective bargaining.

c) The City and County, the San Francisco Unified School District and the San Francisco Community College District shall contribute to the health service system fund 50% of the monthly contributions required for the first dependent of Retired Persons in the system. Except as hereinbefore set forth, the City and County, the School District and the Community College District shall not contribute to the health service system fund any sums on account of participation in the benefits of the system by members' dependents, except surviving spouses and surviving domestic partners, Retired Persons' dependents, except surviving spouses and surviving domestic partners, persons who retired and elected not to receive benefits from the Retirement System; resigned employees and teachers defined in Section A8.425, and any employee whose compensation is fixed in accordance with Sections A8.401, A8.403, orA8.404 of this Charter and whose compensation therein includes an additional amount for health and welfare benefits or whose health service costs are reimbursed through any fund established for said purpose by ordinance of the Board of Supervisors. Notwithstanding any other provision of Charter Section A8.428, the City and County, theSan Francisco Unified School District and the San Francisco Community College District shall not contribute to the health service system fund any contributions for the first dependent of a Retired Person who separated from employment on or before June30, 2001, and who retired on or after January 7, 2012.

d) It shall be the duty of the Board of Supervisors, the Board of Education and the Governing Board of the Community College District annually to appropriate to the health service system fund such amounts as are necessary to cover the respective obligations of the City and County, the School District and the Community College District hereby imposed. Contributions to the health service system fund of the City and County, of the School District and of the Community College Districtshall be charged against the general fund or the school, utility, bond or other special fund concerned.

e) To the extent the Superior Court elects to participate in the City's Health Service System for the provision of active and retiree health care benefits, Superior Court employees shall be treated the same as City employees for the purposes of vesting, employer contribution rates, and benefit levels, in accordance withthe Trial Court Employment Protection and Governance Act and applicable State law. The Superior Court shall pay all administrative and health care costs related to the Superior Court's covered employees or retirees as a participating Employer. The Superior Court may withdraw from participation in the City's Health Service System at any time, which shall not require an amendment to this Charter.

f) Notwithstanding the retiree health care eligibility requirements setforth above, a former employee of the Redevelopment Agency Hired on or Before January 9, 2009 must have been employed by the City and County after January 9, 2009 to

be eligible for retiree health care coverage under this section. In adopting the Charter amendment revising Sections A8.428 and A8.432 on November 4, 2014 the voters do not intend that it affect the rights of former employees of the Redevelopment Agency Hired on or Before January 9, 2009, who were already eligible for retiree healthcare coverage as of November 4, 2014.

g) The purpose of the January 10, 2009, Charter amendment is to amend Section A8.428 to change the required years of service and employer retiree health care contribution amounts for employees hired on or after January 10, 2009. Nothing in that Charter amendment shall expand or contract the groups of employees eligible for retiree health care benefits beyond those groups eligible as of June 3, 2008.

(Amended November 1984; November 2000; November 2004; Proposition B, Approved 6/3/2008; Proposition C, Approved 11/8/2011; Proposition D, Approved 11/4/2014)

18. CHARTER SECTION A8.429 -CONTRIBUTIONS TO FUND.

The health service board shall determine and certify to the controller the amountto be paid monthly by the members of the system to the health service system fund for the purposes of the system hereby created. The controller shall deduct said sums fromthe compensation of the members and shall deposit the same with the treasurer of the City and County to the credit of the health service system fund.

Such deductions shall not be deemed to be a reduction of compensation under any provision of this Charter.

The health service board shall have control of the administration and investment of the health service system fund, provided that all investments shall be of the characterlegal for insurance companies in California. Disbursements from the fund shall be madeonly upon audit by the controller and the controller shall have and exercise the accounting and auditing powers over the health service system fund which are vested inhim by this Charter with respect to all other municipal boards, officers and commissions.

19. CHARTER SECTION A8.430 -"MEDICAL CARE" DEFINED.

The term "medical care" shall be defined by the health service board. All acts performed and services rendered under the provisions of this section shall be performed in accordance with the provisions as to professional conduct prescribed by the statutesof the State of California regulating such professional conduct and services.

20. CHARTER SECTION A8.431 -LIMITATION OF CLAIMS BY MEMBERS.

Except as herein provided, members of the system shall have and possess no claim or recourse against any of the funds of the municipality by virtue of the adoption oroperation of any plan for rendering medical care, indemnifying costs of said care or carrying insurance against such costs, but except as herein provided, the claim and recourse of any such

member shall be limited solely to the funds of the system. All expenses of the system shall be paid exclusively from the health service system fund, and, except as herein provided, the City and County and the San Francisco Unified School District shall not appropriate or contribute funds in any manner for the purposes of the system hereby established and provided.

21. CHARTER SECTION A8.431-1 -SEVERABILITY.

Any Section or part of any Section in this Charter, insofar as it should conflict withthe provisions of Charter Sections 12.200 through 12.203 or A8.420 through A8.431, or with any part thereof, shall be superseded by the contents of Charter Sections 12.200 through 12.203 or A8.420 through A8.431. Charter Sections 12.200 through 12.203 or A8.420 through A8.431 shall be interpreted to be consistent with all federal and state laws, rules and regulations. If any of the words, phrases, clauses, sentences, subsections, or provisions of Charter Sections 12.200 through 12.203 or A8.420 throughA8.431 are held to be invalid or unconstitutional by a final judgment of a court, such decision shall not affect the validity of the remaining words, phrases, clauses, sentences, subsections, or provisions of Charter Sections 12.200 through 12.203 or A8.420 through A8.431. If any words, phrases, clauses, sentences, subsections, or provisions of Charter Sections 12.200 through 12.203 or A8.420 through A8.431 are held invalid as applied to any person, circumstance, employee or category of employee,such invalidity shall not affect any application of Charter Sections 12.200 through 12.203 or A8.420 through A8.431 which can be given effect. Charter Sections 12.200through 12.203 or A8.420 through A8.431 shall be broadly construed to achieve their stated purpose.

(Added by Proposition C, Approved 11/8/2011)

ADMINISTRATIVE CODE SECTIONS

22. ADMINISTRATIVE CODE SECTION 16.550. PURPOSE.

a) The Charter of the City and County of San Francisco provides that the trustees of the Retirement Board, who are entrusted with the administration of the San Francisco City and County Employees' Retirement System ("Retirement System"), shall include three trustees elected from the active and retired members of the Retirement System. As used in this Article XIII, a retired member of the Retirement System shall mean a person who is in receipt of a retirement allowance relating to his or her membership in the Retirement System.

b) The Charter of the City and County of San Francisco provides that the trustees of the Health Service Board, who are entrusted with the administration of the San Francisco City and County Employees' Health Service System ("Health Service System"), shall include four trustees elected from the active and retired members of the Health Service System. For the purposes of a Health Service System election, a retired member of the Health Service System shall mean a person who is a member of the Health Service System retired under the Retirement System, State Teachers Retirement System ("STRS"), Public Employees Retirement System ("PERS"), and the surviving spouse of an active employee and the surviving spouse of a retired employee, provided that the surviving spouse and the active or retired employee have been married for a period of at least one year prior to the death of the active or retired employee.

c) The Charter of the City and County of San Francisco provides that the trustees of the Retiree Health Care Trust Fund, who are entrusted with providing a funding source to defray the cost of the City's and Participating Employers' obligations to pay for health coverage for retired persons and their survivors entitled to health care coverage under Charter Section A8.428, shall include two trustees elected from active employees and retired members of the Health Service System. One of the elected trustees shall be an active City or Participating Employer employee member and one shall be a retired City or Participating Employer member as of the date of their respective elections. For the purposes of a Retiree Health Care Trust Fund election, an active member of the Health Service System shall mean an active City employee or active employee of a Participating Employer. For the purposes of a Retiree Health Care Trust Fund election, a retired member of the Health Service System shall mean a person who retired from City employment, or from a Participating Employer, and who is a member of the Health Service System retired under the Retirement System, STRS, or PERS, and the surviving spouse or domestic partner of an active employee and the surviving spouse or domestic partner of a retired employee, provided that the surviving spouse or domestic partner and the active or retired employee have been married for a period of at least one year prior to the death of the active or retired employee. As used in this section, Participating Employer means the San Francisco Unified School District and the San Francisco Community College District, following a resolution by these employers' respective governing boards to participate in the Retiree Health Care Trust Fund.

d) Retirement System and Health Service System members have an interest in knowing who has spent significant amounts of money to support or oppose candidates for the Retirement Board, the Health Service Board, and the Retiree Health Care Trust Fund Board. In selecting a candidate to represent their interests on these bodies, members will benefit from increased transparency in the election process. Information about the persons or entities who are spending significant funds in support of particular candidates will provide valuable information that will aid members' voting decisions.

e) The failure to abide by election procedure obligations and deadlines in San Francisco Administrative Code Sections 16.550-16.565 shall not invalidate an election if the election has been conducted fairly and in substantial compliance with and conformity to the legal requirements.

f) Whenever the term of office of such an elected trustee expires or whenever a vacancy occurs in such an office so that an election is necessary to fill a present or expected vacancy, the following provisions shall govern the election procedure.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord.378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008 Ord. 212-18, File No. 170738, App. 9/14/2018, Eff. 10/15/2018)

23. ADMINISTRATIVE CODE SECTION 16.551. RETIREMENT BOARD, HEALTH SERVICE BOARD OR RETIREE HEALTH TRUST FUND BOARD TOORDER ELECTIONS.

If a vacancy occurs, or will occur, in the office of an elected trustee prior to the date that the term of that office expires, the Retirement Board, Health Service Board or Retiree Health Trust Fund Board shall order a special election to fill the vacancy for the unexpired portion of the term of office, unless another election to a Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board office is scheduled to be completed within six months after the vacancy has, or shall, occur, in which case the elections shall be combined; provided, however, that a separate special election shall be required if the election which has already been scheduled will occur too soon to nominate and select candidates for the more recent vacancy. Whenever the Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board orders an election, the respective Board shall specify whether the Department of Elections or an unbiased independent contractor ("Contractor") shall conduct the election. Special elections may be held on an expedited basis as determined by the Department of Elections. The first Retiree Health Care Trust Fund Board election shall be a special election conducted by the Department of Elections.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord.378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008; Ord. 212-18, File No. 170738, App. 9/14/2018, Eff. 10/15/2018)

24. ADMINISTRATIVE CODE SECTION 16.552. DATES OF ELECTION.

Whenever an election is necessary, either at the completion of a term of office or to fill an unexpired term of office, the Retirement Board, Health Service Board or RetireeHealth Trust Fund Board shall specify the dates during which ballots may be marked and delivered. However, the dates designated by the Retirement Board, Health Service Board or Retiree Health Trust Fund Board shall not be within one month before or after an election which has been otherwise scheduled and which involves residents of the City and County of San Francisco as electors, unless the Department of Elections agrees to the dates.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

25. ADMINISTRATIVE CODE SECTION 16.553. NOTICE TO MEMBERS AND RETIRED MEMBERS; NOMINATION OF MEMBERS AND RETIRED MEMBERS.

The Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board shall thereafter notify the members of the Retirement System or Health Service System respectively of the following:

a) The necessity for an election;
b) The procedure for nomination and selection of candidates to serve on the Board;
c) The disclosure requirements set forth in Sections 16.553-1, 16.553-2, 16.553-3, and 16.553-4; and
d) The dates that ballots may be marked and delivered and the procedure for voting.

The period of time during which nominations may be made shall be set by the Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board, but in no event shall be less than 31 days. Any person nominated to serve as a trustee of the Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board shall, on forms provided by the respective Board for this purpose, and by the date set by the respective Board, verify acceptance of the nomination and agree to serve if elected before he or she may be listed as a candidate.

In any election for membership on the Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board, when only one candidate has filed nomination papers, the Department of Elections or Contractor shall not conduct an election and shall declare the sole candidate to be a member of the Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008; Ord. 212-18, File No. 170738, App. 9/14/2018, Eff. 10/15/2018)

26. ADMINISTRATIVE CODE SECTION 16.553-1. CANDIDATE INTENTION STATEMENTS.

Candidates seeking election to the Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board shall file with the Ethics Commission, signed under penalty of perjury, a candidate intention statement in a manner specified, and on a form provided, by the Ethics Commission.

(Added by Ord. 285-08, File No. 081190, App. 12/5/2008; amended by Ord. 212-18, File No. 170738, App. 9/14/2018, Eff. 10/15/2018)

27. ADMINISTRATIVE CODE SECTION 16.553-2. – CANDIDATE DISCLOSURE REQUIREMENTS.

a) **Statement of Economic Interests (Form 700).** Each candidate for Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board elections shall file, by the filing of a candidate intention statement, a Statement of Economic Interests (Form 700) disclosing the information required by the disclosure category for the office sought by the candidate established in the Conflict of Interest Code. Candidates shall file such statements with the Ethics Commission. This statement shall not be required if the candidate has filed, within the previous 90 days, a statement at disclosure category one with the Ethics Commission.

b) **Reporting by Candidates.**

1) **Initial Statement of Organization.** Any candidate for the Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board shall file an initial statement of organization with the Ethics Commission.

   a. **Campaign Bank Account.** Upon the filing of an initial statement of organization, the candidate shall establish or identify one campaign bank account at an office of a financial institution located in San Francisco. All contributions made to the candidate, or to a person on behalf of the candidate, shall be deposited in the account. All expenditures made by the candidate in support of his or her election to the Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board shall be made from the account.

2) **Semiannual Statements.** Candidates shall file semiannual statements that comply with the requirements of California Government Code Section 84211 each year no later than July 31 for the period ending June 30, and no later than January 31 for the period ending December 31.

3) **Preelection Statements.** Candidates shall file preelection statements that comply with the requirements of California Government Code Sections 84200.8 and 84211, and San Francisco Campaign and Governmental Conduct Code Section 1.135.

4) **Late Contribution Reports.** Any candidate that receives a late contribution shall file a late contribution report within 24 hours of receiving the late contribution. For purposes of this Section 16.553-2, "late contribution" shall mean a contribution, including a loan, that totals in the aggregate one thousand dollars ($1,000) or more and is made during the period beginning 90 days before the first day on which

ballots may be submitted to the Department of Elections or Contractor and ending on the last day on which ballots may be submitted to the Department of Elections or Contractor. The candidate shall report his or her full name and street address, the date and amount of the late contribution, and whether the contribution was made in the form of a loan. The candidate shall also report the full name of the contributor, his or her street address, occupation, and the name of his or her employer, or if self-employed, the name of the business.

5) **Termination Statements.** Candidates shall be responsible for filing the above statements, until they file a termination statement with the Ethics Commission that indicates they are no longer holding office and have no further financial activity to disclose.

6) **Forms and Filing.** The Ethics Commission shall specify the forms candidates shall use to file the above statements and the manner in which candidates shall electronically file those statements.

c) **Mass Mailings.** For the purposes of this Section 16.553-2, "mass mailing" shall be defined as set forth in the California Political Reform Act, California Government Code section 81000 *et seq.*, provided that the mass mailing advocates for or against one or more candidates for Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board.

1) **Filing Requirements.** Candidates that pay for mass mailings shall, within five working days after the distribution of the mass mailing, file a copy of the mass mailing and an itemized disclosure statement with the Ethics Commission. Within the final 16 days before the election, candidates that pay for mass mailing shall file a copy of the mass mailing and the itemized disclosure statement within 48 hours of the date of the distribution of the mass mailing.

2) **Disclaimers.** Mass mailings, door hangers, flyers, posters, oversized campaign buttons, bumper stickers, or print advertisements shall include the following disclaimer statements, printed in at least 12-point font: "Paid for by _____ (insert the name of the filer)." and "Financial disclosures are available at sfethics.org."

(Added by Ord. 285-08, File No. 081190, App. 12/5/2008; amended by Ord. 212-18, File No. 170738, App. 9/14/2018, Eff. 10/15/2018)

28. ADMINISTRATIVE CODE SECTION 16.554. NOTICE TO DEPARTMENT OF ELECTIONS OR CONTRACTOR.

The Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board shall notify the Department of Elections or Contractor at least 120 days prior to the first day that ballots may be marked and delivered (hereafter referred to as the "First Voting Day") that an election shall be held.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008; Ord. 212-18, File No. 170738, App. 9/14/2018, Eff. 10/15/2018)

29. ADMINISTRATIVE CODE SECTION 16.555. NOTICE TO DEPARTMENT; APPOINTMENT OF ELECTION OFFICERS.

The Department of Elections or Contractor shall notify each department, office and agency of the City and County of San Francisco (hereunder referred to as "department") at least 90 days prior to the First Voting Day that the department must designate an employee who shall serve as Election Officer for that department and must inform the Department of Elections or Contractor at least 60 days prior to the FirstVoting Day of the identity of such officer. The Department of Elections or Contractor shall supply each department with a form which can be returned to the Department of Elections or Contractor which identifies the employee who has been designated Election Officer. If any department has not designated an Election Officer by the appointed deadline, the Department of Elections or Contractor shall treat the department head as the Election Officer until such designation has been made.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

30. ADMINISTRATIVE CODE SECTION 16.556. INSTRUCTIONS TO ELECTION OFFICERS.

The Department of Elections or Contractor shall provide written instructions to each Election Officer at least 21 days prior to the First Voting Day, informing such officer of dates on which ballots will be distributed and collected and the procedure to be followed for their distribution and collection. If any department has failed to designate anElection Officer by the time that the Department of Elections or Contractor sends these written instructions, the Department of Elections or Contractor shall thereafter treat the administrative head of the department as the Election Officer until another employee has been designated as such by that department.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

31. ADMINISTRATIVE CODE SECTION 16.557. DELIVERY OF BALLOTS AND NAMES OF ELIGIBLE VOTERS TO DEPARTMENT OF ELECTIONS OR CONTRACTOR.

The Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board shall furnish the Department of Elections or Contractor with the names of the eligible nominees at least 35 days prior to the First Voting Day.

The Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board shall also furnish the Department of Elections or Contractor with a list of the members and retired members of the Retirement System or Health Service System respectively eligible to vote (“voters”) in the election at the same time that it furnishes the names of the eligible nominees. A supplemental list shall be furnished to the Department of Elections or Contractor within two days of the First Voting Day, which list shall provide the names of

eligible voters not included on the original list. These lists shall be in the format required by the Department of Elections or Contractor. These lists shall include the last known addresses for the members and retired members. For the active members, at the election of the entity conducting the election the department address shall be provided as an alternative.

Upon request, the City's Health Service System shall provide all information to Contractor, or the Department of Elections necessary to conduct the Retiree Health Care Trust Fund Board nomination and election process including, but not limited to, information regarding voter lists, voter contact information and Health Service System membership status.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008; Ord. 212-18, File No. 170738, App. 9/14/2018, Eff. 10/15/2018)

32. ADMINISTRATIVE CODE SECTION 16.558. BALLOTS TO CONTAIN INSTRUCTIONS FOR VOTING.

Each ballot shall contain instructions printed on it informing the voters of the procedure to be used in marking the ballot. Each ballot, or ballot return envelope, shallinform the voter that there are three ways to return the ballot:

a) By placing the ballot in the signed and sealed return envelope provided bythe Contractor or the Department of Elections in the container maintained for such purpose by the Election Officer of the voter's department, or by otherwise using the collection procedure arranged for by the Election Officer;
b) By delivering the signed and sealed return envelope provided by the Contractor or the Department of Elections with the ballot enclosed personally to theDepartment of Elections or the Contractor; and
c) By placing a stamp on the ballot return envelope and mailing the ballotand envelope to the Department of Elections or the Contractor.

The instructions shall also note the date by which ballots must be delivered to be counted.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

33. ADMINISTRATIVE CODE SECTION 16.559. – BALLOTS TO BE PLACED IN ADDRESSED ENVELOPES; EXTRA BALLOTS.

a) Members. Each ballot and ballot return envelope shall be mailed in aseparate envelope addressed to each employee eligible to vote at the member's individual address provided by the Retirement System, Health Service System Retiree Health Trust Fund Board. In the alternative, at the election of the entity conducting the election

of the entity conducting the election, ballots shall be delivered in care of his or her department.

b) Retired Members. Each ballot and ballot return envelope shall be mailed in a separate envelope addressed to the retired member at the address provided by the Retirement System, Health Service System or Retiree Health Trust Fund Board.

c) Additional ballots shall be printed and available for members and retiredmembers of the Retirement System or Health Service System who are eligible to votebut did not receive an individually addressed ballot.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

34. ADMINISTRATIVE CODE SECTION 16.560. DELIVERY OF BALLOTS AND INSTRUCTIONS TO ELECTION OFFICERS

a) Members. The Department of Elections or Contractor shall cause the ballots and accompanying envelopes to be mailed or delivered pursuant to Section 16.559(a) not later than 10 days prior to the First Voting Day, along with written instructions for their proper distribution and collection and any other pertinent guidelinesas set out in these provisions or as otherwise applicable.

b) Retired Members. The Department of Elections or Contractor shall depositin the mail the ballots and accompanying envelopes to each retired member at least 10 business days prior to the First Voting Day.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

35. ADMINISTRATIVE CODE SECTION 16.561. DUTIES OF ELECTION OFFICERS.

Each Election Officer shall:

a) Prior to the date that ballots are delivered, inform the department or employee responsible for distributing paychecks to employees of the department of the dates during which ballots are to be distributed to employees and of the responsibility of the Payroll Department to make arrangements to distribute a ballot by a date that will allow each voter at least three days to mark and deliver the ballot;

b) Upon receipt of the ballots, coordinate his or her efforts and those of the Payroll Department to ensure that the ballots are ready to be distributed by a date that will allow each voter at least three days to mark and deliver the ballot;

c) Provide notice to employees who are in the Retirement System or Health Service System but would not be likely to receive ballots, such as employees on the temporary payroll, that ballots are available;

d) Provide ballots to employees pursuant to the procedure established by the Department of Elections or Contractor;

e) Establish and maintain a collection procedure so that employees have a convenient

method of returning ballots, which method shall, where possible, make use of at least one container in which ballots can be placed; and

f) Return the ballots which have been received or otherwise collected according to the collection procedure established by such officer to the Department of Elections or Contractor, either personally or by the inter-office mail system, in a timely manner so that the ballots will be delivered to the Department of Elections or Contractor by the date established by the Retirement Board, the Health Service Board or Retiree Health Care Trust Fund Board as the final date for such delivery.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008; Ord. 212-18, File No. 170738, App. 9/14/2018, Eff. 10/15/2018)

36. ADMINISTRATIVE CODE SECTION 16.562. RESERVED.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008; repealed by Ord. 212-18, File No. 170738, App. 9/14/2018, Eff. 10/15/2018)

37. ADMINISTRATIVE CODE SECTION 16.563. COUNTING OF BALLOTS AND CERTIFICATION OF NEW TRUSTEE.

a) The Department of Elections or Contractor shall thereafter count the ballots in such a manner that the identity of the individual casting any particular ballot will not be disclosed. Each ballot shall be counted so long as it has been properly marked, signed and delivered. The Department of Elections or Contractor shall certify the new Health Service Board or Retiree Health Care Trust Fund Board trustee.

b) Within five days of the close of voting and prior to certification, the Retiree Health Care Trust Fund Board secretary shall attest to the Department of Elections or Contractor that there is one retired member trustee and one active member trustee candidate to fill the two elected Retiree Health Care Trust Fund Board trustee positions. For purposes of Retiree Health Care Trust Fund Board elections, the date of the election shall be the day the election is certified by the Department of Elections or Contractor. In the event that the active member candidate with the highest number of votes is no longer an active member on the day the election is certified, the Department of Elections or Contractor shall certify the active member candidate with the next highest number of votes. In the event that the retired member candidate with the highest number of votes is no longer a retired member on the day the election is certified, the Department of Elections or Contractor shall certify the retired member candidate with the next highest number of votes.

c) Within five days of the close of voting and prior to certification, the Executive Director of the Retirement System shall attest to the Department of Elections or Contractor whether there is a retired member serving as trustee on the Retirement Board:

1) If, at that time, there is no retired member serving as trustee, the Department of Elections or Contractor shall certify the individual receiving the highest number of votes as the newly elected trustee of the Retirement Board.
2) If, at that time, there is a retired member serving as trustee, the Department of Elections or Contractor shall certify the member (not a retired member) receiving the highest number of votes as the newly elected trustee of the Retirement Board.

Where there is no vacancy, the Department of Elections or Contractor shall certify the new Retirement Board trustee as close to the expiration of the term as reasonably possible.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008; Ord. 212-18, File No. 170738, App. 9/14/2018, Eff. 10/15/2018)

38. ADMINISTRATIVE CODE SECTION 16.564. RETIREMENT BOARD, HEALTH SERVICE BOARD OR RETIREE HEALTH TRUST FUND BOARD TO REIMBURSE DEPARTMENT OF ELECTIONS.

The Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board shall reimburse the Department of Elections for the actual expenses incurred by it in conducting Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board elections respectively. The Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board shall pay all Contractor expenses when the respective Board specifies that a Contractor conduct a Retirement Board, Health Service Board or Retiree Health Care Trust Fund Board election.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008; Ord. 212-18, File No. 170738, App. 9/14/2018, Eff. 10/15/2018)

39. ADMINISTRATIVE CODE SECTION 16.565. GIVING, RECEIVING ANYTHING OF VALUE IN CONSIDERATION OF VOTING PROHIBITED.

a) No person shall directly or through any other person pay, lend, or contribute or offer or promise to pay, lend, or contribute, any money or other valuableconsideration to or for any voter or to or for any other person to:
   1) Induce any person to:

      (A) Vote at any Retirement Board, Health Service Board orRetiree Health Trust Fund Board election;
      (B) Refrain from voting at any Retirement Board, Health ServiceBoard or Retiree Health Trust Fund Board election;
      (C) Vote or refrain from voting at a Retirement Board, Health Service Board or Retiree Health Trust Fund Board election for or against any particular person or measure; or

2) Reward any person for having:

(A) Voted at any Retirement Board, Health Service Board orRetiree Health Trust Fund Board election;
(B) Refrained from voting at any Retirement Board, HealthService Board or Retiree Health Trust Fund Board election; or
(C) Voted or refrained from voting at a Retirement Board, HealthService Board or Retiree Health Trust Fund Board election for or against any particular person or measure.

b) No person may directly or through any other person solicit, accept, receive, agree to accept, or contract for, before, during or after a Retirement Board,Health Service Board or Retiree Health Trust Fund Board election, any money, gift, loan, or other valuable consideration, offer, place, or employment for himself or herselfor any other person because he or she or any other person:
1) Voted or agreed to vote at any Retirement Board, Health ServiceBoard or Retiree Health Trust Fund Board election;
2) Refrained or agreed to refrain from voting at a Retirement Board,Health Service Board or Retiree Health Trust Fund Board election;
3) Voted, agreed to vote, refrained from voting, or agreed to refrainfrom voting for or against any particular person or measure at a Retirement Board, Health Service Board or Retiree Health Trust Fund Board election; or
4) Induced any other person to:

(A) Vote or agree to vote at any Retirement Board, Health Service Board or Retiree Health Trust Fund Board election;
(B) Refrain from voting or agree to refrain from voting at a Retirement Board, Health Service Board or Retiree Health Trust Fund Board election; or
(C) Vote, agree to vote, refrain from voting, or agree to refrainfrom voting for or against any particular person or measure at a Retirement Board, Health Service Board or Retiree Health Trust Fund Board election.

c) Any person violating any of the provisions of this section shall be guilty ofa misdemeanor and, upon a final judgment of conviction of same, shall be removed from office and may also be subject to a penalty of not more than six months in jail and/or fine of not more than $1,000, as well as removal.
d) "Person" means an individual, partnership, corporation, association, firmor other organization or entity, however organized.
e) Nothing in this section shall prohibit the following:
1) Making an expenditure for, offering, providing, accepting or receiving transportation to or from the polls; or
2) Making an expenditure for, organizing or attending a gathering providing complimentary food, beverages and/or entertainment, provided that no valuable consideration is offered, promised, solicited, accepted or received in

consideration of the conduct described in subsection (a); or

3) Making expenditures for the organization and conduct of get-out-the-vote rallies.

f) Pursuant to the procedures set forth in San Francisco Charter Sections 15.102 and C3.699-10 et seq., the Ethics Commission shall adopt regulations consistent with this Section for the purpose of implementing this Section while avoidingany application that would prohibit conduct protected by the United States Constitutionor the California Constitution.

(Added by Ord. 285-08, File No. 081190, App. 12/5/2008)

40. ADMINISTRATIVE CODE SECTION 16.700. PARTICIPATION.

The following shall be eligible to participate in the Health Service System:

a) City and County Employees.
   1) All permanent employees of the City and County of San Franciscowhose normal workweek at the time of inclusion is the system in not less than twenty (20) hours;
   2) All regularly scheduled provisional employees of the City and County of San Francisco whose normal workweek at the time of inclusion in the systemis not less than twenty (20) hours;
   3) All other employees of the City and County of San Francisco, including "as needed" employees, who have worked one thousand and forty hours (1040) in any consecutive twelve (12) month period and whose normal workweek at the time of inclusion in the system is not less than twenty (20) hours.

b) Elected Officials.

c) All Members of The Following Boards And Commissions DuringTheir Time In Service To The City And County Of San Francisco:
   (1) Access Appeals Commission
   (2) Airport Commission
   (3) Art Commission
   (4) Asian Art Commission
   (5) Board of Education
   (6) Board of Appeals
   (7) Building Inspection Commission
   (8) Civil Service Commission
   (9) Commission on the Aging
   (10) Commission on the Environment
   (11) Commission on the Status of Women
   (12) Community College District Governing Board
   (13) Concourse Authority
   (14) Elections Commission
   (15) Entertainment Commission
   (16) Ethics Commission

(17) Fine Arts Museums Board of Trustees
(18) Fire Commission
(19) Film and Video Arts Commission
(20) First Five Commission
(21) Health Commission
(22) Health Service Board
(23) Human Rights Commission
(24) Human Services Commission
(25) Juvenile Probation Commission
(26) Law Library Board of Trustees
(27) Library Commission
(28) Municipal Transportation Authority
(29) Planning Commission
(30) Police Commission
(31) Port Commission
(32) Public Utilities Commission
(33) Public Works Commission
(34) Recreation and Parks Commission
(35) Residential Rent Stabilization and Arbitration Board
(36) Retiree Health Care Trust Fund Board
(37) Retirement Board
(38) Sanitation and Streets Commission
(39) Sheriff's Department Oversight Board
(40) Small Business Commission
(41) Sunshine Ordinance Task Force
(42) War Memorial and Performing Arts Center Board
(43) Youth Commission

d) All Officers and Employees as Determined Eligible by The Board ofEducation of the San Francisco Unified School District.
e) All Officers and Employees as Determined Eligible by The GoverningBoard of the San Francisco Community College District.
f) All Officers and Employees as Determined Eligible by The GoverningBodies of the San Francisco Transportation Authority, San FranciscoParking Authority, San Francisco Redevelopment Agency, Treasure Island Development Authority, San Francisco Superior Court and Any Other Employees as Determined Eligible by Ordinance.
g) All Retirees, Surviving Spouses, Surviving Domestic Partners and Resigned Employees. For The Purposes of This Chapter, Resigned Employees Shall Have the Same Meaning as Used in Section A8.425 Of The Charter.
h) All Dependents of the Foregoing Categories as They Are Determined Eligible By The Appropriate Governing Body.

(Amended by Ord. 67-86, App. 3/7/86; Ord. 289-00, File No. 001549, App. 12/22/2000;Ord. 181-04, File No. 040741, App. 7/22/2004; Ord. 46-15, File No. 131122, App. 4/17/2015, Eff. 5/17/2015)

41. ADMINISTRATIVE CODE SECTION 16.701. ELIGIBILITY FOR EMPLOYER CONTRIBUTIONS.

The following shall be eligible to receive contributions for participation in the Health Service System as set forth below:

a) Members of boards and commissions referenced above in Section 16.700(c) and retirees, surviving spouse and domestic partners referenced above in Section 16.700(g), shall receive only the Charter-determined contribution. Members ofboards and commissions who were in service on the effective date of this ordinance shall maintain the same types of benefits during their term of service.
    (i) Except as may otherwise be required under state or federal law, thesurviving spouse or surviving domestic partner of an active employee who is killed in the performance of his or her duty shall continue to receive health benefits under the same terms and conditions provided to the employee prior to the death, or prior to the accident or injury that caused the death.

b) Employees referenced above in Section 16.700(a), elected officials referenced above in Section 16.700(b), members of the San Francisco Unified School District referenced above in Section 16.700(d) and members of the San Francisco Community College District referenced above in Section 16.700(e) shall receive both the Charter-determined contribution and collectively bargained contributions. Notwithstanding the foregoing, employees referenced above in Section 16.700(a), who are not in active service for more than twelve (12) weeks, shall be required to pay the Health Service System for the full premium cost of membership in the Health Service System, unless the employee shall be on sick leave, workers' compensation, mandatoryadministrative leave, approved personal leave following family care leave, disciplinary suspensions or on a layoff holdover list where the employee verifies they have no alternative coverage. In accordance with the City's obligations under the Meyers-Milias-Brown Act, the Department of Human Resources shall establish rules and regulations governing whether employees who, after inclusion in the system, work less than twenty (20) hours per week, shall lose eligibility in the system or whether the employee shall berequired to make additional contributions to the system.

c) Dependents of employees referenced above in Section 16.700(a) shall only receive collectively bargained contributions. Dependents of elected officials references above in Section 16.700(b) shall only receive contributions specified by ordinance. Dependents of members referenced above in Sections 16.700(d), (e) and (f)shall only receive the contributions specified by the appropriate governing body. Dependents of board and commission members referenced above in Section 16.700(c)shall receive no contribution. Dependents of retired employees referenced above in Section 16.700(g) shall receive contributions only as provided by the Charter.

d) Resigned employees referenced above in Section 16.700(g) shall notreceive any contribution.

e) Those subgroups referenced above in Section 16.700(f) shall receivecontributions as determined by their respective employers.

(Added by Ord. 48-95, App. 3/10/95; amended by Ord. 289-00, File No. 001549, App. 12/22/2000)

42. ADMINISTRATIVE CODE SECTION 16.702. HEALTH SERVICE; BOARD COMPOSITION.

In any election for membership on the Health Service Board when only one candidate has filed nomination papers and no person has filed a declaration of write-incandidacy, the Director of Elections shall not conduct an election and shall declare thesole candidate to be a member of the Board.

(Added by Ord. 439-96, App. 11/8/96)

43. ADMINISTRATIVE CODE SECTION 16.704. -REMEDYING DISCRIMINATION AGAINST EMPLOYEES IN SAME-SEX MARRIAGES OR IN SAME-SEX DOMESTIC PARTNERSHIPS.

a) Findings and Purpose. The City and County of San Francisco (City) finds that its own employees with same-sex spouses or same-sex domestic partners suffer both dignitary and economic harm as a result of discriminatory federal laws. In particular, as a result of discriminatory treatment under federal tax laws that impose taxes on health care coverage provided to employees with same-sex, but not those with opposite-sex, spouses, City employees with same-sex spouses or same-sex domestic partners suffer not only the indignities of being treated as second-class citizens by their own government; they also suffer measurable financial harm that is concrete, persistent,and significant, and in some cases immense.

The City is committed to the equitable principle that all City employees receive equal pay for equal work. That principle is unattainable for City employees with same- sex spouses or same-sex domestic partners so long as: (1) state law prevents same- sex couples from marrying; (2) federal law treats the value of employer contributions for same-sex spouses' or same-sex domestic partners' health insurance premiums as taxable income, and does not tax employer subsidies for opposite-sex spouses' health insurance premiums; and (3) federal law prevents the use of pre-tax dollars by employees to pay health insurance premiums for their same-sex spouses or same-sex domestic partners, while allowing the use of pre-tax dollars by employees to pay healthinsurance premiums for their opposite-sex spouses.

In an effort to offset the discriminatory impact of federal taxation on same-sex spouse and same sex-domestic partner health insurance premiums, and to come closerto achieving the equitable principle of equal pay for equal work, this Section 16.704 requires the City to make payments to City employees who are provided subsidies for, and/or who pay all or part of the premiums for, their same-sex spouses' or same-sexdomestic partners' health insurance premiums.

b) For each City employee Health Service System member who is subject tofederal taxation on health insurance premiums (both medical and dental) paid by the City for a same-sex spouse, or same-sex domestic partner, the City shall pay an amount equal to twenty (20%) percent of the portion of the employee's health insurance premiums attributable to the same-sex spouse, or same-sex partner, as determined by the San Francisco Health Service System. These payments shall not be part of the employee's base pay, are not payments made as compensation for hours of employment, and shall not be included in any overtime or premium pay calculations.

c) Operative Date. This Section 16.704 shall become operative on July 1, 2013.

d) Expiration. This Section 16.704 shall expire in its entirety, or as applied specifically to one or more of the following three groups of City employees – employeeswith same-sex spouses who married in California; employees with same-sex spouses who married outside of California; and employees with same-sex domestic partners – if, and when, the City Attorney's Office certifies to the Mayor and the Board of Supervisorsthat one or more of those groups of City employees are no longer subject to discriminatory federal income taxation of health insurance premiums attributable to theirsame-sex spouses or same-sex domestic partners. This Ordinance shall continue to apply to those groups of City employees listed above who continue to be subject to discriminatory federal income tax on health insurance premiums attributable to their same-sex spouses or same-sex domestic partners.

(Added by Ord. 34-13, File No. 121124, App. 3/12/2013, Eff. 4/11/2013, Oper. 7/1/2013)

44. ADMINISTRATIVE CODE SECTION 16.900. ESTABLISHMENT OF A CAFETERIA PLAN.

The San Francisco Health Services System may establish an employee cafeteriaplan as provided and regulated under Section 125 of Title 26 of the United States Internal Revenue Code.

(Added by Ord. 175-88, App. 4/28/88; amended by Ord. 370-88, App. 8/10/88; Ord. 105-00, File No. 000536, App. 5/26/2000; Ord. 3-12, File No. 111246, App. 1/12/2012,Eff. 2/11/2012)

45. ADMINISTRATIVE CODE SECTION 16.901. PURPOSE.

The purpose of this plan is to extend to employees of the City and County of SanFrancisco, San Francisco Unified School District, San Francisco Community College District, the Superior Court of California, County of San Francisco and the San Francisco County Transportation Authority (Participating Employers), those types of benefits that ordinarily accrue from participation in a cafeteria plan. The City and Countyof San Francisco does not and cannot represent or guarantee that any particular federalor state income, payroll or other tax consequence will occur by reason of an employee'sparticipation in this plan. The participant should consult with his or her own attorney or other representative regarding all tax consequences of participation in this plan.

(Added by Ord. 175-88, App. 4/28/88; amended by Ord. 370-88, App. 8/10/88; Ord. 3-12, File No. 111246, App. 1/12/2012, Eff. 2/11/2012)

46. ADMINISTRATIVE CODE SECTION 16.902. ADMINISTRATION BY THE SAN FRANCISCO HEALTH SERVICE SYSTEM.

The cafeteria plan established pursuant to this Article may be administered by the San Francisco Health Service System which may prescribe such forms, and adopt such rules and regulations as are necessary to carry out the purposes of the plan. The San Francisco Health Service System shall also have the authority to amend the plan toensure compliance with applicable laws and regulations, to reflect changes in benefit offerings by the City and County of San Francisco or Participating Employers, and to make modifications for the reasonable administration of the plan. The San FranciscoHealth Service System may contract with a financially responsible independent contractor to administer and coordinate the plan.

(Added by Ord. 175-88, App. 4/28/88; amended by Ord. 370-88, App. 8/10/88; Ord. 105-00, File No. 000536, App. 5/26/2000; Ord. 3-12, File No. 111246, App. 1/12/2012,Eff. 2/11/2012)

47. ADMINISTRATIVE CODE SECTION 16.903. NO COST TO CITY AND COUNTY.

This cafeteria plan shall be administered free of direct cost to, or appropriation by, the City and County of San Francisco or the Participating Employers. Except as herein provided, all such costs shall be borne by the participants or by any plan administrator appointed hereunder, except to the extent that any subsequent ordinanceor appropriation might provide expressly to the contrary. Nothing contained in this Section shall be deemed to prohibit the inclusion of a hold harmless provision in any contract between the City and any plan administrator appointed hereunder, which provision has been approved by the City's Risk Manager pursuant to Administrative Code Section 1.24.

(Added by Ord. 175-88, App. 4/28/88; amended by Ord. 370-88, App. 8/10/88; Ord. 105-00, File No. 000536, App. 5/26/2000; Ord. 3-12, File No. 111246, App. 1/12/2012,Eff. 2/11/2012)

48. ADMINISTRATIVE CODE SECTION 16.904. VOLUNTARY EMPLOYEE BENEFITS.

Based upon individual authorized deductions, the Controller is hereby authorized to deduct and collect monies from the salaries or wages of employees of the City and County of San Francisco, San Francisco Community College District, and the Superior Court of California, County of San Francisco, in accordance with San Francisco Administrative Code Sections 16.91 and 16.92. Pursuant to Section 125, this voluntary authorized deduction shall not be revocable by the employee during the cafeteria plan year unless the revocation and new election are in conformance with Section 125 andthe terms of the plan.

(Added by Ord. 370-88, App. 8/10/88; amended by Ord. 130-90, App. 4/12/90; Ord. 162-92, App. 6/10/92; Ord. 105-00, File No. 000536, App. 5/26/2000; Ord. 3-12, File No. 111246, App. 1/12/2012, Eff. 2/11/2012)

49. ADMINISTRATIVE CODE SECTION 16.905. CAFETERIA PLAN BENEFITS.

The Board of Supervisors hereby approves the inclusion of those benefit plans qualifying under the employee cafeteria plan as provided and regulated under Section 125 of Title 26 of the United States Code as well as the medical care plans adopted bythe Health Service Board and approved by the Board of Supervisors annually under Section A8.422 of the Charter and Administrative Code Section 16.703 and which medical plans are on file with the Clerk of the Board of Supervisors.

(Added by Ord. 370-88, App. 8/10/88; amended by Ord. 130-90, App. 4/12/90; Ord. 162-92, App. 6/10/92; Ord. 105-00, File No. 000536, App. 5/26/2000; Ord. 3-12, File No. 111246, App. 1/12/2012, Eff. 2/11/2012)

50. ADMINISTRATIVE CODE SECTION 16.906. HEALTH SYSTEM MEMBERSHIP OF FORMER SUPERVISORS.

After leaving office as a member of the Board of Supervisors, a former Supervisor may still participate in any plan of the Health Service System, provided thatthe former Supervisor agrees to, and for so long as he or she does, pay the full cost ofsuch benefit, as determined by the Health Service Board.

(Added by Ord. 13-91, App. 1/15/91)

51. ADMINISTRATIVE CODE SECTION 21.02. DEFINITIONS.

As used in this Chapter the following words shall have the following respective meanings:

"Bid" shall mean a bid, quotation, or other offer, other than a Proposal, from a person or entity to sell a Commodity or Service to the City at a specified price.

"Bidder" shall mean any person or entity which submits a Bid.

"City" shall mean the City and County of San Francisco.

"Code" or "this Code" shall mean the most current version of the San Francisco Charter and the San Francisco Municipal Code.

"Commodity" shall mean products, including materials, equipment and supplies, purchased by the City. "Commodity" shall specifically exclude legal and litigation related contracts or contracts entered into pursuant to settlement of legal proceedings, and employee benefits, including, without limitation, health plans, retirement or deferred

compensation benefits, insurance and flexible accounts, provided by or through the City's Human Resources Department or the Retirement Board.

"Contractor" shall mean any corporation, partnership, individual, sole proprietorship, joint venture or other legal entity which enters into a contract to sell Commodities or Services to the City.

"Contracting Officer" shall mean the City employee who is authorized to execute a contract, which may be either the Department head or a person designated in writing by the Department head, board or commission as having the authority to sign contracts for the Department. A designation of authority to sign contracts on behalf of a Department may specify authority to sign a single contract, specified classes of contracts, or all contracts entered into by a Department.

"Electronic" shall mean electrical, digital, magnetic, optical, electromagnetic or other similar technology for conveying documents or authorizations, excluding facsimile.

"General Services" shall mean those services that are not Professional Services. General Services include, but are not limited to, janitorial, security guard, pest control, parking lot management, and landscaping services.

"Minimum Competitive Amount" shall mean (i) for the procurement of Commodities and Professional Services, the "Minimum Competitive Amount" as defined in Section 6.40(a) of the Administrative Code, which shall be $110,000 and (ii) for the procurement of General Services, an amount equivalent to the "Threshold Amount" as defined in Section 6.1 of the Administrative Code which shall be $600,000, provided that on January 1, 2020 and every five years thereafter, the Controller shall recalculate the Minimum Competitive Amount (and the Threshold Amount from which the Minimum Competitive Amount for General Services is calculated) to reflect any proportional increase in the Urban Regional Consumer Price Index from January 1, 2015, rounded to the nearest $1,000.

"Offer" shall mean a Bid or Proposal submitted to the City in response to an invitation for Bids or a Request for Proposals. "Offer" may include a response to a request for qualifications if no further ranking prior to Contractor selection is contemplated by the procurement process.

"Offeror" shall mean a person or entity that submits an Offer to the City to provide Commodities or Services.

"Professional Services" shall mean those services which require extended analysis, the exercise of discretion and independent judgment in their performance, and/or the application of an advanced, specialized type of knowledge, expertise, or training customarily acquired either by a prolonged course of study or equivalent experience in the field. Professional service providers include, but are not limited to, licensed professionals

such as architects, engineers, and accountants, and non-licensed professionals such as software developers and financial consultants.

"Proposal" shall mean a response to a request for Proposals issued by the City for Commodities or Services, or a response to a request for qualifications if no further ranking prior to Contractor selection is contemplated by the procurement process.

"Proposer" shall mean a person or entity that submits a Proposal in response to a request for Proposals issued by the City.

"Purchase Order" shall mean an authorization document designated as such by the Purchaser for the procurement of Commodities or Services, whether issued in a paper or electronic format, including blanket purchase orders for purchases involving multiple payments.

"Purchaser" shall mean the Purchaser of Commodities or Services of the City and County of San Francisco, or his or her designee(s).

"Quotation" shall mean an Offer to supply Commodities or Services to the City for a specified price (and possibly subject to other terms and conditions) which is acquired without the use of advertising to solicit Bids.

"Services" shall mean Professional Services and General Services. "Services" shall specifically exclude grants to a nonprofit entity to provide services to the community, which may include incidental purchases of commodities; legal and litigation related services or contracts entered into pursuant to settlement of legal proceedings; and services related to employee benefits, including, without limitation, health plans, retirement or deferred compensation benefits, insurance and flexible accounts, provided by or through the San Francisco Health Service System, the Retirement Board or the Retiree Health Care Trust Fund.

"Solicitation" shall mean an invitation for Bids, request for Quotations, request for qualifications, or request for Proposals issued by the City for the purpose of soliciting Bids, Quotations, or Proposals to perform a City contract.

"Technology Store" shall mean the City-wide, multiple award contract for the procurement of certain Commodities and Services awarded pursuant to the "Request for Proposal for Computer Hardware, Software, Peripherals and Appropriate Network, Consulting, Maintenance, Training and Support Services," and any successor contracts thereto.

(Added by Ord. 156-99, File No. 990743, App. 6/2/99; amended by Ord. 9-11, File No. 101007, App. 1/7/2011; Ord. 3-12, File No. 111246, App. 1/12/2012, Eff. 2/11/2012; Ord. 46-15 , File No. 131122, App. 4/17/2015, Eff. 5/17/2015; Ord. 108-15 , File No. 150175, App. 7/2/2015, Eff. 8/1/2015)

SAN FRANCISCO
HEALTH SERVICE SYSTEM
Affordable, Quality Benefits & Well-Being

San Francisco Health Service System Rules

Approved by the Health Service System Board

on December 12, 2024, to be effective January 1, 2025

Table of Contents

The Purpose of the San Francisco Health Service Rules

The San Francisco Health Service System Rules (SFHSS Rules) are designed to provide a clear and structured framework for managing the health benefits offered to the eligible members and their dependents. These rules have been adopted by the Health Services Board consistent with the San Francisco City Charter, the San Francisco Administrative Code, California Government Code, 26 U.S. Code § 125 (also known as IRS Cafeteria Plan Section 125), along with other state and federal regulations.

These rules serve to ensure equitable access to comprehensive healthcare coverage by defining eligibility criteria, enrollment processes, and the scope of benefits available. They also establish guidelines for appeals and compliance with relevant regulations in the administration of health benefits. By outlining these procedures, the SFHSS Rules aim to promote transparency, efficiency, and fairness in the administration of health benefits, ultimately supporting the well-being and health of the eligible members and their dependents.

A. Health Service System Member Eligibility

In accordance with City Charter Section 12.202, and San Francisco Administrative Code Section 16.700, the following persons shall be members of the San Francisco Health Service System. A Member is any individual identified under Section A of the SFHSS Rules and is the primary enrolled subscriber for benefits offered through the Health Service System (HSS). Members are eligible to choose from the benefit plans provided by the Health Service System.

Initial Enrollment Period: Member eligibility for elected benefits must be made within 30 days of their initial date of eligibility (e.g. hire date, appointment date). For Retiree members see Sec. J.1 for enrollment timeline requirements.

1. **City & County of San Francisco Employees**
    a. All permanent employees of the City & County of San Francisco whose normal work week at the time of inclusion in the Health Service System is not less than twenty (20) hours;
    b. All regularly scheduled provisional employees of the City & County of San Francisco whose normal work week at the time of inclusion in the Health Service System is not less than twenty (20) hours;
    c. All other employees of the City & County of San Francisco, including "as needed" employees who have worked one thousand and forty (1,040) hours in any consecutive twelve (12) month period and whose normal work week at the time of inclusion in the Health Service System is not less than twenty (20) hours; and
    d. All other employees who are deemed 'full-time employees' under the shared responsibility provision of the Patient Protection and Affordability Care Act (section 4980H).

2. **Elected Officials**
    All elected officials, including but not limited to:
    a. the Mayor
    b. the Board of Supervisors
    c. the Assessor-Recorder
    d. the Treasurer
    e. the City Attorney
    f. the Public Defender
    g. the Sheriff

3. **All Members of the Following Boards and Commissions During Their Time in Service with the City & County of San Francisco**
    Access Appeals Commission
    Airport Commission
    Art Commission
    Asian Art Commission
    Board of Education

Board of Appeals
Building Inspection Commission
Civil Service Commission
Commission on the Environment
Commission on the Status of Women
Community College District Governing Board
Disability and Aging Services Commission
Elections Commission
Entertainment Commission
Ethics Commission
Fine Arts Museums Board of Trustees
Fire Commission
Film Commission
First Five Commission
Health Commission
Health Service Board
Homelessness Oversight Commission
Human Rights Commission
Human Services Commission
Juvenile Probation Commission
Law Library Board of Trustees
Library Commission
Municipal Transportation Agency Board of Directors
Planning Commission
Police Commission
Port Commission
Public Utilities Commission
Public Works Commission
Recreation and Parks Commission
Residential Rent Stabilization and Arbitration Board
Retiree Health Care Trust Fund Board
Retirement Board
Sanitation and Streets Commission
Sheriff's Department Oversight Board
Small Business Commission
Sunshine Ordinance Task Force
War Memorial and Performing Arts Center Board of Trustees
Youth Commission

4. **All Officers and Employees as Determined Eligible by the Governing Board of Education of the San Francisco Unified School District**

5. **All Officers and Employees as Determined Eligible by the Governing Board of Education of the San Francisco Community College District**

6. **All Officers and Employees as Determined Eligible by the Governing Bodies of the**:
    a. San Francisco Transportation Authority
    b. San Francisco Parking Authority
    c. San Francisco Redevelopment Agency
    d. Treasure Island Development Authority
    e. San Francisco Superior Court

7. **Any Other Employees Not Listed in Sections A.1 –A.6, as Determined Eligible by Ordinance**

8. **Retirees**
    As used in the Health Service System Rules (HSS Rules), a Retiree Member is defined as a former employee member who leaves active employment after meeting their employer's requirements for retirement based on duration of service, disability or vesting and retires under their respective retirement system (SFERS, CalSTRS, CalPERS, or PARS). To be eligible for participation in the Health Service System and to be eligible for health benefits at the premium contribution rate established for retirees (Section Q), a Retiree Member must have elected to receive benefits under their retirement system and must have been enrolled in a health benefit plan through the Health Service System for some period during their term of employment with the City and County of San Francisco, the San Francisco Unified School District (SFUSD), the San Francisco Community College District (SFCCD), or the San Francisco Superior Court. SFUSD and SFCCD may impose additional requirements for health coverage.

