2015

MUNICIPAL EXECUTIVES

Health Benefits Guide

HEALTH SERVICE SYSTEM
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

Contents

Health Benefits

Member Rules and Guidelines

2015 Premium Contribution Rates

What's New 2015

Flex Credit Amounts for Family Coverage and Long-Term Disability Coverage

If you are covered by the Municipal Executive Association Miscellaneous contract with the City and County of San Francisco and you have family health coverage through HSS, you will see a difference in the amount of flex credits provided to you in 2015. This increase reflects the City's commitment to ensuring affordable health coverage for our families. In addition, you will be eligible for employer-paid Long-Term Disability Insurance.

MEA Flex Credits

The policy governing MEA flex credits changed in 2014. Flex credits not used to pay for pre-tax benefits will be paid as taxable—but not pensionable—earnings. You are not required to submit Miscellaneous Reimbursement receipts.

MEA Flex Credit Allocations Will Also Roll Forward

If you do not reallocate flex credits during Open Enrollment, current flex benefit choices (except FSAs) roll forward in 2015. To change flex benefits or enroll in a 2015 FSA, contact EBS (Employee Benefits Specialists) in October 2014 at 1-800-229-7683.

Computer VisionCare Benefit (VDT)

The MEA contracts, excluding Police, Fire, and Superior Court, now provide for employer-paid computer vision care benefits. See page 20 for more details.

Open Enrollment takes place October 1–31, 2014. Any benefit election changes are effective January 1, 2015.

During Open Enrollment you can:

- Change medical and/or dental plan elections.
- Add or drop dependents from medical and/or dental coverage.
- Enroll or re-enroll in a Flexible Spending Account (FSA).

Medical, Dental, and Vision

There are no changes to plans or covered health services in 2015, with the exception of the inclusion of pharmacy costs to the out-of-pocket maximum. There are no increases in co-pays or deductibles. If you do not make changes during Open Enrollment, your current plan choices will remain in place, with the exception of FSAs.

Applications Due October 31

Completed Open Enrollment applications must be received at HSS by 5:00PM October 31, 2014. Deliver Open Enrollment applications in person, by mail or by fax. The HSS fax is 415-554-1721.

Flexible Spending Accounts (FSA)

To make FSA contributions in 2015, you must enroll or re-enroll in a FSA during 2014 Open Enrollment. New in 2015: A minimum of $10 and up to $500 of unreimbursed healthcare funds can be carried over to the next plan year for only one year. Unreimbursed funds beyond $500 will be forfeited and cannot be returned to you.

Premium contribution rates are changing for most bargaining units in 2015.

Under the guidance of the Health Service Board, the Health Service System has made significant progress over the past three years maintaining the same level of quality benefits while negotiating fair insurance premiums. This has lowered cost trend projections, thereby reducing the total cost of providing health insurance coverage for over 110,000 of our employees, retirees and their families.

The Bay area has some of the highest quality medical care in the country. But from a business perspective, our region's doctors and hospitals are consolidated into one market with just a few major players. Fair market competition between Kaiser and Blue Shield's provider networks is essential to spur the continuous innovation that drives quality and efficiency in patient care.

Bending the trend on healthcare costs requires a multi-faceted strategy. This strategy includes implementing employer/employee premium contributions that allow HSS to continue offering the range of plan choices valued by our members. Some of you will see a narrower gap between the 2015 premium contribution for Kaiser and Blue Shield.

Some Kaiser and Blue Shield members will begin paying more in 2015. Overall, these new contribution models and favorable renewal rates are projected to save the City $16.3 million in total insurance costs and preserve fair market competition.

There are no simple solutions when it comes to maintaining healthcare quality while managing costs. Cities, states and private businesses across the country are all wrestling with the same dilemma. If we continue to do our part here in the City and County of San Francisco, we can increase the probability that the health benefits we all value and rely upon will be in place for a long time to come.

The Path to Sustainable Benefits

The Health Service System is one of the largest purchasers of employer-sponsored healthcare in the Bay area. Our goal is to maintain quality benefits over the long term for HSS members. To reach this goal, HSS, labor leaders, elected officials, and individual members are working together to implement a sustainable benefits strategy.

Strategy for Sustainable Benefits

Competitive Marketplace

Drive a fair, free market where Bay area healthcare vendors compete on price and quality.

Continue attracting top-tier medical professionals to work in Bay area hospitals, doctors' offices, and other facilities.

Accountable Healthcare Vendors

Partner with HSS to improve care delivery, patient outcomes, and the patient/caretaker experience.

Participate in healthcare price and quality data transparency, and report initiatives to contain costs and drive improvements in the care delivery system.

Healthy People

Learn, grow, and make personal choices that improve well-being and promote healthy aging.

Participate in a culture of health and well-being in the workplace, at home, and in local neighborhoods and communities.

By working together, we are improving the healthcare delivery system in San Francisco and the Bay area, maintaining quality care and controlling health insurance costs. We are on the right track, but the work will need to continue to ensure these positive changes can be preserved over the long term.

City Influence On Sustainable Health Benefits

Elected Officials

- Regulate a fair and competitive regional healthcare marketplace.
- Support legislation to improve healthcare price and quality data transparency.
- Ensure health facility expansions serve the public good.
- Support a culture of health and well-being for all City residents and visitors.

DHR and Labor

- Support premium contribution strategies that address cost drivers and encourage sustainable benefits.
- Collaborate on strategies to promote a healthy and productive workforce.
- Collaborate on measuring and improving workforce well-being.
- Support policies that encourage wellness in the workplace.

HSS and Health Service Board

- Oversee actuarial premium projections, identify cost drivers, and negotiate rates and benefits.
- Manage vendor contracts with performance guarantees for meeting quality, cost, and transparency goals.
- Develop data analytics to monitor quality of care, cost, and population health.
- Implement workplace wellness programs.

Medical Plan Options

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

Health Maintenance Organization (HMO)

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

- **Blue Shield of California HMO**
- **Kaiser Permanente HMO**

Preferred Provider Organization (PPO)

A PPO is a medical plan that offers benefits through in-network and out-of-network healthcare providers. (Out-of-network providers will cost you more.) You are not assigned to a Primary Care Physician, so you have more responsibility for coordinating your care. Compared to an HMO, enrolling in a PPO usually results in higher out-of-pocket costs. You must pay a plan year deductible. You also pay a coinsurance percentage each time you access service. Because City Health Plan PPO is a self-insured plan, individual premiums are determined by the total cost of services used by the plan's group of participants. HSS offers the following PPO plan:

- **City Health Plan PPO**
  (UnitedHealthcare Choice Plus)

How To Enroll In Medical Benefits

Eligible full-time employees must enroll in an HSS medical plan **within 30 calendar days** of their start work date. (Part-time or temporary employees see page 27.) Submit a completed enrollment application and eligibility documentation to HSS. If you do not enroll by required deadlines, you can only apply during Open Enrollment or due to a qualifying event. Coverage will start the first day of the coverage period after eligibility has been approved by HSS. Verify the date coverage will start with HSS when you enroll. Once enrolled, you must pay all required employee premium contributions. Review your paycheck to make sure correct deductions are being taken. HSS does not guarantee the continued participation of any particular doctor, hospital or medical group in a medical plan. You cannot change your benefit elections because a doctor, hospital or medical group chooses not to participate. You will be assigned or required to select another provider.

An enrolled individual with End Stage Renal Disease may be prohibited by federal Medicare rules from changing health plans.

The Evidence of Coverage (EOC) contains a complete list of benefits and exclusions in effect for each plan from January to December 2015. Review your EOC for plan details. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Download plan EOCs at myhss.org.

Medical Plan Service Areas

County	Blue Shield HMO	Kaiser Permanente HMO
Alameda	■	■
Alpine		
Calaveras		
Contra Costa	■	■
Madera	■	❍
Marin	■	■
Mariposa		❍
Merced	■	
Mono		
Napa		❍
Sacramento	■	■
San Francisco	■	■
San Joaquin	■	■
San Mateo	■	■
Santa Clara	■	❍
Santa Cruz	■	
Solano	■	■
Sonoma	■	❍
Stanislaus	■	■
Tuolomne		
Yolo	■	❍
Outside of California	Urgent/ER Care Only	Urgent/ER Care Only

■ = Available in this county. ❍ = Available in some ZIP codes; verify your ZIP code with the plan to confirm availability.

To enroll in a Blue Shield or Kaiser Permanente HMO, you must reside in a ZIP code serviced by the plan. City Health Plan PPO does not have any service area requirements. If you do not see your county listed above, contact the medical plan to see if service is available to you:

Blue Shield of California: 1-800-642-6155

Kaiser Permanente: 1-800-464-4000

Change of Address?

You must keep your address current with your Human Resources Personnel. If you move out of the service area covered by your plan, you must elect an alternate medical plan that provides coverage in your area. Failure to change your health benefit elections may result in the non-payment of claims for services received.

Choosing Your Medical Plan

PPO vs. HMO

	Blue Shield HMO	Kaiser Permanente HMO	City Health Plan PPO
Must I select a PCP (Primary Care Physician)?	You can choose your PCP after you enroll, or Blue Shield will assign.	You can choose your PCP after you enroll, or Kaiser will assign.	No PCP– you have more responsibility for coordinating care.
Am I required to use the plan's contracted network of service providers?	Yes. Services must be received from the contracted network.	Yes. Services must be received from Kaiser.	No, but out-of-network providers will cost you more.
Is my access to hospitals and specialists determined by my PCP's medical group?	Yes. PCP referrals to specialists and hospitals will be determined by medical group affiliation.	Yes. All services must be received from a Kaiser facility.	No
Do I have to pay an annual deductible?	No	No	Yes
Do I have to file claim forms?	No	No	Only if you use an out-of-network provider.

Blue Shield of California HMO: Choosing a Primary Care Physician (PCP) and Medical Group

If you enroll in Blue Shield, carefully review your choice of Primary Care Physician (PCP). Your PCP affects the network of providers and hospitals that will provide your care. You can change your PCP by calling Blue Shield at 1-800-642-6155.

Blue Shield Provider Networks in San Francisco

PCP Medical Group	Affiliated Hospitals
Hill Physicians hillphysicians.com	UCSF Medical Center
	St. Francis Memorial Hospital
	St. Mary's Medical Center
Brown & Toland brownandtoland.com	California Pacific Medical Center (CPMC)
Chinese Community Health Care Association cchca.com	Chinese Hospital

For more information about Blue Shield physicians and medical groups, including PCPs outside of San Francisco, visit blueshieldca.com/fap.

Tips to Improve Care and Reduce Costs

1 Mail Order Prescriptions

Mail order prescriptions can save you 30–50% on co-pays, plus there's no trip to the pharmacy. In most cases, you can easily order prescription refills by phone or online. Register and get started.

Blue Shield

Call Blue Shield's online pharmacy partner PrimeMail: 1-866-346-7200

-or-

Log into blueshieldca.com, select the Pharmacy tab, then click Mail-Service Prescriptions

Kaiser Permanente

Call 1-888-218-6245

-or-

Log in online: kp.org/rxrefill

City Health Plan

Call Optum Rx at 1-866-282-0125

-or-

Log in online: optumrx.org

2 Nurseline 24/7

Not sure if you need to see a doctor? Need health advice after hours? There is no cost to call a nurseline.

