2011-2012

RETIRED EMPLOYEES

BENEFITS GUIDE

Health Service System

CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

Contents

Open Enrollment Overview

Open Enrollment takes place April 1–29, 2011. Review your choices and make informed decisions.

Things You Can Do During Open Enrollment

- Change medical or dental plan elections.
- Add or drop dependents from medical and/or dental coverage.

Read this guide and visit www.myhss.org for additional resources that can support your decision-making process, such as Evidence of Coverage (EOC) documents, Vendor Report Cards, Summaries of Benefits and other plan information.

Open Enrollment Deadline: April 29, 2011

Completed Open Enrollment applications for plan year 2011-2012 must be received at HSS by 5:30PM, April 29, 2011. Open Enrollment applications can be delivered to HSS in person, sent through the mail or sent by fax. The HSS fax number is (415) 554-1721.

Eligibility Documentation Required

A Social Security number and proof of Medicare enrollment (if eligible) must be provided for all enrollees, including dependents. Additional documentation may also be required. See page 33 for a documentation checklist.

Health Service System Open House April 1–29, 2011

Visit or call HSS and get your questions answered. No appointment necessary. Health plan vendors will be at HSS Monday–Friday, April 18 to April 29, 2011.

Health Service System Office	
1145 Market Street, 2nd Floor	Monday–Friday
San Francisco, CA 94103	8:00AM to 5:00PM

Changing Benefit Elections During Open Enrollment

Any changes you make during April 2011 Open Enrollment will be in effect from July 1, 2011 through June 30, 2012. If you elect to change your medical plan, the plan will issue you a new medical ID card before July 1, 2011. If you do not receive your card by July 1, contact your plan. Newly enrolled Kaiser and Blue Shield members should also contact their plan to confirm their Primary Care Physician (PCP) selection.

Dropped Dependents Not Eligible for COBRA Coverage

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

If You Do Not Make Any Changes During Open Enrollment

If you do not make changes during Open Enrollment, your current medical and dental plan elections and the eligible dependents you have covered will remain the same for plan year 2011-2012.

Medical, dental and vision plan benefit changes– take note of these important updates.

Summary of Changes Effective July 1, 2011:

All Medical, Dental and Vision Plans

Natural children, stepchildren and adopted children are eligible for coverage up to age 26, effective July 1, 2011. See page 32 for details.

All Medical Plans

Depending upon the medical plan you are enrolled in, and number of individuals enrolled, premium contribution rates may change in 2011-2012. See rate charts on pages 43-47.

Some preventive care exams, immunizations and tests will be covered at no co-pay cost. Restrictions, such as using in-network providers, may apply. See your plan's Evidence of Coverage, available on www.myhss.org.

Kaiser Permanente	
Senior Advantage HMO (Medicare Advantage) Traditional HMO (No Medicare)	Southern California service areas added
Blue Shield of California	
65 Plus HMO (Medicare Advantage) Access+ HMO (Medicare Coordinated) This plan is only available to Medicare-enrolled members living outside a 65 Plus service area. Access+ HMO (No Medicare)	$150 co-pay per hospital admittance $45 co-pay 30-day supply non-formulary drugs (pharmacy) $90 co-pay 90-day supply non-formulary drugs (mail order) 20% up to $100 co-pay (specialty drugs) Residential treatment coverage for chemical dependency No lifetime limit on smoking cessation prescriptions
City Health Plan	
United Healthcare PPO	No lifetime coverage maximum $45 co-pay 30-day supply non-formulary drugs (pharmacy) $90 co-pay 90-day supply non-formulary drugs (mail order)
Vision Service Plan	
VSP	$60 maximum co-pay for contact lens fitting Out-of-network eye exam covered up to $50 Out-of-network eye glass frame allowance up to $70

These alerts include highlights only and may not cover every plan change. Please read the Evidence of Coverage (EOC) for details about your plan's benefits. EOCs are available on www.myhss.org.

What's New for 2011–2012

A summary of how federal healthcare reform impacts your health benefits.

Eligibility Rules for Children

Effective July 1, 2011, as a result of the Patient Protection and Affordable Care Act passed by Congress in March 2010, some children up to age 26 are eligible for HSS medical, dental and vision coverage.

Eligible children include:

- Your natural child
- Your adopted child (or child placed for adoption)
- Your stepchild
- Your domestic partner's child

Your children, stepchildren and domestic partner's children have no other eligibility restrictions. They may be married, living independently, or eligible for their own employer coverage and need not be your tax dependent or supported by you.

Dependent eligibility based on tax-deduction status, proven by the submission of member's tax returns, is no longer permitted.

If your child turned age 25 in 2010 and was or will be dropped from your plan, you may re-enroll the child during Open Enrollment, with coverage for the child to begin July 1, 2011, and continue up to age 26.

Children enrolled due to legal guardianship or court order are eligible up to age 19.

See page 32 of this guide for more information about eligibility rules, deadlines and required documentation.

Prohibition on Lifetime and Annual Limits

Healthcare reform law contains a provision stating that group health plans cannot establish a lifetime or annual limit on the dollar value of essential health benefits.

Preventative Care Services

To help people stay healthy, avoid or delay the onset of disease, lead productive lives, and reduce health insurance costs, federal healthcare reform includes a provision focusing on disease prevention. Depending on your age and health plan type, you can access some preventative services, screenings and immunizations at no cost or reduced out-of-pocket cost. For details check your plan's website and read your plan's Evidence of Coverage, available on www.myhss.org.

Medicare and Brand-name Prescription Drugs

As of January 1, 2011, brand-name prescription drugs made and sold by companies that have not agreed to give a discount to Medicare can no longer be paid for by Medicare plans. This includes Blue Shield 65 Plus, Blue Shield Access+ COB and Kaiser Senior Advantage.

This is a summary of federal healthcare reform highlights. For more information on healthcare reform, please visit www.healthcare.gov.

Open Enrollment FAQ

What if I don't want to make any changes to my medical or dental coverage?	If you do not want to choose a different medical or dental plan and are not adding or dropping dependents, you do not need to take any action during April 2011 Open Enrollment.
How do I choose different medical or dental coverage?	Review the plan options carefully, then submit a completed Open Enrollment application form and required eligibility documentation to HSS no later than 5:30PM, April 29, 2011. See page 33.
How do I add a dependent to my medical and/or dental plan?	You must submit a completed Open Enrollment application form and any required eligibility documentation to HSS no later than 5:30PM, April 29, 2011. For a list of required eligibility documentation, see page 33.
How do I drop a dependent from my medical and/or dental plan?	You must submit a completed Open Enrollment application form to HSS no later than 5:30PM, April 29, 2011. No additional documentation is required when you are dropping a dependent from coverage during Open Enrollment.
If I drop a dependent during Open Enrollment is he or she eligible for COBRA?	No. In accordance with federal law, dependents dropped during Open Enrollment are not eligible for COBRA.
May I fax my enrollment application and eligibility documentation to HSS?	Yes, you may fax your Open Enrollment application and required eligibility documentation. For a list of required eligibility documentation, see page 33 of this guide. The secure HSS fax number is (415) 554-1721. Faxed applications must be received by HSS no later than 5:30PM, April 29, 2011. Please do not fax the same application multiple times.
Will I receive a confirmation from HSS after I submit my enrollment application?	Yes, HSS will mail a letter to the home address that is on file with HSS, confirming your benefit elections. These letters will be sent in June 2011 after the close of Open Enrollment. Note: no changes to Open Enrollment elections can be made after April 29, 2011. HSS can only correct administrative errors based on the Open Enrollment application you submitted in April 2011.
How are retiree health premium contributions paid?	Retiree premium contributions are usually deducted from monthly pension checks. See pages 43-47 of this guide for premium contribution rates. Review your pension check to be sure the correct deduction is taken. You are responsible for making sure required healthcare contributions are paid.
What if my pension check does not cover the cost of my premium contributions?	If required monthly premium contributions are greater than the total amount of your pension check, you must contact HSS at (415) 554-1750 to make payment arrangements. One option is HSS Auto-Pay, which allows you to have healthcare contributions deducted automatically from a MasterCard or VISA.
Can an HSS member or dependent be enrolled in two HSS health plans at the same time?	No dual coverage–one plan per person. HSS will automatically eliminate any dual coverage. For a member who is covered both as a member and as a dependent of another member, coverage as a dependent will be terminated. For any dependent covered by two members, the dependent will be covered by the member who covered the dependent first, based on the enrollment application date.

Medicare and Your HSS Benefits

HSS rules require all eligible retired members and their dependents to enroll in Medicare Part A and Part B.

Medicare Basics

Medicare is a federal health insurance program administered by the Centers for Medicare & Medicaid Services (CMS) for people age 65 years or older, under age 65 with Social Security-qualified disabilities, and people of any age with End-stage Renal disease (permanent kidney failure requiring dialysis or transplant). The different parts of Medicare help cover specific services:

- Medicare Part A: Hospital Insurance
- Medicare Part B: Medical Insurance
- Medicare Part D: Prescription Drug Coverage

All eligible retired members and any covered eligible dependents must enroll in Medicare Part A and Part B. **Failure by you or enrolled dependents to enroll in Medicare by required deadlines will mean a change in or loss of medical plan coverage.**

If you are receiving Social Security benefits, the Social Security Administration will notify you prior to your 65th birthday or when you become disabled regarding your eligibility for Medicare. If you are not currently receiving Social Security benefits, it is your responsibility to contact the Social Security Administration prior to your 65th birthday or when you become disabled to apply for Medicare. Failure to do so could result in penalties being assessed by the Social Security Administration and the Health Service System. If you have a Social Security-qualified disability or you have End-stage Renal Disease (permanent kidney failure requiring dialysis or transplant), you should contact the Social Security Administration immediately to apply for Medicare.

