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 11, 2025~~ November 12, 2026, to be effective January 1, 202~~6~~7

Table of Contents

The Purpose of the San Francisco Health Service Rules 3
A. Health Service System Member Eligibility 4
B. Eligible Dependents of Health Service System Members 7
C. Eligibility Documentation Required and Optional 15
D. Taxation of Health Benefits of Domestic Partners 18
E. Member Responsibility to Notify Health Service System When a Dependent Becomes Ineligible 18
F. Open Enrollment Period 19
G. Qualifying Life Events (QLE): Changing Benefit Elections Outside of the Open Enrollment Period 19
H. Transfer of Health Benefit Plans 23
I. HIPAA Special Enrollment Rights for Health Plan Coverage 25
J. Continuation of Health Benefits Coverage After Retirement 26
K. Required Medicare Enrollment 28
L. Medicare Advantage Enrollment 29
M. Dual Health Plan Coverage Restrictions 30
N. Member Health Benefits Coverage Period 30
O. Dependent Health Benefits Coverage Periods 32
P. Waiving Health Benefits Coverage (Voluntary) 34
Q. Member Premium Contributions, Employer Premium Subsidies, and Delinquencies 36
R. Termination of Health Benefits Coverage (Involuntary) 40
S. Employees on Authorized Unpaid Leave 40
T. COBRA Continuation of Health Benefits Coverage 42
U. Other Public Agencies Eligible to Participate in the Health Service System 43
V. Member Appeals and Grievances 44
W. Rules of Interpretation 49
Appendix A: Calendar of Benefits Coverage Periods 50

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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.

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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: Active Member eligibility for elected benefits must be made within 30 days of their initial date of eligibility (e.g. hire date, appointment date). The hire date and appointment date can be used interchangeably and is the official calendar day entered into the HR system that begins the 30-day time period. 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[2] under the shared responsibility provision of the Patient Protection and Affordability Care Act (section 4980H).

2. **Elected Officials**
    All elected officials while in office, including but not limited to:
    a. the Mayor
    b. the Board of Supervisors
        ~~b.~~i. Former members of the San Francisco Board of Supervisors may continue participation in SFHSS health plans following separation from office, provided they pay the full cost of coverage, in accordance with San Francisco City Charter Section A8.425.
    c. the Assessor-Recorder
    d. the Treasurer
    e. the City Attorney
    f. the Public Defender
    g. the Sheriff

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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

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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
      ~~c.~~i. Note: in accordance with California Senate Bill No. 11 (2009–2010), codified in California Government Code Sections 68220–68222, San Francisco Superior Court Judges appointed, elected, or hired on or after February 2009, shall not be eligible for SFHSS-administered benefits, except as otherwise required by applicable law.

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 ("Retiree") is defined as a former employee 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

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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

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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

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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~~ sixty (~~30~~60) 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. In general, ~~C~~coverage will become effective on the first day of the coverage period following the receipt of all documentation by HSS.
~~iv.~~1. When enrolling under the qualifying life event of a newborn, or adopted child, coverage will begin as of the date of the child's birth or date of adoption, in accordance with 29 CFR § 2590.701-6(b)(3)(iii)(B).

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;

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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;

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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/registered domestic partner who is otherwise eligible to enroll in health benefits, will be required to provide the enrollment application and verification of current spousal/registered domestic partnership status within sixty (60) days of the deceased Member's passing. (See Sec C.2 for eligible documents). Marriage Certificate/certificate of registered domestic partnership and a copy of the surviving spouse/registered domestic partner's social security card may be requested if not already on file with SFHSS.

Benefit enrollment will generally take effect prospectively, beginning with the next applicable coverage period. Requests for retroactive enrollment will be reviewed on a case-by-case basis and, if approved, will require payment of all retroactive premiums upfront.

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.

1. 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.

ii. An enrollment application must be submitted by the surviving spouse/registered domestic partner within ~~thirty~~ sixty (~~30~~60) days of the

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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.

1. 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.

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.

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c. **Surviving Spouse or Surviving Domestic Partner of a Retired Member Hired Before January 10, 2009**
   i. 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.
      1. 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.

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.
      1. 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.
   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.
      1. 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

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domestic partner was enrolled in a SFHSS health plan immediately prior to the Member's death.

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~~ sixty (~~30~~60) 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~~ sixty (~~30~~60) 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

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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

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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**

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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 a Member with a qualified IRS tax dependent domestic partner, as defined under 26 U.S. Code § 105(b) who have been registered domestic partners for 18 months or more, a filed copy of a Federal Income Tax Return showing the domestic partner as a qualified tax dependent.
        1. For a Member 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 a Member 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 a Member 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).