Blue Shield

Blue Shield NurseHelp: 1-877-304-0504

-or-

Brown & Toland patients Ask-A-Nurse: 1-855-423-9974

Kaiser Permanente

San Francisco Nurse Advice: 415-833-2200

Call 415-833-2239 for Chinese

Call 415-833-2203 for Spanish

-or-

Other locations call: 1-800-464-4000

City Health Plan

UnitedHealthcare Nurseline: 1-800-846-4678

3 Urgent Care Centers

Need to see a doctor on weekends or during evening hours? If it's not a life-threatening emergency, consider visiting an urgent care center instead of your local hospital's emergency room. That will mean a shorter wait time and lower co-pay for you.

Blue Shield patients should call your Primary Care Physician (PCP) or Blue Shield Member Services to help you find the closest affiliated urgent care center. The Blue Shield Member Services and PCP phone numbers can be found on your Blue Shield member ID card. Blue Shield patients in the Brown & Toland or Hill Physician Medical Groups may also use the following resources to find an urgent care center after hours:

- **Brown & Toland** patients in San Francisco, visit brownandtoland.com/get-care/after-hours-care
- **Hill Physicians** patients, visit HillPhysicians.com/Urgent

Kaiser patients in San Francisco, call 415-833-2200. For other locations, call 1-800-464-4000.

United Healthcare patients, call 1-866-282-0125 or visit myuhc.com and select the CCSF Choice Plus Network.

4 Chronic Condition? Follow Your Doctor's Orders

Based on national data, only 50% of patients follow doctor's orders for managing chronic conditions. If you have a diagnosis of diabetes, heart disease, arthritis, HIV, or another chronic condition, make sure you follow your doctor's advice about medication, diet, and exercise. This could help you avoid serious complications and hospitalizations.

Medical Plan Benefits At-a-Glance

	blue of california	KAISER PERMANENTE®	CITY HEALTH PLAN (UnitedHealthcare Choice Plus) In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
DEDUCTIBLES					
Deductible and out-of-pocket maximum (Combined Pharmacy and Medical)	No deductible Plan year out-of-pocket maximum $2,000/individual; $4,000/family	No deductible Plan year out-of-pocket maximum $1,500/individual; $3,000/family	$250 deductible employee only $500 deductible + 1 $750 deductible + 2 or more Plan year out-of-pocket maximum $3,750/person	$250 deductible employee only $500 deductible + 1 $750 deductible + 2 or more Plan year out-of-pocket maximum $7,500/person	$250 deductible employee only $500 deductible + 1 $750 deductible + 2 or more Plan year out-of-pocket maximum $3,750/person
PREVENTIVE CARE					
Routine physical	No charge	No charge	100% covered no deductible	50% covered after deductible	100% covered no deductible
Immunizations and inoculations	No charge	No charge	100% covered no deductible	50% covered after deductible	100% covered no deductible
Routine gynecologic wellness exam	No charge	No charge	100% covered no deductible	50% covered after deductible	100% covered no deductible
Well-baby care	No charge	No charge	100% covered no deductible	50% covered after deductible	100% covered no deductible
PHYSICIAN & OTHER PROVIDER CARE					
Office and home visits	$25 co-pay	$20 co-pay	85% covered after deductible	50% covered after deductible	85% covered after deductible
Hospital visits	No charge	No charge	85% covered after deductible	50% covered after deductible	85% covered after deductible
PRESCRIPTION DRUGS					
Pharmacy: generic drugs	$10 co-pay 30-day supply	$5 co-pay 30-day supply	$5 co-pay 30-day supply	50% covered after $5 co-pay; 30-day supply	$5 co-pay 30-day supply
Pharmacy: brand-name drugs	$25 co-pay 30-day supply	$15 co-pay 30-day supply	$20 co-pay 30-day supply	50% covered after $20 co-pay; 30-day supply	$20 co-pay 30-day supply
Pharmacy: non-formulary drugs	$50 co-pay 30-day supply	Physician authorized only	$45 co-pay 30-day supply	50% covered after $45 co-pay; 30-day supply	$45 co-pay 30-day supply
Mail order: generic drugs	$20 co-pay 90-day supply	$10 co-pay 100-day supply	$10 co-pay 90-day supply	Not covered	$10 co-pay 90-day supply
Mail order: brand-name drugs	$50 co-pay 90-day supply	$30 co-pay 100-day supply	$40 co-pay 90-day supply	Not covered	$40 co-pay 90-day supply
Mail order: non-formulary drugs	$100 co-pay 90-day supply	Physician authorized only	$90 co-pay 90-day supply	Not covered	$90 co-pay 90-day supply
Specialty drugs	20% up to $100 co-pay 30-day supply	Same as all above	Same as 30-day supply above limitations apply; see EOC	Same as 30-day supply above limitations apply; see EOC	Same as 30-day supply above limitations apply; see EOC
OUTPATIENT SERVICES					
Diagnostic X-ray and laboratory	No charge	No charge	85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	85% covered after deductible; may require prior notification
EMERGENCY					
Hospital emergency room	$100 co-pay waived if hospitalized	$100 co-pay waived if hospitalized	85% covered after deductible; if non-emergency 50% after deductible	85% covered after deductible; if non-emergency 50% after deductible	85% covered after deductible; if non-emergency 50% after deductible
Urgent care facility	$25 co-pay within CA network	$20 co-pay	85% covered after deductible	50% covered after deductible	85% covered after deductible
HOSPITAL/SURGERY					
Inpatient	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	85% covered after deductible; may require prior notification
Outpatient	$100 co-pay per surgery	$35 co-pay	85% covered after deductible	50% covered after deductible	85% covered after deductible

This chart provides a summary of benefits. It is not a contract. For a detailed description of benefits and exclusions for each plan, please review each plan's Evidence of Coverage, available on **myhss.org**.

Note: Out-of-pocket maximum does not include premium contributions.
*In some cases, billed amounts may exceed reasonable and customary fees, resulting in higher out-of-pocket costs.

Medical Plan Benefits At-a-Glance

	blue of california	KAISER PERMANENTE®	CITY HEALTH PLAN (UnitedHealthcare Choice Plus)		
			In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
REHABILITATIVE					
Physical/Occupational therapy	$25 co-pay	$20 co-pay authorization required	85% covered after deductible; 60 visits max per plan year	50% covered after deductible; 60 visits max per plan year	85% covered after deductible; 60 visits max per plan year
Acupuncture	$15 co-pay 30 visits max per plan year; ASH network only	Not covered	50% covered after deductible; $1,000 max per plan year	50% covered after deductible; $1,000 max per plan year	50% covered after deductible; $1,000 max per plan year
Chiropractic	$15 co-pay 30 visits max per plan year; ASH network only	$15 co-pay 30 visits max per calendar year; ASH network only	50% covered after deductible; $1,000 max per plan year	50% covered after deductible; $1,000 max per plan year	50% covered after deductible; $1,000 max per plan year
PREGNANCY & MATERNITY					
Routine pre- and post-partum physician care; for hospital stay, see Hospital	No charge newborn must be enrolled within 30 days of birth; visits limited; see EOC	No charge newborn must be enrolled within 30 days of birth; visits limited; see EOC	85% covered after deductible; newborn must be enrolled within 30 days of birth	50% covered after deductible; newborn must be enrolled within 30 days of birth	85% covered after deductible; newborn must be enrolled within 30 days of birth
INFERTILITY					
IVF, GIFT, ZIFT, and artificial insemination	50% covered limitations apply	50% covered limitations apply	50% covered after deductible; limitations apply; prior notification required	50% covered after deductible; limitations apply; prior notification required	50% covered after deductible; limitations apply; prior notification required
TRANSGENDER					
Office visits and outpatient surgery	Co-pays apply authorization required.	Co-pays apply authorization required.	85% covered after deductible; prior notification required	50% covered after deductible; prior notification required	85% covered after deductible; prior notification required
DURABLE MEDICAL EQUIPMENT					
Home medical equipment	No charge	No charge as authorized by PCP according to formulary	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary	85% covered after deductible; when medically necessary; notification required	50% covered after deductible; when medically necessary; notification required	85% covered after deductible; when medically necessary; notification required
Hearing aids	Evaluation no charge 1 aid per ear every 36 months, up to $2,500 each	Evaluation no charge 1 aid per ear every 36 months, up to $2,500 each	85% covered after deductible; 1 aid per ear every 36 months, up to $2,500 each	50% covered after deductible; 1 aid per ear every 36 months, up to $2,500 each	85% covered after deductible; 1 aid per ear every 36 months, up to $2,500 each
MENTAL HEALTH					
Inpatient hospitalization	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Outpatient treatment	$25 co-pay non-severe and severe	$10 co-pay group $20 co-pay individual	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
CHEMICAL DEPENDENCY					
Inpatient detox	$200 co-pay per admission	$100 co-pay per admission	85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
Residential rehabilitation	$200 co-pay per admission	$100 co-pay per admission; physician approval required	85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
EXTENDED & END-OF-LIFE CARE					
Skilled nursing facility	No charge up to 100 days per plan year	No charge up to 100 days per benefit period	85% covered after deductible; up to 120 days per plan year; notification required; custodial care not covered	50% covered after deductible; up to 120 days per plan year; notification required; custodial care not covered	85% covered after deductible; up to 120 days per plan year; notification required; custodial care not covered
Hospice	No charge authorization required	No charge when medically necessary	85% covered after deductible; prior notification required	50% covered after deductible; prior notification required	85% covered after deductible; prior notification required

This chart provides a summary of benefits. It is not a contract. For a detailed description of benefits and exclusions for each plan, please review each plan's Evidence of Coverage, available on **myhss.org**.

*In some cases, billed amounts may exceed reasonable and customary fees, resulting in higher out-of-pocket costs.

Adult Preventive Care Summary

Preventive vs. Diagnostic Care

If you seek preventive care more often than these guidelines, or if you use an out-of-network provider, you may be billed for diagnostic treatment instead of preventive care (no charge).

The primary reason for the office visit usually determines if the visit is preventive. When the visit is not considered preventive, the appropriate plan co-pay will apply. For questions about your benefit coverage, call your health plan's customer service department.