Medicare Part A: Hospital Insurance

Most people do not pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to qualify for these benefits.

HSS rules require all retired members and dependents to enroll in premium-free Medicare Part A as soon as they are eligible. You are eligible for premium-free Medicare Part A if you are age 65 or older and have worked and contributed to Social Security for at least 10 years (40 quarters). You may also qualify for Medicare Part A through a current, former, or deceased spouse. If you are under age 65 and have End-stage Renal Disease (permanent kidney failure requiring dialysis or transplant) or a Social Security-qualified disability you may also qualify for Medicare Part A. If you are under age 65 with a qualifying disability, Medicare coverage generally begins 24 to 30 months following eligibility. If you have questions about your eligibility for premium-free Medicare Part A, contact the Social Security Administration.

What if I'm not eligible for premium-free Medicare Part A?

If you are not eligible for premium-free Medicare Part A, you will not be required to enroll in Medicare Part A, but you must submit to HSS a statement from the Social Security Administration verifying that you are not eligible for premium-free Medicare Part A coverage. HSS still requires you to enroll in Medicare Part B, even if you are not eligible for Medicare Part A.

Medicare Part B: Medical Insurance

HSS rules require that all retired members and their dependents enroll in Medicare Part B as soon as they are eligible. Medicare Part B helps cover the cost of doctors' services and outpatient medical services. Most people pay a monthly premium to the federal government for Part B coverage. The Medicare Part B monthly premium, which is based on your income per CMS regulations, is usually deducted from your Social Security check. If your income falls after you enroll in Part B, you may be eligible for a Part B premium reduction. For information on Medicare Part B premiums, or to request a Part B premium reduction, contact the Social Security Administration at (800) 772-1213. If you do not enroll in Medicare Part B when you first become eligible, your Part B premium will be higher and penalties may be charged when you do enroll. This higher premium and/or penalty will continue for the entire time you are on Medicare.

What if either I or my dependent did not enroll in Medicare Part A and/or Part B when originally eligible?

If you or a dependent were eligible at age 65, or sooner due to a disability, but did not enroll in Medicare Part A and/or Part B, that individual may be assessed a penalty by the Social Security Administration for each year in which he or she was eligible but failed to enroll. HSS members and dependents are required to enroll in Medicare in accordance with HSS rules, even if they are paying a federal penalty for late Medicare enrollment.

What is the HSS penalty for not enrolling in Medicare Part A and B when eligible, or failing to pay Medicare premiums after enrollment?

For eligible HSS members without Medicare, existing HSS medical plan coverage will be terminated and the member will be automatically enrolled in City Health Plan 20. For eligible dependents without Medicare, HSS medical coverage will be terminated. Full HSS coverage for a member or dependent may be reinstated after HSS receives proof of Medicare enrollment.

What is the City Health Plan 20 for Medicare-eligible HSS member who do not enroll in Medicare, or fail to pay Medicare premiums after enrollment?

An HSS member who does not enroll in Medicare when eligible, or fails to pay required Medicare premiums, will lose existing HSS medical coverage and be automatically enrolled in City Health Plan 20. City Health Plan 20 significantly increases out-of-pocket costs. Under City Health Plan 20, you will be responsible for paying the 80% that Medicare would have paid for a covered service, plus any amounts above usual and customary fees. In addition, under City Health Plan 20, yearly out-of-pocket limits increase to $10,950.

Medicare and Your HSS Benefits

HSS members should not enroll in any individual Medicare Part D plan. Doing so could result in the termination of your HSS medical coverage.

Medicare Part D: Prescription Drug Insurance

There are two types of Medicare Part D prescription drug plans: individual and group. Individual Part D prescription drug coverage is purchased directly by an individual from an insurer or pharmacy. **HSS members should NOT enroll in any individual Medicare Part D plan.** HSS members are automatically enrolled in group Medicare Part D when they enroll in any medical plan offered through HSS. HSS group medical plans offer enhanced group Medicare Part D coverage. (Please refer to page 12, Creditable Coverage Disclosure Notice).

Should either I or my dependents enroll in Medicare Part D?

Do not enroll in an individual Medicare Part D prescription drug plan. The medical coverage you and your dependents are enrolled in through HSS-administered plans includes enhanced group Medicare Part D prescription drug coverage. You may receive marketing information from private insurers, pharmacies and other entities trying to sell individual Medicare Part D prescription coverage plans. Ignore these solicitations.

Beginning in January 2011, Medicare enrollees whose income exceeds certain thresholds will be charged a Part D premium also known as the "Income Related Monthly Adjusted Amount" (IRMAA). In most cases, this Part D premium will be deducted from the individual's Social Security check. For information on Medicare Part D premiums, please contact the Social Security Administration at (800) 772-1213.

Is there a premium for Medicare Part D?

Most people are not required to pay a Medicare Part D premium. However, if your income exceeds a certain threshold, you may be required to pay a Part D premium to the Social Security Administration. If you are charged a Part D premium, but your income changes and falls below the threshold, contact the Social Security Administration to request an adjustment.

What is the HSS penalty if either I or my dependent fails to pay a Part D premium to the Social Security Administration?

Failure to pay a required Part D premium will result in Part D coverage being terminated by the Social Security Administration. Consequently, HSS medical coverage must also be terminated. HSS members who have lost Part D eligibility due to lack of payment will be automatically enrolled in City Health Plan 20. (See page 7.) Dependents' coverage will end. Full HSS medical coverage for a member or dependent may be reinstated after HSS receives proof of Medicare Part D reinstatement.

Medicare Enrollment Is Optional for Retirees Residing Permanently Outside the U.S.

Retiree members and dependents who reside outside the United States must enroll in the City Health Plan PPO or waive HSS coverage.

Medicare enrollment is not required for retired members residing outside the United States. However, healthcare services within the United States will not be covered for foreign residents who do not enroll in Medicare or discontinue Medicare enrollment. Members who choose this option must complete an HSS form certifying that they are waiving Medicare enrollment and waiving health coverage within the United States.

If you are a foreign resident, please contact the Social Security Administration for more information before choosing to disenroll from Medicare. The federal government may charge you significant penalties if you disenroll from Medicare now but decide to re-enroll in the future.

For retiree members and dependents who reside outside the United States, are enrolled in City Health Plan and continue Medicare enrollment, services within the United States will be covered and HSS premium contribution rates for Medicare enrollees will apply. Services outside the United States will be covered by the City Health Plan PPO at the out-of-area reimbursement rate.

What are the financial penalties I can incur if I move out of my plan's service area but fail to notify HSS of my new address?

If you move out of your plan's service area, you must notify HSS before your move and enroll in a different HSS plan that offers coverage at your new address. Medicare does not allow retroactive termination of coverage. If you do not contact HSS and enroll in a different plan before your move, you can be held responsible for paying the costs of any medical services that you or your dependents obtained after you moved out of your plan's service area.

Medicare Contact Information

The Social Security Administration administers Medicare eligibility, Medicare enrollment and Medicare premium payments.

Social Security Administration (SSA)
(800) 772-1213
TTY (800) 325-0778
www.ssa.gov

The Centers for Medicaid & Medicare Services (CMS) administers Medicare benefits.

Centers for Medicaid & Medicare Services
(800) 633-4227
TTY (877) 486-2048
www.medicare.gov

This guide offers general information and does not include everything you need to know about Medicare, including updates to federal law affecting Medicare that may have taken effect after this guide was published.

Kaiser Enrollees and Medicare

All Kaiser participants–HSS members and dependents–must enroll in Medicare Part A and Medicare Part B as soon as they are eligible. In general, individuals are eligible for Medicare:

- at age 65
- under age 65 with a Social Security-qualified disability
- under age 65 with End-stage Renal Disease (ESRD)

If an HSS member or dependent enrolled in HSS retiree medical benefits before age 65, that individual must contact the Social Security Administration (SSA) 90 days before his or her 65th birthday to begin the Medicare enrollment process. HSS requires that all HSS retiree medical plan enrollees complete Medicare enrollment by the first day of the month before the month of their 65th birthday. (Retirees and dependents under age 65 who become eligible for Medicare due to disability or ESRD must not wait until age 65. They are required to enroll as soon as they are eligible.) For information about enrolling in Medicare, call SSA at (800) 772-1213.

Once enrolled in Medicare, a copy of a member or dependent's Medicare card must be submitted to HSS as required. The individual will then be enrolled in Kaiser Senior Advantage. (Individuals eligible for Medicare Part B only can enroll in Senior Advantage.) Under Kaiser Senior Advantage, which is a Medicare Advantage plan, the enrollee assigns Medicare benefits to Kaiser, and the enrollee must use the Kaiser network of doctors and hospitals. **Kaiser Senior Advantage includes enhanced group Medicare Part D prescription drug coverage.**

If a retired member or dependent does not enroll in Medicare and Kaiser Senior Advantage when eligible, does not provide HSS with proof of Medicare enrollment, or fails to pay required Medicare premiums to Social Security, Kaiser coverage will be terminated. See page 7 for information about Medicare enrollment and HSS penalties.