    If hired on or after January 10, 2009, a retiree is eligible to participate in the Health Service System, with no employer contributions toward health insurance premiums, after five (5) years of service. The Health Service System calculates service based on service with the Health Service System's participating employers – the City and County of San Francisco, the SFUSD, the SFCCD and the San Francisco Superior Court. A retiree who retires for industrial disability does not have to meet the five-year service requirement to be eligible for coverage.

9. **Resigned Members**
    As used in these Health Service System Rules (HSS Rules), a Resigned Member is defined as an employee member who resigned and withdrew their funds from a retirement system within thirty (30) days immediately prior to the date on which, but for their resignation, they could have been retired for service as a member of a retirement system. Coverage of a Resigned Member is at the unsubsidized full premium rate. Coverage must be continuous and, if lapsed, may not be reinstated without Board approval. (See San Francisco City Charter Section A8.425 and Administrative Code 16.701(d).)

10. **Former Elective Members of the Legislative Body**
    Members shall also include former elective members of the legislative body who have served in office after January 1, 1981, and whose total service at the time of termination of service on such legislative body is not less than twelve (12) years when the respective legislative body provides for the continuation of health benefits as authorized by Ca. Gov. Code Section 53201.

B. Eligible Dependents of Health Service System Members

An enrolled Health Service System member may enroll the following dependents into health coverage subject to the following conditions and limitations:

1. A Member's Legal Spouse
    a. A member's legal spouse may be enrolled within thirty (30) days of marriage, during an Open Enrollment period or within thirty (30) days of a qualifying event as defined in Section G. A member's spouse shall be eligible as a dependent of the member provided that the member files a copy of their marriage license/certificate, the spouse's Social Security card, and Medicare card (if applicable) with the Health Service System.
        i. Coverage shall be effective on the first day of the coverage period following the date on which HSS receives all required documentation.
    b. When a member is granted a final dissolution of marriage or is legally separated, the member's former spouse shall not be eligible as a dependent, as of the last day of the coverage period in which the legal separation, divorce or final dissolution has been granted. In accordance with Section E a member must immediately notify the Health Service System in writing and provide documentation when the legal separation, divorce or final dissolution of marriage has been granted. Failure to do so can result in termination of coverage and financial penalties. When a member has been granted a final dissolution of marriage, or is legally separated, coverage for their dependent children shall continue as long as they are otherwise eligible. However, coverage for stepchildren will not continue.

2. **A Member's Registered Domestic Partner**
    a. A registered domestic partner may be enrolled within thirty (30) days of registration of domestic partnership, during Open Enrollment, or within thirty (30) days of a qualifying event as defined in Section G.
    b. Registered domestic partner and domestic partner are used interchangeably throughout this document.
    c. The member must provide SFHSS a certificate of domestic partnership that has been processed per the requirements of the issuing city or county:

i. For members residing in San Francisco, domestic partnership must be established by filing the Declaration of Domestic Partnership with the San Francisco County Clerk. Domestic Partnership registration completed through a notary public in San Francisco is not accepted by HSS.
ii. Members residing in California (including San Francisco) may alternatively provide a California Secretary of State Certificate of Registration of Domestic Partnership. (See www.sos.ca.gov.)
iii. If the member resided in a city, county or state that does not issue certification of domestic partnership at the time when the domestic partnership was established, then the member and their domestic partner must sign and submit a notarized Health Service System Declaration of Domestic Partnership form. The requirements for domestic partner eligibility in the Health Service System may be greater than what is required by a city or county for domestic partner registration.

d. The member and their registered domestic partner must certify to the Health Service System that they are economically responsible to each other for the common necessities of life, defined as food, shelter and medical care, and that this shall remain the case for expenses incurred during the period the member's domestic partner is covered by the Health Service System.
e. The certificate of domestic partnership, the domestic partner's Social Security card, and Medicare card (if applicable) must be provided to HSS.
    i. Coverage will be effective on the first day of the coverage period following the date on which HSS receives all documentation.
f. When the member is granted dissolution of domestic partnership, is legally separated, or there is any change of circumstances as attested to in a Declaration of Domestic Partnership, the member's partner is no longer eligible as a dependent. Health benefits will end on the last day of the coverage period in which the dissolution of the domestic partnership or legal separation is granted; or change of circumstances as attested to in the Declaration of Domestic Partnership is submitted to SFHSS. In accordance with Section E a member must immediately notify the Health Service System in writing when the member's partner is not eligible. Failure to do so can result in termination of coverage and financial penalties. Once a member's partner is no longer eligible, any children of the former partner are also no longer eligible.

3. **Children**

To be eligible for health benefits as a dependent child under the Health Service System Rules (HSS Rules), a child must be one of the following and meet all other applicable criteria noted below.

a. **Eligibility Requirements for Natural Children, Adopted Children, and Stepchildren**

To be an eligible dependent child under these rules, a child must be under the age of 26 and one of the following:

A natural child of an enrolled member, a legally adopted child of, or a child placed for adoption with, an enrolled member, or a stepchild who is a natural child, legally adopted child, or a child placed for adoption with, a member's enrolled spouse or domestic partner.

All of the following criteria are required:

i. A child may be enrolled within thirty (30) days of birth, adoption, or adoption placement date, during Open Enrollment, or within thirty (30) days of a qualifying event as defined in Section G;
ii. A member must provide eligibility documentation for the child, including a birth certificate, adoption certificate or court documents, and a Social Security card;
iii. No child of a member may remain, or be enrolled, in the Health Service System past the maximum age of 26 except a disabled child as provided in Section B.3.d;
iv. Coverage will become effective on the first day of the coverage period following the receipt of all documentation by HSS.

b. **Eligibility Requirements for Children Under Legal Guardianship**

To be eligible, a child under legal guardianship of a member, a member's enrolled spouse, or member's enrolled domestic partner, must meet all of the following criteria.

i. Child must be under 19 years of age;
ii. Child may be enrolled within thirty (30) days of the effective date of legal guardianship, during Open Enrollment, or within thirty (30) days of a qualifying event as defined in Section G;
iii. The member must provide eligibility documentation, including a copy of the legal judgment or decree assigning legal guardianship and a Social Security card;
iv. Coverage will become effective on the first day of the coverage period following the receipt of all documentation by HSS; and
v. Grandchildren, nieces and nephews, the spouse of a member's child and other relatives or children of no family relation residing with a member are not eligible to be enrolled in an HSS administered health plan unless the child meets the qualifications for a child under legal guardianship.

c. **Eligibility Requirements for Children Under Court Order**

For the child to be eligible, a member must be required by judgment, decree or order issued by a court to provide health coverage for the child.

All of the following criteria must be met:

i. Child must be under 19 years of age;

ii. The member must provide HSS with a copy of the court order and the child's Social Security card;
iii. Child may be enrolled within thirty (30) days of the effective date of judgment, decree or order, during Open Enrollment, or within thirty (30) days of a qualifying event as defined in Section G; and
iv. Coverage will become effective on the first day of the coverage period following the receipt of all documentation by HSS.

d. **Age Exemption for Eligible Adult Disabled Children**
To qualify a dependent as a 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:
i. Adult Child is enrolled in a San Francisco Health Service System medical plan on their 26th birthday;
ii. Adult Child has met the requirements of being an eligible dependent child under Section B.3 before turning 26 years old;
iii. Adult Child must have been physically or mentally disabled on the date coverage would have otherwise terminated due to age, i.e. turning 26 years old, and continue to be disabled from age 26 on;
iv. Adult Child is incapable of self-sustaining employment due to the physical or mental disability;
v. Adult Child is dependent on HSS Member for substantially all of their economic support, and is declared as a dependent on the Member's federal income tax;
vi. Member is required to comply with their enrolled medical plan's disabled dependent certification process and recertification process every year thereafter or upon request;
vii. Adult Children who qualify for Medicare due to a disability are required to enroll in Medicare (See Section K.2). Member must notify HSS of the Adult Child's eligibility for Medicare, as well as subsequent enrollment in Medicare; and
viii. To maintain ongoing eligibility after the Adult Child has been enrolled, the Member must continuously enroll the Adult Child in an HSS medical plan without interruption and must ensure that the Adult Child remains continuously enrolled with Medicare A/B (if eligible) without interruption.

A newly hired employee who adds an eligible dependent Adult Child, who is age 26 or older, must meet all requirements listed, except d. (i), d. (ii), and d. (iii) above and comply with their enrolled medical plan's disabled dependent certification process specified in d. (vi) within thirty (30) days of employee's hire date.

4. **Eligibility Requirements for Surviving Dependents**

a. **Surviving Spouse or Surviving Registered Domestic Partner of an Active Employee Hired Before January 10, 2009**
    i. The surviving spouse or surviving domestic partner of an active employee hired before January 10, 2009, is eligible to enroll, provided that the surviving spouse or surviving domestic partner and the active employee had been married or registered as domestic partners for a period of at least one (1) year prior to the death of the active employee.
    ii. Coverage will become effective on the first day of the coverage period following the receipt of all documentation by SFHSS, if the spouse or registered domestic partner was not enrolled in a SFHSS health plan immediately prior to the member's death. Eligibility will be continuous with no gap in coverage if the spouse or registered domestic partner was enrolled in a SFHSS health plan immediately prior to the member's death.
    iii. An enrollment application must be submitted by the surviving spouse/registered domestic partner within thirty (30) days of the member's death. Failure to provide the requested information will result in a denial of survivor health benefits and will only allow enrollment during the next Open Enrollment to select health benefits for the following plan year.

b. **Surviving Spouse or Surviving Domestic Partner of an Active Employee Hired On or After January 10, 2009**
    i. The surviving spouse or surviving domestic partner of an active employee hired on or after January 10, 2009, is eligible to enroll if the deceased employee had accrued ten (10) or more years of credited service (as determined by HSS). The surviving spouse or surviving domestic partner and the active employee must have been married or registered as domestic partners for a period of at least one (1) year prior to the death of the active employee.
    ii. The surviving spouse or surviving domestic partner of an active employee hired on or after January 10, 2009, who died in the line of duty is eligible to enroll if the surviving spouse or surviving domestic partner is entitled to a death allowance as a result of the death in the line of duty. The surviving spouse or surviving domestic partner and the active employee must have been married or registered as domestic partners for a period of at least one (1) year prior to the death of the active employee.
    iii. The surviving spouse or surviving domestic partner of an active member hired on or after January 10, 2009, who did not accrue ten (10) years of credited service (as determined by HSS) or who did not die in the line of duty with death allowance entitlement is not eligible.
    iv. The surviving spouse, or surviving domestic partner, and eligible dependent children of a firefighter or peace officer who died in the line of duty, is entitled to health benefits under the same terms and conditions provided prior to the death, or prior to the accident or injury that caused the death, of

the employee (active member rates and employer contributions) unless the surviving spouse elects to receive a lump-sum survivors benefit in lieu of monthly benefits(see Section 4856 of the California Labor Code). If the surviving spouse, or surviving domestic partner, and eligible dependent children of a firefighter or peace officer who died in the line of duty, elects a lump-sum survivors benefit in lieu of member benefits, then the provisions outline in Section Q.3, Employer Premium Subsidy for Eligible Surviving Dependents of an Active Employee Member, would apply.

c. **Surviving Spouse or Surviving Domestic Partner of a Retired Member Hired Before January 10, 2009**
The surviving spouse or surviving domestic partner of a Retiree Member who was hired before January 10, 2009, is eligible to enroll provided that the surviving spouse or surviving domestic partner and the Retiree Member have been married or registered as domestic partners for a period of at least one (1) year prior to the death of the Retiree Member.

d. **Surviving Spouse or Surviving Domestic Partner of a Retired Member Hired On or After January 10, 2009**
   i. The surviving spouse or surviving domestic partner of a Retiree Member who was hired on or after January 10, 2009, is eligible to enroll if the deceased member had accrued ten (10) or more years of credited service (as determined by HSS) and retired within 180 days of separation from employment. The surviving spouse or surviving domestic partner and the retired member must have been married or registered as domestic partners for a period of at least one (1) year prior to the death of the Retiree Member.
   ii. The surviving spouse or surviving domestic partner of a deceased Retiree Member who was hired on or after January 10, 2009, and who retired with a disability retirement from their retirement system, is eligible to enroll if the surviving spouse or the surviving domestic partner and the Retiree Member were married or registered as domestic partners for a period of at least one (1) year prior to the death of the Retiree Member.
   iii. The surviving spouse or surviving domestic partner of a Retiree Member hired on or after January 10, 2009, who did not accrue ten (10) years of credited service (as determined by HSS) or did not retire within 180 days of separation from employment, is not eligible.

e. **Eligibility Requirements for Surviving Dependent Children**
   i. Surviving dependent children of an active employee or Retiree Member must have been enrolled on the member's coverage at the time of the member's death, must meet eligibility requirements in Section B.3, and are only eligible for benefits under a surviving spouse or a surviving domestic partner member, with the following exception:

1. Eligible dependent children of a firefighter or peace officer who died in the line of duty, are entitled to receive health benefits under the coverage provided the surviving spouse or, if there is no surviving spouse, until the age of 21 years, under the same terms and conditions provided prior to the death, or prior to the accident or injury that caused the death (see Section 4856 of the California Labor Code).

f. **Additional Surviving Dependent Enrollment Requirements**
   i. The surviving spouse or surviving domestic partner of a deceased Resigned Member is not eligible.
   ii. Because they are dependents themselves, surviving spouses and surviving domestic partners do not have the member privilege of enrolling any individuals as additional dependents on their coverage. A surviving dependent cannot enroll additional dependents, including children not enrolled at the time of the member's death, or a new spouse or domestic partner.
   iii. Eligible surviving dependents may continue enrollment if they complete the surviving dependent enrollment process within thirty (30) days of a member's death. They may continue to be enrolled as long as they remain eligible. If the surviving dependent enrollment process is not completed within thirty (30) days of the member's death, the surviving dependent must wait until the next Open Enrollment or other qualifying event in order to enroll in coverage.
   iv. Surviving dependents of a firefighter or peace officer killed in the line of duty are eligible for health benefits under the same terms and conditions provided prior to the death, or prior to the accident or injury that caused the death, (active member rates and employer contributions) of the employee unless the surviving spouse elects to receive a lump-sum survivors benefit in lieu of monthly benefits (see California Labor Code Section 4856). If the surviving spouse elects a lump-sum survivors benefit in lieu of member benefits, then the provisions outline in Section Q.3, Employer Premium Subsidy for Eligible Surviving Dependents of an Active Employee Member, would apply.
   v. See Section Q for rules regarding surviving dependent premium contributions, employer subsidy and delinquency.

5. **Subsidy for Surviving Dependents of an Employee or Retiree Member**
   Eligible surviving dependent children pay the full premium and are not eligible for the employer-subsidized premium rate.

   The spouse or domestic partner of a deceased Retiree Member who retired under their retirement system with a pension is eligible for an employer-subsidized premium rate. The

surviving spouse or surviving domestic partner may elect a lump-sum settlement without affecting their eligibility for an employer- subsidized premium rate.

The spouse or domestic partner of a deceased retiree member who did not retire under their retirement system and instead took a lump-sum retirement settlement is not eligible for the employer-subsidized premium rate and must pay the full premium rate.

The employer-subsidized premium rate for the surviving dependent is not affected by remarriage or a new domestic partnership. The new spouse or domestic partner, of the surviving dependent is not eligible for HSS benefits.

The spouse or domestic partner of a deceased retiree member who retired with a disability retirement under their retirement system is eligible for the full employer contribution for their employer-subsidized premium rate.

The spouse or domestic partner of a deceased active member who died in the line of duty where the surviving spouse is entitled to a death allowance is eligible for the full employer contribution for their employer-subsidized premium rate.

C. Eligibility Documentation Required and Optional

1. **Members**
   All members are required to provide eligibility documentation as requested by the Health Service System and as required under federal, state or local law.
   a. Failure to provide eligibility documentation as required shall result in termination of coverage for enrolled Members and/or their dependents or denial of coverage for Members and their dependents not yet enrolled.
   b. The Health Service System may require proof of dependent eligibility at any time. Failure to furnish such proof within thirty (30) days after a request by the Health Service System shall result in termination of coverage. Re-enrollment may occur during the annual Open Enrollment, with coverage effective the first day of the following plan year, upon submission to the Health Service System of a completed enrollment application and required eligibility documentation.
   c. Documents issued in a language other than English, must be accompanied by a certified translation into English, this included but is not limited to marriage and birth certificates
2. Dependent Eligibility Verification
   a. Spouse
      i. Marriage License / Certificate
      ii. Filed copy of a Federal Income Tax Return for spouses married for more than 18 months. Members are required to file married filing jointly/separately, to establish a continuous spousal relationship.

1. Spouses married for less than 18 months will be requested to provide their filed copy of a Federal Income Tax Return (married filing jointly/separately) during the Dependent Eligibility Verification Audit (DEVA).

b. Registered Domestic Partners
   i. Certificate of Domestic Partnership as defined under Section B.2.
   ii. For members with a qualified IRS tax dependent domestic partner, as defined under 26 U.S. Code § 105(b) who have been registered domestic partners for 12 months or more, a filed copy of a Federal Income Tax Return showing the domestic partner as a qualified tax dependent
      1. For members with a qualified IRS tax dependent domestic partners who have been registered domestic partners for less than 18 months the filed copy of the Federal Income Tax Return claiming domestic partners as a dependent will be requested during the Dependent Eligibility Verification Audit (DEVA).
   iii. For members with a non-IRS tax dependent domestic partner, who have been registered domestic partners for 18 months or more, additional documentation of financial interdependency can be illustrated by providing one of the following
      - Mortgage Statement
      - Lease Agreement
      - Homeowners or Renter's Insurance Statement
      - Auto Loan or Auto Insurance Statement
      - Bank Statement (active account)
      - Municipality/County Property Tax Statement

      1. For members with a non-IRS tax dependent domestic partner, who have been registered domestic partners for less than 18 months, documentation of financial interdependency will be requested during the Dependent Eligibility Verification Audit (DEVA).

c. Children
   i. Birth Certificate
      1. If providing a hospital verification of birth document, a birth certificate must be provided within 6-months of the child's birth to avoid termination of benefits.

3. **Social Security Numbers Required**
   All members are required to provide the Health Service System with a Social Security number for themselves and a Social Security card for all enrolled dependents. The failure to provide Social Security card for each dependents will result in the denial or termination of health coverage administered by the Health Service System.

a. Social Security card for a newborn, must be provided within 6 months of the child's birth, if they are added as a dependent for health coverage.
b. Dependents who obtain a Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN) may be enrolled within 30-days of the SSN or ITIN issue date as Qualifying Life Event (See Sec G.8).

Exceptions can be made on a case-by- case basis for members and dependents who do not qualify for Social Security numbers upon approval of the Health Service System Director.

4. **Member Addresses Required**
All members are required to keep a current residential and mailing address on file with the Health Service System. Members must report address changes to the Health Service System within thirty (30) days. Members are responsible for promptly responding to notices mailed by the Health Service System to the address on file with HSS. Health care coverage may be terminated for members who do not keep their address and contact information updated at HSS. The Health Service System will document a minimum of five attempts over a period of two years to contact a member whose address and contact information on file with the Health Service System is incorrect. After five attempts, the member's health benefits will be terminated. A member terminated for failure to keep current their address and contact information may seek reinstatement during the next Open Enrollment period.

5. **Race/Ethnicity Data Optional**
To comply with the CMS requirements, SFHSS requests that Medicare members voluntarily provide SFHSS with race and ethnicity data for themselves and all enrolled Medicare dependents. Any provided race/ethnicity data will not affect a member's health plan coverage or rates.

SFHSS has implemented the appropriate procedures and technology to protect members' personal information, including the race/ethnicity data being requested. SFHSS complies with all Health Insurance Portability and Accountability Act (HIPAA) requirements.
The health plan carrier has the responsibility to provide this information to the Centers for Medicare & Medicaid Services through their normal enrollment processes.

D. Taxation of Health Benefits of Domestic Partners

Premium contributions for the domestic partner's health coverage may or may not be eligible for pre-tax treatment contingent on applicable federal and state income tax law. Thus, coverage of the domestic partner dependent could result in additional imputed income to the member, with possible withholding for payroll taxes, including income and Social Security taxes, on such amounts.

Members who have a 26 U.S. Code § 105(b) qualified dependent must file a *Declaration That Enrolled Dependent Meets IRS Standard For Pre-Tax Health Premium Deduction* form with HSS annually and will

pay member health premium contributions for the domestic partner and/or the partner's children on a pre-tax basis.

An annual declaration must be filed for each qualifying dependent and requires the member to anticipate the dependency status for the entire year. Members are required to report any changes in dependency status during the year to SFHSS because the IRS requires a "look-back" at the dependency status at the end of each calendar year. The dependent will remain eligible for coverage, but this change requires treating the coverage provided for the dependent as taxable to the member for the entire year.

E. Member Responsibility to Notify Health Service System When a Dependent Becomes Ineligible

It is the responsibility of the member to provide immediate written notification to the Health Service System when canceling coverage for any dependent who no longer meets the conditions for eligibility. There shall be no obligation on the part of the Health Service System to provide health coverage to, or refund contributions made on account of, an ineligible dependent. If a member fails to notify the Health Service System when an enrolled dependent becomes ineligible the member may be held responsible for payment of all health premium costs, including but not limited to any employer premium costs and costs for medical services provided, dating back to the date of the dependent's ineligibility.

Dependent eligibility may be audited by HSS 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 and financial interdependency (see Section C.2).

Enrollment of a dependent who does not meet the plan's eligibility requirements as stated in Health Service System 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.

F. Open Enrollment Period

The Health Service System shall conduct an annual Open Enrollment for a period of no less than two weeks as approved by the Health Service Board.

1. A member may change benefit plan elections and add or drop dependents during Open Enrollment.
2. A member must submit all required enrollment applications and eligibility documentation by the Open Enrollment due date established by the Health Service System.
3. A retiree may waive medical coverage at any time. A retiree may only waive dental coverage for themselves and enrolled dependents during Open Enrollment unless there is a Qualifying Life Event (QLE) (see Section G).

4. Dependents who are dropped from coverage during Open Enrollment are not eligible for COBRA continuation coverage.
5. All changes made, and subsequently accepted by the Health Service System, during the annual Open Enrollment period shall be effective on the first day of the following plan year.
6. Except for Flexible Spending Account elections that do require annual elections, if no changes are elected during Open Enrollment, current medical, dental and vision plan elections, voluntary benefit elections (that are available in the following plan year),and enrolled dependents will remain the same (Passive Enrollment). However, the Board may designate any annual Open Enrollment period as requiring members to proactively elect to enroll in health and other benefits for the upcoming plan year (Active Enrollment) for a variety of reasons, including highlighting new plan options or giving members the opportunity to revisit their benefit choices.
7. A member must make Healthcare and Dependent Care Flexible Spending Account elections during the annual Open Enrollment to participate in these programs for the following plan year.

G. Qualifying Live Events (QLE): Changing Benefit Elections Outside of the Open Enrollment Period

For enrollments due to a qualifying change in status, or other qualifying applicable event, the member must notify the Health Service System and complete the enrollment process, including the submission of all required eligibility documentation, no later than thirty (30) calendar days after the qualifying event.

A member may make a benefit election change, Health Care and/or Dependent Care Flexible Spending Account (FSA) change due to a qualifying status change a maximum of twice per plan year.

The following qualifying status changes, or other applicable events, allow a member to make benefit election changes, Health Care and/or Dependent Care Flexible Spending Account (FSA) changes outside of Open Enrollment so long as the election change is a result of and consistent with, the change in status.

1. **Change in Legal Marital or Registered Domestic Partnership Status**
    a. **Marriage**
    A member's marriage allows the member to add their new spouse and eligible stepchildren, as defined in Section B.3., to their existing HSS coverage or, in the alternative, drop their existing HSS coverage by joining the spouse's employer coverage and providing Proof of Coverage on spouse's coverage within thirty (30) days of the coverage effective date.
    b. **Domestic Partnership**
    A member's domestic partnership allows the member to add their new partner and the partner's eligible children, as defined in Section B.3, to their existing coverage or, in the alternative, drop their HSS coverage by joining the domestic partner's

employer coverage and providing Proof of Coverage on domestic partner's coverage within thirty (30) days of the coverage effective date.

c. **Divorce, Legal Separation, Annulment, or Dissolution of Partnership**
In the event of divorce, legal separation, annulment, or dissolution of domestic partnership, a member must immediately terminate health coverage for the ex-spouse or domestic partner and any accompanying covered ineligible children. A member will be responsible for the full cost of all health premiums back to the date of the dependent's ineligibility for failure to terminate health coverage within thirty (30) days for the ex-spouse, domestic partner or any accompanying covered ineligible children.

2. **Change in Number of Dependents**
   a. **Birth**
   The birth of a child allows the member to add the child to their existing coverage.
   b. **Adoption and Placement for Adoption**
   The adoption and placement for adoption of a child allows the member to add the child to their existing coverage.
   c. **Legal Guardianship**
   If an enrolled member, or the member's spouse or domestic partner, assumes legal guardianship of a child, the member may add the child to their existing coverage.
   d. **Court Order**
      i. If a court orders a Member to provide health coverage for a child, the child will be added to the Member's benefits, in accordance with the court order received. If the Member is not enrolled in benefits themselves, Member will be added to the same level of coverage as the court order for the child. If a court order is received to terminate health benefits of the child, the Member may enroll the child as a dependent, and the child will be eligible for benefits up to the age of 26. A child whose coverage was established under a court order can only have their coverage terminated at the age of 19 or through a subsequent court order. Dependent Care Flexible Spending Account (Dependent Care FSA) contributions cannot be modified due to this status change.