	Women age 20–49	Men age 20–49	Women age 50 and up	Men age 50 and up
Annual wellness exam height, weight, blood pressure; tobacco and alcohol use, depression	Yes	Yes	Yes	Yes
Annual well-woman exam age appropriate preventive care	Yes		Yes	
AAA screening abdominal aortic aneurysm				Yes if man ever smoked; ages 65–75; one time
Colorectal cancer screening			Yes ages 50–75	Yes ages 50–75
Contraception birth control, sterilization, counseling	Yes		Yes until fertility ends	
Diabetes type 2 screening blood glucose	Yes	Yes	Yes	Yes
Domestic violence prevention screening and counseling	Yes		Yes	
Flu immunization seasonal flu	Yes annually, if at risk	Yes annually, if at risk	Yes	Yes
Hepatitis A and B immunization	Yes if at risk	Yes if at risk	Yes if at risk	Yes if at risk
Lipid screening blood cholesterol	Yes over age 45 frequency based on risk	Yes over age 35 frequency based on risk	Yes frequency based on risk	Yes frequency based on risk
Mammogram breast cancer screening	Yes over age 40 every 1–2 years		Yes every 1–2 years to age 75	
MMR immunization measles, mumps, rubella	Yes if no proof of immunity	Yes if no proof of immunity	Yes if at risk	Yes if at risk
Osteoporosis screening bone density			Yes over age 65; or high risk	
Pap smear cervical cancer screening	Yes every 2 years, after 3 normal screenings		Yes every 2 years, after 3 normal screenings	
Papillomavirus screening	Yes DNA test if high risk		Yes DNA test if high risk	
Pneumococcal immunization pneumonia			Yes age 65 and up; sooner if high risk	Yes age 65 and up; sooner if high risk
STD screenings and counseling sexually transmitted diseases	Yes if at risk	Yes if at risk	Yes if at risk	Yes if at risk
Tdap/Td immunization tetanus, diphtheria, whooping cough	Yes every 10 years	Yes every 10 years	Yes every 10 years	Yes every 10 years
Varicella immunization chicken pox	Yes if no proof of immunity	Yes if no proof of immunity	Yes if no proof of immunity	Yes if no proof of immunity
Zoster immunization shingles			Yes ages 60 and up; once	Yes ages 60 and up; once

The Affordable Care Act mandates that many preventive services be provided at no cost to insured patients. Consult with your doctor about the types of screenings and immunizations that are right for you.

Behavioral Health Benefits and CCSF HSS Employee Assistance Program (EAP)

Behavioral Health Services

Blue Shield

LifeReferrals 24/7

Speak on the telephone to a counselor at any time at no cost. Three face-to-face visits with a licensed therapist in each six-month period are also included. Call 1-800-985-2405.

Non-Emergency Therapy Services

Call 1-877-263-9952 to schedule a visit with a mental health professional in the Blue Shield network for non-emergency therapy or to discuss concerns about substance abuse.

Residential Substance Abuse Treatment

To access residential treatment for substance abuse, you do not need a referral from your Blue Shield Primary Care Physician. Call 1-877-263-9952.

Kaiser Permanente

Behavioral Health Classes

Kaiser offers classes on depression, anxiety, insomnia, couples communication, anger management, parenting, and more. Visit healthy.kaiserpermanente.org.

Wellness Coaching

Speak with a wellness coach on the phone about issues like stress management and life balance. Call 866-251-4514, 5:00AM to 1:00AM, to schedule.

Therapy and Substance Abuse Treatment

San Francisco Kaiser members, call 415-833-2292 or 415-833-9400 for information or to schedule service. You do not need a referral from your Kaiser PCP. If you live outside San Francisco, contact the mental health department of your regional Kaiser facility.

City Health Plan

Locate Network Therapists and Facilities

To find behavioral health therapists, visit myuhc.com, and click on "Find Mental Health Clinician" under Links and Tools, or call 1-866-282-0125.

Take advantage of behavioral health benefits before issues escalate to a crisis. But in the case of a life-threatening emergency, call 911 or go to the nearest emergency room immediately.

Health Service System Employee Assistance Program (EAP)

EAP provides confidential, voluntary, no-cost behavioral health services to City and County of San Francisco employees, their family members, and significant others. EAP is staffed by licensed therapists.

Short-Term, Solutions-Oriented Counseling

Your first appointment with an EAP counselor usually takes place within 48 hours, and you can utilize up to six EAP sessions per year. Your EAP counselor can also assist you in taking advantage of behavioral health benefits covered by your medical plan. EAP appointments are available between the hours of 8:00AM and 5:00PM, Monday through Friday.

Mediation and Conflict Resolution

EAP provides mediation services to help resolve conflicts between co-workers, or between a manager and an employee. There is no cost for EAP mediation services. Call EAP to schedule.

Group Workshops

Free EAP group workshops offer City employees the opportunity to share, learn and grow, with the goal of becoming more flexible and knowledgeable at all stages of life. For current calendar, visit myhss.org/events/seminars.html.

Critical Incident Debriefing and Trauma Response

EAP critical incident debriefing and trauma response assists people as they process complex emotions, helps them return to a regular routine more quickly, and reduces the likelihood of post-traumatic stress disorder. There is no cost for this service. Please contact EAP immediately if an individual or team in your department can benefit from this service.

Violence Prevention

EAP provides non-violent crisis intervention training for City employees who may come into contact with disruptive or potentially violent members of the public. There is a $100 per person fee for this workshop.

Contact CCSF EAP

Call 1-800-795-2351

Dental Plan Options

Dental benefits are an important part of your healthcare coverage and are key to your overall health.

PPO-Style Dental Plans

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

HSS offers the following PPO-style dental plan:

- **Delta Dental**

If You Enroll in Delta Dental, Save Money By Choosing PPO Dentists

The Delta Dental plan has two different networks. Ask your dentist if he or she is PPO or Premier. Both networks are held to the same quality standards, but choosing a PPO dentist will save you money.

With Delta Dental PPO dentists, you pay lower out-of-pocket costs. Most preventive services are covered at 100%; many other services are covered at 90%.

Delta Dental Premier dentists charge higher out-of-pocket fees. Covered charges are based on pre-arranged charges with each contracted dentist. Most preventive services are covered at 100%; many other services are covered at 80%.

You can also choose any dentist outside of the PPO and Premier networks. When you receive service from an out-of-network dentist, many services are covered at a lower percentage, so you pay more. Also, payment is based on reasonable and customary fees for the geographic area. Your out-of-pocket costs will be higher if your out-of-network dentist charges more than reasonable and customary fees.

Ask your Delta Dental dentist about costs before receiving services. You can request a pre-treatment estimate of costs before you receive care. For more information, call Delta Dental at 1-888-335-8227.

HMO-Style Dental Plans

Similar to medical HMOs, Dental Maintenance Organization (DMO) plans require that you receive all of your dental care from within a network of participating dental offices. These networks are generally smaller than a dental PPO network. Before you elect a DMO plan, make sure that the plan's network includes the dentist of your choice.

HSS offers the following DMO plans:

- **DeltaCare USA**
- **Pacific Union Dental**

Can you enroll in only a dental plan?

Yes, you can elect to enroll in an HSS dental plan even if you elect not to enroll in an HSS medical plan.

Dental Plan Service Areas

To enroll in either DeltaCare USA or Pacific Union Dental, you must reside within a ZIP code serviced by the plan.

County	Delta Dental PPO	DeltaCare USA DMO	Pacific Union DMO
Alameda	■	■	■
Calaveras	■		
Contra Costa	■	■	■
El Dorado	■	■	■
Madera	■	■	■
Marin	■	■	■
Mariposa	■		
Merced	■	■	■
Mono	■		
Monterey	■	■	■
Napa	■	■	■
Sacramento	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Clara	■	■	■
Santa Cruz	■	■	■
Solano	■	■	■
Sonoma	■	■	■
Stanislaus	■	■	■
Tuolomne	■		
Yolo	■	■	■
Outside of California	■		

■ = Available in this county.

If you do not see your county listed above, contact the dental plan to see if service is available to you:

Delta Dental: 1-888-335-8227

DeltaCare USA: 1-800-422-4234

Pacific Union Dental: 1-800-999-3367

Dental Plan Benefits At-a-Glance

	Delta Dental			DeltaCare USA	Pacific Union Dental
	PPO Providers	Premier Providers	Out-of-Network Providers		
Service					
Cleanings and exams	100% covered 2x/year; pregnant women 3x/year	100% covered 2x/year; pregnant wom en 3x/year	80% covered 2x/year; pregnant women 3x/year	100% covered 1 every 6 months	100% covered 1 every 6 months
X-rays	100% covered full mouth 1x/5 years bitewing 2x/year to age 18; 1x/year over age 18	100% covered full mouth 1x/5 years bitewing 2x/year to age 18; 1x/year over age 18	80% covered full mouth 1x/5 years bitewing 2x/year to age 18; 1x/year over age 18	100% covered	100% covered
Extractions	90% covered	80% covered	60% covered	100% covered	100% covered
Fillings	90% covered	80% covered	60% covered	100% covered Limitations apply to resin materials	100% covered Limitations apply
Crowns	90% covered	80% covered	50% covered	100% covered Limitations apply to resin materials	100% covered Limitations apply
Dentures, pontics and bridges	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	100% covered Full and partial dentures 1x/5 years; fixed bridgework, limitations apply	100% covered Full and partial dentures 1x/5 years; fixed bridgework, limitations apply
Endodontic/ Root Canals	90% covered	80% covered	60% covered	100% covered Excluding the final restoration	100% covered
Oral surgery	90% covered	80% covered	60% covered	100% covered	100% covered
Implants	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	50% covered 6-month wait for new enrollees	Not covered	Not covered
Orthodontia	50% covered 6-month wait; child $2,500 lifetime max; adult $1,500 lifetime max	50% covered 6-month wait; child $2,000 lifetime max; adult $1,000 lifetime max	50% covered 6-month wait; child $1,500 lifetime max; adult $500 lifetime max	Employee pays: $1,600/child $1,800/adult $350 startup fee; limitations apply	Employee pays: $1,660/child $1,880/adult $350 startup fee; limitations apply
Maximum					
Annual total dental benefits	$2,500 per person Per year, excluding orthodontia benefits	$2,500 per person Per year, excluding orthodontia benefits	$2,500 per person Per year, excluding orthodontia benefits	None	None
Deductible					
Before accessing benefits	None	None	None	None	None

This chart provides a summary of benefits. It is not a contract. For a more detailed description of benefits and exclusions for each plan, please review each plan's Evidence of Coverage, available on myhss.org.

Dental Plan Comparison

Dental Plan Quick Comparison

	Delta Dental PPO	DeltaCare USA DMO	Pacific Union Dental DMO
Can I choose to receive services from any dentist?	Yes. You can use any licensed dental provider. You pay less when you choose a PPO in-network provider.	No. All services must be received from a contracted network provider. These networks are generally quite small.	No. All services must be received from a contracted network provider. These networks are generally quite small.
Must my primary care dentist refer me to a specialist for certain kinds of dental work?	No	Yes	Yes
Is there a waiting period before I can access treatment?	No waiting period, except for dentures, pontics, bridges, implants and orthodontia, which require a 6-month wait.	No waiting period.	No waiting period.
Will I pay a flat rate for most services?	No. Your out-of-pocket costs are based on a percentage of applicable charges.	Yes	Yes
Must I live in a certain service area to enroll in the plan?	No	Yes. To enroll, you must live in this DMO's service area.	Yes. To enroll, you must live in this DMO's service area.

Vision Plan Benefits

All HSS members and dependents who are enrolled in an HSS medical plan are also enrolled in vision benefits.

Vision Plan Benefits

All HSS members and eligible dependent(s) who enroll in the City Health Plan PPO, Blue Shield HMO, or Kaiser HMO can access vision coverage administered by Vision Service Plan (VSP).

Choice of Providers

You have the choice of using a VSP network doctor or a non-VSP doctor. You can find a VSP network doctor in your area by visiting vsp.com or contacting VSP Member Services at 1-800-877-7195.