KAISER & MEDICARE: HSS REQUIREMENTS AT-A-GLANCE

MEMBER TYPE	MEDICARE PART A	MEDICARE PART B	KAISER SENIOR ADVANTAGE	INDIVIDUAL MEDICARE PART D
Enrollee Age 65 or Older	Must enroll if eligible for premium-free Part A.	Must enroll.	Must enroll; this plan includes enhanced group Medicare Part D prescription drug coverage.	Do not enroll in any individual Medicare Part D plan.
Enrollee with Social Security-qualified Disability	Must enroll in premium-free Part A as soon as eligible.	Must enroll as soon as eligible.	Must enroll when eligible for Medicare; this plan includes enhanced group Medicare Part D prescription drug coverage.	Do not enroll in any individual Medicare Part D plan.
Enrollee with End-stage Renal Disease	Must enroll in premium-free Part A as soon as eligible.	Must enroll as soon as eligible.	Must enroll; this plan includes enhanced group Medicare Part D prescription drug coverage.	Do not enroll in any individual Medicare Part D plan.

If the HSS member moves out of the Kaiser service area, that member and any dependents cannot continue Kaiser coverage. To ensure there is no break in coverage, the member must contact HSS 30 days before moving and enroll in an HSS medical plan that provides service based on the new address. In this case, Kaiser Senior Advantage enrollees may also be required to complete a Senior Advantage disenrollment form, which will release their Medicare assignment from Kaiser Senior Advantage. If a member chooses to drop HSS coverage, he or she must also contact HSS 30 days in advance. **Medicare does not allow retroactive terminations.**

Blue Shield Enrollees and Medicare

All Blue Shield participants–HSS members and dependents–must enroll in Medicare Part A and Medicare Part B as soon as they are eligible. In general, individuals are eligible for Medicare:

- at age 65
- under age 65 with a Social Security-qualified disability
- under age 65 with End-stage Renal Disease (ESRD)

If an HSS member or dependent enrolled in HSS retiree medical benefits before age 65, that individual must contact the Social Security Administration (SSA) 90 days before his or her 65th birthday to begin the Medicare enrollment process. HSS requires that all HSS retiree medical plan enrollees complete Medicare enrollment by the first day of the month before the month of their 65th birthday. (Retirees and dependents under age 65 who become eligible for Medicare due to disability or ESRD must not wait until age 65. They are required to enroll as soon as they are eligible.) For information about enrolling in Medicare, call SSA at (800) 772-1213.

A copy of the member or dependent's Medicare card must be submitted to HSS as required. Medicare-eligible Blue Shield participants who reside in a 65 Plus plan zip code will be covered by the Blue Shield 65 Plus (Medicare Advantage) HMO. (See page 15 for plan service areas.) When enrolled in this plan, the individual assigns Medicare benefits to the plan, and must obtain service from within the Blue Shield 65 Plus HMO network. Out-of-network services will not be covered by Medicare or Blue Shield. **Blue Shield 65 Plus (Medicare Advantage) HMO includes enhanced group Medicare Part D prescription drug coverage.**

Some Medicare-eligible Blue Shield enrollees permanently reside in a service area not covered by Blue Shield 65 Plus. These members and their dependents will be enrolled in Blue Shield Access+ (Medicare Coordinated) HMO and will not assign Medicare benefits to Blue Shield. In this case, both the Medicare card and Blue Shield Access+ ID card must be presented to the service provider. For service obtained outside the Blue Shield Access+ HMO network, Medicare benefits apply. Medicare will pay its share and the enrollee will be responsible for costs not covered by Medicare. Blue Shield Access+ (Medicare Coordinated) HMO includes Blue Shield Medicare Rx. **Blue Shield Medicare Rx is enhanced group Medicare Part D prescription drug coverage**.

If a retired member or dependent does not enroll in Medicare when eligible, does not provide HSS with proof of Medicare enrollment, or fails to pay required Medicare premiums to Social Security as required, Blue Shield coverage will be terminated. See page 7 for more information about penalties.

If an HSS member moves out of a Blue Shield service area, the member and dependents cannot continue Blue Shield coverage. To ensure there is no break in coverage, the member must contact HSS 30 days before moving and enroll in an HSS medical plan that provides service based on the new address. If a member chooses to drop HSS coverage, he or she must contact HSS 30 days in advance. **Medicare does not allow retroactive terminations.**

BLUE SHIELD and MEDICARE: HSS REQUIREMENTS AT-A-GLANCE

MEMBER TYPE	MEDICARE PART A	MEDICARE PART B	BLUE SHIELD PLANS	INDIVIDUAL MEDICARE PART D
Eligible for Medicare A & B due to age, Social Security-qualified disability or ESRD; resides in 65 Plus service area	Must enroll if eligible for premium free Part A.	Must enroll.	Will be enrolled in Blue Shield 65 Plus (Medicare Advantage) HMO; includes enhanced group Medicare Part D benefits.	Do not enroll in any individual Medicare Part D plan.
Medicare-eligible due to age, Social Security-qualified disability or ESRD; resides outside 65 Plus service area	Must enroll if eligible for premium free Part A.	Must enroll.	Will be enrolled in Blue Shield Access+ (Medicare Coordinated) HMO and Blue Shield Medicare Rx, an enhanced group Medicare Part D plan.	Do not enroll in any individual Medicare Part D plan.

Creditable Coverage Disclosure Notice

An important notice about prescription drug coverage and Medicare. Please read carefully and keep with your important documents.

Federal Medicare Part D regulations require the Health Service System (HSS) to provide this Notice of Credible Coverage on an annual basis to:

- participants enrolled in an HSS medical plan that includes prescription drug coverage

and

- participants who are not enrolled, but are eligible to enroll in an HSS medical plan that includes prescription drug coverage.

Retirees and dependents who are not eligible for Medicare can disregard this notice.

The prescription drug coverage that you have through your HSS medical plan is creditable coverage under Medicare Part D. Creditable coverage means that the amount that the plan expects to pay for prescription drugs for individuals covered by the plan on average is the same or more than what standard Medicare prescription drug coverage would be expected, on average, to pay. This means that your current HSS creditable prescription drug coverage is better than the standard level of coverage set by the federal government under the Medicare Part D program that became available on January 1, 2006.

It is important that you retain this notice because Medicare Part D was set up to encourage eligible participants to either be enrolled in creditable coverage (as you currently are) or be enrolled in Medicare Part D. The incentive to do one or the other is created by assessing late enrollment penalties for anyone who, after May 15, 2006, goes without either creditable coverage (like yours) or enrollment in Part D of Medicare.

You only need to worry about this rule if, in the future, you or a Medicare-eligible dependent terminates or loses the healthcare coverage administered through the Health Service System. At that point, your evidence of creditable coverage will prevent you from incurring any late enrollment penalties, as long as you enroll in Medicare Part D no more than 62 days after your coverage terminates. Anyone who fails to act within that time period will incur the late enrollment penalty of at least 1% per month for every month after May 15, 2006 that he or she did not have creditable coverage or enrollment in Part D.

For example, if 19 months passed between the time a person terminated creditable coverage with the Health Service System and that person's enrollment in Medicare Part D, that person's premium would always be at least 19% higher than what most other people pay. That person might also be required to wait until the following November, when the federal government conducts Open Enrollment for Medicare, in order to sign up for Medicare Part D coverage.

If an individual (either you or a dependent) loses current creditable prescription drug coverage through no fault of his or her own, that individual may also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

Issue Date: January 1, 2011

Medical Plan Options

These medical plan options are available to retired HSS members and eligible dependents. Required retiree premium contributions, if any, will be deducted from the member's monthly pension check.

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). You do not pay a deductible before accessing benefits, and co-pays at the point of service are set at a flat, contracted rate. This helps to limit out-of-pocket costs. HSS offers the following HMO plans:

Blue Shield of California HMO	
65 Plus (Medicare Advantage)	Medicare-eligible retirees and dependents who live in a 65 Plus service area must enroll in 65 Plus
Access+ (Medicare Coordinated)	Only available to Medicare-eligible retirees and dependents not living in a 65 Plus service area
Access+ (No Medicare)	Only available to retirees and dependents who are not eligible for Medicare

Kaiser Permanente HMO	
Senior Advantage (Medicare Advantage)	Medicare-eligible retirees and dependents must enroll in Senior Advantage
Traditional Plan (No Medicare)	Only available to retirees and dependents not eligible for Medicare

Preferred Provider Organization (PPO)

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

City Health Plan PPO	
Administered by UnitedHealthcare	Available to all retiree members and eligible dependents

HSS healthcare plans do not guarantee the continued participation of any particular doctor, hospital or medical group. After Open Enrollment, you won't be allowed to change your health benefit elections if a doctor, hospital or medical group chooses not to participate in your plan. You will be assigned or required to select another provider.

If you move out of the service area covered by your plan, you must elect a different medical plan that provides coverage in your area. Failure to change your healthcare elections may result in the non-payment of claims for services received.

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions in effect for the plan from July 1, 2011 through June 30, 2012. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. EOCs are available on www.myhss.org.

