SAN FRANCISCO HEALTH SERVICE SYSTEM
OTHER EMPLOYEE BENEFIT TRUST FUND

Financial Statements and
Required Supplementary Information
(With Independent Auditor's Reports Thereon)

Years Ended June 30, 2026 and 2025

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Independent Auditor's Report

Members of the Health Service Board,
Honorable Mayor and Members of the Board of Supervisors
City and County of San Francisco, California

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of the San Francisco Health Service System Other Employee Benefit Trust Fund (the Trust), managed by Health Service System (the System), a department of the City and County of San Francisco, California (the City), as of and for the years ended June 30, 2026, and 2025, and the related notes to the financial statements, which collectively comprise the Trust's basic financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the fiduciary net position of the San Francisco Health Service System Other Employee Benefit Trust Fund as of June 30, 2026, and 2025, and the changes in its fiduciary net position for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the System and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

The System's management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the System's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Trust's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis as listed in the table of contents be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated October 23, 2026, on our consideration of the System's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the System's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the System's internal control over financial reporting and compliance.

Macias Gini & O'Connell LLP

Walnut Creek, California
October 23, 2026

SAN FRANCISCO HEALTH SERVICE SYSTEM
OTHER EMPLOYEE BENEFIT TRUST FUND
Management's Discussion and Analysis (Unaudited)
Years Ended June 30, 2026, and 2025

The management of the San Francisco Health Service System (the System), a department of the City and County of San Francisco (the City), is pleased to provide this overview and analysis of the financial performance of the San Francisco Health Service System Other Employee Benefit Trust Fund (the Trust) as of and for the years ended June 30, 2026, and 2025. We encourage readers to consider the information presented below in conjunction with the financial statements and notes, which follow.

The Trust is reflected as an Other Employee Benefit Trust Fund in the City's Annual Comprehensive Financial Report (ACFR or Annual Report). The Trust is distinguished from the City's Retiree Health Care Trust Fund in that it pays for the employee and retiree current benefits.

The System is the primary purchaser and administrator of health, dental, and other non-retirement/pension benefits for employees and retirees (and their respective eligible dependents) of the City, the San Francisco Unified School District, the San Francisco Community College District, and the San Francisco Superior Court. The members covered by the System increased by 0.1% from 72,880 as of June 30, 2025, to 72,929 as of June 30, 2026. The System is governed by the Health Service Board (HSB) as described in note 1 to the financial statements.

Medical benefits during the fiscal years are provided to members of the System through eight plan choices:

- United Healthcare (UHC) administered self-insured Preferred Provider Organization (PPO) (UHC PPO Companion Plan)
- United Healthcare (UHC) fully insured Medicare Advantage Prescription Drug PPO (UHC MAPD)
- Kaiser Permanente fully insured Health Maintenance Organization (HMO)
- Kaiser Permanente fully insured Senior Advantage, a Medicare Advantage Health Maintenance Organization Plan (HMO)
- Blue Shield of California Access+ (flex-funded plans with fully insured, capitated components for professional services, provider services, and self-insured components including claims)
- Blue Shield of California Trio HMO Plan (flex funded plans with fully-insured, capitated components for professional services, provider services, and self-insured components including claims)
- Blue Shield of California self-insured PPO Accolade Plan (Blue Shield PPO)
- Health Net CanopyCare HMO (flex-funded plan with fully insured, capitated component for professional services provider services, and self-insured components including claims)

Each of the above plan choices includes a basic vision benefit provided through Vision Service Plan (VSP). There is also a fully employee-paid Premium Vision Plan option available.

The UHC PPO (previously called the City Health Plan), and Blue Shield PPO (initiated on January 1, 2022) which include medical and prescription drug benefits, is a self-insured indemnity plan for active and early retired members and their dependents where the risk of loss due to claims in excess of revenues is borne by the Trust. The UHC MAPD also includes medical and prescription drug benefits and is a fully insured PPO plan for Medicare eligible members and their dependents.

The Kaiser Permanente HMO plan, for active and early retired members and their dependents, is a traditional, fully insured, HMO, where the risk of loss due to excess claims for a given fiscal year is borne by the HMO. The Kaiser Permanente Senior Advantage HMO plan is a fully insured plan for Medicare eligible members and their dependents.

The Blue Shield of California Access+ HMO and Trio HMO Plans are flex-funded plans. The flex-funded plans have a fully insured, capitated component for professional provider services. Hospital and pharmacy services are self-insured, where the risk of loss due to claims in excess of revenues is borne by the Trust. Effective January 1, 2018, Blue Shield of California began offering two plan choices. In addition to the broad Blue Shield network of doctors (Access+), members of the System can select a narrower network of doctors (Trio) and hospitals at a lower premium.

Dental benefits during the fiscal years are provided through three plan choices:

- Delta Dental PPO a dental Preferred Provider Organization
- Delta Care (PMI, DHMO) a Dental Health Maintenance Organization
- United Healthcare Dental (formerly known as Pacific Union) (DHMO).

The Delta Dental (PPO) plan provided to active employees is a self-insured indemnity plan, administered by Delta Dental. Similar to the City Health Plan, however, the risk of loss due to claims in excess of revenues is borne by the Trust. The Delta Dental (PPO) plan offered to retired employees is a fully insured plan, where the risk of loss for a given fiscal year is borne by Delta Dental. The Delta Care (PMI, DHMO) dental plan and United Healthcare Dental (DHMO) plan are managed care dental plans and are fully insured with respect to both active and retired employees.

Overview of Financial Statements

The following discussion is intended to serve as an introduction to the Trust's financial statements, which consist of the statements of net position available for health benefits, the statements of changes in net position available for health benefits, and notes to financial statements:

- The statements of net position available for health benefits are a snapshot of account balances as of June 30, 2026 and 2025. These statements show assets, liabilities, and net position available for health benefits as of those dates.
- The statements of changes in net position available for health benefits show additions and deductions to the Trust's net position during the fiscal years ended June 30, 2026, and 2025.