Accessing Your Vision Benefits

No ID cards are issued for the vision plan. To receive service from a VSP network doctor, contact the doctor, identify yourself as a VSP member, and make an appointment. VSP will provide benefit authorization to the doctor. Services must be received prior to the benefit authorization expiration date.

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

Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every 24 months, per last date of service. If examination reveals Rx change of .50 diopter or more after 12 months, replacement lenses covered.
- Eligible dependent children are covered in full for polycarbonate prescription lenses.
- Cosmetic extras, including progressive, tinted or oversize lenses, will cost you more.

Vision Plan Expenses Not Covered

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

Acute and Urgent Eye Care

With a $5 co-pay, VSP offers limited coverage for urgent and acute eye conditions, including pink eye, sudden onset of flashers and floaters, and diagnosis of eye pain or sudden changes in vision. Visit any VSP network doctor; no appointment is necessary.

VSP acute eye care does not cover chronic eye conditions like diabetes-related eye disease or glaucoma. Chronic eye disease may be covered by your medical plan. (Check your medical plan's Evidence of Coverage, available on myhss.org.)

Computer VisionCare Benefit (VDT)

The MEA contracts excluding Police, Fire, and Superior Court provide for employer-paid computer vision care benefits. Coverage includes an annual computer vision exam, $75 in-network retail frame allowance every 24 months and single vision, lined bifocal, lined trifocal lenses.

No Medical Plan, No Vision Benefits

If you do not enroll in an HSS medical plan, you and your enrolled dependents cannot access VSP vision benefits.

Vision Plan Benefits At-a-Glance

	VSP Network	Out-of-Network
Types of Service		
Well vision exam	$10 co-pay every 12 months*	Up to $50 after $10 co-pay; every 12 months*
Single vision lenses	$25 co-pay every 24 months*	Up to $45 after $25 co-pay; every 24 months*
Lined bifocal lenses	$25 co-pay every 24 months*	Up to $65 after $25 co-pay; every 24 months*
Lined trifocal lenses	$25 co-pay every 24 months*	Up to $85 after $25 co-pay; every 24 months*
Standard progressive lenses	$55 co-pay	Up to $85 After $25 copay; every 24 months*
Premium progressive lenses	$95–$105 co-pay	
Custom progressive lenses	$150–$175 co-pay Every 24 months*	
Scratch-resistant coating	Fully covered every 24 months*	Not covered
Frames	$150 allowance $170 allowance on featured brands after $25 co-pay; 20% off total over $150; every 24 months*	$70 allowance after $25 co-pay; every 24 months*
Contacts (instead of glasses)	$150 allowance every 24 months*	$105 allowance for contacts and contact lens exam every 24 months*
Contact lens exam	Up to $60 co-pay after $60 copay; fitting and evaluation exam covered; every 24 months*	
Urgent eye care	$5 co-pay limited coverage for urgent and acute eye conditions	Not covered
Savings and Discounts		
Non-covered lens options (progressives, anti-reflective coating, photochromic, polycarbonate)	Average 20%–25% savings after co-pay; available on most enhancements	Not applicable
Laser Vision Correction	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities	Not applicable

*Based on your last date of service.

MEA contracts (excluding Police, Fire, and Superior Court) now have access to employer paid Computer VisionCare benefits (VDT). Coverage includes an annual computer vision exam and single vision, lined bifocal, or lined trifocal lenses every 12 months with a $75 in-network retail frame allowance every 24 months.

Flex Credits

2015 Dollar Value Of Flex Credits Bi-Weekly				
	Employee Only	Employee +1	Employee +2	
			Blue Shield or City Health Plan	Kaiser
MEA and Unrepresented Managers	$303.02	$349.64	$700.40	$599.15
MEA MTA	$303.02	$349.64	$700.40	$599.15
MEA Fire and Police	$349.64	$349.64	$349.64	$349.64
MEA Superior Court	$897.00	$897.00	$897.00	$897.00

How Flex Benefits Work

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

$50,000 Group Life Insurance

A $50,000 Group Term Life Insurance policy is also provided at no cost to employees who are eligible for flex credit benefits. You are responsible for keeping your designated beneficiaries up-to-date. For details see myhss.org/benefits/ccsf_other_benefits.html.

New Hires

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

Open Enrollment

During Open Enrollment, municipal executives may change flex credit benefit elections, based on available pre- and post-tax options. Flex credit benefit changes are administered by EBS, and must be completed by Open Enrollment deadlines. During Open Enrollment contact EBS at 1-800-229-7683.

Flex Credit Benefit Options (Except FSAs) Will Roll Forward in 2015

If you are not making any changes to your benefit selections, and you do not wish to fund an FSA (Flexible Spending Account), you do not need to meet with EBS during 2014 Open Enrollment. Your current benefit elections (except FSAs) will roll forward in 2015. To continue making FSA contributions, or to change your benefit choices, you must contact EBS during Open Enrollment. Without re-enrollment, all FSA contributions will cease December 31, 2014.

Qualifying Event Changes

Members may reallocate flex credits outside of Open Enrollment if there is a qualifying event. Contact HSS at 415-554-1750 for more information.

Leaves of Absence

If you are going on an unpaid leave of absence, you may be responsible for making premium payments for selected benefits while no payroll deductions are taken. Contact HSS at 415-554-1750 for more information.

Flex Benefit Options

Maximize Your Benefits

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

Pre-Tax Flex Credit Benefit Options

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

	Tax Status	EOI Required*
Medical and Dental Premium Contributions	Pre-Tax	No
Healthcare Flexible Spending Account WageWorks	Pre-Tax	No
Dependent Care Flexible Spending Account WageWorks	Pre-Tax	No
Cancer Insurance Allstate Workforce Division	Pre-Tax	Yes
Heart and Stroke Insurance Allstate Workforce Division	Pre-Tax	Yes
Accident Insurance Allstate Workforce Division	Pre-Tax	Yes
Long-Term Disability Insurance (Employee Only and Employee + 1) Aetna	Pre-Tax	Yes

Taxable Flex Credit Benefit Options

The benefits listed below are paid post-tax for all enrollees.

	Tax Status	EOI Required
Universal Life Insurance ING	Post-Tax	Yes
Short-Term Disability Insurance ING	Post-Tax	Yes
Long-Term Care Insurance John Hancock, MetLife, Mass Mutual	Post-Tax	Yes
Pet Insurance PetCare	Post-Tax	No
Group Legal Plan Pre-Paid Legal	Post-Tax	No
Supplemental Group Term Life Insurance Aetna	Post-Tax	Yes

*Evidence of Insurability (EOI)

Some benefits require additional information from the applicant before enrollment is completed. This can include medical evidence. The insurer will contact you if specific records are required. It is your responsibility to provide all requested documentation. Enrollment may be denied by the insurer. In 2015, no payroll deductions will be taken until enrollment is approved by each insurer. If approved, there may be a catch-up payroll deduction retroactive to the effective date of your policy. If denied coverage, no premiums for that benefit will be deducted from your paycheck.

Flexible Spending Accounts (FSA)

An FSA helps you save money by paying many everyday expenses, such as healthcare, child daycare, and elder daycare, with tax-free money.

How an FSA Works

Flexible Spending Accounts (FSAs) let you set aside money pre-tax to pay for eligible healthcare and/or dependent care expenses. You can enroll in either a Healthcare FSA, a Dependent Care FSA, or both.

An FSA account can pay qualifying expenses incurred by you, your legal spouse, or qualifying child or relative (as defined in Internal Revenue Code Section 152). To determine who is a qualifying child or relative visit wageworks.com/forms/hcdependents.pdf.

Before enrolling in your FSA, you should calculate a detailed estimate of the eligible expenses you are likely to incur in 2015. Budget conservatively. Unreimbursed funds are forfeited at the end of the 2015 plan year and cannot be returned to you. However, you are allowed to carry over between a minimum of $10 and a maximum of $500 of your healthcare FSA each plan year for one year. Unreimbursed funds under $10 and beyond $500 are forfeited and cannot be returned to you. You can submit claims incurred during the plan year for up to 90 days after the plan year ends.

FSA expenses must meet Internal Revenue Service (IRS) eligibility criteria: irs.gov/pub/irs-pdf/p502.pdf and irs.gov/pub/irs-pdf/p503.pdf.

Healthcare FSA with Carryover

A Healthcare FSA with Carryover can pay for qualifying medical expenses with tax-free funds and you no longer have to precisely predict your out-of-pocket medical expenses a whole year in advance. You may carry over between a minimum of $10 and a maximum of $500 remaining in your account to the next plan year for only one year. Medical expenses such as medical, pharmacy, dental and vision co-payments, other dental and vision care expenses, acupuncture and chiropractic care, weight loss programs, and many others qualify for a healthcare FSA. For a complete list of eligible healthcare expenses, visit wageworks.com.

- Set aside between $260 and $2,500 pre-tax per employee for the plan year. Depending on the amount you elect, deductions between $10 and $96.15 will be taken bi-weekly from your paycheck January–December 2015.
- Submit reimbursement documentation by mail, online, or by smartphone app for eligible out-of-pocket medical expenses to WageWorks.
- When you elect a Healthcare FSA, the total annual amount you designate becomes available for eligible healthcare expenses as of January 1, 2015. You do not have to wait for your contributions to accumulate in your account.
- HSS administers a carryover minimum of $10. At the end of the plan year claim filing period, unreimbursed healthcare FSA funds below $10 and over $500 will be forfeited.
- Carryover fund amounts between $10 and $500 are determined after the end of the claim filing period, and are then available for any claims incurred as of the first day of the new plan year.
- A domestic partner's medical expenses cannot be reimbursed under an FSA unless the domestic partner is a "qualifying relative."
- Carryover funds can be accessed for one plan year. Any remaining carryover funds will be forfeited.

Childcare/Eldercare Dependent Care FSA

A Dependent Care FSA can pay for qualifying child and elder care expenses with tax-free funds, such as certified day care, pre-school, day camp, before/after school programs, and dependent care expenses for a qualified relative such as elder care or adult day care. Dependent care expenses must be incurred to enable you (and your spouse if married) to work. Children must be under age 13. For a complete list of eligible dependent care expenses, visit wageworks.com.

- Set aside between $260 and $5,000 pre-tax per household for the plan year. ($2,500 each if you are married filing separate federal tax returns.) Depending on the amount you elect, deductions between $10 and $192.30 will be taken biweekly from your paycheck in 2015.
- If you have a stay-at-home spouse, you may not enroll in the Childcare/Dependent Care FSA.
- Submit reimbursement documentation to WageWorks by mail, online, or by smartphone app for eligible out-of-pocket expenses.
- Funds for a Childcare/Dependent Care FSA are available after being deducted from your paycheck and received by the plan administrator. Unlike a Healthcare FSA, the entire annual amount for a Dependent Care FSA is not available January 1, 2015.
- Funds for a Childcare/Dependent Care FSA must be used for incurred qualifying expenses during the plan year or be forfeited. **Unlike a Healthcare FSA, there is no carryover option.**

FSA Rules

- FSA enrollment is required each year. You must re-enroll in Flexible Spending Account(s) every Open Enrollment if you want to continue this benefit.
- Expenses for services incurred before January 2015 or after December 2015 are not eligible unless covered by the Healthcare FSA Carryover provision.
- You cannot transfer money between Healthcare and Dependent Care Flexible Spending Accounts.
- You cannot change FSA contributions during the January to December plan year unless you have a qualifying event. For details, visit myhss.org/benefits/fsa.html.
- If your employment ends, in some cases you have the option of continuing your FSA with COBRA. (See page 39.) Without COBRA, you can only file claims for eligible FSA expenses that were incurred while you were actively employed.