PPO vs. HMO

QUICK COMPARISON CHART

	Blue Shield HMO	Kaiser HMO	City Health Plan PPO
Must I select a Primary Care Physician (PCP) to coordinate my care?	You can choose your Blue Shield PCP after you enroll, or Blue Shield will assign.	You can choose your Kaiser PCP after you enroll, or Kaiser will assign.	No. With a PPO plan, you have more responsibility for coordinating care.
Am I required to obtain service from the plan's contracted network of service providers?	Yes. Services must be received from a contracted network provider.	Yes. Services must be received from a Kaiser facility.	You can use any licensed provider. Out-of-network providers will cost you more.
Is my access to hospitals and specialists determined by my Primary Care Physician's medical group affiliation?	Yes. PCP referrals will, in most cases, be made within his or her medical group's network of doctors and hospitals.	Yes. All services must be received from a Kaiser facility.	No
Do I have to pay an annual deductible?	No	No	Yes
Is preventative care covered, such as a routine physical and well baby care?	Yes	Yes	Yes
Does the plan have a maximum lifetime limit for healthcare services?	No	No	No
Do I have to file claim forms?	No	No	Only if you use an out-of-network provider.

This guide offers general information only. Do not rely solely on this guide when making your health insurance decisions. Before enrolling in a plan, you should consult the Evidence of Coverage (EOC) to get specific information about the benefits, costs and way the plan works. EOCs are available as downloadable PDFs on www.myhss.org.

Medical Plan Service Areas

To enroll in a Blue Shield or Kaiser HMO, you must reside in a zip code serviced by the plan. City Health Plan PPO does not have any service area enrollment requirements.

■ = Available in this County. ❍ = Available in some zip codes.

County	Blue Shield of California			Kaiser	County	Blue Shield of California			Kaiser
	65 Plus (MEDICARE ADVANTAGE)	Access+ (MEDICARE COORDINATED)	Access+ (NO MEDICARE)	All Plans (SR. ADV & TRADITIONAL)		65 Plus (MEDICARE ADVANTAGE)	Access+ (MEDICARE COORDINATED)	Access+ (NO MEDICARE)	All Plans (SR. ADV & TRADITIONAL)
Alameda		■	■	■	Orange	■		■	■
Alpine					Placer		❍	❍	❍
Amador				❍	Plumas				
Butte		■	■		Riverside	❍	■	■	❍
Calaveras					Sacramento	■		■	■
Colusa					San Benito				
Contra Costa	■		■	■	San Bernardino	❍	❍	❍	❍
Del Norte					San Diego	❍	❍	❍	❍
El Dorado		❍	❍	❍	San Francisco	■		■	■
Fresno	❍	■	■	❍	San Joaquin	■		■	■
Glenn					San Luis Obispo	■		■	
Humboldt					San Mateo	■		■	■
Imperial	❍	■	■	❍	Santa Barbara			■	
Inyo					Santa Clara	■		■	❍
Kern	❍	❍	❍	❍	Santa Cruz	■		■	
Kings		■	■	❍	Shasta				
Lake					Sierra				
Lassen					Siskiyou				
Los Angeles	■		■	❍	Solano		■	■	■
Madera	❍	■	■	❍	Sonoma		■	■	❍
Marin		■	■	■	Stanislaus		■	■	■
Mariposa				❍	Sutter				❍
Mendocino					Tehama				
Merced		■	■		Trinity				
Modoc					Tulare		■	■	❍
Mono					Tuolumne				
Monterey					Ventura	■		■	❍
Napa				❍	Yolo		■	■	❍
Nevada	❍	❍	❍		Yuba				❍

If you are enrolled in Medicare, the Blue Shield of California Access+ plan is only available to you if you do not live in a service area covered by the Blue Shield of California 65 Plus plan. Contact the medical plan to confirm service areas.

Blue Shield of California 65 Plus: (800) 776-4466
Blue Shield of California Access+: (800) 642-6155
Kaiser Permanente: (800) 464-4000

Retired Employees with Medicare Parts A & B

	blue of california **65 Plus** Medicare Advantage HMO	blue of california **Access+ (Medicare Coordinated)** HMO only for enrollees living outside the 65 Plus plan service area	KAISER PERMANENTE® **Senior Advantage** Medicare Advantage HMO
DEDUCTIBLES			
Plan year deductible	None	None	None
PREVENTATIVE & GENERAL CARE			
Routine physical	No charge	No charge	No charge
Immunizations and inoculations	No charge	No charge	No charge
Routine gynecologic wellness exam	No charge	No charge	No charge
Routine pre/post-partum care	No charge visits limited; see EOC	No charge visits limited; see EOC	No charge visits limited; see EOC
PHYSICIAN & OTHER PROVIDER CARE			
Office and home visits	$20 co-pay	$20 co-pay	$15 co-pay
Hospital visits	No charge	No charge	No charge
PRESCRIPTION DRUGS			
Pharmacy: generic drugs	$5 co-pay 30-day supply	$5 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: brand-name drugs	$20 co-pay 30-day supply	$20 co-pay 30-day supply	$15 co-pay 30-day supply
Pharmacy: non-formulary drugs	$45 co-pay 30-day supply	$45 co-pay 30-day supply	Physician authorized only
Mail order: generic drugs	$10 co-pay 90-day supply	$10 co-pay 90-day supply	$10 co-pay 100-day supply
Mail order: brand-name drugs	$40 co-pay 90-day supply	$40 co-pay 90-day supply	$30 co-pay 100-day supply
Mail order: non-formulary drugs	$90 co-pay 90-day supply	$90 co-pay 90-day supply	Physician authorized only
Specialty drugs	20% up to $100 co-pay 30-day supply	20% up to $100 co-pay 30-day supply	Same as all above
OUTPATIENT SERVICES			
Diagnostic x-ray and laboratory	No charge	No charge	No charge
EMERGENCY			
Hospital emergency room	$50 co-pay	$100 co-pay	$50 co-pay waive if hospitalized
Urgent care facility	$20 co-pay within CA	$20 co-pay within CA	$15 co-pay
HOSPITAL/SURGERY			
Inpatient	$150 co-pay per admittance	$150 co-pay per admittance	$100 co-pay per admittance
Outpatient	$50 co-pay per surgery	$50 co-pay per surgery	$15 co-pay

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 www.myhss.org.

CITY HEALTH PLAN

UnitedHealthcare PPO

In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
$250 retiree only; $500 retiree + 1 $750 retiree + 2 or more Includes Medicare deductible Plan year out-of-pocket maximum $3,750/person	$250 retiree only; $500 retiree + 1 $750 retiree + 2 or more Includes Medicare deductible Plan year out-of-pocket maximum $7,500/person	$250 retiree only; $500 retiree + 1 $750 retiree + 2 or more Includes Medicare deductible Plan year out-of-pocket maximum $3,750/person
100% covered no deductible	Not covered	100% covered no deductible
100% covered no deductible	50% covered no deductible	100% covered no deductible
100% covered no deductible	50% covered after deductible	100% covered no deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
$5 co-pay 30-day supply	50% covered after $5 co-pay; 30-day supply	$5 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
$45 co-pay 30-day supply	50% covered after $45 co-pay; 30-day supply	$45 co-pay 30-day supply
$10 co-pay 90-day supply	Not covered	$10 co-pay 90-day supply
$40 co-pay 90-day supply	Not covered	$40 co-pay 90-day supply
$90 co-pay 90-day supply	Not covered	$90 co-pay 90-day supply
Same as all above	Same as all above	Same as all above
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible; 50% after deductible if non-emergency	85% covered after deductible; 50% after deductible if non-emergency	85% covered after deductible; 50% after deductible if non-emergency
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible

Note: Out-of-pocket maximum does not include premium contributions or annual deductible. City Health Plan co-insurance amounts shown reflect what will be covered after Medicare has paid its portion of a claim.

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

Retired Employees with Medicare Parts A & B

	blue of california **65 Plus** Medicare Advantage HMO	blue of california **Access+ (Medicare Coordinated)** HMO only for enrollees living outside the 65 Plus plan service area	KAISER PERMANENTE® **Senior Advantage** Medicare Advantage HMO
REHABILITATIVE			
Physical/Occupational therapy	$20 co-pay	$20 co-pay	$15 co-pay authorization req.
Acupuncture	$15 co-pay 30 visits/yr; ASH network only	$15 co-pay 30 visits/yr; ASH network only	Not covered
Chiropractic	$15 co-pay 30 visits/yr; ASH network only	$15 co-pay 30 visits/yr; ASH network only	$15 co-pay 30 visits/yr; ASH network only
TRANSGENDER			
Office visits and outpatient surgery	Co-pays apply authorization req. $75,000 lifetime max	Co-pays apply authorization req. $75,000 lifetime max	Co-pays apply authorization req. $75,000 lifetime max
DURABLE MEDICAL EQUIPMENT			
Home medical equipment	No charge	No charge	No charge as authorized by PCP according to formulary
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary	No charge when medically necessary
Hearing evaluation and aids	Eval. no charge aids 1 per ear; $2,500 max every 36 months	Eval. no charge aids 1 per ear; $2,500 max every 36 months	Eval. no charge aids 1 per ear; $2,500 max every 36 months
MENTAL HEALTH			
Inpatient hospitalization	$150 co-pay per admittance	$150 co-pay per admittance	$100 co-pay per admittance
Outpatient treatment	$20 co-pay non-severe and severe	$20 co-pay non-severe and severe	$7 co-pay group $15 co-pay individual
CHEMICAL DEPENDENCY			
Inpatient detox	$150 co-pay per admittance	$150 co-pay per admittance	$100 co-pay per admittance
Residential rehabilitation	$150 co-pay per admittance	$150 co-pay per admittance	$100 co-pay per admittance; physician approval required
EXTENDED & END-OF-LIFE CARE			
Extended care / Skilled nursing facility	No charge up to 100 days per benefit period	No charge up to 100 days per benefit period	No charge up to 100 days per benefit period
Hospice	No charge authorization required	No charge authorization required	No charge when medically necessary
OUTSIDE SERVICE AREA			
Care access and limitations	Urgent care $50 co-pay; guest membership benefits for college student dependents in some areas.	Urgent care $50 co-pay; guest membership benefits for college student dependents in some areas.	Limited to emergency services before condition permits transfer to nearest Kaiser facility. Co-pays apply.