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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 dependent 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 Work Authorization Number may be enrolled within 30-days of the SSN or Work Authorization Number 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.

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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.

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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 Health Care and Dependent Care Flexible Spending Account elections during the annual Open Enrollment to participate in these programs for the following plan year.

G. Qualifying Life 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.

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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. (See Sec I.1.b.i for exceptions).
    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. (See Sec I.1.b.i for exceptions).
    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. (See Sec I.1.b.ii for exceptions).
    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. (See Sec I.1.b.ii for exceptions).
    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. (See Sec I.1.b.ii for exceptions).
    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

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(Dependent Care FSA) contributions cannot be modified due to this status change. (See Sec I.1.b.ii for exceptions).

3. **Change in the Employment Status of Spouse, Domestic Partner, or Other Dependent**
   a. **Involuntary Loss of Other Coverage**
   Members and eligible dependents who lose other coverage involuntarily 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.

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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 Health Care Flexible Spending Account contributions. Dependent Care FSA contributions cannot be changed due to this status change.

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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.
   a. When a Retiree waives coverage, the health benefits will be terminated prospectively, starting the first pay period after the Health Benefits Enrollment Application requesting the waiver is submitted.
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 a Work Authorization Number, Member may enroll their dependent under this Qualifying Life Event. Enrollment must occur within 30-days of the SSN/ Work Authorization Number issuance date.

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**

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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 the Blue Shield of California Medicare Advantage Prescription Drug (MAPD) 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.

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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, for which they are eligible to enroll, within their service area.

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 themself 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.

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ii. Child(ren) – A Member must request enrollment within ~~30~~ 60 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

SFHSS shall administer retiree health benefit eligibility, applicable employer contributions, and enrollment timelines ~~-~~in accordance with San Francisco City Charter Section A8.428.

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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.

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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

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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.

6. Retirees rehired under San Francisco City Charter Section A8.511(c) (sometimes known as Prop F employee) shall not be eligible for A~~a~~ctive Member health benefits by virtue of this employment. These individuals shall retain their existing SFHSS R~~r~~etiree Member health benefits and applicable retiree premium contributions, subject to continued compliance with all applicable SFHSS eligibility requirements.

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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.

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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 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.
   a. The Retiree may reenroll in a SFHSS sponsored Medicare plan upon establishing proof that their non-SFHSS Medicare coverage has been terminated.

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.

1. In general, 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 ~~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.
2. In accordance with 42 CFR §§ 422.74(d)(4)(v), 422.74(b)(2)(iii), and 422.74(d)(6), SFHSS-sponsored coverage for Retiree Members and/or Medicare eligible dependents, who are incarcerated or deceased shall be terminated effective the date their Medicare coverage is terminated by the Social Security Administration.

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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

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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

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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~~ sixty (~~30~~60) 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~~ sixty (~~30~~60) 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~~ sixty (~~30~~60) 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.

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d. **Eligible Adopted Children and Children Placed for Adoption**

Eligibility Event Data	Coverage Effective Date
Within ~~thirty~~ sixty (~~30~~60) 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~~ sixty (~~30~~60) 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~~ sixty (~~30~~60) 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~~ sixty (~~30~~60) 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~~ sixty (~~30~~60) 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~~ sixty (~~30~~60) days of commencement of legal custody. Such enrollment shall be made by application to the Health Service System and shall be

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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

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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 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).
        ~~d.~~i. Retiree health benefits will be terminated prospectively, starting the first pay period after the Health Benefits Enrollment Application requesting the waiver is submitted.
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."

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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**
   SFHSS shall administer retiree health benefit eligibility and applicable employer contributions in accordance with San Francisco City Charter Section A8.428.

   Definition: "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.

   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.

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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**

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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

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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 or payment is 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.

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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.
9. Continued eligibility for SFHSS retiree health benefits is contingent upon the Retiree Member remaining eligible to receive and maintain retirement benefits through their retirement system.
    a. If the Retiree Member's retirement systeme determines that a Retiree Member is no longer eligible to maintain their retirement benefits, SFHSS coverage for the Retiree Member and any enrolled dependents will be terminated.
    b. Eligibility for SFHSS coverage may be reinstated if the Retiree Member's retirement system restores their retirement benefits and all other applicable SFHSS eligibility requirements are met.