WageWorks

- FSA benefits are administered by WageWorks.
- For a complete list of FSA eligible healthcare and dependent care expenses, visit wageworks.com.
- Visit the Wageworks EZ Receipts™ Mobile Application at wageworks4me.com/aboutmobile.
- To estimate your annual FSA amount and calculate savings visit the WageWorks FSA Calculator at FSAWorks4Me.com.
- For FSA account information, visit wageworks.com or call 1-877-924-3967, Monday-Friday, 8:00AM–8:00PM Eastern Time.

Avoid Forfeiting FSA Contributions

FSA expenses for the 2015 plan year must be incurred in 2015, and received by WageWorks no later than March 31, 2016. Per IRS rules, you forfeit all funds remaining in an FSA by the end of the claim filing period unless they are covered by the Healthcare FSA Carryover provision. There are no exceptions.

FSAs and Unpaid Leaves of Absence

Healthcare FSA

During an unpaid leave of absence, no payroll deductions can be taken. You may suspend your Healthcare FSA if you notify HSS at the beginning of your leave. Accounts that remain unpaid for three consecutive pay periods will be suspended retroactively to the first missed pay period. To reinstate your Healthcare FSA you must notify HSS **within 30 days** of your return to work. A retroactive reinstatement back to the FSA suspension date allows claims incurred during your leave to be reimbursable. In this case, you must increase your bi-weekly FSA deductions for the remainder of the January to December plan year, so your annual FSA contribution is equal to the total designated during Open Enrollment. You also have the option of reinstating a Healthcare FSA on a go-forward basis, at the original bi-weekly deduction amount. This will reduce your total FSA contribution for January–December 2015.

Dependent Care FSA

A Dependent Care FSA must be suspended while you are on leave. Claims incurred during leave are not reimbursable. To reinstate your FSA, you must notify HSS **within 30 days** of your return to work. Reinstatement of a Dependent Care FSA is only allowed on a go-forward basis. You may reinstate at the original bi-weekly FSA deduction amount or you can increase bi-weekly FSA deductions for January–December 2015. If you increase deductions, total contributions from January to December 2015 must equal, and cannot exceed, the amount that you designated during Open Enrollment.

FSA Reinstatement Rules

If you do not notify HSS **within 30 days** of your return to work and request reinstatement of your FSA payroll deduction, FSA(s) will be cancelled—no exceptions. If you return to work after December 2015, a suspended Healthcare or Dependent Care FSA initiated during 2015 cannot be reinstated—no exceptions.

New or Returning Employees

New or Rehired Employees Must Enroll within 30 Days

Eligible new and rehired employees must enroll in an HSS medical and/or dental plan **within 30 calendar days** of their start work date. If you do not enroll within this 30-day period, you can only apply for benefits during the next Open Enrollment or **within 30 days** of losing other coverage.

Newly Eligible Temporary Exempt Employees

Temporary exempt employees who have worked more than 1,040 hours in any consecutive 12-month period and whose normal work week is not less than 20 hours typically become eligible to enroll in an HSS medical and/or dental plan. (The determination of eligibility is made by the Department of Human Resources; documentation is required.) These employees must enroll **within 30 calendar days** of the date they met eligibility requirements per DHR. Otherwise, they will need to wait until the next Open Enrollment or when a qualifying event occurs. (See pages 34-36.)

How To Enroll

To enroll in an HSS healthcare plan, new or returning employees must submit a completed enrollment application and any required eligibility documentation to HSS. For a checklist of required eligibility documentation, see page 33. Please submit copies of eligibility documentation–not your original documents. If you choose not to hand in an application during your new employee orientation, applications and supporting documentation can be mailed, faxed or dropped off at the HSS office **within 30 calendar days** of your official start work date. See page 46 for HSS phone, fax and address details.

When Coverage Begins

Coverage starts on the first day of the coverage period following your eligibility date, provided you have submitted the required application and eligibility documentation to HSS within the 30-day deadline. Contact HSS Member Services at 415-554-1750 if you have questions about when your coverage will begin.

Employee Responsibility for Healthcare Premium Contributions

Employee premium contributions are deducted from paychecks bi-weekly. Carefully review your paycheck to verify that the correct employee premium contribution is being deducted. If the deduction is incorrect or does not appear on your paycheck, contact HSS Member Services at 415-554-1750. You are responsible for all required employee premium contributions, whether or not they are deducted from your paycheck. (See chart on page 30 for contribution due dates.) If you fail to make a required employee premium contribution by the date it is due, your coverage will be terminated and you will not be permitted to re-enroll in coverage until Open Enrollment in October 2014, with coverage to begin January 1, 2015.

Approaching Retirement

Transition to Retirement

The transition of health benefits from active to retiree status does not happen automatically. If eligible, you must elect to continue retiree health coverage by submitting the retiree enrollment form and supporting documents to HSS. Contact HSS three months before your retirement date to learn about enrolling in retiree benefits. You are required to notify HSS of your retirement, even if you are not planning to elect HSS coverage on your retirement date.

Depending on your retirement date, there can be a gap between when active employee coverage ends and retiree coverage begins. Setting a retirement date at the end of the month will help avoid a gap in HSS coverage. Call HSS at 415-554-1750 to review your options before deciding on your retirement date.

If you choose to continue medical and/or dental coverage through HSS after you retire, your retiree premium contribution may be higher than your active employee contributions. As a retired member, you will also be required to pay for dental coverage. Costs will depend on your plan choices, number of dependents covered, and your Medicare status. **If you choose to take a lump-sum pension distribution, your retiree healthcare premium contributions will be unsubsidized**, and you will pay the full cost.

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

Health premium contributions will be taken from your pension check. If required monthly contributions are greater than the total amount of your pension check, you must contact HSS to make payment arrangements. Premium contribution rates are subject to change every plan year.

All retirees and dependents who are Medicare-eligible due to age or disability are required to enroll. Failure of a retired member or dependent to enroll in Medicare when eligible will result in penalties, limitations in retiree member coverage, and the termination of retiree dependent coverage.

Active Employee Medicare Enrollment

If you are working and eligible for HSS health coverage at age 65 or older, you are not required to enroll in Medicare. However, even though it is not required, you are eligible for Medicare at age 65 and can enroll if you choose to do so. Many employees over age 65 choose to enroll in premium-free Medicare Part A while they are still working. If you enroll in Part A, remember you must contact the Social Security Administration and enroll in Medicare Part B when you retire or otherwise leave City employment. If you are over age 65 and not enrolled in both Medicare Part A and Part B upon retirement, you may be charged penalties by the federal government.

Married Spouse Medicare Enrollment

A legally married spouse covered on an employee's HSS plan is not required to enroll in Medicare. If you have a same-sex spouse, HSS recommends you get a written statement from Social Security confirming Medicare late enrollment penalties will not apply to your same-sex spouse as long as he or she is covered on your employer-sponsored plan. When you retire, a Medicare-eligible spouse must be enrolled in Medicare to be covered on a retiree's health plan.

Domestic Partner Medicare Enrollment

A domestic partner of an active employee who is eligible for Medicare must be enrolled in Medicare to qualify for HSS medical coverage. If enrolled in HSS medical coverage without Medicare, domestic partner benefits can be terminated. The federal government charges a premium for Medicare Part B, and in some cases, for group employer Part D. All Medicare premium payments must be paid to maintain continuous Medicare enrollment. Be aware that domestic partners who fail to enroll in Medicare Part B when first eligible may later be charged significant late enrollment penalties by the federal government.

Hired after January 9, 2009

If you were hired after January 9, 2009, you will retire under new rules for retiree health benefits that are separate and distinct from your retirement pension rules. As you approach retirement, it is important that you meet with an HSS representative to verify that you have met the new eligibility criteria for retiree health benefits and that you are prepared for the higher premium contributions that will be required. Call HSS to schedule an appointment. Visit myhss.org for more information on the new rules in the HSS Retiree Benefits Guide.

Health Coverage Calendar

Payroll Deductions Taken Bi-Weekly

Employee premium contributions are deducted from paychecks bi-weekly—a total of 26 payroll deductions for the January to December 2015 plan year. As of 2015, all employee premium contributions for any benefits coverage period will be paid concurrent with the coverage period. Premiums will no longer be paid in advance.

Work Dates	Pay Date	Benefits Coverage Period
January 3, 2015-January 16, 2015	January 27, 2015	January 1, 2015–January 16, 2015
January 17, 2015–January 30, 2015	February 10, 2015	January 17, 2015–January 30, 2015
January 31, 2015–February 13, 2015	February 24, 2015	January 31, 2015–February 13, 2015
February 14, 2015–February 27, 2015	March 10, 2015	February 14, 2015–February 27, 2015
February 28, 2015–March 13, 2015	March 24, 2015	February 28, 2015–March 13, 2015
March 14, 2015–March 27, 2015	April 7, 2015	March 14, 2015–March 27, 2015
March 28, 2015–April 10, 2015	April 21, 2015	March 28, 2015–April 10, 2015
April 11, 2015–April 24, 2015	May 5, 2015	April 11, 2015–April 24, 2015
April 25, 2015–May 8, 2015	May 19, 2015	April 25, 2015–May 8, 2015
May 9, 2015–May 22, 2015	June 2, 2015	May 9, 2015–May 22, 2015
May 23, 2015–June 5, 2015	June 16, 2015	May 23, 2015–June 5, 2015
June 6, 2015–June 19, 2015	June 30, 2015	June 6, 2015–June 19, 2015
June 20, 2015–June 30, 2015	July 14, 2015	June 20, 2015–July 3, 2015
July 1, 2015–July 3, 2015	July 14, 2015	Not applicable
July 4, 2015–July 17, 2015	July 28, 2015	July 4, 2015-July 17, 2015
July 18, 2015–July 31, 2015	August 11, 2015	July 18, 2015–July 31, 2015
August 1, 2015–August 14, 2015	August 25, 2015	August 1, 2015–August 14, 2015
August 15, 2015–August 28, 2015	September 8, 2015	August 15, 2015–August 28, 2015
August 29, 2015–September 11, 2015	September 22, 2015	August 29, 2015–September 11, 2015
September 12, 2015–September 25, 2015	October 6, 2015	September 12, 2015–September 25, 2015
September 26, 2015–October 9, 2015	October 20, 2015	September 26, 2015–October 9, 2015
October 10, 2015–October 23, 2015	November 3, 2015	October 10, 2015–October 23, 2015
October 24, 2015–November 6, 2015	November 17, 2015	October 24, 2015–November 6, 2015
November 7, 2015–November 20, 2015	December 1, 2015	November 7, 2015–November 20, 2015
November 21, 2015–December 4, 2015	December 15, 2015	November 21, 2015–December 4, 2015
December 5, 2015–December 18, 2015	December 29, 2015	December 5, 2015–December 18, 2015
December 19, 2015–January 1, 2016	January 12, 2016	December 19, 2015–December 31, 2016

If you take an approved unpaid leave of absence, you must pay HSS directly for the premium contributions that were being deducted from your paycheck. Employee premium contributions are due no later than the pay date of the benefits coverage periods above. See page 38 for more information about maintaining health coverage during a leave of absence.