3. **Change in the Employment Status of Spouse, Domestic Partner, or Other Dependent**
   a. **Loss of Other Coverage**
   Members and eligible dependents who lose other coverage may be enrolled in Health Service System coverage. Proof of loss of coverage must be provided by the HSS member.
      i. **Termination of Employment**
      If a member or eligible dependent loses other coverage due to employment termination, the member may enroll themselves and/or the member's spouse, domestic partner, and any affected eligible children, in HSS health coverage within thirty (30) days of the loss of coverage. The member also has

the option of initiating or modifying the Health Care and Dependent Care FSA contributions.

ii. **Change from Full-Time to Part-Time Employment**
If a member or enrolled dependent loses other coverage, or cannot afford other coverage, due to a change from full-time to part-time employment, the member may enroll themselves, and the member's spouse, domestic partner, and any affected eligible children, in SFHSS health coverage within thirty (30) days of the change in employment status. The member also has the option of initiating or modifying the Health Care and Dependent Care FSA contributions.

iii. **Open Enrollment Under Dependent's Employer**
If a dependent drops coverage during their employer's Open Enrollment period, the member may add themselves, their spouse, domestic partner and any affected eligible children, to HSS health coverage within thirty (30) days of the loss of coverage. The member also has the option of initiating or modifying Dependent Care FSA contributions. Health Care FSA contributions cannot be modified.

iv. **Commencement of an Unpaid Leave of Absence**
If a dependent loses other coverage due to an unpaid leave of absence, the member may enroll the spouse, domestic partner and any affected eligible children, on HSS health coverage within thirty (30) days of the loss of coverage. The member also has the option of initiating or modifying the Health Care and Dependent Care FSA contributions.

v. **Loss of Medicare or Medicaid**
If a member or eligible dependent loses other coverage due to ineligibility for Medicare or Medicaid, that individual may be enrolled on HSS health coverage within thirty (30) days of the loss of coverage. The member also has the option of initiating or modifying the Health Care FSA contributions. Dependent Care FSA contributions cannot be modified due to this status change.

b. **Gain of Other Coverage**
Members and eligible dependents who gain other coverage may be disenrolled from Health Service System coverage. Proof of gain of other coverage must be provided by the HSS member.

i. **Commencement of Employment**
If an enrolled dependent gains other coverage due to new employment, the member may waive HSS coverage for themselves, and/or drop dependent(s) from HSS coverage within thirty (30) days of the date the other coverage begins. If member waives coverage, dependent coverage must also be dropped. The member also has the option of modifying the Health Care and Dependent Care FSA contributions.

ii. **Change from Part-Time to Full-Time Employment**

If an enrolled member or dependent gains other coverage due to the dependent's change from part-time to full-time employment, the member may waive coverage for themselves, and/or drop dependent(s) from HSS coverage, within thirty (30) days of the date other coverage begins. The member also has the option of modifying the Health Care and Dependent Care FSA contributions.

iii. **Open Enrollment Under Dependent's Employer**
If an enrolled member or dependent gains other coverage during the Open Enrollment period of the dependent's employer, the member may waive HSS coverage for themselves, and/or drop dependent(s) within thirty (30) days of the date other coverage begins. If member waives coverage, dependent coverage must also be dropped. The member also has the option of modifying Dependent Care FSA contributions. Health Care FSA contributions cannot be changed due to this status change.

iv. **Return From an Unpaid Leave of Absence**
If an enrolled member or dependent gains other coverage upon the dependent's return from an unpaid leave-of-absence, the member may waive HSS coverage for themselves, and or drop dependent(s) from coverage within thirty (30) days of the date other coverage begins. The member also has the option of modifying the Health Care and Dependent Care FSA contributions.

v. **Entitlement to Medicare or Medicaid**
If the member or dependent gains other coverage due to eligibility for Medicare or Medicaid, the member may waive coverage for themselves, and drop dependents from HSS coverage, consistent with the entitlement change. The Member may also enroll themself and their dependent(s) in SFHSS health coverage. Proof of gain of Medicare or Medicaid coverage is required. The eligible Members also has the option of modifying healthcare Flexible Spending Account contributions. Dependent Care FSA contributions cannot be changed due to this status change.

4. **A Retiree Member May Waive Medical Coverage for Self or Dependents at Any Time Outside of Open Enrollment by Submitting Required Forms to HSS**
If a Retiree Member waives coverage, they may not re-enroll self or dependents until the next Open Enrollment or Qualifying Life Event (QLE) as defined in Section G. Retirees may not waive dental coverage outside of Open Enrollment unless there is a QLE as defined in Section G.

5. **A Surviving Dependent May Waive Medical Coverage for Self or Dependents at Any Time Outside of Open Enrollment by Submitting Required Forms to HSS**
If surviving spouse or domestic partner waives coverage, they may not re- enroll until the next Open Enrollment, or if there is a QLE as defined in Section G. If coverage is waived for surviving eligible children those children cannot be re-enrolled.

6. **Significant Change in Health Coverage During a Plan Year**
   If there is a mid-year change in coverage such as a substantial decrease in medical providers under a plan, or a significant increase in deductible, copayment or out-of-pocket limits, the Health Service Board may direct HSS to allow mid-year plan changes due to this applicable event. When so directed, a member may elect to drop HSS coverage or change HSS coverage options. Health Care FSA contributions cannot be changed due to this status change.

7. **Dependent Care Flexible Spending Accounts: Significant Change in Dependent Care Costs**
   If there is a significant increase or decrease in the cost for dependent care, the member may increase or decrease Dependent Care FSA contributions. This is allowed only if the cost change is required by a dependent care provider who is not a relative of the member. Proof of cost change is required.

8. **Dependent Obtains a Social Security Number or an Individual Taxpayer Identification Number**
   If a dependent gains eligibility for a Social Security Number (SSN) or an Individual Taxpayer Identification Number (ITIN), member may enroll their dependent under this Qualifying Life Event. Enrollment must occur within 30-days of the SSN/ITIN issuance.

H. Transfer of Health Benefit Plans

The application to change from one health benefit plan to another may be made only during the annual Open Enrollment period each year with coverage to become effective the first day of the following plan year, unless otherwise provided for by these Rules.

1. **Members Moving Primary Residence Outside a Health Benefit Plan Service Area**
   Members who move their primary residence to a location outside their health plan's service area will no longer be able to obtain services through that plan. Members will need to enroll in a different HSS plan that offers services based on the new primary address. A member must complete an HSS application to elect a new plan within thirty (30) days of their move. Coverage in the new plan will be effective the first day of the coverage period following the date HSS receives the completed enrollment application. Coverage will be terminated for active employee members who move their primary residence outside their health plans service area and do not enroll in a new plan within thirty (30) days of their move. Retiree Members who move their primary residence outside the service area of their health plan service area and do not enroll in a new plan in thirty (30) days will automatically be moved to Blue Shield of California PPO Plan.

2. **Members Residing Temporarily Outside a Health Benefit Plan Service Area for Six or More Months**

A member who is leaving the area of service of a health benefit plan temporarily for a period in excess of six (6) months, may apply for a transfer to a health benefit plan servicing the area of residence. Application must be submitted to the Health Service System in writing at least thirty (30) days prior to the member's leaving the service area of the current plan. Transfer into the new health benefit plan shall become effective on the first day of the coverage period after such application is received by the Health Service System. A member may return to the original health benefit plan if written application to the Health Service System is made within thirty (30) days of return to the area of service.

3. **Retirees Establishing Permanent Residence Outside of the United States**
    a. Retiree Members and dependents, regardless of health benefit plan, who reside outside of the United States are required to enroll in the Blue Shield of California Out-of-Area PPO Plan or temporarily waive coverage.
    b. Medicare enrollment is not required for members residing outside the United States and United States Territories; however, services within the United States and United States Territories will not be covered if Medicare enrollment is waived or discontinued. Members will be required to complete an HSS form certifying that they are waiving Medicare enrollment and waiving health coverage within the United States and United States Territories.
    c. For retired members and dependents, who reside outside the United States and United States Territories and continue their Medicare enrollment, services within the United States and United States Territories will be covered. Services outside the United States and United States Territories will be paid in accordance with the health benefits plan in which the retired member and their dependents enroll.
    d. Applications must be made thirty (30) days in advance of leaving the United States. Retiree Members who establish permanent residency outside the United States may retain coverage in the HSS plan(s) available for members outside of the United State or United States Territories and must make the required premium payments directly to the Health Service System by the applicable due dates.

4. **Members Enrolled in a Discontinued Health Benefit Plan**
    Members of a health benefit plan discontinued during the benefit year will be provided a special enrollment period to select an alternative health benefit plan. A member who does not enroll in an alternate health benefit plan during the special enrollment period will automatically be enrolled in the lowest cost health benefit plan, which you are eligible to enroll, within your service are.

5. **Entitlement to Medicare**
    Since all family members must be enrolled under the same health plan provider, when a dependent of an active employee (other than a spouse), a retired member, or a retired member's dependents become entitled to Medicare, and enroll in a HSS covered Medicare Advantage and Medicare Prescription Drug Plan, all HSS enrolled family members, including the primary retiree or active employee, will be transferred to the same health benefit plan

provider as the Medicare eligible and enrolled dependent of an active employee (other than a spouse), a retired member, or a retired member's dependent.

I. HIPAA Special Enrollment Rights for Health Plan Coverage

1. Under a federal law called the Health Insurance Privacy and Portability Act of 1996 (HIPAA), members (active employees and retirees)have the right to enroll in SFHSS coverage under its Special Enrollment Provision if they acquire a dependent, or if they decline SFHSS health coverage for themselves or an eligible dependent(s) (including their spouse) while other coverage is in effect and later lost that other coverage for certain qualifying reasons.

    a. **Special Enrollment Provision for Loss of Other Coverage**
    If a member declines enrollment for oneself or for an eligible dependent(s) (i.e. spouse, domestic partner, child(red)) while other health insurance or health plan coverage is in effect, the member may be able to enroll themself and their dependent(s) in a SFHSS health plan if they or their dependents lost eligibility for that other coverage (or if their employer stops contributing toward their or their dependents' other coverage). The member must request enrollment within 30 days after their or their dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

    b. **Special Enrollment Provision for New Dependent(s)**
        i. Marriage - If a member has a new dependent as a result of marriage, the member may be able to enroll themself and their new dependent if the member requests enrollment within 30 days after the marriage. Step-children may also be added within 30 days of the marriage.
        ii. Child(ren) – A member must request enrollment within 30 days after:
            1. Birth,
            2. Adoption / placement for adoption,
            3. Foster child placement, or
            4. Grant of legal guardianship

    c. **State Medical Assistance and Children's Health Insurance Program (CHIP)**
    If a member meets any of the following scenarios, the member and their dependents may be able to enroll in SFHSS health plans within 60 days if:

        i. They qualify for premium assistance under the state's medical assistance program or Children's Health Insurance Program (CHIP)
        ii. You no longer qualify for health coverage under the state's medical assistance program or CHIP.

If a member's dependent(s) becomes eligible for a special enrollment rights, the member may add the dependent(s) to their current coverage or change to another SFHSS health, dental, or vision plan.

J. Continuation of Health Benefits Coverage After Retirement

1. **Service, Disability or Vesting Retirement for Members Who Have Been Enrolled in Health Service System Health Benefit Plans While Actively Employed**
   A member who retires for service, disability or vesting may continue coverage through the Health Service System at the rate established for retired employees, provided they apply for continuation of coverage within thirty (30) days of their retirement date or the date their retirement is approved by their Retirement System. Coverage begin date will be the date of retirement as identified by the retiree's retirement system or the end of the pay-period in which Active Employee benefits are paid through. Thereafter, application for enrollment may be made only during Open Enrollment, with coverage to become effective the first day of the following plan year. In addition to Health Service System requirements, San Francisco Unified School District and San Francisco Community College District employees must meet their employer's respective eligibility requirements. To be eligible for health benefits at the premium contribution rate established for retirees, a member must have been enrolled in a health benefit plan through the Health Service System for some period during their term of employment with the City & County of San Francisco, the San Francisco Unified School District or the San Francisco Community College District.

2. **Service, Disability or Vesting Retirement for Members Who Have Not Been Enrolled in Health Service System Health Benefit Plans While Actively Employed**
   Per City Charter Section A8.428, an individual who would qualify for coverage under Section J.1. above, but for the fact that they have never been enrolled in a health benefit plan through the Health Service System for some period during their term of employment with the City & County of San Francisco, San Francisco Unified School District, San Francisco Superior Court, or San Francisco Community College District, may enroll in a health benefit plan as described in Section J.1., except that they shall pay the full, unsubsidized rate. The full, unsubsidized rate is the total premium paid to the health plan consisting of both the retiree contribution and the employer contribution.

3. **Resigned Retiree or Active Members**
   A member who resigned and withdrew their funds from a retirement system within thirty (30) days immediately prior to the date on which, but for their resignation, they could have been retired for service as a member of a retirement system, may continue coverage at the full unsubsidized rate for resigned employees as established by the Health Service Board under the provisions of the City Charter Section A8.425.

A Resigned Member also includes teachers who moved funds from the San Francisco Employees Retirement System (SFERS) to the State Teachers Retirement System (CalSTRS). Such Resigned Members must apply for continuation of coverage within thirty (30) days after resignation. Such Resigned Members (including surviving spouse dependents) must make arrangements to pay contributions monthly in advance to the Health Service System by the applicable due dates. Coverage of a Resigned Member must be continuous and, if lapsed, cannot be reinstated without Health Service Board approval.

4. **Retiree Premium Contribution Payments Required**
   If sufficient funds are available, the Health Service System requires all premium payments to be deducted from the retiree member's pension check. If sufficient funds are not available, the retiree must make required premium contributions directly to the Health Service System by applicable due dates. Per Section Q of these rules, failure to make full premium contributions by the applicable due dates will result in termination of coverage.

5. **Retiree Must Notify the Health Service System of Current Primary Address**
   A retiree member who is enrolled in a Health Service System administered health benefit plan must maintain their correct primary residential address on file with the Health Service System and notify the Health Service System within thirty (30) days of any primary address change. Change in primary residence may require a change in health plan. A retiree who becomes ineligible for coverage because they moved outside of the plan's service area may be required by the plan to pay for all services received while ineligible.

   Health care coverage may be terminated for retiree members who do not keep their address and contact information updated at HSS. The Health Service System will document a minimum of five attempts over a period of two years to contact a member whose address and contact information on file with the Health Service System is incorrect. After five attempts, the members' health benefits will be terminated. A retiree member terminated for failure to keep current their address and contact information may seek reinstatement during the next Open Enrollment period.

K. Required Medicare Enrollment

Medicare is a federal health insurance program for people age 65 years or older, and those who are under age 65 with a Social Security-qualified disability. The different parts of Medicare help cover specific services: Part A covers hospital insurance; Part B covers medical insurance; and Part D covers prescription drug insurance. (See medicare.gov.)

1. **Active Members Age 65 and Over**
   As long as HSS-based health plan coverage is maintained, an active Member may elect to delay enrolling in Medicare until the employee's employment ends or the coverage stops,

whichever happens first. Medicare eligible Members will have a special-enrollment period (SEP) to enroll in Medicare after they end their employment.

a. Active members who chose to enroll in Medicare will remain enrolled in the Active Member coverage.

2. **Dependents of Active Employee Members**
   a. Subject to CMS rules, all married spouses, natural children, stepchildren, adopted children or children under legal guardianship of an active member who are Medicare-eligible due to either age or disability, have the option, but are not required, to enroll in Medicare Part A and Medicare Part B as soon as they are eligible.
      i. Dependents listed in Section K.2.a, who choose to enroll in Medicare will remain enrolled in the Active Member's coverage.
   b. Subject to CMS rules, all domestic partner dependents of active employee members who are Medicare-eligible must enroll in both Medicare Part A and Medicare Part B as soon as they become eligible. Some dependents will only qualify for Medicare Part B. If an active employee member's domestic partner is Medicare-eligible but fails to enroll in either Medicare Part A or Medicare Part B, the dependent's HSS medical coverage will be terminated.
      Registered domestic partners who enroll in Medicare will be transitioned to their chosen Medicare Advantage plan. Members will be required to transition to the corresponding non-Medicare plan as their registered domestic partner.

3. **Retiree Members**
   Retiree Members who are Medicare-eligible due to either age or disability must enroll in both premium-free Medicare Part A) and Medicare Part B. Some retired members will only qualify for Medicare Part B. It is the responsibility of the member to notify the Health Service System of Medicare eligibility and enrollment. A Retiree Member who is eligible but fails to enroll in both premium-free Medicare Part A and Medicare Part B of Medicare, will be automatically transferred to either the Blue Shield of California-20 Plan, until proof of Medicare enrollment is provided. The Blue Shield of California-20 Plan provides coverage at a higher out-of-pocket cost to the Retiree Member.

   Dependents of non-compliant Medicare Retirees, (Retirees who fail to provide proof of Medicare premium-free Part A and Part B enrollment) will have their SFHSS coverage terminated. Dependents can be re-enrolled in coverage upon the Retirees Medicare enrollment compliance. (See Sec. G.3.b.5).

4. **Dependents of Retiree Members**
   All dependents of Retiree Members who are eligible due to either age or disability must enroll in both premium-free Medicare Part A and Medicare Part B. If a dependent is eligible but fails to enroll in either Part A or Part B of Medicare that dependent's coverage will be terminated. Some dependents will only be eligible for Medicare Part B.

L. Medicare Advantage Enrollment

Medicare Advantage and Medicare Prescription Drug program (MAPD) participation is required for all Medicare-eligible Retiree Members and dependents who are enrolled in a plan administered by SFHSS. Retiree Members who fail to maintain enrollment in Medicare premium-free Part A and Medicare Part B, will need to waive their coverage or will be automatically transferred to the either the Blue Shield of California-20 Plan. The Blue Shield of California-20 Plan provides coverage at a higher out-of-pocket cost to the Retiree Member.

M. Dual Health Plan Coverage Restrictions

1. **No Dual Health Service System Coverage**
   Health Service System members and their dependents cannot be enrolled in two SFHSS-administered medical or dental plans at the same time. In other words, members may not be enrolled in an SFHSS-administered plan both as a member and as a dependent of another member. If dual enrollment elections are submitted, SFHSS will automatically eliminate dual coverage as follows:
   a. For any member who is covered both as a member and as a dependent of another member, coverage as a dependent will be terminated.
   b. For dependents who are covered by two different HSS members, the dependent(s) will be covered by the member who covered the dependent(s) first based on date of enrollment.

2. **No Dual Medicare Coverage**
   For the SFHSS Medicare Advantage or Medicare-sponsored plans, members and their dependents enrolled in these plans cannot be simultaneously enrolled in a non-HSS administered Medicare plan. Medicare will allow only the most recent enrollment to apply and will require disenrollment from the prior plan. Other non-Medicare dual coverage must be disclosed to the Health Service System.

N. Member Health Benefits Coverage Period

1. **Coverage Effective Date**
   Coverage shall be effective as set forth below. See Appendix A for coverage period schedules for the current plan year.
   a. **Eligible Permanent, Provisional and Temporary Exempt Employees of the City & County of San Francisco and Other Designated Employers**

Eligibility Event Data	Coverage Effective Date
1st – 31st	1st day of the following coverage period

   b. **Eligible Commissioners of the City & County of San Francisco**

Eligibility Event Data	Coverage Effective Date
1st – 31st	1st day of the following coverage period

   c. **Eligible Employees of the San Francisco Unified School District**
      i. Monthly

Eligibility Event Data	Coverage Effective Date
1st – 31st	1st day of the following coverage period

      ii. Bi-Weekly

Coverage Effective Date
1st day of the pay period following the eligibility event date

   d. Eligible Employees of the San Francisco Community College District

Eligibility Event Data	Coverage Effective Date
1st—15th	16th of the month
16th—31st	1st day of the following coverage period

2. **Coverage Termination Date**
   Coverage shall terminate as set forth below:
   a. **Eligible Permanent, Provisional and Temporary Exempt Employees of the City & County of San Francisco and Other Designated Employers**

Eligibility Event Data	Coverage Termination Date
1st – 31st	Last day of the coverage period for which the employee premium contributions have been made in full

   b. **Eligible Commissioners of the City & County of San Francisco**

Eligibility Event Data	Coverage Termination Date
1st – 31st	Last day of the coverage period for which the employee premium contributions have been made in full

c. **Eligible Employees of the San Francisco Unified School District**

i. Monthly

Eligibility Event Data	Coverage Termination Date
1st – 31st	Last day of the coverage period for which the employee premium contributions have been made in full

ii. Bi-Weekly

Coverage Termination Date
Last day of the pay period following the eligibility event date

d. **Eligible Employees of the San Francisco Community College District**

Eligibility Event Data	Coverage Termination Date
1st—15th	15th of the month
16th—31st	Last day of the coverage period for which the employee premium contributions have been made in full

e. **Termination Date for Deceased Eligible Members**

Coverage Termination Date
Coverage terminated as of the day after death

O. Dependent Health Benefits Coverage Periods

1. **Coverage Effective Dates**
   Eligibility qualification requires submission of completed application form and other required documentation to the Health Service System within thirty (30) days of a Qualifying Life Event (QLE). Coverage shall be effective as set forth below. See Appendix A for coverage period schedules for the current plan year.

a. **Eligible Dependents**

Eligibility Event Data	Coverage Effective Date
At the time of the member's original enrollment	1st day of the coverage period after a completed application is filed with the Health Service System

A member may enroll their eligible dependents at the time of original enrollment. Coverage for eligible dependents becomes effective on the same day as the member.

b. **Eligible Spouses, or Domestic Partners, and Other Eligible Dependents Acquired By Marriage or Domestic Partnership**

Eligibility Event Data	Coverage Effective Date
Within thirty (30) days after the date of marriage or domestic partnership	1st day of the coverage period after a completed application is filed with the Health Service System

An active employee or Retiree Member, who marries or enters into a domestic partnership after becoming a member, may enroll their spouse or domestic partner and other eligible dependents acquired by marriage or domestic partnership. Enrollment is to be made within thirty (30) days after the date of marriage or domestic partnership, and coverage for eligible dependents so enrolled shall become effective as of the 1st day of the coverage period after a completed application is filed with Health Service System. Documentation of marriage or domestic partnership is required.

c. **Eligible Newborn**

Eligibility Event Data	Coverage Effective Date
Within thirty (30) days after birth or commencement of legal custody	The date of birth as long as a completed application is filed with the Health Service System within thirty (30) days of the date of birth

A member's newborn child must be enrolled in the Health Service System to have coverage, provided such enrollment is made within thirty (30) days after birth. Such enrollment shall be made by application to the Health Service System and shall be effective from the date of birth. Documentation of birth is required.

d. **Eligible Adopted Children and Children Placed for Adoption**

Eligibility Event Data	Coverage Effective Date
Within thirty (30) days of the commencement of legal custody or placement	The commencement of legal custody as long as a completed application is filed with the Health Service System within thirty (30) days of the date of adoption

An adopted child of a member (or member's spouse or domestic partner) may be enrolled, provided such enrollment is made within thirty (30) days of commencement of legal custody. Such enrollment shall be made by application to the Health Service System and shall be effective from the date on which such legal custody commenced. Documentation of adoption is required.

e. **Limited Exceptions for Newborn and Adopted Child Enrollments**
Notwithstanding the foregoing, after the expiration of the applicable period of thirty (30) days set forth in Sections O.1.c. and O.1.d. above, the Health Service System Director may permit the enrollment of a newborn child or a newly adopted child

into a medical benefit plan offered by the Health Service System upon satisfaction of each of the following conditions:

i. The Director has found that the member has acted in good faith and not in willful violation of the rules contained in Sections O.1.c. and O.1.d. above;
ii. The child's membership will be effective on the date of birth or the date of commencement of legal custody, as the case may be;
iii. The Health Service System receives full payment of all premiums (both employer-paid and member-paid portions) required to enroll the child for the period from such effective date through the end of the current coverage period; and
iv. To comply with agreements established with the health benefit plan vendors, newborns must be enrolled within six (6) months of the date of birth to be eligible for coverage.

f. **Eligible Dependent Children for Whom the Member (or Member's Spouse or Domestic Partner) Has Assumed Legal Guardianship**

Eligibility Event Data	Coverage Effective Date
Within thirty (30) days of the commencement of legal custody	1st day of the coverage period after a completed application is filed with the Health Service System

An eligible dependent child of whom the member (or member's spouse or domestic partner) has assumed legal custody may be enrolled provided such enrollment is made within thirty (30) days of commencement of legal custody. Such enrollment shall be made by application to the Health Service System and shall be effective the first day of the coverage period after a completed application is filed with the Health Service System. Documentation of eligibility is required.

g. **Other Eligible Dependents Who Have Entered the United States or Have Moved Into the Service Area of the Member's Health Benefit Plan**

Eligibility Event Data	Coverage Effective Date
Within thirty (30) days of the date the dependent changes his or her primary residence	1st day of the coverage period after a completed application is filed with the Health Service System.

Other eligible dependents who have either entered the United States or have moved into the service area of the member's health benefit plan may be enrolled provided such enrollment is made within thirty (30) days of the date the dependent changes their primary residence. Coverage will be effective on the first day of the coverage period after a completed application is filed with the Health Service System. Documentation is required.

h. **Eligible Dependents Who Lose Group Health Insurance Coverage Through Job Displacement**

Eligibility Event Data	Coverage Effective Date
Within thirty (30) days of the last date of group coverage under another employer.	1st day of the coverage period after a completed application is filed with the Health Service System

Eligible dependents who lose group health insurance coverage through job displacement may apply for coverage through the Health Service System within thirty (30) days of the last date of group coverage under another employer. Such application for coverage requires a letter from the former employer or former health benefit plan vendor stating the reason for lost coverage and the last date of coverage. The approval or rejection of the application and effective date of any coverage other than listed above is subject to the discretion of the Health Service System.

i. **Open Enrollment Coverage Effective Date**
Dependents not enrolled by the member at the time of the member's enrollment, or within the applicable periods of eligibility as described in this Section O. may thereafter be enrolled only during Open Enrollment with coverage to be effective the first day of the following plan year. Documentation of eligibility is required.

P. Waiving Health Benefits Coverage (Voluntary)

A member may waive coverage by submitting a completed Health Benefits Enrollment Application and requesting that coverage be waived. It shall be the sole responsibility of the member to apply for a coverage waiver in accordance with these Rules. Unless otherwise noted in the subsections below, if an enrolled member waives coverage for themselves or any enrolled dependents, the termination date of coverage will vary depending on the member's premium contribution dates and corresponding coverage periods.