- Notes to the basic financial statements provide additional information that is essential to a full understanding of the numbers in the financial statements.

The financial statements and accompanying notes are presented in all material respects in accordance with the basis of accounting and accounting principles, as explained in note 2 to the basic financial statements. The Trust presents basic financial statements reflecting full accrual basis accounting.

Financial Analysis – Condensed Schedule of Net Position Available for Health Benefits

As of June 30, 2026, there was $72.0 million in net position available to meet future health care obligations. This compares to $101.6 million as of June 30, 2025 and $109.3 million as of June 30, 2024.

				2026 - 2025		2025 - 2024	
	2026	2025	2024	Dollar Change	Percent Change	Dollar Change	Percent Change
Total assets	$ 240,231,707	$ 247,087,912	$ 156,625,311	$ (6,856,205)	-2.8%	$ 90,462,601	57.8%
Total liabilities	168,250,696	145,506,915	47,305,536	22,743,781	15.6%	98,201,379	207.6%
Net position	$ 71,981,011	$ 101,580,997	$ 109,319,775	$ (29,599,986)	-29.1%	$ (7,738,778)	-7.1%

Fiscal Year 2026

The net position available for health benefits decreased by $29.6 million in 2026. The components of the decreases are:

- $14.4 million decrease in the UHC PPO and Blue Shield PPO net position was primarily due to excess claim costs over premium equivalents of $16.1 million, use of claim stabilization, per HSB approved policy, of $3.4 million, offset by pharmacy rebates of $5.1 million.
- $22.4 million decrease in the Blue Shield flex-funded plan net position was due to excess claim costs over premium equivalents of $60.5 million, offset by an increase in claim stabilization funding, per HSB approved policy, of $7.8 million, and pharmacy rebates of $30.3 million.
- $2.3 million decrease in the dental plans' net position was primarily due to use of claim stabilization, per HSB approved policy, of $3.7 million.
- $2.3 million increase in Kaiser plan net position was based on pay calendars for the San Francisco Unified School District, and the San Francisco Community College District; contractual provisions governing the timing of premium payments; and members moving from active to retiree and from non-Medicare to Medicare status.
- $0.6 million decrease in HealthNet HMO net position due to excess claim costs over premium equivalents of $0.7 million, and use of claim stabilization, per HSB approved policy, of $0.6 million, offset by pharmacy rebates of $0.7 million.
- $1.2 million increase in administrative cost due to spending more on communications, wellness programs, and actuarial work.

- $1.3 million increase in flexible spending account employee contributions over claim reimbursements to participants.
- $5.2 million increase in Trust Fund investment earnings.
- $0.1 million increase in plan provider penalties, forfeitures, and settlements due to providers not meeting their minimum performance metric guarantees per their contracts

Fiscal Year 2025

The net position available for health benefits decreased by $7.7 million in 2025. The components of the decreases are:

- $2.4 million increase in the UHC PPO and Blue Shield PPO net position was primarily due to pharmacy rebates of $4.8 million.
- $12.0 million decrease in the Blue Shield flex-funded plan net position was due to excess claim costs over premium equivalents of $40.1 million and use of claim stabilization funding, per HSB approved policy, of $0.7 million, offset by pharmacy rebates of $28.8 million.
- $6.3 million decrease in the dental plans' net position was primarily due to use of claim stabilization, per HSB approved policy, of $6.7 million.
- $0.1 million increase in Kaiser plan net position was based on pay calendars for the San Francisco Unified School District, and the San Francisco Community College District; contractual provisions governing the timing of premium payments; and members moving from active to retiree and from non-Medicare to Medicare status.
- $0.7 million increase in HealthNet HMO net position due to excess premium equivalents over claim costs.
- $0.2 million decrease in administrative savings due to spending more on communications, wellness programs, and actuarial work.
- $0.3 million decrease in flexible spending account employee contributions over claim reimbursements to participants.
- $7.6 million increase in Trust Fund investment earnings.
- $0.3 million increase in plan provider penalties, forfeitures, and settlements due to providers not meeting their minimum performance metric guarantees per their contract and receipt of Sutter settlement distribution.

Fiscal Year 2026

- Cash and investments held with the City Treasurer as of June 30, 2026, totaled $189.5 million compared to $164.3 million as of June 30, 2025, an increase of 15.3 percent. The cash and investment balance fluctuated throughout the year depending on collections, claims, and timing of vendor payments. In addition, pursuant to the HSB Self-Insured Stabilization policy, $8.7 million was used to reduce 2025 and 2026 rates as described in note 6(b).

- Contributions receivable from employer decreased from $52.1 million as of June 30, 2025, to $29.6 million as of June 30, 2026, a 43.2 percent decrease. Contributions receivable from employees decreased from $10.5 million, as of June 30, 2025, to $6.8 million as of June 30, 2026, a 35.6 percent decrease. These changes were due to the timing of health premium collections from both employers and the employees.
- Other receivables and assets decreased from $18.6 million as of June 30, 2025, to $13.0 million as of June 30, 2026, a 30.1 percent decrease, mainly due to a decrease in pharmacy rebates receivable.
- Reserves for claims under Blue Shield flex and self-funded plans, Health Net, and Delta Dental were $48.8 million as of June 30, 2026, and $39.0 million as of June 30, 2025. The increase was mainly due to an increase in estimated Blue Shield claims. The reserve was actuarially determined.
- Premiums payable to HMO, dental, and disability plans increased by 15.3 percent, from $73.2 million as of June 30, 2025, to $84.3 million as of June 30, 2026. The increase was due to the timing of payments to health care providers for payments after the end of the fiscal year for the prior fiscal year.
- Unearned contributions represent health contributions received in advance of the period of benefit coverage. Unearned contributions totaled $35.2 million as of June 30, 2026, and $33.3 million as of June 30, 2025. This increase was due to the timing of health premium collections from both employers and the employees for July 2026 coverage.