Eligibility

These rules govern which employees and dependents may be eligible for HSS health coverage.

Member Eligibility

The following are eligible to participate in the Health Service System as members:

- All permanent employees of the City & County of San Francisco whose normal work week is not less than 20 hours.
- All regularly scheduled provisional employees of the City & County of San Francisco whose normal work week is not less than 20 hours.
- All other employees of the City & County of San Francisco, including temporary exempt or "as needed" employees, who have worked more than 1,040 hours in any consecutive 12-month period and whose normal work week is not less than 20 hours.
- Elected Officials of the City & County of San Francisco.
- All members of designated boards and commissions during their time in service to the City & County of San Francisco as defined in San Francisco Administrative Code Section 16.700(c).
- All officers and employees as determined eligible by the governing bodies of the San Francisco Transportation Authority, San Francisco Parking Authority, Treasure Island Development Authority, San Francisco Superior Court, and any other employees as determined eligible by ordinance.
- All other employees who are deemed "full-time employees" under the shared responsibility provision of the federal Patient Protection and Affordability Care Act (Section 4980H).
- Temporary exempt employees of the Superior Court appointed for a specified duration of greater than six months with a normal work week not less than 20 hours become eligible on their start date.

Dependent Eligibility

Spouse or Domestic Partner

A member's legal spouse or domestic partner may be eligible for HSS healthcare coverage. Proof of legal marriage or domestic partnership is required, as well as the dependent's Social Security number. Enrollment in HSS benefits must be completed **within 30 days** of the date of marriage or partnership. In that case, coverage begins on the first day of the coverage period after a completed application and eligibility documentation is filed with HSS. A legal spouse or domestic partner can also be added to a member's coverage during Open Enrollment.

Natural Children, Stepchildren, Adopted Children

A member's natural child, stepchild, adopted child (including child placed for adoption), and the natural or adopted child of a member's enrolled domestic partner are eligible for coverage up to 26 years of age. Coverage terminates at the end of the coverage period in which the child turns 26. Eligibility documentation is required upon initial enrollment.

Legal Guardianships and Court-Ordered Children

Children under 19 years of age who are placed under the legal guardianship of an enrolled member, a member's spouse, or domestic partner are eligible. If a member is required by a court's judgement, decree, or order to provide health coverage for a child, that child is eligible up to age 19. Coverage terminates at the end of the coverage period in which the child turns 19. The member must provide HSS with proof of guardianship, court order, or decree by required deadlines.

Adult Disabled Children

Children who are disabled may be covered beyond the age limits stated previously, provided all of the following criteria are met. (A newly hired employee who enrolls an adult disabled child age 26 or older must meet all requirements below, except 1 and 2.)

1. Adult child was enrolled in an HSS medical plan on the child's 19th birthday and continuously covered for at least one year prior to the child's 19th birthday.
2. Adult child was continuously enrolled in an HSS medical plan from age 19 to 26.
3. Adult child is incapable of self-sustaining employment due to the disability.
4. Adult child is unmarried.
5. Adult child permanently resides with the employee member.
6. Adult child is dependent on the member for substantially all of his or her economic support, and is declared as an exemption on the member's federal income tax.
7. Member submits to HSS acceptable medical documentation—a certification that an adult child is enrolled in Medicare due to a Social Security-qualifying disability, or HSS disabled dependent forms completed and signed by a physician—at least 60 days prior to child's attainment of age 26 and every year thereafter as requested.
8. All enrolled dependents who qualify for Medicare due to a disability are required to enroll in Medicare. Members must notify HSS of any dependent's eligibility for, and enrollment in, Medicare.
9. Once enrolled, the member must continuously enroll the disabled adult child in HSS coverage and Medicare (if eligible) to maintain future eligibility.

Medicare Enrollment Requirements

Under Social Security law, Medicare is the primary coverage for an active employee's domestic partner who becomes Medicare-eligible at age 65. The domestic partner must have Medicare Part A and Part B in effect when first eligible at 65.

Medicare also provides primary coverage for a disabled dependent who has been entitled to Social Security Disability Insurance (SSDI) benefits for more than 24 months, or when Medicare eligibility is due to End Stage Renal Disease (ESRD). Medicare primary coverage begins approximately 30 months after the diagnosis of ESRD.

You and your dependents must have Medicare Parts A and B in effect when first eligible for Medicare primary coverage. Failure to enroll when first eligible may result in a late-enrollment penalty from Medicare. HSS Rules require members to enroll when eligible for Medicare primary coverage. Proof of Medicare coverage is required by HSS.

Financial Penalties for Failing to Disenroll Ineligible Dependents

Members must notify HSS **within 30 days** and cancel coverage for a dependent who becomes ineligible. If a member fails to notify HSS, the member may be held responsible for the costs of ineligible dependent health premiums and any medical service provided.

Required Eligibility Documentation

	Evidence Of Hire	Marriage Certificate	Domestic Partner Cert	Birth Certificate	Adoption Certificate	Proof Of Placement	Court Order Or Decree	Medical Evidence	Social Security #
Employee: Permanent/Provisional	■								■
Employee: Temporary/Exempt									■
Spouse		■							■
Domestic Partner			■						■
Child: Natural				■					■
Stepchild: Spouse		■		■					■
Stepchild: Domestic Partner			■	■					■
Child: Adopted					■				■
Child: Placed for Adoption						■			■
Child: Legal Guardianship							■		■
Child: Court Ordered							■		■
Adult Child: Disabled				■				■	■

Note: Proof of Medicare enrollment is also required for a legal domestic partner who is Medicare eligible due to age, disability or End Stage Renal Disease (ESRD). If you have questions about eligibility or required documentation, contact HSS Member Services at 415-554-1750.

Changing Elections Outside of Open Enrollment

A member may make a benefits election change due to a qualifying event during the January–December 2015 plan year. For changes to benefit elections due to a qualifying event, the member must notify the Health Service System and complete the enrollment process. This includes the submission of all required documentation **no later than 30 calendar days** after the qualifying event. A Social Security number is required for all newly enrolled individuals.

Family Status	Enrollment Change	Documentation	Coverage
Marriage Legal Domestic Partnership	Add new spouse or partner to medical and/or dental coverage	• HSS enrollment application • Legal marriage certificate or certification of partnership • Proof of Medicare enrollment for Medicare-eligible domestic partner of either gender	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.
	Add new stepchild to medical and/or dental coverage	• HSS enrollment application • Legal marriage certificate or certification of partnership • Child's birth certificate	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.
	Waive member's medical and/or dental coverage	• HSS enrollment application • Proof of member enrollment in other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.
Divorce Legal Separation Dissolution of Partnership Annulment	Drop former spouse, partner and associated stepchilden from coverage	• HSS enrollment application • Divorce decree or legal documents proving separation, dissolution of partnership or annulment	These individuals are no longer eligible for HSS coverage; failure to drop may result in penalties. Coverage terminates the last day of the coverage period in which the legal divorce, dissolution or separation was granted.
Birth of a Child Adoption of a Child Child Placed for Adoption	Add child to medical and/or dental coverage	• HSS enrollment application • If newborn, birth verification letter from hospital; birth certificate when issued • If adopted, adoption certificate or proof of adoption or placement	Coverage is effective the day of the child's birth, or for an adoption, the date of legal custody. Documentation must be submitted within 30-day deadline.
Legal Guardianship of a Child	Add child to medical and/or dental coverage	• HSS enrollment application • Court decree	Coverage effective the date guardianship takes effect, if documentation submitted within 30-day deadline.
Court-Ordered Coverage for a Child	Add child to medical and/or dental coverage	• HSS enrollment application • Court order to add child	Coverage effective the date of court order, if documentation submitted within 30-day deadline.
	Drop child from medical and/or dental coverage	• HSS enrollment application • Court order for other coverage • Proof child has other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.

A member or eligible dependent who loses other coverage due to termination of employment, a change from full-time to part-time employment, dropping other employer coverage during an Open Enrollment, ineligibility for Medicare or Medicaid, or the commencement of an unpaid leave of absence may enroll in HSS coverage **within 30 calendar days** of these qualifying events.

Loss of Coverage	Enrollment Change	Documentation	Coverage
Member Loses Other Coverage	Enroll member (and dependents who also lost coverage) in medical and/or dental coverage	• HSS enrollment application • Proof of loss of coverage • All required dependent eligibility documentation (See page 33.)	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.
Spouse or Partner Loses Other Coverage	Enroll spouse or partner in medical and/or dental coverage	• HSS enrollment application • Proof of loss of coverage • Legal marriage certificate or certification of partnership	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.
Dependent Child or Stepchild Loses Other Coverage	Enroll child or stepchild in medical and/or dental coverage	• HSS enrollment application • Proof of loss of coverage • Child's birth certificate • Legal marriage certificate or certification of partnership (if stepchild)	Coverage is effective the first day of the coverage period following submission of required documentation within 30-day deadline.

A member or dependent who gains other coverage due to commencement of employment, a change from part-time to full-time employment, adding other coverage during another employer's Open Enrollment, eligibility for Medicare or Medicaid, or return to work from an unpaid leave of absence may drop HSS coverage **within 30 calendar days** of these qualifying events. A member may only waive coverage for him or her self and/or dependents outside of Open Enrollment with proof of obtaining other coverage. If a member waives coverage, dependent coverage must also be waived.

Gain of Coverage	Enrollment Change	Documentation	Coverage
Member Gains Other Coverage	Waive member's medical and/or dental coverage	• HSS enrollment application • Proof of other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.
Spouse or Partner Gains Other Coverage	Drop spouse or partner from medical and/or dental coverage	• HSS enrollment application • Proof of other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.
Dependent Child or Stepchild Gains Other Coverage	Drop child or stepchild from medical and/or dental coverage	• HSS enrollment application • Proof of other coverage	Coverage terminates the first day of the coverage period following submission of required documentation within 30-day deadline.

Death of a Dependent

If an enrolled dependent dies, you should notify HSS as soon as possible and submit a copy of the death certificate **within 30 days** of the date of death. Coverage for your deceased dependent will terminate the day after the dependent's death.

Death of a Member

In the event of a member's death, the surviving dependent or survivor's designee should contact HSS to obtain information about eligibility for survivor health benefits. To be eligible for health benefits, the surviving spouse or domestic partner of an employee must have been legally married to the member, or registered as the member's domestic partner, for at least one year prior to the death of the member. The surviving spouse or domestic partner of an active member hired after January 9, 2009, may not be eligible for HSS benefits. Other restrictions apply.