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 www.myhss.org.

CITY HEALTH PLAN

UnitedHealthcare PPO

In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
85% covered after deductible; 60 visits/year	50% covered after deductible; 60 visits/year	85% covered after deductible; 60 visits/year
50% covered after deductible; $1,000/year	50% covered after deductible; $1,000/year	50% covered after deductible; $1,000/year
50% covered after deductible; $1,000/year	50% covered after deductible; $1,000/year	50% covered after deductible; $1,000/year
85% covered after deductible; prior notification required; $75,000 lifetime max	50% covered after deductible; prior notification required; $75,000 lifetime max	85% covered after deductible; prior notification required; $75,000 lifetime max
85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
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
100% covered after deductible; 1 per ear every 36 months; $2,500 max	100% covered after deductible; 1 per ear every 36 months; $2,500 max	100% covered after deductible; 1 per ear every 36 months; $2,500 max
85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification
85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
85% covered after deductible; up to 120 days max; custodial care not covered	50% covered after deductible; up to 120 days max; custodial care not covered	85% covered after deductible; up to 120 days max; custodial care not covered
85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. Out-of-area coverage percentages and co-pays apply.

City Health Plan co-insurance amounts shown reflect what will be covered after Medicare has paid its portion of a claim.

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

Retired Employees Not Eligible for Medicare

	blue of california Access+ HMO	KAISER PERMANENTE® Traditional Plan HMO
DEDUCTIBLES		
Plan year deductible	None	None
PREVENTIVE & GENERAL CARE		
Routine physical	No charge	No charge
Immunizations and inoculations	No charge	No charge
Routine gynecologic wellness exam	No charge	No charge
Routine pre/post-partum care	No charge visits limited; see EOC	No charge visits limited; see EOC
PHYSICIAN & OTHER PROVIDER CARE		
Office and home visits	$20 co-pay	$15 co-pay
Hospital visits	No charge	No charge
PRESCRIPTION DRUGS		
Pharmacy: generic drugs	$5 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: brand-name drugs	$20 co-pay 30-day supply	$15 co-pay 30-day supply
Pharmacy: non-formulary drugs	$45 co-pay 30-day supply	Physician authorized only
Mail order: generic drugs	$10 co-pay 90-day supply	$10 co-pay 100-day supply
Mail order: brand-name drugs	$40 co-pay 90-day supply	$30 co-pay 100-day supply
Mail order: non-formulary drugs	$90 co-pay 90-day supply	Physician authorized only
Specialty drugs	20% up to $100 co-pay 30-day supply	Same as all above
OUTPATIENT SERVICES		
Diagnostic x-ray and laboratory	No charge	No charge
EMERGENCY		
Hospital emergency room	$100 co-pay waived if hospitalized	$100 co-pay waived if hospitalized
Urgent care facility	$20 co-pay within CA service area	$15 co-pay
HOSPITAL/SURGERY		
Inpatient	$150 co-pay per admittance	$100 co-pay per admittance
Outpatient	$50 co-pay per surgery	$15 co-pay

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 www.myhss.org.

CITY HEALTH PLAN (PPO administered by United Healthcare)

In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
$250 retiree only $500 retiree + 1 $750 retiree + 2 or more Plan year out-of-pocket maximum $3,750/person	$250 retiree only $500 retiree + 1 $750 retiree + 2 or more Plan year out-of-pocket maximum $7,500/person	$250 retiree only $500 retiree + 1 $750 retiree + 2 or more Plan year out-of-pocket maximum $3,750/person
100% covered no deductible	Not covered	100% covered no deductible
100% covered no deductible	50% covered no deductible	100% covered no deductible
100% covered no deductible	50% covered after deductible	100% covered no deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible	50% covered after deductible	85% covered after deductible
$5 co-pay 30-day supply	50% covered after $5 co-pay; 30-day supply	$5 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
$45 co-pay 30-day supply	50% covered after $45 co-pay; 30-day supply	$45 co-pay 30-day supply
$10 co-pay 90-day supply	Not covered	$10 co-pay 90-day supply
$40 co-pay 90-day supply	Not covered	$40 co-pay 90-day supply
$90 co-pay 90-day supply	Not covered	$90 co-pay 90-day supply
Same as all above	Same as all above	Same as all above
85% covered after deductible	50% covered after deductible; prior notification	85% covered after deductible
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
85% covered after deductible	50% covered after deductible	85% covered after deductible
85% covered after deductible; prior notification	50% covered after deductible; prior notification	85% covered after deductible; prior notification
85% covered after deductible	50% covered after deductible	85% covered after deductible

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

Retired Employees Not Eligible for Medicare

	blue of california Access+ HMO	KAISER PERMANENTE® Traditional Plan HMO
REHABILITATIVE		
Physical/Occupational therapy	$20 co-pay	$15 co-pay authorization required
Acupuncture	$15 co-pay 30 visits/yr; ASH network only	Not covered
Chiropractic	$15 co-pay 30 visits/yr; ASH network only	$15 co-pay 30 visits/yr; ASH network only
TRANSGENDER		
Office visits and outpatient surgery	Co-pays apply authorization required; $75,000 lifetime maximum	Co-pays apply authorization required; $75,000 lifetime maximum
DURABLE MEDICAL EQUIPMENT		
Home medical equipment	No charge	No charge as authorized by PCP according to formulary
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary
Hearing evaluation and aids	Evaluation no charge hearing aids 1 per ear; $2,500 max every 36 months	Evaluation no charge hearing aids 1 per ear; $2,500 max every 36 months
MENTAL HEALTH		
Inpatient hospitalization	$150 co-pay per admittance	$100 co-pay per admittance
Outpatient treatment	$20 co-pay non-severe and severe	$7 co-pay group $15 co-pay individual
CHEMICAL DEPENDENCY		
Inpatient detox	$150 co-pay per admittance	$100 co-pay per admittance
Residential rehabilitation	$150 co-pay per admittance	$100 co-pay per admittance; physician approval required
EXTENDED & END-OF-LIFE CARE		
Skilled nursing facility	No charge up to 100 days per year	No charge up to 100 days per year
Hospice	No charge authorization required	No charge when medically necessary
OUTSIDE SERVICE AREA		
Care access and limitations	Urgent care $50 co-pay; guest membership benefits for college student dependents in some areas.	Limited to emergency services before condition permits transfer to nearest Kaiser facility. Co-pays apply.

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 www.myhss.org.

CITY HEALTH PLAN (PPO administered by United Healthcare)

In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
85% covered after deductible; 60 visits/year	50% covered after deductible; 60 visits/year	85% covered after deductible; 60 visits/year
50% covered after deductible; $1,000/year	50% covered after deductible; $1,000/year	50% covered after deductible; $1,000/year
50% covered after deductible; $1,000/year	50% covered after deductible; $1,000/year	50% covered after deductible; $1,000/year
85% covered after deductible; prior notification required; $75,000 lifetime maximum	50% covered after deductible; prior notification required; $75,000 lifetime maximum	85% covered after deductible; prior notification required; $75,000 lifetime maximum
85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
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
100% covered after deductible; 1 per ear every 36 months; $2,500 max	100% covered after deductible; 1 per ear every 36 months; $2,500 max	100% covered after deductible; 1 per ear every 36 months; $2,500 max
85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
85% covered after deductible; 120 days per year; prior authorization required; custodial care not covered	50% covered after deductible; 120 days per year; prior authorization required; custodial care not covered	85% covered after deductible; 120 days per year; prior authorization required; custodial care not covered
85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. Out-of-area coverage percentages and co-pays apply.

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

Adult Preventative Care Summary

	adult women age 20-49	adult men age 20-49	adult women age 50 and up	adult men age 50 and up
Annual wellness exam check height, weight, blood pressure; assess tobacco and alcohol use, depression risk and other concerns	Yes	Yes	Yes	Yes
Diabetes type 2 screening blood glucose	Yes	Yes	Yes	Yes
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
STD screenings sexually transmitted diseases	Yes if at risk	Yes if at risk	Yes if at risk	Yes if at risk
Pap smear cervical cancer screening	Yes every 2 years; after 3 normal screenings as doctor recommends		Yes every 3 years; discontinue at age 65 if low risk	
Mammogram breast cancer screening	Yes, over age 40 every 1-2 years		Yes every 1-2 years; up to age 75	
Osteoporosis screening bone density			Yes over age 65; sooner if high risk	
Colorectal cancer screening			Yes ages 50-75	Yes ages 50-75
AAA screening abdominal aortic aneurysm				Yes if man ever smoked; ages 65-75; one time
Annual flu immunization seasonal flu	Yes if at risk	Yes if at risk	Yes	Yes
Hepatitis A immunization	Yes if at risk	Yes if at risk	Yes if at risk	Yes if at risk
Hepatitis B immunization	Yes if at risk	Yes if at risk	Yes if at risk	Yes if at risk
HPV immunization human papillomavirus	Yes up to 26 years old			
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
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
Pneumococcal immunization pneumonia			Yes age 65 and up; sooner if high risk	Yes age 65 and up; sooner if high risk

Consult with your doctor about the types of screenings and immunizations that are right for you. This is a brief summary based on U.S. Preventative Services Task Force guidelines for adults. For more details, including recommendations for children, see www.healthcare.gov/center/regulations/prevention/recommendations.html.