1. **Voluntary Waiver of Health Benefits Coverage**
    a. A member may elect to waive coverage when they first qualify for Health Service System eligibility in accordance with Section A.
    b. A member may elect to waive coverage during Open Enrollment by submitting all required forms and documentation to the Health Service System no later than the required deadlines. Disenrollment from benefit plans takes effect the first day of the following plan year.
    c. Based on the rules governing Qualifying Life Events (QLEs) set forth in Section G, a member may waive coverage outside of Open Enrollment by submitting required forms and documentation by the deadlines prescribed by the Health Service System.
    d. A Retiree Member may waive medical coverage for themselves or a dependent at any time by completing the Health Benefits Enrollment Application and submitting it to SFHSS for processing. Retiree dental coverage can only be waived during Open Enrollment unless there is a QLE (see Section G).

2. **Duration of Voluntary Waived Health Benefits Coverage**
    a. Waiver of coverage will remain in effect until lifted by the member, which shall only take place during the Open Enrollment or if there is a QLE. To enroll in coverage a member must complete the required enrollment application and submit required documentation to the Health Service System by applicable due dates.
    b. A member who has waived coverage and who loses group coverage through job displacement of a spouse or domestic partner may apply for coverage through the Health Service System within thirty (30) days of the last date of group coverage under the same provisions as provided for dependents in Section O.1.h.
    c. A member may waive coverage if other medical or dental coverage has been obtained. An application form and required documentation must be submitted to HSS within thirty (30) days of the date other coverage begins. The waiver will be effective the first day of the coverage period following receipt of the complete application and required documents.

3. **Potential Impact of Waiving Employee Health Benefits on Eligibility For Retiree Health Benefits**
    Under City Charter Section A8.428, an active employee must participate in a Health Service System health plan while an active employee to qualify for participation in the Health Service System as a "Retired Person" at the rate established for retired employees after service, disability or vesting retirement. Charter Sections A8.428(a)(1) and (a)(4) require that "Retired Person(s)" be a "former member of the Health Service System."

Q. Member Premium Contributions, Employer Premium Subsidies, and Delinquencies

1. **Employer Premium Subsidy for Active Employee Members**
    An active employee is eligible for the full employer contribution for their employer-subsidized premium rate.

2. **Employer Premium Subsidy for Retiree Members**
    a. A Retiree Member hired before January 10, 2009, is eligible for the full employer contribution for their employer-subsidized premium rate with the following exception:
        i. A Retiree Member who retires after January 6, 2012, and who left employment before June 30, 2001, is not eligible for the Proposition E 50% reduction toward their premium (Charter Section A8.428(b)(3)(iii)) or the employer contribution of 50% of healthcare premiums for the first dependent (Charter Section A8.428(c).
    b. A Retiree Member hired on or after January 10, 2009, who retired with a disability retirement, is eligible for the full employer contribution for their employer-subsidized premium rate.

c. A Retiree Member hired on or after January 10, 2009, with ten (10) or more years of credited service (as determined by HSS), and who retires within 180 days of separation from employment, is eligible for the pro-rated employer contribution for their employer-subsidized premium rate based on the member's years of credited service:
    i. With twenty (20) or more years of credited service, the Retiree Member is eligible for the full employer contribution for their employer-subsided premium rate.
    ii. With at least fifteen (15) years but less than twenty (20) years of credited service, the Retiree Member is eligible for the 75% employer contribution for their employer-subsided premium rate.
    iii. With at least ten (10) years but less than fifteen (15) years of credited service, the Retiree Member is eligible for the 50% employer contribution for their employer-subsided premium rate.
    iv. With at least five (5) years but less than ten (10) years of credited service, the Retiree Member must pay the full premium rate and is not eligible for any employer-subsided premiums.

3. **Employer Premium Subsidy for Eligible Surviving Dependents of an Active Employee Member**
    a. If the deceased active employee member was hired before January 10, 2009, the member's enrolled surviving spouse or surviving domestic partner is eligible for the full employer contribution for their employer-subsidized premium rate.
    b. If the deceased active member was hired on or after January 10, 2009, and had at least ten (10) years of credited service (as determined by HSS), the member's enrolled surviving spouse or surviving domestic partner is eligible for a pro-rated employer contribution rate, with an employer-subsidized premium rate based on the deceased member's years of credited service.
        i. The surviving spouse or surviving domestic partner of a deceased active member with twenty (20) or more years of credited service (as determined by HSS) will receive the full employer contribution to their employer-subsidized premium rate.
        ii. The surviving spouse or surviving domestic partner of a deceased active member with more than fifteen (15) but less than twenty (20) years of credited service (as determined by HSS) will receive 75% of the employer contribution to their employer-subsidized premium rates.
        iii. The surviving spouse or surviving domestic partner of a deceased active member with more than ten (10) but less than fifteen (15) years of credited service (as determined by HSS) will receive 50% of the employer contribution to their employer-subsidized premium rate.
        iv. A surviving spouse or surviving domestic partner of a deceased active member who died in the line of duty, where the surviving spouse or

surviving domestic partner is entitled to a death allowance, will receive the full employer contribution to their employer-subsidized premium rate.

v. Surviving dependent children are charged the full premium and are not eligible for the employer-subsidized premium. With the exception of surviving dependent children under Section 4856 of the California Labor Code.

4. **Employer Premium Subsidy for Eligible Surviving Dependents of a Retiree Member Hired Before January 10, 2009**
   A surviving spouse or surviving domestic partner of a deceased Retiree Member (as defined in Section A.8) hired before January 10, 2009, is eligible for the full employer contribution to their employer-subsidized premium rate.

5. **Employer Premium Subsidy for Eligible Surviving Dependents of a Retiree Member Hired On or After January 10, 2009**
   a. The surviving spouse or surviving domestic partner of a deceased Retiree Member who retired with a disability retirement under their retirement system is eligible for full employer contribution to their employer- subsidized premium rate.
   b. An enrolled surviving spouse or surviving domestic partner of a deceased Retiree Member who was hired on or after January 10, 2009, with at least ten (10) years of credited service (as determined by HSS), and retired within 180 days of separation from employment, is eligible for the pro-rated employer contribution rate for their employer-subsidized premium rate, based on the member's years of credited service:
      i. The surviving spouse or surviving domestic partner of a deceased Retiree Member with twenty (20) or more years of credited service (as determined by HSS) will receive the full employer contribution to their employer-subsidized premium rate.
      ii. The surviving spouse or surviving domestic partner of a deceased Retiree Member with more than fifteen (15) but less than twenty (20) years of credited service (as determined by HSS) will receive 75% of the employer contribution to their employer-subsidized premium rate.
      iii. The surviving spouse or surviving domestic partner of a deceased Retiree Member with more than ten (10) but less than fifteen (15) years of credited service (as determined by HSS) will receive 50% of the employer contribution to their employer-subsidized premium rate.

6. **Additional Rules for Employer Premium Subsidy for Eligible Surviving Dependents**
   a. A surviving spouse or surviving domestic partner of a retiree member may elect a lump-sum settlement without affecting eligibility (Section B.5) or the employer contribution to the employer-subsidized premium rate.
   b. The surviving spouse or surviving domestic partner who remarries, or enters into a new domestic partnership, does not lose their current coverage including current

employer-subsidized premium rate. However, no new dependents can be added. (See section B.5.)

c. Eligible surviving dependent child, designated as the first dependent, will receive the 50% employer Charter contribution toward the healthcare premiums. Other eligible surviving dependent children are charged the full premium and are not eligible for the employer-subsidized premium rate.

7. **Members and Surviving Dependents Not Subject to Payroll or Pension Deductions**
   a. It is the responsibility of the member, or surviving dependent, to make payments directly to the Health Service System for employee and retiree premium contributions which are not made or cannot be, made fully by payroll or pension deductions.
   b. Members not subject to payroll, or retirement pension, deductions must pay the Health Service System directly by applicable due dates.
   c. Premium contributions are due by the last day of the effective coverage period. See Appendix A.

8. **Delinquent Payments**
   a. Any member premium contributions not paid when due shall constitute delinquent payments. After any payment becomes delinquent, the Health Service System shall provide to each affected member a notice of delinquency. Such notice shall be addressed to the current address on file with HSS and shall be sent by U.S. mail. Such delinquency notice shall indicate that, unless all premium contributions are paid by the due date specified, coverage shall be terminated on the last day of the coverage period in which full payment was made.
   b. If member fails to pay all delinquent premium contributions not made by the due date specified in the notice, coverage shall be terminated as of the last day of the coverage period in which full payment was made. HSS shall provide each affected member, or surviving dependent, a notice of termination of coverage. If payment is made within 14 calendar days of notice of termination, HSS will reinstate coverage.
   c. Members, and surviving dependents, will be allowed one period of delinquent payment per benefit year. Repeated payment delinquency periods will result in termination of coverage.
   d. Partial payment of delinquent premium contributions shall not be sufficient to avoid or delay termination. Any such partial payment received by the Health Service System shall be applied to the most delinquent full coverage period. Premium contributions insufficient for a full coverage period will be returned or refunded.
   e. An employee member who does not make required premium contributions while on authorized leave will have their health plan benefits terminated. The health plan benefits in which they were enrolled prior to going on leave will resume on the first day of the coverage period following their return to active employee status, provided the employee notifies the Health Service System in writing within thirty (30) days of the date they return to work.

f. Notwithstanding anything to the contrary contained herein, if any applicable memorandum of understanding should require that the Health Service System continue coverage for any insured whose employee premium contributions are delinquent hereunder, then the Health Service System shall not terminate such insured so long as the insured's employer has provided written notice to the Health Service System of the memorandum of understanding, and all employee premium contributions are paid to the Health Service System by such employer when due.

R. Termination of Health Benefits Coverage (Involuntary)

1. Unless noted in the subsections below, termination date of coverage will vary depending on the member's premium contribution dates and corresponding coverage periods.
2. When a member is delinquent in the payment of employee or retiree premium contributions, benefits coverage for the member and any enrolled dependents will be terminated. (See Section Q.8.)
3. If a member does not supply the Health Service System with all required eligibility documentation by required deadlines benefits coverage will be terminated (see Section C).
4. If a member does not maintain correct address and contact information on file with the Health Service System and cannot be contacted after a minimum of five attempts over two years, benefit coverage will be terminated. A member terminated for failure to keep current their address and contact information may seek reinstatement during the next Open Enrollment period (see Section C.4).
5. Benefits of a member or dependent who becomes ineligible for any reason shall terminate on the last day of the coverage period for which full premium payments have been received. In the event that the date of ineligibility cannot be determined, termination shall be effective on the last day of the coverage period in which discovery of ineligibility occurs. See Section E for member penalties that will be incurred when a member fails to notify the Health Service System when a member's dependent becomes ineligible.
6. Failure to comply with the conditions and requirements set forth in these Rules may result in retroactive termination of coverage.
7. Upon termination of a member's coverage, dependent coverage shall also be terminated.
8. An eligible member who has had benefits terminated may re-enroll themselves and their eligible dependents during annual Open Enrollment, with benefits coverage to commence the first day of the following plan year.

S. Employees on Authorized Unpaid Leave

Eligibility for membership in the Health Service System continues for the duration of all approved unpaid leaves. If an employee does not notify the Health Service System regarding their preference for either continuing or waiving coverage prior to going on authorized unpaid leave, existing health coverage will continue, and the employee will be responsible for making all required health premium payments to the Health Service System by applicable due dates. Employees must notify HSS in

advance or immediately upon their leave to either waive coverage or arrange for payment of employee premium contributions while on leave.

1. **Continuing Coverage While on Authorized Unpaid Leave**
   While on authorized leave, an employee can continue existing coverage for themselves and enrolled dependents. Employees may not make changes to medical or dental coverage after unpaid leave has begun. Provided the employee is on a leave that by law, policy or contract provides for twelve weeks of subsidized health insurance, the employer subsidy will continue for the first twelve (12) weeks, and the member will only be responsible for employee premium contribution amounts. If the approved leave continues beyond twelve (12) weeks, the employer subsidy will end and the member will be responsible for paying entire premium contribution amount directly to the Health Service System, by the applicable due dates. To return premium contributions to active status, employees must immediately notify the Health Service System–no later than thirty (30) days of the employee returning to work.

2. **Waiving Coverage While on Authorized Unpaid Leave**
   At any time during an authorized leave, an employee may waive their existing coverage. To waive coverage, an employee must notify the Health Service System and submit all required forms and documentation to ensure proper termination of coverage. Coverage will be dropped on either, failure to make required premium payments or receipt of the waiver request (and all applicable documents) whichever comes first. Employee must immediately notify the Health Service System no later than thirty (30) days of the employee returning to work in order to resume coverage and return premium contributions to active status. Coverage will resume the first day of the next coverage period following HSS notification of return to work.

3. **Educational Leave and Personal Leave**
   Membership in the Health Service System continues for the duration of the approved leave. For the first twelve (12) weeks, the employer subsidy continues, and the member is only responsible for employee premium contribution amounts. If the approved leave continues beyond twelve (12) weeks, the employer subsidy will end and the member will be responsible for paying the entire premium amount, which is the combined total of the employee's and employer's premium contributions. Payments must be made directly to the Health Service System by the applicable due dates.

4. **Leave for Employment as an Employee Organization Officer or Representative**
   Membership in the Health Service System continues for the duration of the approved leave. For the first twelve (12) weeks, the employer subsidy continues, and the member is only responsible for employee premium contribution amounts. If the approved leave continues beyond twelve (12) weeks, the employer subsidy will end and the member will be responsible for paying entire premium contribution amount directly to the Health Service System, by the applicable due dates. In certain cases, the union in which the member is serving will pay the cost of the member's health and/or dental insurance. In these cases, it is still the member's

responsibility to make sure the premiums are paid. The Health Service System will not seek payment directly from the member's union.

5. **Family Care Leave**
   While a member is on family care leave, Health Service System coverage continues as long as the member continues to pay the applicable employee contribution. The employer subsidy continues for the duration of the family care leave. The member is responsible for ensuring that the required health coverage payments are paid directly to the Health Service System by the applicable due dates.

6. **Personal Leave Following Family Care Leave**
   If a member has been on family care leave, has maintained their health coverage, and continues their leave by personal leave for the same reason, then the employer subsidy continues for the duration of the leave. The member is responsible for ensuring that the required health coverage payments are paid directly to the Health Service System by the applicable due dates.

T. COBRA Continuation of Health Benefits Coverage

1. Pursuant to the federally mandated Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), and any subsequent federal legislation regarding COBRA, members and dependents who have lost coverage for the following reasons shall be entitled to elect COBRA continuation coverage under the Health Service System.
   a. **COBRA Qualifying Events for Employees**
      i. The employee's employment is terminated (voluntarily or involuntarily) for reasons other than gross misconduct.
      ii. The employee's regular work hours are reduced, resulting in loss of coverage.

   b. **COBRA Qualifying Events for an Employee's Spouse or Legal Domestic Partner Who is Covered on the Employee's Health Benefit Plan**
      i. Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
      ii. Reduction in the hours worked by the covered employee
      iii. Covered employee becoming entitled to Medicare
      iv. Divorce or legal separation of the covered employee
      v. Death of the covered employee

   c. **COBRA Qualifying Events for Dependent Children Covered on an Employee's Health Benefit Plan**
      i. Loss of dependent child status under either Health Service System or health benefit plan vendor rules
      ii. Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct

iii. Reduction in the hours worked by the covered employee
iv. Covered employee becoming entitled to Medicare
v. Divorce or legal separation of the covered employee
vi. Death of the covered employee

2. **Duration of COBRA Coverage**
The duration of COBRA coverage listed below may be extended (or shortened) in accordance with provisions in the original federal act as well as subsequent federal and state legislation relating to COBRA.

COBRA Qualifying Event	Individual Eligibility	Duration of COBRA Coverage
• Employee's termination • Employee's reduction in working hours	• Employee • Spouse • Dependent children	18 months from the date active employee coverage ends

COBRA Qualifying Event	Individual Eligibility	Duration of COBRA Coverage
• Covered employee's death • Covered employees divorce or legal separation	• Spouse • Dependent children	36 months from the date active employee coverage ends
• Loss of dependent child status	• Child	36 months from the date active employee coverage ends

3. A COBRA-eligible individual who elects COBRA coverage will have a contribution rate which shall not exceed 102 percent of the applicable contract rate.
4. The deadlines for notices and payments shall be the same with respect to dependents as the deadlines applicable to employee members with COBRA coverage.
5. Dependents may elect continuation coverage for themselves as individuals, or in combination with each other and/or the eligible member, consistent with COBRA.
6. Employees and dependents who have exhausted continuation coverage under federal COBRA, may be eligible for Cal-COBRA if they are entitled to less than 36 months of federal COBRA. Continuation coverage under both federal and state coverage will not exceed 36 months. Self-funded PPO plans are not eligible for Cal-COBRA.

U. Other Public Agencies Eligible to Participate in the Health Service System

1. **Election to Participate**
San Francisco Administrative Code Section 16.700 authorizes specified public agencies other than the City & County of San Francisco to participate in the Health Service System, and to

determine, by resolution of the appropriate governing body, the officers and employees who are eligible to enroll in the Health Service System. If a resolution electing to participate in the Health Service System is filed with the Health Service System on or before April 1st, then the participating agency and its employees, retirees, and dependents shall be eligible to enroll the following January 1st. These time requirements may be modified only with the approval of the Health Service Board.

2. **Reports and Payments**
   A participating agency shall perform the functions necessary to enroll its employees and to submit timely and accurate reports and payments as may be required by the Director of the Health Service System; provided, however, that the Director may not impose any reporting or payment requirements that differ from those applicable to the City & County of San Francisco, without approval of the Health Service Board.

3. **Terminating Participation**
   A participating agency may end its participation in the Health Service System by filing a resolution of its governing body with the Health Service Board. The resolution must be filed with the Health Service Board no later than April 1st to be effective the following January 1st . Coverage of all agency employees, retirees and dependents will terminate on December 31st , the end of the plan year. The resolution electing to end participation in the Health Service System is irrevocable after it is filed with the Health Service Board. An agency may not file a resolution electing to resume participation in the Health Service System for five (5) years after the effective date of its exit from the Health Service System.

4. **Exclusive Plans**
   A participating agency may not maintain for its employees any medical plan or program offering hospital and medical care, other than the plans offered by the Health Service System, except as expressly agreed to by the Health Service Board.

V. Member Appeals and Grievances

1. **Appeals**
   a. Members who believe that there has been an administrative error in handling their or their dependent(s) eligibility for SFHSS administered health benefits may file an appeal.
      i. Administrative errors include misapplication of the rules or procedures, documented in the SFHSS Rules, Sec. 125 Cafeteria Plan, City Charter, San Francisco Administrative Code, or other applicable state or federal regulations.
      ii. Eligibility appeals may be submitted by the Member by completing a written request or the San Francisco Health Service System Member Appeal Form within sixty (60) calendar days of the event giving rise to the appeal.

iii. Appeals may be submitted to:
San Francisco Health Service System
Attention: Member Appeals
1145 Market Street, Suite 300
San Francisco, CA 94103

iv. The Health Service System shall consider each appeal and shall notify the Member of its decision within sixty (60) calendar days of receiving the appeal.

b. Any Member dissatisfied with the Health Service System's decision shall retain the right to appeal the decision, by making a written request to the Health Service Board.

i. The appeal must be made within fifteen (15) business days after the date the Health Service System mails its decision to the Member.

1. The Health Service Board may grant an extension of time upon the showing of good cause.

ii. Email the Health Service Board at health.service.board@sfgov.org or mail request to:
San Francisco Health Service System
Attention: HSB Appeals
1145 Market Street, Suite 300
San Francisco, CA 94103

iii. The Health Service Board shall consider each appeal and shall notify the Member of its decision within sixty (60) calendar days of receiving the appeal (see City Charter Section 12.200(5)).

1. The appeal to the Health Service System Board shall specifically identify the basis of the Member's disagreement with the Health Service System decision in writing.
2. Prior to the Health Service System Board hearing, the Health Service System shall serve a written response to the Member's appeal upon the Member and the Board.
3. All appeals to the Health Service System Board shall be heard in closed session, unless the Member requests that it be held in open session. The Health Service Board minutes shall not reflect any Member-identifiable information relating to appeals.
4. Members shall be allowed to bring a personal representative of their choosing to the Health Service Board hearing, along with any other witnesses the Member believes may have direct knowledge of the facts underlying the Member's claim. The Health Service System shall also be allowed to bring any witnesses it believes will help the Board in its decision-making process. The Health Service System Board may exclude any witness upon a finding that their testimony would be duplicative, without foundation and/or not relevant to the Member's claim.

iv. All actions taken by the Health Service Board shall be final.

2. **Grievance of Health Plan Decisions**
    a. Members who have a grievance with a specific benefit plan must first try and resolve their grievance through the plan's Member assistance process. Grievances will not be considered by the Health Service System until this action is taken and documentation is submitted to HSS.
        i. Members are advised that grievances relating to medical service received (or not received) from a Health Maintenance Organization (HMO) plan must be filed with the California Department of Managed Healthcare (DMHC).
        ii. Grievances relating to Preferred Provider Organization (PPO) medical services must be filed with the California Department of Insurance (DOI). Grievances related to a self- insured plan are filed with the Health Service System.
        iii. To be considered by the Health Service System, Member grievances must be submitted within sixty (60) calendar days of the denial of the grievance by the Member's specific benefit plan under Section V.2.

W. Rules of Interpretation

The Health Service System has absolute discretionary authority to control and manage the operation and administration of the Health Service System, to correct errors, and to construe and interpret the Health Service System Rules including, but not limited to, determinations regarding benefits, eligibility and qualifying status change events. All decisions and interpretations of the Health Service System and the Health Service Board shall be conclusive and binding upon all persons and shall be given the greatest deference permitted by law.

Any activity or transaction between members, dependents and the Health Service System not explicitly determined by these Rules remains under the discretion of the Health Service System and/or the Health Service Board. To the extent these Rules conflict with the City Charter, the express language of the Charter, and not these Rules, shall apply.

Appendix A: Calendar of Benefits Coverage Periods

City and County of San Francisco, the San Francisco Superior Court, and Municipal Executives Association (MEA)
For January 1, 2025through December 31, 2025, benefit coverage periods for members on a bi-weekly premium payment schedule of **twenty-six (26)** premium payments per year:

	Coverage Period
1	December 21, 2024 – January 3, 2025
2	January 4, 2025 – January 17, 2025
3	January 18, 2025 – January 31, 2025
4	February 1, 2025 – February 14, 2025
5	February 15, 2025 – February 28, 2025
6	March 1, 2025 – March 14, 2025
7	March 15, 2025 – March 28, 2025
8	March 29, 2025 – April 11, 2025
9	April 12, 2025 – April 25, 2025
10	April 26, 2025 – May 9, 2025
11	May 10, 2025 – May 23, 2025
12	May 24, 2025 – June 6, 2025
13	June 7, 2025 – June 20, 2025
14	June 21, 2025 – July 4, 2025
15	July 5, 2025 – July 18, 2025
16	July 19, 2025 – August 1, 2025
17	August 2, 2025 – August 15, 2025
18	August 16, 2025 – August 29, 2025
19	August 30, 2025 – September 12, 2025
20	September 13, 2025 – September 26, 2025
21	September 27, 2025 – October 10, 2025
22	October 11, 2025 – October 24, 2025
23	October 25, 2025 – November 7, 2025
24	November 8, 2025 – November 21, 2025
25	November 22, 2025 – December 5, 2025
26	December 6, 2025 – December 19, 2025

San Francisco Unified School District

For January 1, 2025 through December 31, 2025, benefit coverage periods for members on a bi-weekly premium payment schedule of **twenty-six (26)** premium payments per year:

	Coverage Period
1	January 01, 2025 - January 14, 2025
2	January 15, 2025 - January 28, 2025
3	January 29, 2025 - February 11, 2025
4	February 12, 2025 - February 25, 2025
5	February 26, 2025 - March 11, 2025
6	March 12, 2025 - March 25, 2025
7	March 26, 2025 - April 08, 2025
8	April 09, 2025 - April 22, 2025
9	April 23, 2025 - May 06, 2025
10	May 07, 2025 - May 20, 2025
11	May 21, 2025 - June 03, 2025
12	June 04, 2025 - June 17, 2025
13	June 18, 2025 - July 01, 2025
14	July 02, 2025 - July 15, 2025
15	July 16, 2025 - July 29, 2025
16	July 30, 2025 - August 12, 2025
17	August 13, 2025 - August 26, 2025
18	August 27, 2025 - September 09, 2025
19	September 10, 2025 - September 23, 2025
20	September 24, 2025 - October 07, 2025
21	October 08, 2025 - October 21, 2025
22	October 22, 2025 - November 04, 2025
23	November 05, 2025 - November 18, 2025
24	November 19, 2025 - December 02, 2025
25	December 03, 2025 - December 16, 2025
26	December 17, 2025 - December 30, 2025

San Francisco Unified School District

For January 1, 2025 through December 31, 2025, benefit coverage periods for members on a bi-weekly premium payment schedule of **twenty-one (21)** premium payments per year:

	Coverage Period
1	January 01, 2025 - January 14, 2025
2	January 15, 2025 - January 28, 2025
3	January 29, 2025 - February 11, 2025
4	February 12, 2025 - February 25, 2025
5	February 26, 2025 - March 11, 2025
6	March 12, 2025 - March 25, 2025
7	March 26, 2025 - April 08, 2025
8	April 09, 2025 - April 22, 2025
9	April 23, 2025 - May 06, 2025
10	May 07, 2025 - May 20, 2025
11	May 21, 2025 - June 03, 2025
12	January 01, 2025 - January 14, 2025
13	January 15, 2025 - January 28, 2025
14	January 29, 2025 - February 11, 2025
	Summer Coverage Period *(extra payroll deductions taken January to June pre-pay this summer coverage period)*
15	August 13, 2025 - August 26, 2025
16	August 27, 2025 - September 09, 2025
17	September 10, 2025 - September 23, 2025
18	September 24, 2025 - October 07, 2025
19	October 08, 2025 - October 21, 2025
20	October 22, 2025 - November 04, 2025
21	November 05, 2025 - November 18, 2025

San Francisco Unified School District

For January 1, 2025 through December 31, 2025, benefit coverage periods for members on a bi-weekly premium payment schedule of **eleven (11)** premium payments per year:

	Coverage Period
1	January 01, 2025 - January 31, 2025
2	February 01, 2025 - February 28, 2025
3	March 01, 2025 - March 31, 2025
4	April 01, 2025 - April 30, 2025
5	May 01, 2025 - May 31, 2025
6	June 01, 2025 - June 30, 2025 Summer Coverage Period *(extra payroll deductions taken January to June pre-pay this summer coverage period)*
7	August 01, 2025 - August 31, 2025
8	September 01, 2025 - September 30, 2025
9	October 01, 2025 - October 31, 2025
10	November 01, 2025 - November 30, 2025
11	December 01, 2025 - December 31, 2025

City College of San Francisco

For January 1, 2025 through December 31, 2025, benefit coverage periods for members on a bi-weekly premium payment schedule of **twenty-six (26)** premium payments per year:

	Coverage Period
1	December 21, 2024 – January 3, 2025
2	January 4, 2025 – January 17, 2025
3	January 18, 2025 – January 31, 2025
4	February 1, 2025 – February 14, 2025
5	February 15, 2025 – February 28, 2025
6	March 1, 2025 – March 14, 2025
7	March 15, 2025 – March 28, 2025
8	March 29, 2025 – April 11, 2025
9	April 12, 2025 – April 25, 2025
10	April 26, 2025 – May 9, 2025
11	May 10, 2025 – May 23, 2025
12	May 24, 2025 – June 6, 2025
13	June 7, 2025 – June 20, 2025
14	June 21, 2025 – July 4, 2025
15	July 5, 2025 – July 18, 2025
16	July 19, 2025 – August 1, 2025
17	August 2, 2025 – August 15, 2025
18	August 16, 2025 – August 29, 2025
19	August 30, 2025 – September 12, 2025
20	September 13, 2025 – September 26, 2025
21	September 27, 2025 – October 10, 2025
22	October 11, 2025 – October 24, 2025
23	October 25, 2025 – November 7, 2025
24	November 8, 2025 – November 21, 2025
25	November 22, 2025 – December 5, 2025
26	December 6, 2025 – December 19, 2025

City College of San Francisco

For January 1, 2025 through December 31, 2025, benefit coverage periods for members on a bi-weekly premium payment schedule of **twenty-one (21)** premium payments per year:

	Coverage Period
1	December 21, 2024 – January 3, 2025
2	January 4, 2025 – January 17, 2025
3	January 18, 2025 – January 31, 2025
4	February 1, 2025 – February 14, 2025
5	February 15, 2025 – February 28, 2025
6	March 1, 2025 – March 14, 2025
7	March 15, 2025 – March 28, 2025
8	March 29, 2025 – April 11, 2025
9	April 12, 2025 – April 25, 2025
10	April 26, 2025 – May 9, 2025
11	May 10, 2025 – May 23, 2025
	Summer Coverage Period *(extra payroll deductions taken January to June pre-pay this summer coverage period)*
12	August 2, 2025 – August 15, 2025
13	August 16, 2025 – August 29, 2025
14	August 30, 2025 – September 12, 2025
15	September 13, 2025 – September 26, 2025
16	September 27, 2025 – October 10, 2025
17	October 11, 2025 – October 24, 2025
18	October 25, 2025 – November 7, 2025
19	November 8, 2025 – November 21, 2025
20	November 22, 2025 – December 5, 2025
21	December 6, 2025 – December 19, 2025

City College of San Francisco

For January 1, 2025 through December 31, 2025, benefit coverage periods for members on a bi-weekly premium payment schedule of **twelve (12)** premium payments per year:

	Coverage Period
1	January 1, 2025 - January 31, 2025
2	February 1, 2025 - February 28, 2025
3	March 1, 2025 - March 31, 2025
4	April 1, 2025 - April 30, 2025
5	May 1, 2025 - May 31, 2025
6	June 1, 2025 - June 30, 2025
7	July 1, 2025 - July 31, 2025
8	August 1, 2025 - August 31, 2025
9	September 1, 2025 - September 30, 2025
10	October 1, 2025 - October 31, 2025
11	November 1, 2025 - November 30, 2025
12	December 1, 2025 - December 31, 2025

City College of San Francisco

For January 1, 2025 through December 31, 2025, benefit coverage periods for members on a bi-weekly premium payment schedule of **nine (9)** premium payments per year:

	Coverage Period
1	January 1, 2025 - January 31, 2025
2	February 1, 2025 - February 28, 2025
3	March 1, 2025 - March 31, 2025
4	April 1, 2025 - April 30, 2025
5	May 1, 2025 - May 31, 2025
	Summer Coverage Period *(extra payroll deductions taken January to May)*
6	September 1, 2025 - September 30, 2025
7	October 1, 2025 - October 31, 2025
8	November 1, 2025 - November 30, 2025
9	December 1, 2025 - December 31, 2025

San Francisco Health Service System
Section 125 Cafeteria Plan

Plan Year January – December 2025

SAN FRANCISCO
HEALTH SERVICE SYSTEM

www.sfhss.org

TABLE OF CONTENTS

Page

CITY AND COUNTY OF SAN FRANCISCO SECTION 125 CAFETERIA PLAN

INTRODUCTION

Effective January 1, 2025, the City and County of San Francisco amends and restates the City and County of San Francisco Section 125 Cafeteria Plan ("Plan") to incorporate applicable legislative developments and certain changes in Plan features.

Authorization

This Plan was first adopted effective December 1, 1988, pursuant to ordinance adopted by the Board of Supervisors of the City and County of San Francisco, subsequently amended (Plan added by Ord. 175-88, App. 4/28/88; amended by Ord. 370-88, App. 8/10/88; Ord. 105-00, File No. 000536, App. 5/26/2000) and, as of the date of this amendment and restatement, codified in the Administrative Code of the City and County of San Francisco at Chapter 16, Article XVII, sections 16.900 – 16.906.

Components of Plan

The Plan is a cafeteria plan under Internal Revenue Code Section 125, which allows Eligible Employees a choice between current Compensation or pre-tax salary reductions used:

a) To pay the Eligible Employee's cost of Benefit Program coverage under the Premium Conversion Benefit Component - Appendix A;

b) To fund flexible spending accounts under:

1. The Health Care Flexible Spending Account (Health Care FSA) Component – Appendix B;

2. The Child Care Dependent Care Flexible Spending Account (Dependent Care FSA) Component pursuant to Internal Revenue Code Section 129 – Appendix C; and/or

3. For certain Eligible Employees of the City and County of San Francisco, the Superior Court of California County of San Francisco and elected officials, as designated from time to time by the Superior Court of California County of San Francisco Department of Human Resources, or the San Francisco Superior Court Human Resources Department as applicable, the Flexible Credits Benefit Component of the Plan – Appendix D.

Not an ERISA Plan

This Plan is sponsored by a local governmental entity and is not subject to ERISA.

Employers Participating in this Plan

The City and County of San Francisco and other public entities affiliated with the City and County of San Francisco that offer benefits to employees permitted under Internal Revenue Code Section 125, as authorized from time to time by a properly adopted Charter amendment or

Ordinance of the Board of Supervisors of the City and County of San Francisco are employers participating in this Plan.

The list of other public entities affiliated with the City and County of San Francisco that are Participating Employers may be modified from time to time by a properly adopted Charter amendment, or Ordinance of the Board of Supervisors of the City and County of San Francisco, without written amendment to this Plan.

As of the date of this amendment and restatement, employers, in addition to the City and County of San Francisco, participating in this Plan include but are not limited to:

City and County of San Francisco Unified School District
San Francisco Community College District
Superior Court of California County of San Francisco

Employees Participating in this Plan

Employees participating in this Plan are individuals eligible under the Health Service System Rules and/or as specified by a properly adopted Ordinance of the Board of Supervisors of the City and County of San Francisco. Most eligible employees are covered by various collective bargaining agreements.

ARTICLE I
DEFINITIONS

When used in this Plan document, the following words and phrases have the following meanings unless the context clearly indicates otherwise.

Annual Open Enrollment Election Period
"Annual Open Enrollment Election Period" means the annual period as determined by the Plan Administrator in its sole discretion during which Eligible Employees elect Salary Reduction amounts and benefit allocations thereof for the following Plan Year. The Annual Open Enrollment Election Period for the Plan and each Benefit Component will be held before the Period of Coverage for which new elections are effective.

Benefit
"Benefit" means any of the Benefit Program options available to a Participant as outlined in Section 6.1.

Benefit Component
The "Benefit Components" are:

(a) Premium Conversion Benefit Component (Appendix A):
(b) Health Care Flexible Spending Account Benefit Component (Appendix B);
(c) Dependent Care Flexible Spending Account Benefit Component (Appendix C); and
(d) Flexible Credits Benefit Component (Appendix D)

Benefit Program
"Benefit Program" means any of the optional benefit choices available to a Participant offered through this Plan under the Health Service System Benefit Programs.

Benefit Program Premium
"Benefit Program Premium" means the amount an Eligible Employee is required to pay as a condition of coverage under the Benefit Program(s) in which Eligible Employees and Eligible Dependents, if any, are entitled to participate.

Benefit Program Material
"Benefit Program Material" means the most current provisions describing the Benefit Programs offered through this Plan. Notwithstanding any implication or statement to the contrary in any of the Benefit Program Material incorporated herein by reference, which may from time to time refer to such benefits as a "plan," the Plan is a single plan.

Charter
"Charter" means the Charter of the City and County of San Francisco.

Child
"Child" means the child of a Participant as further defined in Section 2.2.

City
"City" or "the City" means the City and County of San Francisco, a municipal corporation, acting by and through both its Director of the Health Service System or the Director's designated agent.

COBRA
"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended,

and regulations promulgated thereunder as they now exist, or may be amended from time to time.

Code
“Code” means Title 26 of the United States Code (26 U. S. C.) formally the Internal Revenue Code of 1986, as amended, and regulations promulgated thereunder as they now exist, or may be amended from time to time.

Covered Employee
"Covered Employee" means a Covered Employee as set forth in the definition of "Qualified Beneficiary."

Compensation
“Compensation” means the total cash remuneration received by the Participant from the Employer during a Plan Year prior to any reductions pursuant to a Salary Reduction Agreement authorized in this Plan; provided, however, Compensation shall not include cash remuneration received before the Participant began participation in the Plan.

Contributions
“Contributions” means the contributions taken from the Participant’s salary on a before-tax basis, pursuant to a Salary Reduction Election.

Dependent
"Dependent" means an individual as defined in Section 2.3.

Dependent Care Flexible Spending Account (Dependent Care FSA)
“Dependent Care Flexible Spending Account (Dependent Care FSA)” means the Dependent Care Flexible Spending Account described in Appendix C of this Plan, or as it may be amended from time to time.

Domestic Partner
“Domestic Partner” means a partner as further defined in Section 2.3.

Effective Date of First Adoption of Plan
“Effective Date of First Adoption of Plan” means December 1, 1988.

Effective Date of This Amendment and Restatement
“Effective Date of this Amendment and Restatement” means January 1, 2025.

Eligible Child
“Eligible Child” means an Eligible Child as set forth in Section 2.3.

Eligible Dependent
“Eligible Dependent” means an Eligible Dependent as set forth in Section 2.3.

Eligible Domestic Partner
“Eligible Domestic Partner” means a Domestic Partner as further defined in Section 2.3.

Eligible Employee
“Eligible Employee” means a regular Employee who is eligible to participate as set forth in Section 2.2, unless such Employee does not qualify pursuant to applicable law, as eligible to participate in an Internal Revenue Code Section 125 plan.

Notwithstanding any other provision, an Eligible Employee under this Plan does not include: (i) a temporary or "as needed" employee who is not scheduled for, or who has not earned, more than one thousand and forty (1,040) hours of compensation during any consecutive twelve (12) month period.; (ii) a leased employee within the meaning of Code Section 414(n); (iii) a nonresident alien with no U.S. source of income; (iv) an individual who is not on the U.S. payroll of the Employer; (v) an individual employed pursuant to a written agreement which provides that such individual shall not be eligible for participation in the Plan; (vi) an independent contractor; or (vii) any other individual whose compensation is not fixed by the San Francisco Board of Supervisors or by statue or whose compensation is not paid by the City or a Participating Employer.

Eligible Spouse
"Eligible Spouse" means a Spouse as further defined in Section 2.3.

Employee
"Employee" means a common law employee of the Employer who is categorized as an Employee by the City and County of San Francisco Department of Human Resources (or by the appropriate governing body with respect to each Participating Employer), and whose compensation is fixed by statute and/or by the San Francisco Board of Supervisors (or by the appropriate governing body with respect to each Participating Employer), and whose compensation is paid by the City or a Participating Employer. The term "Employee" shall exclude any individual, including a leased individual or an independent contractor, during any period they are not classified as a common-law employee by the Employer, without regard to whether such an individual is subsequently determined by a state or federal court or agency to have been a common-law employee of the Employer for tax or any other legal purpose during such period.

Employer
"Employer" means the City and County of San Francisco and all Participating Employers.

ERISA
"ERISA" means Public Law No. 93 406, the Employee Retirement Income Security Act of 1974, as amended, and regulations promulgated thereunder as they now exist, or from time to time may be amended.

Experience Gain
"Experience Gain" means the excess of required Premiums paid and income (if any) over the total claims reimbursements and reasonable administrative costs for the Plan Year.

Health Care Flexible Spending Account (Health Care FSA)
"Health Care Flexible Spending Account (Health Care FSA)" means the Health Care Flexible Spending Account described in Appendix B of this Plan, or as it may be amended from time to time.

HIPAA
"HIPAA" mean the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations promulgated thereunder as they now exist or from time to time may be amended.

Health Service System
"Health Service System" or "HSS" means the San Francisco Health Service System.

Health Service System Benefit Programs
"Health Service System Benefit Programs" means Benefit Programs under this Plan offered through the Health Service System.

Health Service System Rules
"Health Service System Rules" means the rules as approved by the Health Service System Board, as they may be amended from time to time, which are, as applicable to this Plan, hereby incorporated by reference. See Appendix F for the Health Service System Rules website address current as of the date of this amendment and restatement.

Participant
"Participant" means an Eligible Employee who participates in the Plan pursuant to Articles II and III and has not for any reason become ineligible to participate further in the Plan.

Participating Employer
"Participating Employer" means a public entity affiliated with the City and County of San Francisco as determined from time to time by a properly adopted Charter Amendment, or Ordinance of the City and County of San Francisco, to participate in this Plan without written amendment to this Plan. As of the Effective Date of This Amendment and Restatement, the Participating Employers include, but are not limited to:

(a) City and County of San Francisco Unified School District;
(b) San Francisco Community College District; and
(c) Superior Court of California County of San Francisco

Period of Coverage
"Period of Coverage" means the Plan Year, unless otherwise provided in this document, e.g., in the case of a Qualifying Status Change Event or a newly hired Eligible Employee.

Plan
"Plan" means the City and County of San Francisco Section 125 Cafeteria Plan, the terms of which are set forth herein, as it may be amended from time to time.

Plan Administrator
"Plan Administrator" shall mean the Health Service System for purposes of the administration of this Plan and for Benefit Programs under this Plan which are offered by the HSS and are permitted to be offered under Code Section 125. The Health Service System may delegate plan administration duties and/or responsibilities pursuant to Article VII of this Plan to others, including a Participating Employer.

Plan Sponsor
"Plan Sponsor" shall mean the City and County of San Francisco.

Plan Year
The term "Plan Year" shall mean the twelve (12) month period beginning on each January 1 and ending on December 31.

Premium Conversion Benefit Component
"Premium Conversion Benefit Component" means the Premium Conversion Benefit Component described in Appendix A of the Plan, or as it may be amended from time to time.

Premium Expenses
"Premium Expenses" or "Premiums" mean the Participant's cost for the insured Benefits described in Section 6.1.

Qualified Beneficiary
A "Qualified Beneficiary" is a person who is covered under the Plan on the day before a Qualifying Event who is:

(a) an Eligible Employee who is covered under the Plan (hereinafter referred to as "Covered Employee");
(b) a spouse of a Covered Employee; or
(c) a dependent child of a Covered Employee (including a child born to or placed for adoption with the Covered Employee while the Covered Employee is covered under continuation coverage).

Qualifying Status Change Event
“Qualifying Status Change Event” means a change in an Eligible Employee’s status as described in Section 4.5 of this Plan.

Salary Reduction
“Salary Reduction” means a specified amount by which a Participant’s Compensation is decreased, pursuant to a Salary Reduction Election, for federal income tax and Social Security tax purposes and, wherever permitted, under applicable law for state and local income tax purposes.

Salary Reduction Election
“Salary Reduction Election” means the authorization to the Employer by the Eligible Employee to reduce their pay by an amount on a before-tax basis for selected Plan benefits.

Security Incident
“Security incident” shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI.

Spouse
“Spouse” means the legally married partner of a Participant as further defined in Section 2.3.

ARTICLE II
ELIGIBILITY

2.1 Eligibility in General

Eligibility of Employees shall be determined as set forth in the Health Service System Rules, as approved by the City and County of San Francisco Health Service System Board, effective January 1, 2025, attached hereto as Appendix F. The Health Service System Rules may be amended from time to time without formal amendment to this Plan document.

2.2 Eligible Employee

(a) Eligible Employee shall mean with respect to Health Service System Benefit Programs, an Employee eligible pursuant to the Health Service System Rules.

(b) Eligible Employees shall be eligible to participate in the Plan with respect to Health Service System Benefit Programs, the date they become entitled to membership in the Health Service System pursuant to the Health Service System Rules.

(c) Eligible Employees shall be the only individuals permitted as Participants in the Plan.

(d) Rehired former Participants shall be treated as new Employees for the purposes of Plan eligibility if rehired more than 30 days after termination. A former Participant who terminates employment with the Employer and then returns to employment with the Employer as a Participant within 30 days following their termination of employment, shall be reinstated in their elections under the Plan prior to the termination. If such former Participant returns to employment with the Employer within 30 days following their termination of employment and such person's absence spans 2 Plan Years, the Participant will be covered under the Plan immediately upon reemployment provided that the Participant must reenroll in the Plan and make a new election for the remainder of the Plan Year.

(e) Notwithstanding the foregoing, the Health Service System shall make eligibility determinations with respect to employees of the City and County of San Francisco. The appropriate governing body shall make eligibility determinations with respect to each Participating Employer. Each Participating Employer shall determine which Health Service System Benefit Programs are available for its employees.

2.3 Eligible Dependents

The following are Eligible Dependents under the Plan:

(a) Eligible Spouse shall mean an Eligible Employee’s Legal Spouse as defined in the Health Service System Rules with respect to Health Service System Benefit Programs;

(b) Eligible Domestic Partner shall mean an Eligible Employee’s Legal Domestic Partner as defined in the Health Service System Rules with respect to Health Service System Benefit Programs.

(c) Eligible Child shall mean an individual described in the Health Service System Rules with respect to Health Service System Benefit Programs.

ARTICLE III PLAN PARTICIPATION

3.1 Effective Date of Participation

(a) An Eligible Employee shall be eligible to participate in the Plan on the date the individual becomes an Eligible Employee.

Participation, or a change in election, as applicable, shall be effective in a Benefit Component as applicable, as set forth in the Health Service System Rules.

The effective date of participation, or change in election, as applicable, shall only be effective if the Eligible Employee completes the enrollment procedure, or change in election as applicable, in accordance with the timeframe and manner prescribed by the Plan Administrator (or its delegate) to elect to participate (or change an election).

(b) Notwithstanding the foregoing, participation, or a change in election, as applicable, shall be effective in a Benefit Component on the date an Eligible Child is newly acquired due to birth, adoption, or placement for adoption, provided that all applicable conditions of the special enrollment rules of the HIPAA are satisfied and, provided further, that an election form is submitted in accordance with the timeframe and manner prescribed by the Plan Administrator, or its delegate, to elect to participate in the Plan.

3.2 Election to Participate

(a) Participation in this Plan by an Eligible Employee shall be contingent upon participation in a Benefit Component, and receipt by the Plan Administrator, or its delegate, of such applications, consents, proofs of birth or marriage, elections, beneficiary designations, proof of reimbursable expenses and other documents and information as required by this Plan, the Plan Administrator, or the Plan Administrator's delegate.

(b) The election made shall be irrevocable until the end of the applicable Plan Year, unless the Participant is entitled to change their election(s) pursuant to a Qualifying Status Change Event.

(c) An Eligible Employee shall also be required to execute a Salary Reduction Election during the Annual Open Enrollment Election Period for the Plan Year during which they wish to participate in the Plan.

(1) Any such Salary Reduction Election shall be effective for the first pay period beginning on or after the Eligible Employee's effective date of participation pursuant to Section 3.1.

(2) Participants who do not have sufficient salary to enter into a Salary Reduction Agreement shall make applicable after-tax premium payments directly to the Plan Administrator within the designated time period.

3.3 Authorized Leaves of Absence

(a) A Participant who goes on an authorized leave of absence, including authorized unpaid leave as set forth in the Health Service System Rules, may continue to receive group health benefit coverage under the Benefit Programs and the Health Care FSA as long as the Participant pays the applicable premium payments or FSA contributions within the designated time period.

(b) Contributions for the period covered by the leave of absence may be paid for in a manner consistent with applicable law and in accordance with the terms as set forth in the Health Service System Rules.

(c) Upon return from an authorized leave of absence during which the required contributions under the Plan by a Participant are not made, the Participant's reinstatement shall be determined in accordance with the rules set forth in Section 3.6.

3.4 USERRA (Military) Leaves of Absence

(a) A Participant who goes on an unpaid military leave of absence under the Uniformed Services Employment and Reemployment Rights Act (USERRA) may continue to receive group health benefit coverage under the Benefit Programs and the Health Care FSA during the USERRA leave until the earlier to occur of: (a) the day after the date on which the Participant fails to return to employment, as described in USERRA (United States Code Chapter 43 of Title 38); or (b) twenty-four (24) months from the date of commencement of the USERRA leave.

(b) If the USERRA leave is less than 31 days, Participants' required contributions will remain the same as when they were actively employed.

(c) If the USERRA leave is 31 days or longer, Participants may be required to pay up to 102 percent of the full premium cost.

(d) Contributions for the period covered by the leave of absence may be paid for in accordance with the terms as set forth in the Employer's written materials distributed to Participants, and consistent with applicable law.

(e) Upon return from a USERRA leave during which the required contributions under the Plan by a Participant are not made, the Participant's reinstatement shall be determined in accordance with the rules set forth in Section 3.5.

3.5 Cancellation and Suspension of Participation

(a) A Participant who goes on an authorized leave of absence from the Employer during the Plan Year:

(1) May choose to cancel or suspend group health benefit coverage under the Benefit Programs and the Health Care FSA effective upon commencement of the leave of absence.

(2) Participation in the Dependent Care FSA will be automatically suspended upon the commencement of a leave of absence.

(b) During periods of cancelled or suspended participation, no contributions shall be made, and no benefits shall be provided under the Plan, except as otherwise explicitly stated in a Benefit Program or as required by COBRA.

(c) A Participant who returns to an Employer's service during the same Plan Year in which they took an unpaid authorized leave of absence shall be eligible to be reinstated in the Benefit Programs and in the Health Care FSA and the Dependent Care FSA in effect when their participation was suspended. However, a suspended Participant's participation in the Plan shall terminate if, after return to employment following the end of a leave of absence, the Participant does not resume coverage as set forth in the Health Service System Rules (Appendix F) and consistent with applicable law.

(d) With respect to the Health Care FSA and the Dependent Care FSA, a Participant who suspended participation in the Health Care FSA and/or the Dependent Care FSA during their leave of absence may elect to increase their required contributions for the remainder of the Plan Year by the amount of the contributions the Participant failed to make during the leave of absence. The amount of the increase shall be spread ratably over the remaining pay periods in the Plan Year. If such an election is made, the maximum reimbursement under the Health Care FSA and/or the Dependent Care FSA shall be the same amount with respect to expenses incurred both before and after the leave of absence. In the absence of such an election, the Participant, upon returning from leave, shall resume their required contributions for the remainder of the Plan Year at the same level being made prior to the leave of absence, and the maximum reimbursement for expenses incurred after the leave of absence shall be reduced by the amount of the required contributions the Participant failed to make during the leave of absence. Regardless of what election is made, if coverage is suspended during the leave of absence, no expenses incurred during the leave will be reimbursed under the Plan.

3.6 Termination and Reinstatement of Participation

Except as otherwise provided in a Benefit Program, in the event an Eligible Employee who has made an election under the Plan ceases to be an Eligible Employee, takes an unauthorized leave of absence, or ceases to have enough Compensation to cover their Salary Reduction under the Plan, and does not make applicable premium payments to the Plan Administrator within the designated time period, such person's election and coverage under the Plan shall terminate.

(a) If the Employee becomes eligible to participate: (i) within 30 days of the date on which their participation was terminated; and (ii) within the same Plan Year, their active participation in the Plan shall be reinstated and the most recent election shall remain in effect, except as otherwise permitted pursuant to Section 3.5.

If such Employee becomes eligible to participate: (i) more than 30 days after the date on which participation terminated; or (ii) in a subsequent Plan Year, such person shall be treated as a newly Eligible Employee and shall be permitted to make a new election under the Plan.

(b) Except for the Health Care FSA and the Dependent Care FSA, participation in the Plan shall terminate as of the earlier of:

1. The date of termination of the Plan, unless otherwise communicated to Participants; or

2. The last day of the coverage period in which the Eligible Employee ceases to be a Participant in all Benefit Programs.

3. The date on which the Participant stops making any required contributions (except where otherwise allowed by the Plan).

3.7 Termination of Employment

If a Participant terminates employment with an Employer for any reason other than death, their participation in the Plan shall cease as of the last day of the pay period in which such termination occurs, subject to the Participant's right to continue coverage under any insurance contracts for which the Premiums have already been paid. However, such Participant may submit claims for expenses incurred prior to termination for the remainder of the Plan Year in which such termination occurs.

3.8 Death

If a Participant dies, their participation in the Plan shall cease. However, such Participant's beneficiaries, or the representative of his estate, may submit claims for expenses or benefits for the portion of the Plan Year preceding their date of death. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Plan Administrator may designate the Participant's Eligible Spouse, Eligible Domestic Partner, or Eligible Child or a representative of their estate.