After being notified of a member's death, HSS will send instructions to the spouse or partner, including a list of documentation required for enrolling in surviving dependent health coverage. To avoid a break in coverage for survivors who were enrolled in HSS benefits at the time of the member's death, the following must be submitted to HSS **within 30 days** of the member's date of death:

- Completed surviving dependent enrollment form
- Copy of member's death certificate
- Copy of certificate of marriage or partnership (if not already on file at HSS)
- Copy of survivor's Medicare card (if survivor is Medicare-eligible)

A surviving spouse or partner who is not enrolled on the deceased member's health plan at the time of the member's death may be eligible for coverage, but must wait until Open Enrollment to enroll. Surviving dependent children of a member must meet eligibility requirements for dependent children and be enrolled at the time of the member death and are only eligible for benefits under a surviving spouse or surviving domestic partner.

Moving Out of a Plan's Service Area

If you move your primary residence to a location outside your health plan's service areas, you will no longer be able to obtain services through that plan. You will need to enroll in a different HSS plan that offers service based on your new address. You must complete an HSS application to elect a new plan **within 30 days** of your move. Coverage under the new plan will be effective the first day of the coverage period following the date HSS receives your completed enrollment application. If you do not enroll in a new plan **within 30 days** of your move, you must wait until the next Open Enrollment.

Changing Contributions to a Flexible Spending Account (FSA)

Per IRS regulations, some qualifying events allow you to initiate or modify contributions to a Healthcare and/or Dependent Care Flexible Spending Account during the January to December 2015 plan year. For a list of qualifying events and corresponding authorized FSA contribution changes, call HSS at 415-554-1750 or visit myhss.org/benefits/fsa.html.

Financial Penalties for Failing to Disenroll Ineligible Dependents

Members must notify HSS **within 30 days** and cancel coverage for a dependent who becomes ineligible. If a member fails to notify HSS, the member may be held responsible for the costs of ineligible dependent health premiums and any medical service provided.

Please note that you or any covered dependent with End Stage Renal Disease may be prohibited from changing health plan enrollment.

Domestic Partner Health Benefits Taxation

Health coverage for a domestic partner and a partner's children is a taxable benefit under federal law.

Tax Treatment of Domestic Partner Benefits

The federal government does not recognize domestic partnership for tax purposes. Employer contributions to health premiums for an employee's domestic partner and children of a domestic partner are taxable (imputed) income. Also, employee premium contributions are taken post-tax. By comparison, if an employee is legally married, no taxable imputed income results from employer contributions to the spouse's health premium costs and employee premium contributions for the spouse are paid pre-tax.

IRS Exemption for Enrolled Health Plan Dependents Who Meet Certain Requirements

The Internal Revenue Service (IRS) offers a tax break for health-related expenses incurred by a "qualifying relative." Under IRS code section 152, a domestic partner (of either gender), and children of a domestic partner qualify for favorable tax treatment if:

1. Partner or child receives more than half of his or her financial support from the employee; and
2. Partner or child lived with the employee as a member of his or her household for the entire calendar year (January 1–December 31), with the exception of temporary absences due to vacation, education or military service; and
3. Partner or child is a citizen of the United States, or a resident of the United States, Canada or Mexico.

If an enrolled dependent meets all requirements, the employee may submit an annual declaration to HSS, and there will be no imputed income for the employer contribution to dependent health premiums. To receive favorable tax treatment, you must file the declaration annually with HSS by required deadlines.

Equitable California State Tax Treatment

If a domestic partner and associated dependents do not meet the IRS requirements for favorable tax treatment under federal law, you may be able to take advantage of equitable California state tax treatment. This California law only applies to same-sex domestic partners–not opposite-sex domestic partners. To obtain equitable tax treatment under California state law, you are required to have a Declaration of Domestic Partnership issued by the Secretary of the State of California. You will need to deduct the value of the employer-paid health insurance premiums for your same-sex domestic partner, and his or her children, when filing your California state income tax return.

Same-Sex Spouses

Health premium contributions for same-sex spouses and their children are no longer taxable imputed income under federal law, due to the Supreme Court ruling, which declared the federal Defense of Marriage Act unconstitutional.

Consult with Your Tax Advisor

This is a brief overview regarding the tax treatment of health benefits for domestic partners. Laws are subject to change. Please consult with a professional tax advisor before taking any action. It is your responsibility to comply with state and federal tax law.

Notifying HSS About a Leave of Absence

Type of Leave	Eligibility	Your Responsibilities
Family and Medical Leave (FMLA) Worker's Compensation Leave Family Care Leave Military Leave	If you notify HSS **within 30 days** of when your leave begins, you may be eligible to continue or discontinue (waive) your healthcare coverage for the duration of your approved leave of absence. You may have additional rights under an approved FMLA leave. Contact your departmental personnel representative for details.	1. Notify your department's personnel officer. They will provide HSS with important information about your leave. 2. Contact HSS **within 30 days** of when leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits. 3. Contact HSS immediately (**within 30 days** of return to work) to request that premium contributions return to active status.
Personal Leave Following Family Care Leave	If you have been on an approved Family Care Leave and elect to extend your leave period as a Personal Leave, you may be eligible to continue (or waive) your healthcare coverage for the duration of your approved Personal Leave, if: • The reason for the Personal Leave is the same as the reason for the prior Family Care Leave. • Your required employee premium contribution payments, if any, are current. • You notify HSS before your leave begins.	1. Notify your department's personnel officer. They will provide HSS with important information about your leave. 2. Contact HSS **within 30 days** of when leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits. 3. Contact HSS immediately (**within 30 days** of return to work) to request that premium contributions return to active status.
Educational Leave Personal Leave Leave for Employment as an Employee Organization Officer or Representative	If you notify HSS **within 30 days** of when your leave begins, you may be eligible to continue (or waive) your healthcare coverage for the duration of your approved leave of absence.	1. Notify your department's personnel officer. They will provide HSS with important information about your leave. 2. Contact HSS **within 30 days** of when leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits. 3. If your leave lasts beyond 12 weeks, you must pay the total cost of medical and dental coverage for yourself and any covered dependents. This includes your employee premium contribution amount, plus the City & County of San Francisco's contribution. Contact HSS for details. 4. Contact HSS immediately (**within 30 days** of return to work) to request that premium contributions return to active status.

For a complete list of types of leave, visit sfdhr.org/index.aspx?page=442

Holdover, COBRA and Covered California

Holdover Rights

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

1. Employees must certify, on an annual basis, that they are unable to obtain healthcare coverage from another source.
2. Premium contributions must be paid by the due date listed on the 2015 Health Coverage Calendar (see page 30). Rates are subject to increase each plan year.

COBRA

Under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), employees without holdover rights, or whose holdover rights have ended, may be eligible to continue medical, dental, and vision coverage for themselves and eligible dependents. Current year FSAs may also be COBRA-eligible. COBRA is administered by WageWorks. For questions about COBRA, call WageWorks at 1-877-502-6272.

COBRA Qualifying Events

Employees may elect to continue healthcare coverage through COBRA if coverage is lost due to:

- Voluntary or involuntary termination of employment (except for gross misconduct).
- Hours of employment reduced, making the employee ineligible for employer health coverage.

Covered spouses or domestic partners may also elect to be covered under COBRA if coverage is lost due to:

- Voluntary or involuntary termination of the employee's employment (except for misconduct).
- Divorce, legal separation, or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

Covered dependent children may elect COBRA coverage if healthcare coverage is lost due to:

- Loss of dependent child status under the plan rules.
- Voluntary or involuntary termination of the employee employment (except for misconduct).
- Hours of employment reduced, making the employee ineligible for employer health coverage.
- Parent's divorce, legal separation, or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

Dependents dropped from coverage during Open Enrollment are not eligible for COBRA.

COBRA Notification and Election Time Limits

If an employee and any enrolled dependents lose HSS coverage due to separation from employment, WageWorks will notify the employee of the opportunity to elect COBRA coverage. The employee or dependent has 60 days from the COBRA notification date to complete enrollment and continue coverage. Coverage will be retroactive to the date of the COBRA-qualifying event, so there is no break in coverage. Employee coverage ends on the last day of the coverage period in which employment terminates. However, if the termination date falls on the first day of the coverage period, coverage ends that same day.

If an enrolled dependent of an employee loses coverage due to divorce, dissolution of partnership, or aging out, the employee or the dependent must notify WageWorks **within 30 days** of the qualifying event and request COBRA enrollment information.

Duration of COBRA Continuation Coverage

COBRA coverage is generally available for a maximum of 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a coverage extension for up to 36 months. Employees and dependents who are eligible for less than 36 months of federal COBRA may also be eligible for Cal-COBRA. Continuation coverage under both federal and California state COBRA will not exceed 36 months.

Employees who are disabled on the date of their qualifying event, or at any time during the first 60 days of COBRA coverage, are eligible for 29 months of coverage. Beginning the 19th month of coverage, the cost will rise to 150% of group rate.

Paying for COBRA

It is the responsibility of covered individuals enrolled in COBRA to pay required healthcare premium payments directly to WageWorks. COBRA premiums are not subsidized by the employer.

2015 Monthly COBRA Premium Rates

City Health Plan	
Employee Only	$1,032.66
Employee +1	$2,027.10
Employee +2 or More	$2,855.82

Blue Shield	
Employee Only	$660.32
Employee +1	$1,318.58
Employee +2 or More	$1,864.93

Kaiser	
Employee Only	$565.06
Employee +1	$1,128.05
Employee +2 or More	$1,595.33

Delta Dental	
Employee Only	$67.27
Employee +1	$141.26
Employee +2 or More	$201.80

DeltaCare USA	
Employee Only	$27.49
Employee +1	$45.35
Employee +2 or More	$67.08

Pacific Union Dental	
Employee Only	$28.36
Employee +1	$46.82
Employee +2 or More	$69.22

Flexible Spending Accounts and COBRA

To continue FSA benefits under COBRA, year-to-date FSA contributions must exceed year-to-date claims as of your employment termination date. To keep your FSA open, you apply under COBRA and continue making the bi-weekly contribution plus a 2% administrative charge. COBRA Flexible Spending Account contributions are made post-tax.

Termination of COBRA Continuation Coverage

COBRA coverage will end if:

- You obtain coverage under another group plan.
- You fail to pay the premium required under the plan within the grace period.
- The applicable COBRA period ends.

COVERED CALIFORNIA

Covered California

Individuals who are not eligible for HSS coverage should consider obtaining health insurance through the state insurance exchange, Covered California.

Based on income, individuals and families who do not have access to employer-sponsored coverage may qualify for a federal premium tax credit and/or cost sharing reductions when purchasing health insurance through Covered California. For information about Covered California health plans, call 1-888-975-1142 or visit coveredca.com.

Compare the plans and premiums available through Covered California before making a decision about enrolling in COBRA.

Privacy

Use and Disclosure of Your Personal Health Information

The Health Service System maintains policies to protect your personal health information, in accordance with HIPAA, the federal Health Insurance Portability and Accountability Act. These policies are designed to avoid disclosure of your health information, except for the following uses:

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

Other than the uses listed above, the Health Service System will not disclose your health information other than with your written authorization. If you authorize the Health Service System to disclose your health information, you may revoke that authorization in writing at any time.