Fiscal Year 2025

- Cash and investments held with the City Treasurer as of June 30, 2025, totaled $164.3 million compared to $116.8 million as of June 30, 2024, an increase of 40.8 percent. The cash and investment balance fluctuated throughout the year depending on collections, claims, and timing of vendor payments. In addition, pursuant to the HSB Self-Insured Stabilization policy, $1.1 million was used to reduce 2024 and 2025 rates as described in note 6(b).
- Contributions receivable from employer increased from $25.5 million as of June 30, 2024, to $52.1 million as of June 30, 2025, a 104.5 percent increase. Contributions receivable from employees increased from $5.3 million, as of June 30, 2024, to $10.5 million as of June 30, 2025, a 99.4 percent increase. These changes were due to the timing of health premium collections from both employers and the employees.
- Other receivables and assets increased from $7.4 million as of June 30, 2024, to $18.6 million as of June 30, 2025, a 152.0 percent increase. In 2025, increase in other receivables and assets was mainly due to an increase of $11.2 million in pharmacy rebates receivable from the prior year.
- Reserves for claims under UHC, Blue Shield flex and self-funded plans, Health Net, and Delta Dental were $39.0 million as of June 30, 2025, and $36.5 million as of June 30, 2024. The increase was mainly due to an increase in estimated Blue Shield Access+ claims. The reserve was actuarially determined.

- Premiums payable to HMO, dental, and disability plans increased by 1,027.1 percent, from $6.5 million as of June 30, 2024, to $73.2 million as of June 30, 2025. The increase was due to the timing of payments to health care providers for payments after the end of the fiscal year for the prior fiscal year.
- Unearned contributions represent health contributions received in advance of the period of benefit coverage. Unearned contributions totaled $33.3 million as of June 30, 2025, and $4.3 million as of June 30, 2024. This increase was due to the timing of health premium collections from both employers and the employees for July 2025 coverage.

Financial Analysis – Condensed Schedule of Changes in Net Position Available for Health Benefits

For the year ended June 30, 2026, there was a $29.6 million decrease in net position. This compares to a $7.7 million decrease and $4.6 million increase in net position for the years ended June 30, 2025, and 2024, respectively. The highlights regarding the changes in net position are as follows:

				2026 - 2025		2025 - 2024	
	2026	2025	2024	Dollar Change	Percent Change	Dollar Change	Percent Change
Additions:							
Employee and retiree contributions	$ 237,772,236	$ 219,632,274	$ 200,900,853	$ 18,139,962	8.3%	$ 18,731,421	9.3%
Employer contributions	1,106,417,774	1,033,051,571	939,067,828	73,366,203	7.1%	93,983,743	10.0%
Total contributions	1,344,190,010	1,252,683,845	1,139,968,681	91,506,165	7.3%	112,715,164	9.9%
Plan provider penalties, forfeitures and settlements	78,133	327,150	4,792,299	(249,017)	-76.1%	(4,465,149)	-93.2%
Total additions	1,344,268,143	1,253,010,995	1,144,760,980	91,257,148	7.3%	108,250,015	9.5%
Deductions:							
Preferred provider organization health benefits	208,766,633	183,093,121	164,359,382	25,673,512	14.0%	18,733,739	11.4%
Health maintenance organization health benefits	1,051,939,042	970,623,124	875,950,612	81,315,918	8.4%	94,672,512	10.8%
Vision plan health benefits	11,981,812	11,525,578	10,934,203	456,234	4.0%	591,375	5.4%
Dental benefits	71,066,894	70,142,805	66,314,639	924,089	1.3%	3,828,166	5.8%
Disability and flexible benefits	35,307,437	33,011,535	30,025,876	2,295,902	7.0%	2,985,659	9.9%
Total deductions	1,379,061,818	1,268,396,163	1,147,584,712	110,665,655	8.7%	120,811,451	10.5%
Change in net position before investment earnings	(34,793,675)	(15,385,168)	(2,823,732)	(19,408,507)	126.2%	(12,561,436)	444.9%
Investment earnings	5,193,689	7,646,390	7,399,036	(2,452,701)	-32.1%	247,354	3.3%
Change in net position	$ (29,599,986)	$ (7,738,778)	$ 4,575,304	$ (21,861,208)	282.5%	$ (12,314,082)	-269.1%

Fiscal Year 2026

- Employee and retiree contributions totaled $237.8 million during the year ended June 30, 2026, compared to $219.6 million for the prior year, an increase of 8.3 percent primarily due to increases in premiums. Active employees contributed $162.3 million and retirees contributed $75.5 million of the $237.8 million collected in fiscal year 2026. The number of covered lives decreased 0.3 percent from the 2025 levels. Of the total contributions, $181.8 million are for medical and vision coverage, $26.6 million for dental coverage, and $29.3 million for flexible spending accounts.