3.9 Continuation Coverage (COBRA)

(a) COBRA coverage under the Health Care FSA and the Benefit Programs for which COBRA is offered shall be extended and financed in accordance with the administrative procedures adopted by the Employer to comply with applicable law and with the group health plans sponsored by the Employer. Appendix B provides additional detail regarding COBRA benefits as related to the Health Care FSA.

(b) To the extent required by COBRA, if a person ceases to be an Eligible Employee and agrees to pay the premium for COBRA continuation coverage, the person shall be treated as a Participant to the extent required by law, and coverage under the Health Care FSA shall continue for as long as such premiums are paid, if applicable, but not beyond the Plan Year in which the COBRA qualifying event occurs, subject to the terms and conditions of the Plan.

ARTICLE IV
ELECTIONS TO PARTICIPATE

4.1 In General

The Plan Administrator, or its delegate, shall establish procedures and deadlines for filing Salary Reduction Elections.

4.2 Salary Reduction Election

Each Eligible Employee who wishes to participate shall timely file a Salary Reduction Election with the Employer. The election shall provide that the Participant's Compensation in each payroll period shall be reduced by a specific amount; provided, however, that the amount shall not exceed the lesser of the limits set forth in such individual's elected Benefit Components, or the Participant's Compensation for that payroll period. Except as provided in Section 4.5, a Participant's Salary Reduction Election shall be irrevocable for a Plan Year.

4.3 Default Elections

(a) Premium Conversion. Unless provided otherwise by Plan Administrator, if a Participant does not make a new election with respect to the Benefit Programs during an Annual Enrollment Period, the Participant's coverage under the Benefit Programs will remain the same and will continue to apply during the next Plan Year; provided, however, that the amount of the reduction in the Participant's Compensation for such subsequent Plan Year to pay for such Benefit Program shall be adjusted automatically in the event of a change in the cost of the coverage. However, the Plan Administrator may designate any annual Open Enrollment period as requiring Participants to proactively elect to enroll in health and other benefits for the upcoming plan year (Active Enrollment) in the Plan Administrator's discretion, which could be, for example, to toto highlight new plan options or give members the opportunity to revisit their benefit choices.

(b) **Health Care Flexible Spending Account, Dependent Care Flexible Spending Account Component.** If a Participant does not make a new election with respect to the Participant's coverage under the Health Care FSA or the Dependent Care FSA Component, such coverage shall cease on the last day of the Plan Year.

4.4 Compensation in Lieu of Election to Participate

Eligible Employees with collective bargaining agreements, which specifically make available the option to receive compensation in lieu of benefits, and do not elect to participate in a Benefit Component shall receive regular taxable cash Compensation in lieu of benefits, as agreed to within the collective bargaining agreement.

4.5 Qualifying Status Change Events

A Participant's Salary Reduction Election for any Plan Year may not be changed after the first payroll period to which it applies, except for events constituting a Qualifying Status Change Event as permitted by applicable law and set forth in the Health Service System Rules.

(a) The Eligible Employee must provide the Plan Administrator, or its delegate, with timely written documentation that a Qualifying Status Change Event has occurred.

(b) With respect to the Dependent Care FSA, the Plan Administrator may establish a maximum number of election changes made in a specified Plan Year, for any Participant by notifying all Participants of the maximum number. Any election change requested by a Participant who has reached the maximum number for the applicable period shall be made only if such change request must be honored by applicable law.

4.6 Change of Election

(a) In the event of a Qualifying Status Change Event, an Eligible Employee may revoke or change their election in accordance with the time frame and the manner set forth in the Employer's written summary material and Health Service System Rules distributed to Participants as of the date such Qualifying Status Change Event occurs. An Eligible Employee who becomes eligible under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") for coverage under an accident or health benefit offered by the Employer will be allowed to make a consistent election, or election change under this Plan.

(b) In any case, if the Eligible Employee misses the deadline to revoke or change their election, the Eligible Employee must then wait until the next following Annual Open Enrollment Election Period or Qualifying Status Change Event, whichever occurs earlier, to make an election revocation or change.

(c) An election revocation or change must be due to, and consistent with, the Qualifying Status Change Event to the extent required by applicable law. The Plan Administrator, or its delegate, in its sole discretion, shall determine whether or not a requested election revocation or change is so due to, and consistent with, the Qualifying Status Change Event.

ARTICLE V
PLAN RECORDKEEPING

The Employer shall make all contributions required by the Benefit Components out of its general assets. The Employer will retain title to, and beneficial ownership of, assets which are earmarked for payment of benefits under this Plan. No pre-funding of benefits will be required.

For bookkeeping purposes only, the Plan Administrator, or its delegate, will maintain an account for each Participant. This account will be divided into sub-accounts which will be credited with the amount of Salary Reduction specified by such Participant for each Benefit Component.

ARTICLE VI
BENEFITS

6.1 Benefits

Benefits under a Benefit Component shall be payable, or provided, for a Period of Coverage only if such benefits relate to, and such costs were incurred during, periods in which the individual has properly elected to participate in that Benefit Component. Amounts credited to each Benefit Component subaccount shall be payable in accordance with the terms of the Benefit Component.

6.2 Benefit Program Options

Each Participant may elect to participate in one or more of the Benefit Programs that may be authorized from time to time by the Employer. Changes to the Benefit Programs may be made without formal amendment to this Plan.

The Health Service System Benefit Program complies with Charter § A8.422 to include benefits that render medical care such as medical plans, dental plans, vision plans, and long-term disability plans. Additionally, other benefits administered under the Health Service System Benefit Program include flexible credits, life insurance, flexible spending accounts, long term care insurance, and others as set forth in Appendix E.

ARTICLE VII
PLAN ADMINISTRATION

7.1 Plan Administrator

(a) The Plan Administrator has absolute discretionary authority to control and manage the operation and administration of the Plan, to correct errors, and to construe and interpret Plan provisions including, but not limited to, determinations regarding eligibility and benefits.

(b) The Plan Administrator may delegate duties and responsibilities as it deems appropriate to facilitate the day-to-day administration of the Plan and, unless the Plan Administrator expressly provides to the contrary, such delegation will carry with it the Plan Administrator's full discretionary authority to accomplish the delegation.

(c) All decisions and interpretations of the Plan Administrator shall be conclusive and binding upon all persons and shall be given the greatest deference permitted by law. Benefits under the Plan will be paid only if the Plan Administrator or its designee decides in its sole discretion that a Participant is entitled to such benefits, or that an Employee is an Eligible Employee.

7.2 Payment Of Expenses

All proper expenses incurred in administering the Plan will be paid by the Plan, unless paid by the Employer, unless the Plan or the Employer (as applicable) determines that administrative costs shall be borne by the Participants under the Plan consistent with applicable Federal, State and local law. The Plan Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated Employees.

7.3 Insurance Control Clause

In the event of a conflict between the terms of this Plan and the terms of an insurance contract, including the Health Service System rider of a particular insurer whose product is then being used in conjunction with this Plan, the terms of the insurance contract including the Health Service System rider shall control as to those Participants receiving coverage under such insurance contract. For this purpose, the insurance contract, including the Health Service System rider, shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to, and the circumstances under which insurance terminates.

7.4 Benefits of Unlocated Persons

If a payment is due under the Plan, and if notice of such payment due is mailed to the last known address of such person, as shown on the Plan records, and within six (6) months after such mailing such person has not made written claim therefore, the Plan Administrator shall, unless otherwise provided in the Benefit Program Materials, direct that such payment and all remaining contributions otherwise due to such person be canceled, and upon such cancellation, the Plan shall have no further liability therefore.

7.5 Experience Gains

(a) If the Health Care FSA has an Experience Gain with respect to a Plan Year, such Experience Gain may be used to pay expenses of the Health Care FSA, or other Plan expenses as otherwise determined by the Plan Administrator, consistent with applicable laws and regulations.

(b) If the Dependent Care FSA has an Experience Gain with respect to a Plan Year, such Experience Gain may be used to pay expenses of the Dependent Care FSA, or other Plan expenses as otherwise determined by the Plan Administrator, consistent with applicable laws and regulations.

(c) In no event shall Experience Gains be allocated among Participants based, directly or indirectly, on the level of their Health Care FSA or Dependent Care FSA reimbursement amounts.

7.6 Priority of Contributions

Contributions shall be deemed to come first from amounts contributed by Eligible Employees and then from amounts contributed by the Employer.

ARTICLE VIII
CLAIMS

8.1 Claims Procedures

(a) The claims procedure set forth in the Health Service System Rules shall govern eligibility claims for Benefit Programs under this Plan.

(b) Any claim for benefits provided under an insurance contract issued by the insurer shall be made to the insurer. If the insurer denies any claim, the Participant or beneficiary shall follow the insurer's claims review procedure.

(c) Any other claim for Benefits shall be made in a manner determined by the Plan Administrator. See also additional claims procedures for the Health Care FSA and the Dependent Care FSA set forth in Appendix B and Appendix C, respectively.

ARTICLE IX
HIPAA PRIVACY AND SECURITY

9.1 Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the regulations issued thereunder, impose obligations on group health plans with respect to protected health information ("PHI") and electronic protected health information ("e-PHI") as defined in 45 CFR Parts 160 and 164 ("the HIPAA regulations").

9.2 Plan Subject to HIPAA

In this Article IX, "Plan" includes the group health benefit offerings by the City and County of San Francisco, including the group health care components of this City and County of San Francisco Section 125 Cafeteria Plan.

9.3 Uses and Disclosures of PHI

The Plan and the Plan Administrator may disclose a Plan Participant's PHI to Plan Sponsor (or to Plan Sponsor's agent) for the following Plan administration functions under 45 CFR 164.504(a), to the extent not inconsistent with the HIPAA regulations:

(a) Customer service assistance with claims issues;

(b) Plan management, quality assessment and auditing.

The Plan will not provide PHI to a Participating Employer without the authorization of the individual who's PHI is being sought, as otherwise allowed by law in the Plan Administrator's discretion, or as required by law.

9.4 Restriction on Plan Disclosure of PHI to the Plan Sponsor

The Plan, its Business Associates, health insurance issuers, or HMOs, will not disclose PHI to the Plan Sponsor except upon the Plan's receipt of the Plan Sponsor's certification that the Plan has been amended to incorporate the agreements of the Plan Sponsor under Section 9.6 below, and/or except as otherwise permitted or required by law. A copy of this Plan document may serve as such certification.

9.5 Privacy Agreements of the Plan Sponsor

As a condition for obtaining PHI from the Plan, its Business Associates, Insurers, and HMOs, the Plan Sponsor agrees it will:

(a) Not use or further disclose such PHI, other than as permitted by Section 9.4 above and as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

(b) Require that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(c) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(d) Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(e) Make the PHI of a particular Participant or other enrollees available for purposes of their written requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation Sections 45 CFR 164.524 and 164.526;

(f) Make the PHI of a particular Participant or other enrollees available for purposes of required accounting of disclosures by the Plan Sponsor pursuant to their requests for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;

(g) Make the Plan Sponsor's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA regulations;

(h) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(i) Require that there is adequate separation between the Plan and the Plan Sponsor by implementing the terms of (1) through (3), below:

(1) *Employees with access to PHI*: The following employees, or other individuals under the control of Health Service System, are the only individuals that may access PHI received from the Plan:

a. All Health Service System personnel for Plan administration purposes;
b. City finance personnel for Plan administration purposes;
c. Staff from Office of the City Attorney who assist Health Service System and/or City finance with Plan administration purposes;
d. Staff from the City Department of Technology who provide technical assistance or support to Health Service System and/or City finance.

(2) *Use Limited to Plan Administration*: The access to, and use of, PHI by the individuals described in (1), above, is limited to Plan Administration functions defined in HIPAA regulation 45 CFR 164.504(a).

(3) *Mechanism for Resolving Noncompliance*: If the Plan Sponsor, Plan Administrator, or any other person(s) responsible for monitoring compliance determines that any person described in (1), above, has violated any of the restrictions of this Article IX, then such individual shall be disciplined in accordance with the Plan Sponsor's standard disciplinary policies and procedures, as those policies and procedures may be amended from time to

time. The Plan Sponsor shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

9.6 Security Provisions of the Plan Sponsor

The Plan Sponsor who receives e-PHI shall in accordance with HIPAA and related regulations:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Require that the adequate separation between the Plan and the Plan Sponsor as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) Require that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

(d) Report to the Plan any Security Incident of which it becomes aware. “Security incident” shall mean successful unauthorized access, use, disclosure, modification, or destruction of, or interference with, the e-PHI; and

(e) Upon request from the Plan, the Plan Sponsor agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification, or destruction of the e-PHI to the extent such information is available to the Plan Sponsor.

9.7 PHI and e-PHI not Subject to the Provisions of Article IX

Notwithstanding the foregoing, the terms of this Article IX shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504 (f)(l)(ii) or (iii); or to PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted under Federal law.

9.8 Definitions

All capitalized terms within this Article IX not otherwise defined by the provisions of this Article shall have the meaning given them in the Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under HIPAA.

ARTICLE X
MISCELLANEOUS

10.1 Nondiscrimination

The Plan Administrator may unilaterally change or revoke any election by an Eligible Employee if the Plan is, or is likely to become, discriminatory or to otherwise violate applicable law.

10.2 Notice

Any notice to be delivered under this Plan shall be given in writing and delivered, personally, by facsimile or, by certified mail, postage prepaid, addressed to the Plan Administrator, the Participant, or any beneficiaries, as the case may be, at their last known address. Nothing herein shall prevent the use of electronic or such other forms of notification as the Plan Administrator may choose to employ.

Notice to the Plan Administrator shall be addressed as follows:

Director
Health Service System
1145 Market Street, Suite 300
San Francisco, CA 94103

With a copy to:

Health Service System General Counsel
Office of the City Attorney
City Hall, Room 234
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

10.3 Captions

The captions of the sections of this Plan are for convenience only and shall not control the meaning or construction of any of its provisions.

10.4 Severability of Provisions

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and this Plan shall be construed and enforced as if such provisions had not been included.

10.5 Governing Law

This Plan shall be construed and enforced in accordance with the Code to the extent it is not preempted by federal law, with the laws of the State of California and the Charter and the ordinances of the City and County of San Francisco. Any action relating to, arising out of, or involving, the Plan shall be litigated in a state or federal court located in San Francisco County, California.

10.6 Masculine and Feminine, Singular and Plural

Whenever used herein, a pronoun shall include the opposite gender, the singular shall include the plural, and the plural shall include the singular, whenever the context shall plainly so require.

10.7 Separate Plans

To the extent required to satisfy applicable law, including, but not limited to, the nondiscrimination provisions of the Code, and any privacy and security laws, each coverage level, each group of employees covered by the Plan, and each class of benefits provided under the Plan, will constitute a separate "plan."

10.8 Right to Offset Future Payments

In the event a payment, or the amount of a payment, is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to, or on behalf of such individual, by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

10.9 Right to Recover Payments

Whenever a payment has been made by the Plan, including an erroneous payment, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person or entity to, or for, whom the payment was made.

10.10 Non-Alienation of Benefits

No benefit, right or interest of any person hereunder shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

10.11 Exclusive Benefit

This Plan shall be maintained for the exclusive benefit of the Participants.

10.12 Action by the Employer

Whenever the Employer under the terms of the Plan is permitted (or required) to do (or perform) any act of matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

10.13 Additional Taxes or Penalties

If there are any taxes or penalties payable by the Employer on behalf of any Participant, such taxes or penalties shall be payable by the Participant to the Employer to the extent such taxes would have been originally payable by the Participant had this Plan not been in existence.

10.14 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan shall be excludable from the Participant's gross income for federal, state, or local income tax purposes or for Social Security tax purposes, or that any other federal or state tax treatment shall apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether payment under the Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes, and social security tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not excludable.

10.15 Indemnification Of Employer By Participants

If a Participant receives one or more reimbursements under their Dependent Care FSA that are not for Dependent Care Expenses or under their Health Care FSA that are not for Qualifying Medical Expenses, the Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from the reimbursements; provided, however, the Participant's indemnification and reimbursement shall not exceed the amount of additional federal, state, or local income tax that the Participant would have owed if the reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on that compensation, less any such additional income and Social Security tax actually paid by the Participant.

10.16 Limitation of Rights and Obligations

Neither the establishment nor maintenance of the Plan, nor any amendment thereof, nor any act or omission under the Plan resulting from the operation of the Plan shall be construed:

(a) as conferring upon any Participant, beneficiary, or any other person a right or claim against the Employer, the Plan Administrator, or a designee, except to the extent that such right or claim shall be specifically expressed or provided in the Plan;

(b) as creating any responsibility or liability of any Employer, the Plan Administrator or a designee for the validity or effect of the Plan;

(c) as a contract or agreement between any Employer and any Participant or other person;

(d) as being consideration for, or an inducement or condition of, employment of any Participant or other person, or as affecting or restricting in any manner or to any extent whatsoever the rights or obligations of the Employer or any Participant or other person to continue or terminate the employment relationship at any time;

(e) as to give any Participant or other person, the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or other person at any time.

10.17 Misrepresentation

Any material misrepresentation on the part of the Participant making application for coverage or receipt of benefits, shall render the coverage null and void.

10.18 Employment of Consultants

The Plan Administrator, or a fiduciary named by the Plan Administrator pursuant to the Plan, may employ one or more persons to render advice with regard to their respective responsibilities under the Plan.

10.19 Designation of Fiduciaries

The Plan Administrator may designate another person or persons to carry out any fiduciary responsibilities of the Plan Administrator under the Plan. The Plan Administrator shall not be liable for any act or omission of such person in carrying out such responsibility.

10.20 Counterparts

The Plan may be executed in any number of counterparts, each of which shall be deemed to be an original. All counterparts shall constitute but one and the same instrument, and shall be evidenced by any one counterpart.

10.21 Disclaimer of Liability

Nothing contained herein shall confer upon a Participant any claim, right, or cause of action, either at law or at equity, against the Plan, Plan Administrator, a designee, or any Employer, for the acts or omissions of any provider of services or supplies for any benefits provided under the Plan.

10.22 Legal Counsel

The Plan Administrator, and/or its designee, may from time to time consult with counsel, who may be counsel for the Employer, and shall be fully protected in acting upon the advice of such counsel.

10.23 Protective Clause

Neither the Employer, the Plan Administrator, nor a designee shall be responsible for the validity of any contract of insurance or other benefit contract or policy by any benefit provider, or for the failure on the part of any insurance company or other benefit provider to make payments thereunder.

10.24 Receipt and Release

Any payments to any Participant shall, to the extent thereof, be in full satisfaction of the claim of such Participant being paid thereby. The Plan Administrator, or a designee may condition payment thereof on the delivery by the Participant of the duly executed receipt and release in such form as may be determined by the Plan Administrator, or a designee.

10.25 Legal Actions

If the Plan Administrator is made a party to any legal action regarding the Plan, except for a breach of fiduciary responsibility of such person or persons, any and all costs and expenses, including reasonable attorneys' fees, incurred by the Plan Administrator in connection with such proceeding shall be paid by the Employer.

10.26 Reliance

The Plan Administrator or a designee shall not incur any liability in acting upon any verbal, written, electronic, notice, believed by the Plan Administrator or a designee to be genuine or to be executed or sent by an authorized person.

10.27 Participant Incapacitation

When any Participant is under legal disability or, in the Employer's opinion, is in any way incapacitated so as to be unable to manage their affairs, the Employer may cause the Participant's benefits to be paid to their legal representative for Participant’s benefit. The payment of benefits pursuant to this Section shall completely discharge the liability of the Employer for the benefits.

10.28 Rules of Interpretation

The Plan is to be administered consistent with Code Section 125. The Health Care Flexible Spending Account is to comply with the requirements of Code Sections 105 and 106 and the Dependent Care Flexible Spending Account is to comply with the requirements of Code Section 129. The Plan Administrator has absolute discretionary authority to control and manage the operation and administration of the Plan, to correct errors, and to construe and interpret Plan provisions including, but not limited to, determinations regarding eligibility and benefits. All decisions and interpretations of the Plan Administrator shall be conclusive and binding upon all person,and shall be given the greatest deference permitted by law.

10.29 Entire Plan

The Plan document, and the documents incorporated by reference herein, will constitute the only legally governing documents for the Plan. All statements made by any Employer or Administrator will be deemed representations and not warranties. No oral statement or other communication will void or reduce coverage under the Plan, or amend or modify the terms of the Plan, or be used in defense to a claim, unless in writing signed by the Administrator.

ARTICLE XI
AMENDMENT AND TERMINATION

11.1 Amendment

The Plan Sponsor, Plan Administrator, or its authorized delegate, may amend any or all of the provisions of the Plan, any Benefit Program, or any contract providing benefits without the consent of any Employee, Participant or Participating Employer at any time. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment complies with federal, state or local laws, statutes or regulations.

The Plan Sponsor, or its authorized delegate, may also remove or change any insurance company or health maintenance organization at any time.

11.2 Termination

A Participating Employer, or its authorized delegate, may terminate or partially terminate its participation in the Plan, or any Benefit Program, over which it has administrative discretion, or reduce or discontinue its Employer contributions at any time consistent with federal, state or local laws, statutes, regulations and the San Francisco Health Service System Rules. Any such decision by a Participating Employer shall be evidenced in writing by the governing body of the Participating Employer (or its delegate) that shall be filed with the Health Service Board no later than April 1 of the year prior to the effective date of the termination. When a termination resolution is provided, it must be sent to the Health Service System and it will, irrevocably, terminate such coverage for the applicable Participating Employer's employees, dependents, and retirees effective the end of the Plan Year in which the notice is provided. In addition, the Participating Employer will not be eligible to resume participation for five (5) Plan Years after the effective date of its termination of participation. The Health Service Board, in its sole discretion, may waive or reduce the time period referenced in this paragraph. Notwithstanding any other provision of this Plan, the Health Service Board, or the authorized delegate, may terminate or partially terminate the Plan or any Benefit Program, or reduce or discontinue Employer contributions at any time consistent with federal, state, or local laws, statutes, regulations, and Health Service System Rules, and without the consent of any Employee, Participant or Participating Employer.

ARTICLE XII
EXECUTION

In Witness Whereof, the San Francisco Health Service System has caused this amended and restated City and County of San Francisco Section 125 Cafeteria Plan document to be duly executed effective as of January 1, 2025.

By: Abbie Yant Executive Director
San Francisco Health Service System

APPENDIX A

PREMIUM CONVERSION

BENEFIT COMPONENT

OF THE

CITY AND COUNTY OF SAN FRANCISCO SECTION 125 CAFETERIA PLAN

SECTION A1
GENERAL

Except to the extent provided otherwise in this Appendix or in the Plan, the Premium Conversion Benefit Component incorporates by reference all the provisions of the Plan.

SECTION A2
ELIGIBILITY AND PARTICIPATION

The election by an Eligible Employee must include an election to be covered by a Benefit Program that results in a Salary Reduction. Each Participant will be deemed to have made a written Salary Reduction Election to have their annual Compensation reduced, but not below zero, by the amount of the Benefit Program Premiums the Participant is required to pay. Each Participating Employer shall determine which Benefit Programs under the Premium Conversion Benefit Component are available for their respective Eligible Employees.

SECTION A3
BENEFITS

A3.1 Plan Benefits

Salary Reduction amounts shall be applied to pay the amount of any Benefit Program Premium for Employee and/or Dependent coverage otherwise payable by a Participant each payroll period during the Period of Coverage.

A3.2 Limit on the Amount of Salary Reduction to be credited to the Premium Conversion Benefit Component

The total annual benefit under the Premium Conversion Benefit Component for a Participant shall not exceed the total of all Benefit Program Premiums for Benefit Programs in which the Participant is enrolled.

APPENDIX B

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HEALTH CARE FSA)

BENEFIT COMPONENT

OF THE

CITY AND COUNTY OF SAN FRANCISCO SECTION 125 CAFETERIA PLAN

SECTION B1
GENERAL

Except to the extent provided otherwise in this Appendix or in the Plan, the Health Care Flexible Spending Account (Health Care FSA) incorporates by reference all the provisions of the Plan.

B1.1 Establishment of Plan

(a) This Health Care Flexible Spending Account Plan is intended to qualify as a medical reimbursement plan under Code Section 105, and shall be interpreted in a manner consistent with Code Section 105 and the Treasury regulations thereunder.

(b) Participants who elect to participate in this Health Care Flexible Spending Account Plan may submit claims for the reimbursement of medical expenses. All such amounts reimbursed under this Health Care Flexible Spending Account Plan shall be paid from amounts allocated to the Participant's Health Care Flexible Spending Account.

SECTION B2
DEFINITIONS

Definitions in the Plan apply to this Health Care FSA, with the following additions:

B2.1 Eligible Dependent

"Eligible Dependent" means a Participant's Eligible Spouse, Eligible Domestic Partner and/or Eligible Child provided such individual also qualifies for tax-free health coverage under the Code.

B2.2 Medical Expense

"Medical Expense" means an amount paid for medical care (including dental care, vision care and non-prescription drugs) within the meaning of Code Section 213(d) and as allowed under Code Sections 105 and 106(f) and the rulings, and Treasury regulations, thereunder and as updated from time to time by the Internal Revenue Service.

B.2.3 Qualifying Medical Expense

"Qualifying Medical Expense" means a Medical Expense for which the Participant or any Eligible Dependent has not been reimbursed, and which has been incurred and paid for by the Participant or by a Participant's Dependent. The Participant or Eligible Dependent must have a legal obligation to pay the expense, and the expense must not be eligible for reimbursement through insurance or otherwise. Qualifying Medical Expenses do not include:

(a) Premiums paid by a Participant, or an Eligible Dependent, for coverage under any group health plan or under an individual plan/policy; or

(b) Premiums paid by a Participant or a Dependent for long term care benefits described in Code Section 7702B(c) or coverage for any product which is advertised, marketed, or offered as long-term care insurance; or,

SECTION B3
BENEFITS

B3.1 Maximum Contribution and Uniform Benefit

(a) Maximum Contribution

(1) Period of Coverage effective on first day of Plan Year

a. The Maximum Contribution for an Eligible Employee whose participation becomes effective on the first day of the Plan Year shall not exceed $3,200 during a Period of Coverage.

(b) Pursuant to the "uniform benefit rule", the Maximum Contribution elected by the Participant under the Health Care FSA shall be available at all times during the Period of Coverage (properly reduced as of any particular time for prior reimbursements for the same Period of Coverage).