Your Rights With Regard to Your Health Information

You may request restrictions on the use and disclosure of your health information by sending your request in writing to the Health Service System. The Health Service System will evaluate and reply to your request. For example, you may:

- Ask that the Health Service System only communicate with you at a certain phone number or at a certain email address.
- Ask for a copy of your health information on file with the Health Service System (a fee may be charged for paper copies).
- Ask that incorrect records held by the Health Service System be corrected.
- Request a list of Health Service System disclosures of your personal health information for reasons other than facilitating treatment, or maintaining business and finance operations.

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

Written requests or complaints should be sent to:

Health Service System
1145 Market Street, 3rd Floor
San Francisco, CA 94103
Attn: Privacy Officer

Full Legal Notice

This is a summary of a legal notice that details Health Service System privacy policy. The full legal notice is available at myhss.org/health_service_board/privacy_policy.html.

You may also contact the Health Service System to request a written copy of the full legal notice.

Premium Contribution Rates

City & County of San Francisco Employees, Municipal Transportation Agency, Police and Fire

BI-WEEKLY MEDICAL PREMIUM CONTRIBUTION RATES: EMPLOYEE ONLY

MEDICAL PLAN RATES	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
CCSF—CITY & COUNTY OF SAN FRANCISCO EMPLOYEES						
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives (MEA) MISC Unrepresented Managers Elected Officials Municipal Executives (MEA)—Fire Municipal Executives (MEA)—Police	$262.06	$36.73	$255.68	0	$262.06	$205.21
MTA—MUNICIPAL TRANSPORTATION AGENCY EMPLOYEES						
Municipal Executives (MEA)—MTA Unrepresented Managers	$262.06	$36.73	$255.68	0	$262.06	$205.21

BI-WEEKLY MEDICAL PREMIUM CONTRIBUTION RATES: EMPLOYEE + 1

MEDICAL PLAN RATES	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
CCSF—CITY & COUNTY OF SAN FRANCISCO EMPLOYEES						
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives (MEA) MISC Unrepresented Managers Elected Officials Municipal Executives (MEA)—Fire Municipal Executives (MEA)—Police	$262.06	$334.58	$255.68	254.75	$262.06	$655.18
MTA—MUNICIPAL TRANSPORTATION AGENCY EMPLOYEES						
Municipal Executives (MEA)—MTA Unrepresented Managers	$262.06	$334.58	$255.68	254.75	$262.06	$655.18

BI-WEEKLY FLEX CREDITS[1]

	EMPLOYEE ONLY	EMPLOYEE +1
MEA Miscellaneous Unrepresented Managers	$303.02	$349.64
Municipal Executives (MEA)—MTA	$303.02	$349.64
Unrepresented Managers—MTA	$303.02	$349.64
MEA—Fire and Police	$349.64	$349.64

[1]Flex Credits for Employee + 2 or more are imbedded in the table for Employee + 2 or more.

All rates, including flex credit amounts, published in this guide are subject to final approval of employers and the San Francisco Board of Supervisors. To learn of any changes to rates, please visit myhss.org.

See pages 22-23 for information about flex credits, which can be allocated toward employee premium contributions.

BI-WEEKLY MEDICAL PREMIUM CONTRIBUTION RATES: EMPLOYEE + 2 OR MORE

MEDICAL PLAN RATES	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
CCSF—CITY & COUNTY OF SAN FRANCISCO EMPLOYEES						
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives (MEA) MISC Unrepresented Managers Elected Officials	0	$843.86	0	$721.87	0	$1,292.22
*Flex Credits**		($700.40)		($599.15)		($700.40)
Net	0	$143.46	0	$122.72	0	$591.82
MTA—MUNICIPAL TRANSPORTATION AGENCY EMPLOYEES						
Municipal Executives (MEA)—MTA Unrepresented Managers	0	$843.86	0	$721.87	0	$1,292.22
*Flex Credits**		($700.40)		($599.15)		($700.40)
Net	0	$143.46	0	$122.72	0	$591.82
CCSF – CITY & COUNTY OF SAN FRANCISCO EMPLOYEES—POLICE AND FIRE						
Municipal Executives (MEA)—Fire Municipal Executives (MEA)—Police	$262.06	$581.80	$255.68	$466.19	$262.06	$1,030.16
Flex Credits		($349.64)		($349.64)		($349.64)
Net	$262.06	$232.16	$255.68	$116.55	$262.06	$680.52

*Flex credits for Employees + 2 or more have been increased to reflect the City's commitment to ensuring affordable health coverage for families.

BI-WEEKLY DENTAL PLANS PREMIUM CONTRIBUTION RATES

DELTA DENTAL	EMPLOYEE ONLY		EMPLOYEE +1		EMPLOYEE +2 OR MORE	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Delta Dental	$28.13	$2.31	$59.30	$4.62	$84.39	$6.92
DeltaCare USA	$12.44	0	$20.52	0	$30.35	0
Pacific Union Dental	$12.83	0	$21.18	0	$31.32	0

All rates, including flex credit amounts, published in this guide are subject to final approval of employers and the San Francisco Board of Supervisors. To learn of any changes to rates, please visit myhss.org.

See pages 22-23 for information about flex credits, which can be allocated toward employee premium contributions.

Superior Court of California, County of San Francisco

BI-WEEKLY MEDICAL PREMIUM CONTRIBUTION RATES: EMPLOYEE ONLY

MEDICAL PLAN RATES	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives (MEA) Unrepresented Managers Court Duty Officer Courts Commissioners' Association	0	$298.79	0	$255.68	0	$467.27

BI-WEEKLY MEDICAL PREMIUM CONTRIBUTION RATES: EMPLOYEE + 1

MEDICAL PLAN RATES	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives (MEA) Unrepresented Managers Court Duty Officer Courts Commissioners' Association	0	$596.64	0	$510.43	0	$917.24

BI-WEEKLY MEDICAL PREMIUM CONTRIBUTION RATES: EMPLOYEE + 2 OR MORE

MEDICAL PLAN RATES	BLUE SHIELD HMO		KAISER PERMANENTE HMO		CITY HEALTH PLAN PPO	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Municipal Executives (MEA) Unrepresented Managers Court Duty Officer Courts Commissioners' Association	0	$843.86	0	$721.87	0	$1,292.22

BI-WEEKLY FLEX CREDITS

	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE +2	
			Blue Shield or City Health Plan	Kaiser
MEA Superior Court	$897.00	$897.00	$897.00	$897.00

BI-WEEKLY DENTAL PLANS PREMIUM CONTRIBUTION RATES

	Delta Dental		DentalCare USA		Pacific Union Dental	
	Employer Pays	Employee Pays	Employer Pays	Employee Pays	Employer Pays	Employee Pays
Employee Only	$30.44	0	$12.44	0	$12.83	0
Employee + 1 Dependent	$63.92	0	$20.52	0	$21.18	0
Employee + 2 or More Dependents	$91.31	0	$30.35	0	$31.32	0

All rates, including flex credit amounts, published in this guide are subject to final approval of employers and the San Francisco Board of Supervisors. To learn of any changes to rates, please visit myhss.org.

See pages 22-23 for information about flex credits, which can be allocated toward employee premium contributions.

Health Service Board

Per the San Francisco City Charter, the Health Service Board conducts an annual review of health benefit costs, ensures benefits are applied without favor or privilege, and administers the business of the Health Service System. One commissioner is a City Supervisor, two commissioners are appointed by the Mayor and one is appointed by the City Controller. Three commissioners are elected from the HSS membership to serve five-year terms.

2015 Health Service Board Commissioners

Karen Breslin
Elected

Retired
San Francisco
Probation Department

Sharon Ferrigno
Elected

Deputy Chief
San Francisco
Police Department

Wilfredo Lim
Elected

Accounting Manager
San Francisco
General Hospital

Mark Farrell
Appointee (by the Board of Supervisors)

San Francisco
Board of Supervisors

Jean S. Fraser (President)
Appointee (by the Mayor)

Health System Chief
San Mateo County

Randy Scott
Appointee (by the Controller)

Vice President
Human Resources
Institute on Aging

Jordan Shlain, M.D.
Appointee (by the Mayor)

Internal Medicine
Private Practice
San Francisco

Health Service Board meetings are held the second Thursday of the month, at 1:00PM in San Francisco City Hall, Room 416. Meeting announcements are posted at myhss.org/health_service_board.

Watch Health Service Board meetings on SFGovTV at sanfrancisco.granicus.com/ViewPublisher.php?view_id=168.

Submit a comment to the Health Service Board at surveymonkey.com/s/hssboard.

Key Contact Information

HEALTH SERVICE SYSTEM

Member Services
1145 Market Street, 3rd Floor
San Francisco, CA 94103
(Civic Center Station between 7th and 8th)
Tel: 415-554-1750
1-800-541-2266 (outside 415)
Fax: 415-554-1721
myhss.org

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

MEDICAL PLANS

City Health Plan (UnitedHealthcare)
Tel: 1-866-282-0125
Group 752103
myuhc.com

Blue Shield of California
Tel: 1-800-642-6155
Group H12187
blueshieldca.com/sfhss

Kaiser Permanente
Tel: 1-800-464-4000
Group 888 (Northern California)
Group 231003 (Southern California)
my.kp.org/ca/cityandcountyofsanfrancisco

DENTAL PLANS

Delta Dental
Tel: 1-888-335-8227
Group 9502-0003
deltadentalins.com/ccsf

DeltaCare USA Dental
Tel: 1-800-422-4234
Group 01797-0001
deltadentalins.com/ccsf

Pacific Union Dental (UnitedHealthcare)
Tel: 1-800-999-3367
Group 705287-0046
myuhcdental.com

FLEX CREDIT BENEFITS

Employee Benefits Specialists (EBS)
Tel: 1-800-229-7683
ebsbenefits.com

VISION PLAN

Vision Service Plan (VSP)
Tel: 1-800-877-7195
Group 12145878
vsp.com

FLEXIBLE SPENDING ACCOUNTS (FSAs) and COBRA

WageWorks
FSAs: 1-877-924-3967
COBRA: 1-877-502-6272
wageworks.com

LONG-TERM DISABILITY (LTD) and GROUP LIFE INSURANCE

Aetna
LTD: 1-866-326-1380
Life Insurance: 1-800-541-2266
Group 839201
aetna.com/group/aetna_life_essentials

OTHER AGENCIES

Department of Human Resources
Tel: 415-557-4800
sfgov.org/dhr

Department of the Environment (Commuter Benefits)
Tel: 415-355-3729
sfenvironment.org

San Francisco Employees' Retirement System (SFERS)
Tel: 415-487-7000
sfers.org

CalPERS
Tel: 1-888-225-7377
calpers.ca.gov

Covered California
Tel: 1-888-975-1142
coveredca.com

This guide was printed in the USA with soy ink on forest friendly, recycled paper. When it has outlived its usefulness to you, please recycle.

The Health Service System of the City & County of San Francisco is dedicated to preserving and improving sustainable, quality health benefits and enhancing the well-being of employees, retirees and their families.

HEALTH SERVICE SYSTEM
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

hss-oe-bnftsgd-mea-15