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

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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

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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

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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

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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. **Definitions**:
   a. **Appeal**: A request to reconsider or overturn a specific decision, such as a denial of coverage, benefits, or services.
   b. **Grievance**: A complaint expressing dissatisfaction with a plan, provider, service, or administrative process.
   c. **Fully Insured Plan**: SFHSS pays the health plan a fixed premium, typically per enrolled member, to provide covered benefits. The health plan assumes the financial risk for claims.
   d. **Flex Funded Plan**: SFHSS pays the health plan an administrative fee and funds member claims according to the plan's contractual funding arrangement, which may include financial limits or adjustments based on claims experience.

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e. **Self-Funded Plan**: SFHSS pays the actual cost of member claims and administrative fees, assuming the financial risk for claims rather than paying a fixed insurance premium.

f. **Regulating Body**: A governing agency responsible for establishing, overseeing, and enforcing laws, regulations, standards, or requirements applicable to a health plan or benefit program.

i. Regulating bodies include, but are not limited to— California Department of Managed Health Care (DMHC), California Department of Insurance (CDI), Centers for Medicare & Medicaid Services (CMS), and San Francisco Health Service Board (SFHSB)

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For a description of the funding method applicable to your health plan, please refer to the SFHSS Section 125 Cafeteria Plan Document.

2. **First Level Appeals**

a. SFHSS Eligibility Appeals

i. 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.

1. 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 laws or regulations.
2. 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.
3. Appeals may be submitted to:
   San Francisco Health Service System
   Attention: Member Appeals
   1145 Market Street, Suite 300
   San Francisco, CA 94103
4. 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. Fully Insured Plans, Flex Funded Plans, and Self-Funded Plans Appeals

i. For information on where to submit first-level Appeals, refer to plan materials.

3. **Second Level Appeal**

a. SFHSS Eligibility Appeals

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i. 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.
   1. The Appeal must be made within fifteen (15) business days after the date the Health Service System mails its decision to the Member.
      a. The Health Service Board may grant an extension of time upon the showing of good cause.
   2. To make a Second Level Appeal, the Member must either 1) email the Appeal to the Health Service Board at health.service.board@sfgov.org or 2) mail the Appeal to:
      San Francisco Health Service System
      Attention: HSB Appeals
      1145 Market Street, Suite 300
      San Francisco, CA 94103
   3. The Appeal to the Health Service System Board must specifically identify the basis of the Member's disagreement with the Health Service System decision in writing.
   4. 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)).
   5. 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.
   6. 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.
   7. 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.
   8. All actions taken by the Health Service Board shall be final.

b. Fully Insured Plan, Flex Funded Plan, and Self-Funded Plan Appeals
   i. For information on where to submit first-level Appeals, refer to plan materials. This may include contacting the plan Regulator.
   ii. Exception:

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1. Self Funded Active Dental PPO second level Appeals should be filed with the San Francisco Health Service System, following instructions on the Appeal decision letter.

4. **Grievance**

a. Members who wish to express dissatisfaction, submit a complaint, or provide general feedback regarding services received from a plan or SFHSS may submit a Grievance to the applicable plan or SFHSS for review. Each Grievance will be reviewed on a case-by-case basis, and appropriate follow-up which may include corrective action will be taken when warranted. The submission of a Grievance provides members with an opportunity to have their concerns reviewed and addressed; however, it does not guarantee a change in a plan decision, benefit determination, or prior outcome.

~~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~~

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~~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.~~

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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.

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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, 2026~~6~~7 through December 31, 2027~~5~~6, benefit coverage periods for Members on a bi-weekly premium payment schedule of **twenty-six (26)** premium payments per year:

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San Francisco Unified School District

For January 1, 2027~~6~~ through December 31, 2027~~6~~, benefit coverage periods for Members on a bi-weekly premium payment schedule of **twenty-six (26)** premium payments per year:

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City College of San Francisco

For January 1, 20276 through December 31, 20276, benefit coverage periods for Members on a bi-weekly premium payment schedule of **twenty-six (26)** premium payments per year:

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City College of San Francisco

For January 1, 20276 through December 31, 20276, benefit coverage periods for Members on a bi-weekly premium payment schedule of **twenty-one (21)** premium payments per year:

City College of San Francisco

For January 1, 20276 through December 31, 20276, benefit coverage periods for Members on a bi-weekly premium payment schedule of **twelve (12)** premium payments per year:

City College of San Francisco

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For January 1, 2026~~7~~ through December 31, 2027~~6~~, benefit coverage periods for Members on a bi-weekly premium payment schedule of **nine (9)** premium payments per year:

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