Additional Wellness Benefits

Health Plan Wellness Programs

Blue Shield of California

Healthy Lifestyle Rewards, Health Risk Assessment, 24/7 registered nurse hotline, condition management programs and more:

www.blueshieldca.com/hw/

Wellness discounts and savings:
www.blueshieldca.com/bsc/hw/hw_375.jhtml

Blue Shield 65 Plus HMO also includes Silver Sneakers as a benefit. This fitness membership offers group exercise classes, workouts, education seminars, and more. For more information visit:
www.silversneakers.com

Kaiser Permanente

Hundreds of classes, Health Risk Assessment, audio podcasts and more:

www.kp.org/healthyliving

ChooseHealthy discounts and savings:
www.kp.org/healthyroads

UnitedHealthcare

Live nurse chat, conditions A-Z, online symptom checker, Health Risk Assessment and more:

www.myuhc.com

Delta Dental

Oral health A-Z, dental health education videos, kids' games and more:

www.wekeepyousmiling.org/group_oral_health
www.mysmilekids.com

Vision Service Plan (VSP)

Eye care recommendations by age, diabetes and vision information, and educational games:

www.vsp.com/cms/edc/discovery.html
www.vsp.com/cms/edc/diabetes-discovery.html

HSS Fitness Classes and Wellness Seminars

HSS offers employees and retirees a variety of free and low-cost movement classes and wellness seminars throughout the year. View the monthly class calendar online at: www.myhss.org

Maximize Your Benefits Health Fair

HSS presents an anual no-cost health fair with free flu shots, health screenings, fitness and nutrition demonstrations and more. For information, visit:
www.myhss.org

HSS eUpdates

In addition to providing important updates about your health benefits, the HSS monthly email newsletter offers wellness tips, website picks and select Bay area events that celebrate well being. Sign up at:
www.myhss.org

24 Hour Fitness Discount

Retirees can take advantage of a special offer from 24 Hour Fitness gyms. There is no initiation fee and no processing fee. Membership is paid monthly with no long-term contract. Proof of retirement from a City employer may be required at time of enrollment; other limitations may apply. Enroll online (enter code 100961) or call (800) 224-0240.
www.24hourfitness.com/corp/sanfranemps

Complete Your Health Risk Assessment

Each medical plan offers a no-cost Health Risk Assessment (HRA). Complete your plan's confidential online questionnaire and share the results with your doctor.

Dental Plan Options

Dental benefits are an important part of your healthcare coverage and are key to your overall health. HSS offers a choice of plans, providers, and coverage options for retired HSS members.

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 dentist.

HSS offers the following PPO dental plan:

- **Delta Dental**

The Delta Dental PPO has two different networks of participating dentists and dental care providers:

- Delta Dental In-Network providers offer the highest benefit. Most preventive services are covered at 100%; many other services are covered at 80%.
- The Delta Dental Premier pays benefits based on a pre-arranged fee agreed to by contracted dentists. Most preventive services are covered at 80%; many other services are covered at 50%.

You can go to any dentist in either network, or choose any dentist outside of these networks. When you go to a licensed dentist not in one of the networks described above, the plan pays the same percentage of cost that it pays a Delta Dental network dentist. However, payment is based on reasonable and customary costs for the geographical area. Your share of the expenses will be higher if your out-of-network dentist charges more than reasonable and customary fees. Please ask a dentist about costs before receiving services. Delta Dental can also help you estimate costs before you receive treatment. Call Delta Dental at (888) 335-8227.

HMO-style Dental Plans

Similar to medical HMOs, Dental Maintenance Organization (DMO) dental 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.

You will be required to select a primary care dental office, and you must go to this office for all of your dental care. Before you elect a DMO plan, make sure that the plan's network includes the dentist of your choice.

HSS offers you the following DMO plans:

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

Dental Plan Only?

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 in a zip code serviced by the plan. Be sure to ask your dentist which plan(s) he or she contracts with before making your selection.

■ = Available in this county

County	Delta Dental	DeltaCare USA	Pacific U
Alameda	■	■	■
Alpine			
Amador	■		
Butte	■	■	■
Calaveras	■		
Colusa	■		
Contra Costa	■	■	■
Del Norte	■		
El Dorado	■	■	■
Fresno	■	■	■
Glenn	■		
Humboldt	■	■	
Imperial	■	■	■
Inyo	■		
Kern	■	■	■
Kings	■	■	■
Lake	■	■	
Lassen	■		
Los Angeles	■	■	■
Madera	■	■	■
Marin	■	■	■
Mariposa	■		
Mendocino	■		
Merced	■	■	■
Modoc	■		
Mono	■		
Monterey	■	■	■
Napa	■	■	■
Nevada	■		

County	Delta Dental	DeltaCare USA	PacificU
Orange	■	■	■
Placer	■	■	■
Plumas	■		
Riverside	■	■	■
Sacramento	■	■	■
San Benito	■	■	■
San Bernardino	■	■	■
San Diego	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Luis Obispo	■	■	
San Mateo	■	■	■
Santa Barbara	■	■	■
Santa Clara	■	■	■
Santa Cruz	■	■	■
Shasta	■	■	
Sierra	■		
Siskiyou	■		
Solano	■	■	■
Sonoma	■	■	■
Stanislaus	■	■	■
Sutter	■	■	
Tehama	■		
Trinity	■		
Tulare	■	■	■
Tuolumne	■		
Ventura	■	■	■
Yolo	■	■	■
Yuba	■		
Outside California	■		

Refer to the chart above to determine whether or not you live in the plan's service area. If you do not see your county listed above, contact the dental plan to see if service is available to you:

Delta Dental: (888) 335-8227

DeltaCare USA: (800) 422-4234

Pacific Union Dental: (800) 999-3367

Dental Plan Benefits-at-a-Glance

	DELTA DENTAL PPO		DELTACARE USA DMO	PACIFIC UNION DENTAL DMO
	Preferred In-Network Providers	Out-of-Network & Premier Providers		
Types of Service				
Cleanings and exams	100% covered Limit 2x per plan year; 3x pregnant women; periodontal clean 50%	80% covered Limit 2x per plan year; 3x pregnant women; periodontal clean 50%	100% covered Limit 1 every 6 months	100% covered Limit 1 every 6 months
X-rays	100% covered	80% covered	100% covered	100% covered
Extractions	80% covered	80% covered	100% covered	$5 co-pay
Fillings	80% covered	80% covered	100% covered Limitations apply to resin materials.	$5 co-pay
Crowns	50% covered	50% covered	100% covered Limitations apply to resin materials.	$85 co-pay
Dentures, pontics and bridges	50% covered	50% covered	No charge Full and partial dentures 1x every 5 yrs; fixed bridgework; certain limitations apply.	$85 - $100 co-pay
Endodontic/ Root Canals	50% covered	50% covered	100% covered Excluding the final restoration	$50 co-pay
Oral surgery	50% covered	50% covered	100% covered	Co-pays vary
Implants	50% covered	50% covered	Not covered	Not covered
Orthodontia	Not Covered	Not Covered	Member pays: $1,600/child $1,880/adult $350 startup fee; limitations apply.	Member pays: $1,600/child $1,800/adult $350 startup fee; limitations apply.
Annual Maximum				
Total dental benefits	$1,000 per person per plan year	$1,000 per person per plan year	None	None
Annual Deductible				
Before accessing benefits	None	$50 per person $150 for family for all services except diagnostic and preventative care.	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 www.myhss.org.

Dental Plan Benefits At-a-Glance

DENTAL PLAN QUICK COMPARISON

	Delta Dental PPO	Pacific Union DMO	Deltacare USA DMO
Can I choose to receive services from any dentist?	Yes. You can use any licensed dental 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	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 eligible dependents who are enrolled in an HSS medical plan receive vision benefits, including an annual eye exam.

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 www.vsp.com or contacting VSP Member Services at (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 www.vsp.com.

Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every 24 months, based on last date of service. If retractor examination reveals an Rx change of .50 diopter or more after 12 months, replacement is 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 www.myhss.org.)

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*
Progressive lenses	Average 20-25% off Of provider's usual and customary charges; every 24 months*	Up to $65 After $25 co-pay; every 24 months*
Scratch-resistant coating	Fully covered Every 24 months*	Not covered
Frames	Up to $150 After $25 co-pay; 20% off total over $150; every 24 months*	Up to $70 After $25 co-pay; every 24 months*
Contact lenses, fitting and evaluation	Up to $150 Every 24 months*; fitting and evaluation exam fully covered after a maximum $60 co-pay	Up to $105 Every 24 months*
Urgent eye care	$5 co-pay Limited coverage for urgent and acute eye conditions	Not covered

*Based on your last date of service.

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 www.myhss.org.

Eligibility

These rules govern which employees can become retired members of the Health Service System and which retiree dependents may be eligible for coverage.

Retiree Member Eligibility

The San Francisco City Charter requires that the retiree must have been a member of HSS at some time during active employment to be eligible for retiree healthcare coverage. (This means you must have been enrolled in HSS health benefits at some time during active employment.) If you choose to take a lump sum pension distribution, your retiree healthcare premium contributions will be unsubsidized, and you will pay full cost. Other eligibility restrictions may apply.