- Employer contributions on behalf of active employees increased from $738.1 million during the year ended June 30, 2025, to $792.5 million during the year ended June 30, 2026, an increase of 7.4 percent over the prior year due to increases in premiums.
- Employer contributions on behalf of retirees increased from $294.9 million for the year ended June 30, 2025, to $313.9 million for the year ended June 30, 2026, or 6.4 percent due to increases in premiums. The cost of the plan benefits, retiree's number of dependents, and Medicare status of the retiree and dependents determine the premium for retirees. The 10-County Average Survey is used to calculate the retiree rates.
- Health benefits for UHC PPO and Blue Shield PPO, which cover medical and prescription drug expenses, increased from $183.1 million for the year ended June 30, 2025, to $208.8 million for the year ended June 30, 2026, or 14.0 percent. The increase was due to an increase in claims, premiums, and membership.
- HMO expenditures increased from $970.6 million for the year ended June 30, 2025, to $1,051.9 million for the year ended June 30, 2026, or 8.4 percent, due primarily to increases in contract rates, medical and pharmacy claims.
- Vision plan health benefits totaled $12.0 million for the year ended June 30, 2026, compared to $11.5 million for the year ended June 30, 2025, for an increase of $0.5 million or 4.0 percent. The increase is due to an increase in membership with an introduction of Vision Premier Plan effective January 2018.
- Dental benefits totaled $71.1 million for the year ended June 30, 2026, compared to $70.1 million for the year ended June 30, 2025, for an increase of $0.9 million or 1.3 percent, due to an increase in dental premiums.
- Disability and flexible benefits totaled $35.3 million for the year ended June 30, 2026, compared to $33.0 million for the year ended June 30, 2025, for an increase of 7.0 percent, due to an increased participation in these plans.
- Net investment earnings totaled $5.2 million for the year ended June 30, 2026, and $7.6 million for the year ended June 30, 2025. The decrease is due to the decreases in interest income and fair value of investments.

Fiscal Year 2025

- Employee and retiree contributions totaled $219.6 million during the year ended June 30, 2025, compared to $200.9 million for the prior year, an increase of 9.3 percent primarily due to increases in premiums. Active employees contributed $149.7 million and retirees contributed $69.9 million of the $219.6 million collected in fiscal year 2025. The number of covered lives increased 0.8 percent from the 2024 levels. Of the total contributions, $169.0 million are for medical and vision coverage, $25.5 million for dental coverage, and $25.1 million for flexible spending accounts.
- Employer contributions on behalf of active employees increased from $666.1 million during the year ended June 30, 2024, to $738.1 million during the year ended June 30, 2025, an increase of 10.8 percent over the prior year due to increases in premiums.

- Employer contributions on behalf of retirees increased from $272.9 million for the year ended June 30, 2024, to $294.9 million for the year ended June 30, 2025, or 8.1 percent due to increases in premiums. The cost of the plan benefits, retiree's number of dependents, and Medicare status of the retiree and dependents determine the premium for retirees. The 10-County Average Survey is used to calculate the retiree rates.
- Health benefits for UHC PPO and Blue Shield PPO, which cover medical and prescription drug expenses, increased from $164.4 million for the year ended June 30, 2024, to $183.1 million for the year ended June 30, 2025, or 11.4 percent. The increase was due to an increase in claims, premiums, and membership.
- HMO expenditures increased from $876.0 million for the year ended June 30, 2024, to $970.6 million for the year ended June 30, 2025, or 10.8 percent, due primarily to increases in contract rates, medical and pharmacy claims, and increases in membership.
- Vision plan health benefits totaled $11.5 million for the year ended June 30, 2025, compared to $10.9 million for the year ended June 30, 2024, for an increase of $0.6 million or 5.5 percent. The increase is due to an increase in membership with an introduction of Vision Premier Plan effective January 2018.
- Dental benefits totaled $70.1 million for the year ended June 30, 2025, compared to $66.3 million for the year ended June 30, 2024, for an increase of $3.8 million or 5.7 percent, due to an increase in dental premiums.
- Disability and flexible benefits totaled $33.0 million for the year ended June 30, 2025, compared to $30.0 million for the year ended June 30, 2024, for an increase of 10.0 percent, due to an increased participation in these plans.

Net investment earnings totaled $7.6 million for the year ended June 30, 2025, and $7.4 million for the year ended June 30, 2024. The increase is due to the increases in interest income.

Currently Known Facts, Conditions, or Decisions

Effective March 1, 2027, the System will discontinue offering Health Net CanopyCare HMO plan to eligible employees and retirees.

Request for Information

This report is designed to provide a general overview of the System's finances for the years ended June 30, 2026 and 2025. Questions regarding any of the information provided in this report or requests for additional information should be addressed to:

San Francisco Health Service System
City and County of San Francisco
Teresa Tan, Chief Financial and Affordability Officer
1145 Market Street, Suite 200
San Francisco, CA 94103-1523

SAN FRANCISCO HEALTH SERVICE SYSTEM
OTHER EMPLOYEE BENEFIT TRUST FUND
Statements of Net Position Available for Health Benefits
June 30, 2026, and 2025

	2026	2025
Assets:		
Cash and investments held with City and County Treasurer	$ 189,474,082	$ 164,340,883
Contributions receivable from:		
Employer	29,587,420	52,077,363
Employees	6,786,413	10,543,276
Interest receivable	1,382,863	1,521,924
Other assets	13,000,929	18,604,466
Total assets	240,231,707	247,087,912
Liabilities:		
Reserves for claims – medical, prescription drugs and dental	48,755,989	39,030,173
Health Maintenance Organization, Preferred Provider Organization, dental, disability claims and premiums payable	84,305,587	73,152,336
Unearned contributions	35,189,120	33,324,406
Total liabilities	168,250,696	145,506,915
Total net position	$ 71,981,011	$ 101,580,997

See accompanying notes to financial statements.