B3.2 Minimum Contribution

The Minimum Contribution shall be no less than $10 per pay period for a Participant during the Period of Coverage.

B3.3 Health Care Flexible Spending Accounts

The Plan Administrator shall establish a Health Care Flexible Spending Account for each Participant who elects to participate in the Health Care Flexible Spending Account. The Health Care Flexible Spending Account shall be for bookkeeping purposes only, and except as otherwise required by law, amounts credited to a Participant's Health Care Flexible Spending Account shall remain a part of the Employer's general assets.

B3.6 Forfeiture of Unused Balances – Use or Lose Rule and Carryover

The amount in a Participant's Health Care Flexible Spending Account at the end of any Plan year, and after the processing of all claims for such Plan Year, shall be forfeited and may be used as described in the Plan provisions related to Experience Gains in Section 7.5. In such event, the Participant shall have no further claim to such amount for any reason.

Members who elected a Health Care FSA with a remaining balance will be permitted to 'carryover' to the immediately following plan year between a minimum of $10 and a maximum of $640 of any amount remaining unused. Carryover is defined as Health Care FSA balance remaining after the run-out period of the plan year that the member elects to transfer to the next plan year Health Care FSA, up to $640. The carryover amount is moved into the Health Care FSA balance for the next plan year. Carryover

funds are available for one plan year only. Any unused carryover funds will be forfeited at the end of the plan year. In addition, the carryover of up to $640 does not count against or otherwise affect the indexed salary reduction limit applicable to each plan year.

The Carryover of between a minimum of $10 and a maximum of $640 may be used to pay or reimburse medical expenses under the Health Care FSA incurred during the entire plan year to which it is carried over. For this purpose, the amount remaining unused carryover funds as of the end of the plan year is the amount unused after medical expenses have been reimbursed at the end of the plan's run-out period for the plan year.

B3.7 Military Reservist Distributions

A Participant ordered or called to active military duty (by reason of being a member of a reserve component as defined in section 101 of title 37, United States Code) for a period in excess of 179 days, or for an indefinite period of time, may elect to receive a Qualified Military Reservist Distribution as defined in Code Section 125(h)(2). The Qualified Military Reservist Distribution must be made on or after the date of the call, or order, to active military service, and prior to three calendar months after the end of the Plan Year in which the call or order to active military duty occurred.

(a) No Qualified Military Reservist Distribution shall be made to a Participant electing to continue Health Care FSA participation under Sections 3.3, 3.4 or 3.6.

(b) Participants may receive a Qualified Military Reservist Distribution by submitting a written request to the Plan Administrator, or its designee, prior to three calendar months after the end of the Plan Year in which the Participant was ordered or called to active military duty.

(c) A Participant electing to receive a Qualified Reservist Distribution shall terminate participation in the Health Care FSA on the date that the Participant makes such election. Such a former Participant may again participate in the Health Care FSA when they again becomes an Eligible Employee.

SECTION B4
CLAIMS DEADLINE

B4.1 Health Care Flexible Spending Account Claims

Claims under the Health Care FSA must be submitted pursuant to procedures established by the Plan Administrator, or its delegate, and no later than March 31 following the close of the Plan Year in which the costs were incurred, as the case may be. Claims must be supported by documentation requested by the Plan Administrator.

SECTION B5
TERMINATION OF PARTICIPATION

B5.1 Termination of Participation

Participation in this Health Care FSA shall terminate on the earliest of:

(a) The date of termination of the Plan, unless otherwise communicated to Participants;

(b) The date on which the Participant fails to be an Eligible Employee;

(c) The date on which the Participant fails to make any required Health Care FSA Contribution; or

(d) The end of the Plan Year.

SECTION B6
CONTINUATION OF COVERAGE

B6.1 Qualified Beneficiary

Only Qualified Beneficiaries as, defined by 26 CFR § 54.4980B-3, may elect continuation coverage under the Plan after a Qualifying Life Event.

B6.2 Qualifying Events

The right to continued coverage is triggered by any of the following Qualifying Life Events, which, but for the continued coverage, would result in a loss of coverage under the Plan. For purposes of this Article, a "Qualifying Life Event" occurs upon:

(a) The death of the Covered Employee;

(b) The termination (other than by reason of gross misconduct) of the Covered Employee's employment, or reduction of hours of a Covered Employee that would result in a termination of coverage under the Plan;

(c) The divorce or legal separation of the Covered Employee from the Covered Employee's Eligible Spouse;

(d) The Covered Employee becoming entitled to Medicare benefits; or

(e) An eligible Child of the Covered Employee ceasing to be a dependent child under the eligibility requirements.

B6.3 Election of Continuation Coverage

Continuation coverage does not begin unless it is elected by a Qualified Beneficiary. The election period shall begin on or before the date that the Qualified Beneficiary would lose coverage under the Plan due to the Qualifying Life Event, and shall not end before the date that is sixty (60) days after the later of: (a) the date the Qualified Beneficiary would lose coverage due to the Qualifying Life Event; or (b) the date on which notice of the right to continued coverage is sent by the Plan Administrator or its designee. The election of continuation coverage must be made on a form provided by the Plan

Administrator or its designee and payment for coverage, as described in the notice, must be made when due. An election is considered to be made on the date it is sent to the Plan Administrator or its designee. Each Qualified Beneficiary who loses coverage as a result of a Qualifying Life Event shall have an independent right to elect continuation coverage, regardless of whether any other Qualified Beneficiary with respect to the same Qualifying Event elects continuation coverage.

Qualified Beneficiaries will not be offered an election to continue coverage under the Health Care FSA if, as of the date of the Qualifying Life Event, the amount remaining in the Health Care FSA for reimbursements is less than the amount that the Qualified Beneficiary would have to pay for continuation coverage under the Health Care FSA for the remainder of the Plan Year in which the Qualifying Life Event occurs. In determining the amount remaining in a Health Care FSA as of the date of a Qualifying Life Event, the claim reviewer will take the full amount credited to a Health Care FSA at the beginning of the Plan Year and subtract all of the reimbursements made from the Health Care FSA as of the date of the Qualifying Life Event. For example, assume that a Participant elected $1,200 at the beginning of the Plan Year and then terminated employment on June 30. Prior to June 30, the Participant was reimbursed for $1,000 in Qualifying Medical Expenses from their Health Care FSA. The Participant would not be offered continuation coverage because they would have to pay $612 in COBRA premiums for the rest of the Plan Year ($100 per month from July through December, plus a 2% administrative fee), but the Participant would only be able to receive another $200 in Qualified Medical Expense reimbursements (the $1,200 annual election reduced by the $1,000 in Qualified Medical Expense reimbursements the Participant received before the Qualifying LifeEvent).

B6.4 Period of Continuation Coverage

COBRA coverage under the Health Care FSA shall extend only until the end of the Plan Year in which the Qualified Beneficiary's Qualifying Life Event occurs.

B6.5 End of Continuation Coverage

Continuation coverage shall end earlier than the period designated under Section B6.4 (above) if:

(a) Timely payment of premiums for the continuation coverage is not made;

(b) The Qualified Beneficiary first becomes covered under any other group health plan, after the COBRA election, as an employee or otherwise, unless such other plan contains a limitation (other than a limitation which does not apply by virtue of HIPAA) with respect to any pre-existing condition of the Qualified Beneficiary;

(c) The Qualified Beneficiary first becomes entitled to benefits under Medicare, after the COBRA election;

(d) The Employer ceases to provide any group health plan to any Employee;

(e) The Qualified Beneficiary ceases to be disabled, if continuation coverage is due to the disability;

(f) The period of continuation coverage expires; or

(g) As provided under Section 6.2

Notwithstanding the foregoing, the Plan may also terminate the continuation coverage of a Qualified Beneficiary for cause on the same basis that the Plan could terminate the coverage of a similarly situated non-COBRA beneficiary for cause (e.g., in the case of submitting fraudulent claims to the Plan).

B6.6 Cost of Continuation Coverage

The Qualified Beneficiary is responsible for paying the cost of continuation coverage, hereinafter referred to as "premium." The premiums are payable on a monthly basis. After a Qualifying Life Event, a notice shall be provided which shall specify the amount of the premium, to whom the premium is to be paid, and the date of each month payment is due. Failure to pay premiums on a timely basis shall result in termination of coverage as of the date the premium is due. Payment of any premium, other than that referred to below, shall only be considered to be timely if made within thirty (30) days after the date due. A premium must be paid for the cost of continuation coverage for the time period between the date of the event which triggered continuation coverage and the date continued coverage is elected. This payment must be made within forty-five (45) days after the date of election. Notice shall be given which shall specify the amount of the premium, to whom the premium is to be paid, and the date payment is due. Failure to pay this premium on the date due shall result in cancellation of coverage back to the initial date coverage would have been terminated.

B6.7 Notification of Requirements

(a) General Notice to Covered Employee and Spouse. The Plan shall provide, at the time of commencement of coverage, written notice to each Covered Employee and to the spouse of the Covered Employee (if any) of their rights to continuation coverage. The Plan may satisfy this obligation by furnishing a single notice addressed to both a Covered Employee and the Covered Employee's spouse if they both reside at the Covered Employee address, and the spouse's coverage commences on or after the date on which the Covered Employee's coverage commences, but not later than the date by which this general notice must be provided under this subparagraph (a). No separate notice is required to be sent to dependents who share a residence with a Covered Employee or a Covered Employee's spouse. This general notice shall be provided not later than the earlier of: (1) ninety (90) days after such individual's coverage commencement date under the Plan; or (2) the date on which the Plan Administrator is required to furnish a COBRA election notice as described in subparagraph (d) of this Section.

(b) Employer Notice to Plan Administrator. The Employer shall notify the Plan Administrator or its designee in the event of a Covered Employee's: (1) death; (2) termination of employment (other than gross misconduct); (3) reduction in hours; or (4) entitlement to Medicare benefits, within thirty (30) days after the date of the Qualifying Event.

(c) Covered Employee/Qualified Beneficiary Notice to Plan Administrator. The Covered Employee or Qualified Beneficiary must notify the Plan Administrator or its designee of: (1) a divorce or legal separation of the Covered Employee from the Covered Employee's spouse, as applicable; (2) a dependent ceasing to be a dependent under

the eligibility requirements of the Plan; or (3) a second Qualifying Life Event. Notification must occur as soon as possible, and for events under (1), (2) or (3) above, such notice must occur not later than sixty (60) days after the later of: (1) the date of such Qualifying Life Event; (2) the date that the Qualified Beneficiary loses or would lose coverage due to such Qualifying Event; or (3) the date on which the Qualified Beneficiary is informed, via the Plan's summary or the general COBRA notice, of the Qualified Beneficiary's obligation to provide such notice and the Plan procedures for providing such notice.

The Covered Employee, Qualified Beneficiary, or a representative acting on behalf of the Covered Employee or Qualified Beneficiary, may provide such notice. The provisions of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Life Event. Failure to provide such timely notice shall result in the loss of any right to elect continuation coverage.

The Plan shall establish reasonable procedures for the furnishing of the notice described above and shall publish such procedures in the Plan's summary. A Qualified Beneficiary's failure to follow such procedures within the times prescribed above shall result in a denial of continuation coverage.

(d) Plan Administrator Notice to Qualified Beneficiary. Upon receipt of a notice of a Qualifying Life Event under subsections (b) or (c), the Plan Administrator, or its designee, shall provide to each Qualified Beneficiary notice of their right to elect continuation coverage, no later than fourteen (14) days after the date on which the Plan Administrator, or its designee, received notice of these the Qualifying Life Event. Any notification to a Qualified Beneficiary who is the spouse of the Covered Employee shall be treated as a notification to all other Qualified Beneficiaries residing with such spouse at the time such notification is made.

Unavailability of Coverage. If the Plan Administrator, or its designee, receives a notice of an applicable Qualifying Life Event under subsection ©, and determines that the person is not entitled to continuation coverage, the Plan Administrator shall notify the person with an explanation as to why such coverage is not available within the time frame designated under subsection (d) above.

(e) Notice of Termination of Coverage. The Plan Administrator, or its designee, shall provide notice to each Qualified Beneficiary of any termination of continuation coverage which is effective earlier than the end of the maximum period of continuation coverage applicable to such Qualifying Life Event as soon as practicable following the Plan Administrator’s determination that continuation coverage should terminate.

Use of a Single Notice. Notices required under subsections (d), €, and (f) must be provided to each Qualified Beneficiary or individual; however, (1) a single notice can be provided to the Covered Employee and the Covered Employee’s spouse if the Covered Employee spouse resides with the Covered Employee, and/or (2) a single notice can be provided to the Covered Employee, or the Covered Employee’s spouse for a dependent child of the Covered Employee, if the dependent child resides with the Covered Employee or the Covered Employee’s spouse (as applicable).

B6.8 Continuation Health Benefits Provided

The continuation coverage provided to a Qualified Beneficiary who elects continued coverage shall be identical to the coverage provided under the Health Care FSA under the Plan to similarly situated persons covered by the Plan with respect to whom a Qualifying Life Event has not occurred. If coverage is modified under the Health Care FSA under the Plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are Qualified Beneficiaries under the Flexible Spending Account under the Plan. Continuation coverage may not be conditioned on evidence of good health. If the Plan provides an Open Enrollment period during which similarly situated active employees may choose to be covered under the Health Care FSA of the Plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to Qualified Beneficiaries who have elected continuation coverage.

B6.9 Bankruptcy Proceedings

Special continuation coverage provisions apply in the event of bankruptcy of the Employer. Notwithstanding any of the preceding Sections, in the event of a bankruptcy proceeding under Title XI of the United States Code, where a loss of coverage or substantial elimination of coverage occurs with respect to a Covered Employee who had retired on or before the date of the loss or substantial elimination of coverage (and any other individual who, on the day before the bankruptcy proceeding, is a beneficiary under the Plan as a spouse, dependent child, or surviving spouse of a Covered Employee) within one (1) year before or after the date of the commencement of the bankruptcy proceeding, continuation coverage shall be provided under the Health Care FSA of the Plan to the extent required under Code Section 4980B.

APPENDIX C

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

BENEFIT COMPONENT

OF THE

CITY AND COUNTY OF SAN FRANCISCO SECTION 125 CAFETERIA PLAN

SECTION C1
GENERAL

Except to the extent provided otherwise in this Appendix or in the Plan, the Dependent Care Flexible Spending Account (Dependent Care FSA) incorporates by reference all the provisions of the Plan.

C1.1 Establishment of Dependent Care Flexible Spending Account

(a) This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 for the reimbursement of employment-related dependent care expenses and shall be interpreted in a manner consistent with Code Section 129.

(b) Participants who elect to participate in this program may submit claims for the reimbursement of employment-related dependent care expenses. All such amounts shall be reimbursed under this Dependent Care FSA program.

C1.2 Report to Participants On or Before January 31 of Each Year

On or before January 31 of each year, the Plan Administrator or its designee shall furnish to each Participant who has received reimbursements under the Dependent Care FSA during the prior calendar year, a written statement showing the amount of all Dependent Care FSA during the prior calendar year, a written statement showing the amount of all Dependent Care FSA reimbursements paid to or on behalf of the participant during the prior calendar year. Pursuant to Internal Revenue Service guidance, this written statement requirement may be satisfied, at the discretion of the Plan Administrator, by reporting the amount of Dependent Care FSA reimbursements on Form W-2.

SECTION C2
DEFINITIONS

Definitions in the Plan apply to this Dependent Care FSA, with the following additions:

C2.1 Dependent

“Dependent” means a "qualifying individual," as defined in Code Section 21(b).

C2.2 Dependent Care Service Provider

“Dependent Care Service Provider” means a person who provides care or other dependent care services, which qualify for the federal tax credit under Code Section 21, but shall not include: (a) a dependent care center (as defined in Code Section 21(b)(2)(D)) unless the requirements of Code Section 21(b)(2)(C) are satisfied; or (b) a related individual as described in Code Section 129(c).

C2.3 Qualifying Dependent Care Expenses

“Qualifying Dependent Care Expenses” means any dependent care expenses incurred by a Participant for dependent care services which qualify for the federal tax credit under

Code Section 21, and which have been incurred by or on behalf of a Participant, or Dependent, during a Period of Coverage. Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

SECTION C3
BENEFITS

C3.1 Maximum Contribution

For a calendar year, Dependent Care FSA Contributions, combined with any other dependent care assistance received through an employment-related plan by the Participant, or their spouse or registered domestic partner, may not exceed the lesser of:

(a) $5,000 ($2,500 if the Participant is married and files a federal income tax return for the calendar year separately from their spouse); or

(b) The Participant's actual or deemed Earned Income, as defined in Code Section 32(c)(2), after all reductions in Compensation including the reduction related to participation in the Dependent Care Flexible Spending Account; or

(c) The Earned Income of the Participant's spouse, if the Participant is married. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of care for themselves, such spouse shall be deemed to have earned income of not less than $250 per month if the Eligible Employee has one Dependent, and $500 per month if the Eligible Employee has two or more Dependents.

C3.2 Marital Status Determination

The determination as to the marital status of a Participant shall be made as of the close of the Plan Year.

C3.3 No Uniform Benefit

The Maximum Contribution elected by the Participant under the Dependent Care FSA shall not be available at all times during the Period of Coverage. Instead, at any time during the Period of Coverage, only the amount of the actual Contributions shall be available for reimbursement.

C3.4 Minimum Contribution

The Minimum Contribution shall be no less than $10 per pay period for a Participant during the Period of Coverage.

C3.5 Dependent Care Flexible Spending Account

The Plan Administrator shall establish a Dependent Care Flexible Spending for each Participant who elects to participate in the Dependent Care FSA program.

C3.6 Forfeitures

The amount in a Participant's Dependent Care FSA as of the end of any Plan year, and after the processing of all claims for such Plan Year, shall be forfeited and may be used as described in the Plan provisions related to Experience Gains in Section 7.5. In such event, the Participant shall have no further claim to such amount for any reason.

SECTION C4
CLAIMS DEADLINE

Claims under the Dependent Care FSA must be submitted pursuant to procedures established by the Plan Administrator, or its delegate, no later than March 31 following the close of the Plan Year in which the costs were incurred. Claims must be supported by documentation requested by the Plan Administrator.

SECTION C5
TERMINATION OF PARTICIPATION

C5.1 Termination of Participation

Participation in this Dependent Care FSA shall terminate on the earliest of:

(a) The date of termination of the Plan, unless otherwise communicated to Participants;

(b) The date on which the Participant fails to be an Eligible Employee;

(c) The date on which the Participant fails to make any required FSA contribution; or

(d) The end of the Plan Year.

APPENDIX D

FLEXIBLE CREDITS BENEFIT COMPONENT

OF THE

CITY AND COUNTY OF SAN FRANCISCO SECTION 125 CAFETERIA PLAN

FOR

CERTAIN "FLEXIBLE BENEFITS ELIGIBLE EMPLOYEES"

SECTION D1
GENERAL

Except to the extent provided otherwise in this Appendix, or in the Plan, the Flexible Credits Benefit Component incorporates by reference all the provisions of the Plan.

SECTION D2
DEFINITIONS

Definitions in the Plan apply to this Flexible Credits Benefit Component with the following additions:

D2.1 Flexible Credits

"Flexible Credits" means the dollar value a Flexible Credits Eligible Employee is allocated in credits in lieu of dependent coverage subsidized by the Employer to be applied to eligible Pre-Tax Benefit Options.

D2.2 Flexible Credits Eligible Employee

A "Flexible Credits Eligible Employee" is an Employee who

(a) is eligible for Municipal Executive Association benefits pursuant to an applicable Memorandum of Understanding; or

(b) is an unrepresented Employee who is determined from time to time by the City and County of San Francisco Department of Human Resources, or the Human Resources Department of the Superior Court, County of San Francisco, to be eligible for Municipal Executive Association (MEA) benefits.

D2.3 Pre-Tax Benefit Options

"Pre-Tax Benefit Options" means the pre-tax benefit options permitted under Code section 125 and available under this Plan for election by a Flexible Credits Eligible Employee using Flexible Credits.

SECTION D3
ELIGIBILITY AND PARTICIPATION

Flexible Benefits Eligible Employees shall be eligible to participate in this Flexible Credits Benefit Component.

SECTION D4
BENEFITS

D4.1 Plan Benefits

(a) Flexible Credits shall be allocated as determined by the Flexible Benefits Eligible Employee and applied to eligible Pre-Tax or Post-Tax Benefit Options.

(b) Pre-Tax and Post-Tax Benefit Options may be established, and announced from time to time, by the Employer without formal written amendment of this Plan document. The Pre-Tax Benefit Options are as provided in Appendix E.

D4.2 Dollar Value of Flexible Credits

(a) The total annual dollar value of the Flexible Credits shall be established, and announced from time to time, by the Employer without formal written amendment of this Plan document.

(b) The Plan Year 2025-dollar value of the Flexible Credits is as follows:

1. All City and County of San Francisco Flexible Credit Eligible Employees have the following amounts of Flexible Credits available to purchase from the Benefits Options as set forth in Appendix E:
    a. $418.69 in credits bi-weekly for a medically-single employee or an employee who waives medical coverage;
    b. $555.80 in credits bi-weekly for an employee with one dependent;
    c. $952.72 in credits bi-weekly for an employee with two or more dependents who selects Kaiser;
    d. $1,070.17 in credits bi-weekly for an employee with two or more dependents who selects Blue Shield Trio;
    e. $855.18 in credits biweekly for an employee with two or more dependents who selects Healthnet Canopy Care or
    f. $1,259.02 in credits biweekly for an employee with two or more dependents who selects Blue Shield Access+ or Blue Shield PPO
2. Superior Court Flexible Credit Eligible Employees: $1,490.00 in credits bi-weekly to purchase from the Benefit Options listed in Appendix E.

D4.3 Unallocated Flexible Credits

The amount of any Flexible Credits remaining (unallocated) to either pre-tax or post-tax benefits will be paid to the employee as taxable earnings each pay period.

APPENDIX E

HEALTH SERVICE SYSTEM BENEFIT PROGRAMS
As of January 1, 2025

The following are the Health Service System Benefit Programs available as of January 1, 2025. Eligibility for a particular Health Service System Benefit Program shall be as determined from time to time by the Employer without written amendment to this Plan

Pre-Tax Benefit Program	Funding	Insurer or Third Party Administrator	Policy or Contract Number
Pre-Tax Benefit Options			
Pre-Tax Medical			
Blue Shield of California Access + HMO	Flex-Funded	Blue Shield of California	W0051448
Blue Shield of California Trio HMO	Flex-Funded	Blue Shield of California	W0051448
Blue Shield of California PPO	Self-Funded	Blue Shield of California	W0051448
Blue Shield of California PPO (COB) (*Enrollment Limited to Retirees eligible for Medicare Part B Only*)	Fully Insured	Blue Shield of California	W0051448
Health Net CanopyCare HMO	Flex-Funded	Health Net	G0727A
Kaiser HMO	Fully Insured	Kaiser Permanente	888 (Northern California), 231003 (Southern California)
Kaiser HMO (*Early Retiree Plan Only*)	Fully Insured	Kaiser Permanente	10119 (Hawaii)
Kaiser HMO (*Early Retiree Plan Only*)	Fully Insured	Kaiser Permanente	21227 (Northwest)
Kaiser HMO (*Early Retiree Plan Only*)	Fully Insured	Kaiser Permanente	1665900 (Washington)
Pre-Tax Dental			
DeltaCare USA DMO	Fully Insured	Delta Dental of California	71797
Delta Dental PPO	Self-Funded	Delta Dental of California	09502
United Healthcare Dental DMO	Fully Insured	UnitedHealthcare	275550
Pre-Tax Vision			
Vision Service Basic Plan	Fully Insured	Vision Service Plan	12145878
Vision Service Premier Plan	Fully Insured	Vision Service Plan	12145878

Pre-Tax Benefit Program	Funding	Insurer or Third Party Administrator	Policy or Contract Number
Pre-Tax Benefit Options			
Pre-Tax Health Flexible Spending Account (FSA)			
Health Flexible Spending Account	Self-Funded	P&A Group	N/A
Pre-Tax Employer Paid Long Term Disability Insurance			
Long Term Disability Insurance	Fully Insured (Voluntary)	P&A Group	804927
Pre-Tax Employer Paid Long Term Disability Insurance			
Long Term Disability Insurance	Fully Insured	The Hartford	804927
Pre-Tax Employer Paid Group Term Life Insurance			
Group Term Life Insurance	Fully Insured	The Hartford	804927

Post-Tax Benefit Program	Funding	Insurer or Third Party Administrator	Policy or Contract Number
Post-Tax Benefit Options			
Post-Tax Accident Insurance			
Accident Insurance	Fully Insured (Voluntary)	Workterra - MetLife	0229012
Post-Tax Critical Illness			
Critical Illness	Fully Insured (Voluntary)	Workterra – Met Life	0229012
Post-Tax Group Supplemental Life Insurance			
Supplemental Life Insurance and AD&D up to $500,000 Supplemental Dependent Spouse Life Insurance and AD&D Supplemental Dependent Child Life Insurance	Fully Insured (Voluntary)	Workterra- The Hartford	GP-839201
Lifetime Benefit Group Term Life Insurance with Accelerated Death Benefit for Long-Term Care	Fully Insured (Voluntary)	Workterra - Combined/Chubb	Group Policy Number: PYS-LBT - Unique to each member
Post-Tax Identity Theft Protection			
Identity Theft Protection	Fully Insured (Voluntary)	Workterra -Allstate	5105

Post-Tax Benefit Program	Funding	Insurer or Third Party Administrator	Policy or Contract Number
Post-Tax Benefit Options			
Post-Tax Pet Insurance			
Pet Insurance	Fully Insured (Voluntary)	Workterra -PetsBest	Group number 5951526 - Unique to each member
Post-Tax Short Term Disability			
Short Term Disability	Fully Insured (Voluntary)	Workterra-Manhattan Life	01758 s/b 890641
Post-Tax Legal & Identity Theft Protection			
Legal & Identity Theft Protection	Fully Insured (Voluntary)	Workterra-LegalShield	43909

APPENDIX F

HEALTH SERVICE SYSTEM RULES

The Health Service System Rules, as approved by the Health Service System Board and posted on http://www.sfhss.org/ and as they may be amended from time to time, are hereby incorporated by reference without further amendment to this document.