Newly eligible retirees must enroll in retiree medical and/or dental coverage within 30 days of their retirement effective date. You must provide HSS with a completed enrollment application and all required eligibility documentation, including paperwork from your retirement system and a Social Security number, within the initial 30-day enrollment period. Members eligible for Medicare at the time of their retirement must also provide proof of Medicare enrollment. If you fail to meet required deadlines, you must wait until the next Open Enrollment to enroll in retiree coverage.

New retiree coverage will take effect on the first day of the month following the retirement effective date. Depending on your retirement date, there can be a gap between when employee coverage ends and retiree coverage begins. Setting a retirement date at the end of the month will help avoid a coverage gap.

Contact HSS Member Services at (415) 554-1750 three months before your retirement date to prepare for enrollment in new retiree benefits. You must notify HSS of retirement even if you are not planning to elect HSS coverage on your retirement date.

For more information, visit:
www.myhss.org/member_services/new_retirees.html

Dependent Eligibility

Spouse or Domestic Partner
A retiree member's legal spouse or domestic partner may be eligible for HSS healthcare coverage. Proof of Medicare enrollment must also be provided for a spouse or domestic partner who is Medicare-eligible due to age or disability. 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 month after a completed application and eligibility documentation is filed with HSS. Legal spouses and domestic partners can also be added to a member's coverage during annual Open Enrollment.

Natural Children, Stepchildren, Adopted Children
A member's natural child, stepchild, or adopted child (including a child placed for adoption), and the natural or adopted child of a member's enrolled domestic partner, are eligible for coverage up to 26 years of age. Eligibility documentation (listed on page 33) must be provided upon initial enrollment of the child.

Legal Guardianships and Court-ordered Children
Children under 19 years old 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. The member must provide HSS with proof of guardianship, court order or decree by required deadlines.

Eligibility

Adult Disabled Children

Children who are disabled may be covered beyond the age limits stated previously, provided all of the following criteria are met.

1. Adult child was enrolled in an HSS medical plan on the child's 19th birthday and continuously for at least one year prior to the child's 19th birthday;
2. Adult child was continuously enrolled in an HSS-administered 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 retiree member;
6. Adult child is dependent on the member for substantially all of his 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.

Financial Penalties for Failing to Disenroll Ineligible Dependents

It is the responsibility of the member to notify HSS within 30 days and cancel coverage for a dependent who becomes ineligible due to divorce, dissolution of partnership, age or any other reason. If a member fails to notify HSS, the member may be held responsible for payment of the costs of ineligible dependent health premiums and any medical service provided.

REQUIRED ELIGIBILITY DOCUMENTATION

	EVIDENCE OF RETIREMENT	MARRIAGE CERTIFICATE	DOMESTIC PARTNER CERT.	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	PROOF OF PLACEMENT	COURT DECREE OR ORDER	MEDICAL EVIDENCE	SOCIAL SECURITY #	MEDICARE CARD
Retiree	■								■	■
Spouse		■							■	■
Domestic Partner			■						■	■
Child: Natural				■					■	
Child: Adopted					■				■	
Child: Placed for Adoption						■			■	
Stepchild: Spouse		■		■					■	
Stepchild: Domestic Partner			■	■					■	
Child: Legal Guardianship							■		■	
Child: Court Ordered							■		■	
Adult Child: Disabled								■	■	■

Note: Proof of Medicare enrollment is not required for a retiree, spouse, partner or disabled child who is not eligible for Medicare per federal Social Security Administration eligibility rules.

Changing Benefit Elections

You can only change your benefits elections during annual Open Enrollment, unless there is a qualifying change in your family status.

Waiving Retiree Coverage

A retiree may waive medical coverage for his or her self and an enrolled dependent at any time, without a qualifying event. (Note: a retiree who waives his or her own coverage must also waive dependent coverage.) To waive medical coverage, the retiree must submit a completed retiree enrollment application to HSS. Once medical coverage is waived, the retiree may only re-enroll during Open Enrollment, or if there is a qualifying event, such as loss of other medical coverage. Retiree dental coverage can only be waived during Open Enrollment, or if an enrollee obtains other dental coverage.

Marriage or Domestic Partnership

To enroll a new spouse or domestic partner and eligible children of a spouse or partner in HSS healthcare coverage, you must submit a completed HSS enrollment application, a copy of your marriage certificate or certificate of domestic partnership, and a birth certificate for each child to HSS **within 30 days** from the date of the marriage or certification of domestic partnership. HSS also requires a Social Security number and proof of Medicare enrollment (if eligible) for all covered individuals. Coverage for your spouse or domestic partner and his or her eligible children will be effective the first day of the month following the submission of the required application and documentation. If you do not complete the enrollment process **within 30 days** from the date of your marriage or certification of domestic partnership, you must wait until the next Open Enrollment to add your new family members.

Birth or Adoption

Coverage for your newborn child is effective on the child's date of birth, provided you meet application deadline and documentation requirements. Coverage for your newly adopted child is effective on the date the child is placed with you, provided you meet application deadline and documentation requirements. To enroll your newborn or newly adopted child, you must submit a completed HSS enrollment application form and a copy of the birth certificate or adoption documentation **within 30 days** from the date of birth or placement for adoption. If you do not complete the enrollment process **within 30 days** from the date of birth or placement for adoption of a new child, you will have to wait until the next Open Enrollment. A Social Security number must be provided within 6 months of the date of birth or adoption, or your child's coverage may be terminated. For information about obtaining a Social Security number see: www.ssa.gov/pubs/10023.html.

Domestic Partner/Same Sex Spouse Health Benefits Tax Alert

Healthcare coverage for a domestic partner or same sex spouse (and any children of that partner or spouse) is typically a taxable benefit, per federal law. This is referred to as imputed income. However, under IRS code section 152, a domestic partner (of either gender), a same sex spouse, and associated children may qualify for favorable tax treatment. Also, the State of California allows for equitable tax treatment of same sex domestic partners and spouses if certain conditions are met. Please consult with your tax advisor for details. Learn more online: www.myhss.org/member_services

Loss of Other Healthcare Coverage

Retirees and eligible dependents who lose other coverage may be enrolled by submitting a completed HSS enrollment application form and proof of the loss of coverage **within 30 days** from the date other coverage terminates. Documentation of lost coverage must indicate the date other coverage ends and the names of the individuals losing coverage. If HSS receives a completed HSS enrollment application and eligibility documentation **within 30 days** of the loss of coverage, HSS coverage will be effective on the first day of the following month. There may be a break in coverage between the date other coverage terminates and the date HSS coverage begins. If you do not complete the HSS enrollment process **within 30 days** from the date other coverage ends for either yourself or an eligible family member, you must wait until the next annual Open Enrollment.

Divorce, Separation and Dissolution of Partnership

Termination of HSS health coverage for your ex-spouse or domestic partner due to divorce, legal separation or dissolution of domestic partnership is required by law. To drop the dependent, submit a completed HSS application form and a copy of the divorce decree, legal separation documents or dissolution of domestic partnership documents **within 30 days** from the date of divorce, legal separation or dissolution of partnership. Coverage for your ex-spouse or domestic partner will terminate on the last day of the month in which the divorce, legal separation or dissolution of domestic partnership occurred, provided you meet the deadline and documentation requirements stated above. If you do not complete the coverage termination process **within 30 days** from the date of your divorce, legal separa-tion or dissolution, coverage for your ex-spouse or domestic partner will terminate on the last day of the month in which you submit a completed HSS enrollment application and required documentation. You will then be responsible for paying all required premium contributions for that dependent up to the coverage termination date. Failure to notify HSS of a divorce or dissolution of domestic partnership may result in financial penalties equal to the cost of benefits and services provided for any ineligible dependent.

Obtaining Other Coverage

Upon enrolling in other coverage, you may end HSS healthcare coverage for yourself and/or any enrolled dependent. (If you waive coverage for yourself, coverage for your enrolled dependents must also be waived.) Submit a completed HSS enrollment application form and proof of other healthcare coverage enrollment **within 30 days** from the date of enrollment in the other health plan. Proof of coverage must indicate effective date of coverage and the names of enrolled individuals. Your HSS coverage will terminate on the last day of the month in which HSS receives a completed HSS enrollment application, provided you meet the 30-day deadline and documentation requirements. There may be an overlap of healthcare coverage between the date other coverage begins and the date your HSS coverage terminates. You are responsible for paying all required contributions up to the termination date of your HSS healthcare coverage. If you do not complete the coverage termination process **within 30 days** from the date of enrollment in another healthcare plan, you must wait until the next annual Open Enrollment.

Moving Out of Your Plan's Service Area

If you move your primary residence to a location outside your health plan's service areas, you no longer will 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. If you do not complete enrollment in a new plan **within 30 days** of your move, you may be subject to financial penalties (see page 9) and you must wait for the next Open Enrollment.

Changing Benefit Elections

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** from 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 a retiree must have been married to the member, or registered as the member's domestic partner, for at least one year prior to the death of the member. 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
- 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 retiree member must meet eligibility requirements for dependent children. (See page 32.) Eligible surviving dependent children may be enrolled, but do not qualify for employer-subsidized benefits.