SAN FRANCISCO HEALTH SERVICE SYSTEM
OTHER EMPLOYEE BENEFIT TRUST FUND
Statements of Changes in Net Position Available for Health Benefits
For the Years Ended June 30, 2026 and 2025

	2026	2025
Additions:		
Employee and retiree contributions	$ 237,772,236	$ 219,632,274
Employer contributions for:		
Active employees	792,545,557	738,139,634
Retired employees	313,872,217	294,911,937
Total contributions	1,344,190,010	1,252,683,845
Plan providers penalties, forfeitures, and settlements	78,133	327,150
Investment earnings:		
Net change in fair value of investments	(472,647)	1,681,961
Interest income	5,666,336	5,964,429
Total investment earnings	5,193,689	7,646,390
Total additions	1,349,461,832	1,260,657,385
Deductions:		
City Health Plan health benefits	208,766,633	183,093,121
Health Maintenance Organization health benefits	1,051,939,042	970,623,124
Vision benefits	11,981,812	11,525,578
Dental benefits	71,066,894	70,142,805
Disability and flexible benefits	35,307,437	33,011,535
Total deductions	1,379,061,818	1,268,396,163
Change in net position available for health benefits	(29,599,986)	(7,738,778)
Net position:		
Beginning of year	101,580,997	109,319,775
End of year	$ 71,981,011	$ 101,580,997

See accompanying notes to financial statements.

(1) Description of San Francisco Health Service System

(a) General

The City and County of San Francisco (the City) established the San Francisco Health Service System (the System) in March 1937, by amendment of the City Charter. A new City Charter was adopted on November 7, 1995 and became effective July 1, 1996. The City provides health care benefits to eligible active and retired employees and their dependents through the System. The System also provides health care benefits to active and retired employees and their dependents of the San Francisco Unified School District, the San Francisco Community College District, and the San Francisco Superior Court. Under Charter Section A8.422, the Health Service Board is responsible for adopting a plan or plans for providing medical care to members of the System.

The System is considered to be a part of the City's financial reporting entity and is included in the City's basic financial statements as an Other Employee Benefit Trust Fund (the Trust) (also referred to as the Health Service System Trust Fund). The financial statements present only the Trust and do not purport to, and do not, present fairly the financial position of the City as of June 30, 2026, and 2025, and the changes in its financial position for the years then ended, in accordance with U.S. generally accepted accounting principles. The System, a City department, is overseen by the Health Service Board (HSB). The HSB voted, on April 3, 2017, to continue to have the Trust's cash balances deposited with, and managed by, the Office of the Treasurer and Tax Collector.

The overarching principles in setting the rates and benefits are to provide quality health care, contain costs, and stabilize insurance premiums for the members and the employer. The HSB must consider the impact resulting from the Patient Protection and Affordable Care Act (ACA) and other federal legislation in determining the plan designs and premiums.

The composition of the seven-member HSB includes a seated member of the San Francisco Board of Supervisors (the Board), appointed by the Board President; an individual who regularly consults in the health care field, appointed by the Mayor; a doctor of medicine, appointed by the Mayor; a member nominated by the Controller and approved by the HSB; and three members of the System, active or retired, elected from among their members. The HSB is responsible for appointing a full-time administrator, who serves at the pleasure of the HSB and sets the policy for and oversees the administration of the System.

Under Charter Section A8.423, the City's contribution towards the System's medical plans is determined by the results of an annual survey of the amount of premium contributions provided by the 10 most populous counties in California (other than the City). The survey is commonly called the 10-County Average Survey and is used 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." Under Charter Section A8.423, the City is required to contribute to the Health Service System Trust Fund an amount equal to the "average contribution" for each City Beneficiary.

In the June 2014, collective bargaining for the 2015 Plan Year, the impact of the "average contribution" on rates was eliminated in the calculation of premiums for almost all active employees represented by most unions, in exchange for a percentage-based employee premium contribution model. It is anticipated that the long-term impact of the premium contribution model will be the reduction in the relative proportion of the projected increases in the City's contributions for healthcare, stabilization of the medical plan membership and maintenance of competition among plans. The contribution amounts are paid by the City into the Trust. The 10-County Average Survey is used as a basis for calculating all City retiree premiums and premiums for the San Francisco Superior Court, the San Francisco Unified School District, and the San Francisco Community College District.

Membership in the System is available to (i) all active permanent employees, as well as eligible retired employees, of the City, and of the San Francisco Unified School District, San Francisco Community College District, and the San Francisco Superior Court; (ii) temporary employees who meet eligibility requirements; (iii) eligible dependents of members; and (iv) certain dependents of deceased and retired employees. Eligibility terminates when a member leaves employment for reasons other than retirement. The System is responsible for designing health care benefits, selecting and managing plan providers, and determining some aspects of benefit eligibility to supplement the eligibility rules contained in the Charter and applicable ordinances. In addition, the System is responsible for administration of health care benefits, including maintaining employee membership and financial accounting records.

Pursuant to provisions of the ACA, the System implemented, effective January 2015, the employer mandate that requires that "large employers" (i.e., employers with 50 or more full-time employees or full-time equivalents) offer affordable coverage that provides minimum value to all full-time employees and their dependents. ACA defined a full-time employee as one who works on average 30 hours a week. However, a threshold of 20 hours or more over a 12-month period was implemented.

Pursuant to the Charter, most administrative costs of the System are paid for by the City, the Unified School District, and the Community College District and are reflected in the respective financial statements of those entities. Certain expenses related to the typical annual open enrollment and member marketing and communications are, however, paid from the Trust pursuant to Section A8.423 of the Charter. In addition, third-party claims administration costs for the self-funded plans (UHC PPO, Blue Shield PPO and Delta Dental for active employees) and flex-funded plans (Blue Shield of California for active employees and early retirees) are included in the respective premium rates for those plans.

Pursuant to provisions of the ACA, two direct fees (Patient Centered Research Institute Fee and the Transitional Reinsurance Fee) and one Health Insurance Tax (HIT) were put in place beginning in fiscal year 2014.

The Patient Centered Research Institute Fee (PCORI) was set to expire in 2019. Congress revived and extended the PCORI fee and it now applies to policy or plan years ending on or after October 1, 2012, and before October 1, 2029. The PCORI fee, adopted in the

ACA, is paid by issuers of health insurance policies and plan sponsors of self-insured health plans to help fund the Patient-Centered Outcomes Research Institute. The fee is based on the average number of lives covered under the policy or plan.

(b) Types of Benefits and Premium Rates

Medical benefits during the fiscal years are provided to members of the System through eight plan choices:

- United Healthcare administered self-insured Preferred Provider Organization (PPO) (UHC PPO Companion Plan)
- Blue Shield of California self-insured PPO Accolade Plan (Blue Shield PPO)
- United Healthcare fully insured Medicare Advantage Prescription Drug (PPO) (UHC MAPD)
- Kaiser Permanente fully insured Health Maintenance Organization (HMO)
- Kaiser Permanente fully insured Senior Advantage, a Medicare Advantage HMO Plan
- Blue Shield of California Access+ HMO Plan (flex-funded plan with fully insured, capitated, and self-insured components)
- Blue Shield of California Trio HMO Plan (flex-funded plan with fully insured, capitated, and self-insured components)
- Health Net CanopyCare HMO (flex-funded plan with fully insured, capitated, and self-insured components).

Each of the above plan choices includes a basic vision benefit provided through Vision Service Plan (VSP). In 2018, a vision buy-up plan, under VSP, was added that is entirely employee paid.

The UHC PPO Companion Plan, which includes medical and prescription drug benefits, is a self-insured indemnity plan, where the risk of loss due to claims in excess of revenues is borne by the Trust. UHC also offers a fully insured Medicare Advantage PPO for retirees with Medicare.

The Kaiser HMO is a fully insured HMO, where the risk of loss due to excess claims for a given fiscal year is borne by the HMO.

On January 1, 2013, the Blue Shield of California Plan was converted from a fully insured external HMO plan to a flex-funded plan. The flex-funded plan has a fully insured, capitated component for professional services provided in physician offices. Hospital and pharmacy services are self-insured, where the risk of loss due to claims in excess of revenues is borne by the Trust. In 2017, Medicare coverage offered through Blue Shield of California was eliminated as an option to System members.

Effective January 1, 2018, Blue Shield of California began offering two plan choices. In addition to the broad Blue Shield network of doctors, members of the System can select

a narrower network of doctors and hospitals at a lower premium. Effective January 1, 2022, Blue Shield of California began offering a self-insured PPO plan.

Effective January 1, 2022, Health Net CanopyCare HMO began offering a flex-funded plan with fully insured capitated component for professional services and a self-insured component including claims.

Effective January 1, 2025, Blue Shield of California began offering Medicare Advantage Prescription Drug (MAPD) fully insured PPO plan for Medicare members.

Dental benefits during the fiscal years are provided through three plan choices:

- Delta Dental (PPO) a dental Preferred Provider Organization
- Delta Care (PMI) (DHMO) a Dental Health Maintenance Organization
- United Healthcare Dental (formerly known as Pacific Union) (DHMO).

The Delta Dental plan provided to active employees is a self-insured indemnity plan, administered by Delta Dental and the risk of loss due to claims in excess of revenues is borne by the City and any other participating employers. The Delta Dental plan offered to retired employees is a fully insured plan, where the risk of loss for a given fiscal year is borne by Delta Dental. The Delta Care (PMI, DHMO) and United Healthcare Dental (DHMO) dental plans are managed care dental plans and are fully insured with respect to both active and retired employees.

Premium rates for the fully insured plans are set through periodic competitive solicitation of carriers and an annual negotiation process that includes participation of the System's independent actuary and consultants. Premium rates for the self-insured plans are set based on recommendations and certification of such actuaries and consultants.

The System offers two types of flexible spending accounts for all City employees: a health care reimbursement account and a dependent care reimbursement account. Most of the administration for these accounts is provided through a third-party administrator, whose fees are provided by the City through the System. The administrator was P & A Group in fiscal years 2026 and 2025.

The System utilizes a third-party administrator to provide most of the administration for a cafeteria plan offered to employees represented by the Municipal Executives Association, elected officials, and certain unrepresented employees. The fees of this administrator are provided by the City through the System. The administrator was WORKTERRA in fiscal years 2026 and 2025.

In addition, the City provides a long-term disability plan to most of its employees. All costs of the long-term disability plan are paid by contributions from the City. In fiscal years 2026 and 2025, the plan providers were the Hartford Life and Accident Insurance Company, and, effective January 1, 2026, Life Insurance Company of North America (New York Life).

The City also provides employer-paid group term life insurance to most employee groups. Voluntary accidental death and personal loss insurance is offered to most employee groups paid by the members. In fiscal years 2026 and 2025, the plan providers were the Hartford Life and Accident Insurance Company, and, effective January 1, 2026, Life Insurance Company of North America (New York Life).

In 2017, the City offered a new adoption and surrogacy assistance plan paid for by the Trust.

(c) Determination of Employer and Member Contributions

The overall cost of benefits is determined using ongoing periodic member eligibility data and the premium rates referred to above. The costs are allocated among members, the City, the San Francisco Unified School District, the San Francisco Community College District, and the San Francisco Superior Court as set forth below. Member premiums are received at the time of the benefit period. The medical and dental plans and costs are determined annually by the HSB and approved by the San Francisco Board of Supervisors. Member contribution rates vary depending on the number of dependents, the cost of the plans selected by the member, and differing employer contribution levels depending on the employee's status as an active employee or a retiree and the application of employer subsidies tied to collective bargaining agreements for active employees or Medicare eligibility for retirees. Member contributions do not accumulate or vest.

Employer contributions for health benefits are determined annually in accordance with Charter requirements and the applicable collective bargaining agreements with various employee organizations. The Charter-based contributions are determined using a formula based on surveying similar contributions made by the 10 most populous counties in California, not including San Francisco. In addition, most active employee groups have collectively bargained for enhanced contributions for single coverage as well as employer subsidized dependent health coverage, some in exchange for the 10-County Average. The 10-County Average is used as a basis for calculating all retiree premiums and premiums for the San Francisco Superior Court, San Francisco Unified School District, and San Francisco Community College District.

Pursuant to Charter section A8.428b(3), for retired employees hired on or before January 9, 2009, 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, 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 partners of 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 subsection (i) and (ii), the City, the School District, and the Community College District shall contribute 50% of retired persons' remaining monthly contribution. Pursuant to Charter section AB.428b(4), for retired employees who were hired on or after January 10, 2009, employers shall contribute 100% of the employer contribution for:

(i) A retired employee who was hired on or after January 10, 2009, with 20 or 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.

Pursuant to A8.428b(5), for retired employees who were hired on or after January 10, 2009, for retired persons identified in Subsections (a)(4), (a)(5), and (a)(6), the employers shall contribute:

(i) 50% percent of the employer contribution established in 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, with at least 10 but less than 15 years of credited service with the employers; and

(ii) 75% percent of the employer contribution established in 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.

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

The accompanying financial statements are prepared using the economic resources measurement focus and the accrual basis of accounting. The preparation of the financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

The System follows U.S. generally accepted accounting principles as promulgated by the Governmental Accounting Standards Board (GASB).

(b) Cash and Investments Held by the City

The Trust maintains its cash and investments as part of the City's pool of cash and investments (Pool). The Trust's portion of this Pool is displayed on the balance sheet as "Cash and investments held with City and County Treasurer." Cash and investments are recorded at their fair value in accordance with GASB Statement No. 72, *Fair Value Measurement and Application*. Changes in fair value of investments are recorded in the statement of changes in net position available for health benefits in the year in which the changes occurred. Interest income arising from pooled investments is allocated monthly to the System based on the Trust's average daily cash balance in relation to the total pooled investments.

The City Treasurer manages the Pool in accordance with the City's investment policy and the California State Government Code. The objectives of the City's investment policy are, in order of priority, safety, liquidity, and yield. The policy addresses soundness of financial institutions in which the City will deposit funds, types of investment instruments as permitted by the California Government Code, and the percentage of the portfolio which may be invested in certain instruments with longer terms to maturity.

As of June 30, 2026, and 2025, the total amount invested by all public agencies in the Pool is approximately $18.5 billion and $18.3 billion, respectively. The Pool is not rated. The City's Treasury Oversight Committee (Committee) previously had oversight responsibility for the Pool. However, in May 2026, the Board of Supervisors approved the Commission Streamlining Task Force's proposed ordinance to eliminate the Committee since Committee meetings were based on monthly investment reports produced by the Office of the Treasurer and Tax Collector which continue to be published regardless of the Committee's existence. The value of the System's shares in the Pool, which may be withdrawn, is based on the book value of the System's percentage participation, which is different from the fair value of the System's percentage participation in the Pool. At June 30, 2026 and 2025, the Pool has weighted average maturities of 584 days and 487 days, respectively. Additional information regarding investment risks of the Pool is presented in the notes to the City's basic financial statements, which may be obtained by contacting the City's Controller's Office, Room 316, City Hall, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102.

(c) Unearned Contributions

Unearned contributions represent monies received from members and from the City, San Francisco Unified School District, San Francisco Superior Court, and San Francisco Community College District prior to year-end for benefits in future periods.

(d) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(3) Other Assets

As of June 30, 2026, other assets included $13.0 million in pharmacy rebates. As of June 30, 2025, other assets included $0.3 million in prepayments to the health care providers, $18.0 million in pharmacy rebates, and $0.3 million in performance guarantee.

(4) Reserves for Claims for Self-Insured Plans – Medical, Prescription Drugs, and Dental

Reserves for claims for Self-Insured Plans, including medical, prescription drugs, and dental, which have been actuarially determined, represent estimates of claims reported and in process of payment and estimates of claims incurred but not yet reported. Reserves for medical claims are based on actual claim lag reports and historical payment patterns. The net position of the Trust is available to be used as directed by the HSB and may be used to minimize the impact of possible future adverse experience. Management believes that the actuarially determined reserves are adequate to cover the ultimate cost of all claims incurred but unpaid at year end.

Blue Shield PPO, and the hospital and pharmacy services for employees and early retirees under the Blue Shield of California Access+ and Trio Plans, and Health Net CanopyCare are self-funded plans. Should deductions from the net position of the self-funded plans exceed related additions to net position and reserves, System members and participating employers would be required to provide such additional funds. The City's contributions to the Trust for employees in the Delta Dental plan are made on an estimated basis during the year and any over or under payment will be reflected in the subsequent year's rate using claims stabilization reserves. The reserves for dental benefits are actuarially determined based on actual claim payment patterns.

Reserves for prescription drug benefits are also actuarially determined based on claim payment patterns.

The following summarizes the changes in the reserves for claims of the System's Self-Insured Plans which consist of Blue Shield PPO, Blue Shield Flex-Funded Access+ and Trio Plans, and Health Net (medical benefits and prescription drug benefits), and dental plans during the years ended June 30, 2026, and 2025:

	Medical Benefits	Prescription Drugs	Dental Benefits	Total Reserves
Reserves as of June 30, 2024	$ 33,410,962	$ 122,512	$ 3,009,669	• 36,543,143
Claim Payments	(273,281,763)	(103,852,584)	(45,817,508)	(480,778,349)
Current Year Claims and Changes in Estimates	275,827,879	103,730,072	45,880,934	425,438,885
Reserves as of June 30, 2025	$ 35,957,078	$ -	$ 3,073,095	$ 39,030,173
Claim Payments	(322,648,341)	(112,506,171)	(45,623,837)	(480,778,349)
Current Year Claims and Changes in Estimates	332,154,373	112,506,171	45,843,621	490,504,165
Reserves as of June 30, 2026	$ 45,463,110	$ -	$ 3,292,879	$ 48,755,989

(5) Postretirement Health Benefits

Medical benefits for eligible retired employees feature the same basic plan design as those for active employees and such benefits are paid for by both the former employer and the retiree (note 1).

The total employer cost of providing benefits for 31,654 and 31,254 retirees as of June 30, 2026, and 2025, respectively, is shown as employer contributions to the Trust totaling $313.9 million ($263.9 million for the City and $50.0 million for the San Francisco Unified School District and the San Francisco Community College District) and $294.9 million ($249.4 million for the City and $45.5 million for the San Francisco Unified School District and the San Francisco Community College District) for the years ended June 30, 2026, and 2025, respectively, in the accompanying financial statements.

(6) Commitments and Contingencies

(a) Contingency Reserve Policy

The HSB adopted a contingency reserve policy for the self-funded health plans including Blue Shield PPO, the Delta Dental self-funded plan, the Blue Shield Flex-funded Plan, and Health Net CanopyCare Flex-funded Plan. The contingency reserve is an actuarially determined amount, based on historical claims experience required to cover the exposure of excess losses above anticipated claims expenses. The amount is established for the self-funded plans and is calculated on a fiscal year basis. At their March 14, 2024, meeting, the HSB voted, based on recommendations from the third-party actuary, to modify the contingency reserves as of June 30, 2023, to be set at a 95 percent confidence interval of the statistical variance of the historical claims experience instead of the 99 percent confidence interval.

At June 30, 2026, the contingency reserve was $7.1 million for the Blue Shield PPO self-insured plan, $15.6 million for the Blue Shield flex-funded plan, and $1.1 million for the Health Net CanopyCare flex-funded plan, compared with $6.3 million, $13.6 million, and $0.9 million, respectively, at June 30, 2025.The Contingency Reserve is part of the Trust's net position.

(b) Stabilization Reserve

The HSB adopted a self-funded plans' stabilization policy for the self-funded health plans, including the UHC and Blue Shield PPO plan, Blue Shield Access+ and Trio plans, Health Net CanopyCare HMO plan, and the Delta Dental PPO plan for active employees. The objective of a stabilization reserve is to spread any underwriting gains and losses into the following 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 premiums. The stabilization reserves are calculated annually as of December 31, the last day of the plan year. Use of the stabilization reserves through buy downs (when the reserve has a surplus) or buy ups (when the reserve is in a deficit) are applied towards the premium rates for the following plan year.

As of December 31, 2025:

- The UHC and Blue Shield PPO plan stabilization surplus was $1.6 million. The HSB approved the use of one third, or $0.5 million, to be applied as a buy-down of rates across all rating tiers for plan year 2027, leaving a remaining carry forward surplus balance of $1.0 million for plan year 2028.
- The Blue Shield Access+ and Trio flex funded HMO plans deficit was $(34.6) million. The HSB approved the use of one third, or $11.5 million, to be applied as a buy-up of rates across all rating tiers for plan year 2027, leaving a remaining carry forward deficit balance of $(23.0) million for plan year 2028.
- The Delta Dental PPO plan stabilization surplus was $4.1 million. The HSB approved the use of two-thirds, or $1.4 million, to be applied as a buy-down of rates across all rating tiers for plan year 2027, leaving a carry forward surplus balance of $2.7 million for plan year 2028.
- Health Net CanopyCare HMO plan stabilization surplus was $1.3 million. The HSB approved the use of one third, or $0.4 million, to be applied as a buy-down of rates across all rating tiers for plan year 2027, leaving a carry forward surplus balance of $0.9 million for plan year 2028.

As of December 31, 2024:

- The UHC and Blue Shield PPO plan stabilization surplus was $13.2 million. The HSB approved the use of one third, or $4.4 million, to be applied as a buy-down of rates across all rating tiers for plan year 2026, leaving a remaining carry forward surplus balance of $8.8 million for plan year 2027.

- The Blue Shield Access+ and Trio flex funded HMO plans deficit was $(25.5) million. The HSB approved the use of one third, or $8.5 million, to be applied as a buy-up of rates across all rating tiers for plan year 2026, leaving a remaining carry forward deficit balance of $(17.0) million for plan year 2027.
- The Delta Dental PPO plan stabilization surplus was $4.0 million. The HSB approved the use of two-thirds, or $1.3 million, to be applied as a buy-down of rates across all rating tiers for plan year 2026, leaving a carry forward surplus balance of $2.6 million for plan year 2027.
- Health Net CanopyCare HMO plan stabilization surplus was $2.1 million. The HSB approved the use of one third, or $0.7 million, to be applied as a buy-down of rates across all rating tiers for plan year 2026, leaving a carry forward surplus balance of $1.4 million for plan year 2027.

The Stabilization Reserve is part of the Trust's net position.

(c) Contingent Incentive Obligations

Based on calendar plan year results, the System calculated incentive obligation payments to medical groups under the Blue Shield Accountable Care Organization (ACO) network. The System's actuarial consultant negotiates an annual plan year cost target with the HMO and each participating ACO provider partnership group. Incentive payments are only distributed if underwriting gains are achieved at or above the negotiated target. An incentive payment of $0.8 million was made in July 2026 for plan year 2025.

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Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

Members of the Health Service Board,
Honorable Mayor and Members of the Board of Supervisors
City and County of San Francisco, California

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*), the financial statements of the San Francisco Health Service System Other Employee Benefit Trust Fund (the Trust), managed by the Health Service System (the System), a department of the City and County of San Francisco, California (the City), as of and for the year ended June 30, 2026, and the related notes to the financial statements, which collectively comprise the Trust's basic financial statements, and have issued our report thereon dated October 23, 2026.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the System's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control. Accordingly, we do not express an opinion on the effectiveness of the System's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the System's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the System's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.



Walnut Creek, California
October 23, 2026