Responsibility for Premium Contributions

When you update coverage because of a qualifying change in family status, carefully review your pension check to verify that the correct premium contribution is being deducted. If the deduction is incorrect or does not appear on your check, contact HSS Member Services at (415) 554-1750. If a required retiree premium contribution is not made within 30 days from the date it is due, coverage will be terminated and you will not be permitted to re-enroll until the next Open Enrollment, with coverage to begin the following July.

Ineligible Dependent Penalty

Members who fail to notify HSS when an enrolled dependent becomes ineligible are responsible for paying the total cost of premiums and services provided back to the original date of the dependent's ineligibility.

COBRA

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted in 1986 allows retirees and their covered dependents to elect temporary extension of healthcare coverage in certain instances where coverage would end. These include:

- Children who are aging out of HSS coverage.
- A retiree's spouse, domestic partner or stepchildren who are losing HSS coverage due to legal separation, divorce or dissolution of partnership.
- Covered dependents who are not eligible for survivor benefits and are losing HSS coverage due to the death of an HSS retiree member.
- New retirees who opt to enroll in COBRA dental coverage when they first lose HSS active employee dental benefits.

Time Limits for COBRA Elections

The COBRA administrator will notify you of the opportunity to elect COBRA coverage. You have 60 days from the notification date to complete COBRA enrollment. Coverage will be retroactive to the date of the COBRA qualifying event, so there is no break in your healthcare coverage. While covered under COBRA, you have 30 days to add newly eligible dependents (spouse, domestic partner, newborn or adopted child) to COBRA coverage, based on the date of the qualifying event (marriage, partnership, birth, adoption).

In the case of a dependent losing coverage (due to divorce or aging out of a plan) the retiree or dependent must notify the COBRA Administrator within 30 days of the qualifying event. Dependents dropped from coverage during Open Enrollment are not eligible for COBRA.

Duration of COBRA Continuation Coverage

Group 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.

COBRA enrollees 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 percent of the group rate.

Termination of COBRA Continuation Coverage

COBRA coverage will end if:

- You obtain coverage under another group plan if no pre-existing condition limitation under the new plan applies to the covered individual.
- You fail to pay the premium required under the plan within the grace period.
- The applicable COBRA period ends.

Paying for COBRA

Once COBRA continuation coverage is elected, it is the responsibility of the covered individuals to remit the required healthcare premium payments directly to the COBRA Administrator. For COBRA rate information, visit www.myhss.org or contact HSS.

COBRA Continuation Coverage Alternatives

As an alternative to COBRA continuation coverage, you may be able to purchase individual health coverage from your healthcare plan or other insurers. Contact plans directly for details and costs.

All retirees and dependents who were covered under an HSS-administered health plan are entitled to a certificate showing evidence of prior health coverage. This certificate of prior coverage may assist the retiree and/or dependents in purchasing new health coverage that excludes pre-existing medical conditions.

For up-to-date information about COBRA benefits, contact Fringe Benefits Management Company, a Division of WageWorks, at (800) 342-8017.

Glossary of Healthcare Terms

Brand-name Drug
FDA approved prescription drugs marketed under a specific brand name by manufacturers.

COBRA
This federal law allows individuals who are enrolled in an employer-sponsored plan to temporarily continue receiving health coverage after certain qualifying events like termination or divorce.

Co-insurance
Co-insurance refers to the amount of money that a member is required to pay for healthcare services, after any required deductible has been paid. Co-insurance is often specified by a percentage. For example, the retiree pays 15% toward the charges for a covered service and the insurance company pays 85%.

Co-payment
The flat fee you pay each time you utilize a healthcare service or fill a prescription.

Deductible
The specified amount you must pay for healthcare in a plan year before the plan will begin to cover all or a portion of your costs. Some plans have no deductible.

Dependent
A family member or other individual who meets the eligibility criteria established by HSS for enrollment in an available healthcare plan.

Dental Maintenance Organization (DMO)
An entity that provides dental services through a closed network. DMO participants can only obtain service from network dentists and typically need pre-approval from a primary care dentist before seeing a specialist.

Effective Date
The actual date your healthcare coverage is scheduled to begin. You are not covered until the effective date.

Employer Premium Contribution
The amount your employer pays toward the cost of your health plan premiums.

Employer-subsidized Benefits
Benefits that are paid for, all or in part, with money contributed by the employer.

Enrollee
Individual enrolled in a health plan.

Explanation of Benefits (EOB)
Written, formal statement sent to PPO enrollees that lists the services provided, amounts paid and costs billed by the health plan.

Evidence of Coverage (EOC)
The Evidence of Coverage is a legal document that gives details about the benefits and exclusions of a health plan and how to get the care you need. It explains your rights, benefits and responsibilities as a member of your plan and the plan providers' responsibilities to you.

Exclusions
The list of conditions, injuries, or treatments that are not covered under your health insurance policy. Exclusions can be found in your plan document called the Evidence of Coverage (EOC).

Formulary
A comprehensive list of prescription drugs that are covered by a medical plan. The formulary is designed to assist physicians in prescribing drugs that are medically necessary and cost-effective for members. The formulary is updated periodically.

Generic Drug
FDA-approved prescription drugs that are a therapeutic equivalent to the brand-name drug, contain the same active ingredient as the brand-name drug, and cost less than the brand-name drug equivalent.

Health Maintenance Organization (HMO)
An entity that provides health services through a closed network. Unlike PPOs, HMOs either employ their own staff or contract with groups of providers. HMO participants typically need pre-approval from a primary care provider before seeing a specialist.

Imputed Income
Federal IRS regulations require that the value of non-cash compensation, such as an employer's contribution to the health insurance of an employee or retiree's domestic partner, be reported as taxable income on a federal income tax return.

In-network
These providers or facilities are contracted with a health plan to provide services at pre-negotiated fees. Enrollees usually pay less when using an in-network provider, because these networks provide

Glossary of Healthcare Terms

services at lower cost to the insurance companies with which they have contracts.

Medical Group
An independent group of physicians and other healthcare providers that contract to provide services to members of an HMO.

Medicare Advantage Plan
A health plan where a participant signs Medicare over to a private insurer that administers Medicare and added benefits. These plans may include a group Medicare Part D prescription drug benefit.

Medicare Coordinated Plan
A health plan offered by a private insurer, where Medicare remains the primary payer and the private insurer is the secondary payer of supplemental or enhanced coverage. May include group Medicare Part D prescription drug coverage.

Medicare Part A
Hospital insurance provided by the federal government to individuals who are eligible based on age or certain qualifying disabilities.

Medicare Part B
Outpatient medical insurance provided by the federal government to individuals who are eligible based on age or certain qualifying disabilities.

Medicare Part D
Prescription drug insurance provided by the federal government to individuals who are eligible based on age or qualifying disabilities. There are individual Part D plans and group Part D plans.

Member
An employee or retiree designated as the primary plan subscriber, per HSS rules.

Non-formulary Drug
Prescription drug which is not on a health plan's list of covered drugs.

Open Enrollment
The period of time when you can change your health benefit elections without a qualifying event.

Out-of-area
A location outside the geographic area covered by a health plan's network of providers.

Out-of-network
Providers or healthcare facilities which are not in your health plan's provider network. Some plans do not cover Out-of-Network service costs. Others charge a higher co-payment for this type of service.

Out-of-pocket Costs
The actual costs you pay–including premiums, co-payments and deductibles–for your healthcare.

Out-of-pocket Maximum
The amount of money that an individual must pay out of their own pocket, before an insurance company will pay 100% for an individual's healthcare expenses.

PDP
A prescription drug plan.

Preferred Provider Organization (PPO)
An entity that contracts to provide healthcare services to subscribers at negotiated, often discounted, rates.

Premium
The amount charged by an insurer for healthcare coverage. This cost is usually shared by employer and employee or retiree.

Primary Care Physician (PCP)
The doctor (or nurse practitioner) who coordinates medical care and treatment. HMOs require all plan participants be assigned to a PCP.

Qualifying Event
A change in your life situation that allows you to make a change in your benefit elections outside Open Enrollment. This includes marriage, domestic partnership, separation, divorce or dissolution of partnership, the birth or adoption of a child and the death of a dependent as well as obtaining or losing other healthcare coverage.

Reasonable and Customary Charges
The average fee charged by a particular type of healthcare practitioner within a geographic area. Often used by medical plans as the amount of money they will pay for a specific test or procedure. If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference.

Retiree Premium Contribution
The amount a retiree must pay toward the cost of retiree health premiums.

Privacy Policy

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read this notice carefully.

Use and Disclosure of Health Information

The City & County of San Francisco Health Service System (the "Health Service System") may use your health information, that is, information that constitutes Protected Health Information (PHI) as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Health Service System has established a policy to guard against unnecessary disclosure of your health information.

The following is a summary of the circumstances under which your healthcare information may be used and disclosed.

To Make or Obtain Payment

The Health Service System may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the City Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate the payment of benefits.

To Conduct Healthcare Operations

The Health Service System may use or disclose health information for its own operations to facilitate administration and as necessary to provide coverage and services to all Health Service System members. A health care operation includes:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guidelines and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of City Health Plan, including customer service and resolution of internal grievances.

For example, the Health Service System may use your health information to conduct case management, quality improvement and utilization review and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment Alternatives

The Health Service System may use and disclose your health information to tell you about or recommend treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services

The Health Service System may use or disclose your health information to provide you information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Actuaries

The Health Service System may provide summary health information to the plan sponsor; may solicit premium bids from other health plans; or may modify, amend or terminate the plan.

When Legally Required

The Health Service System will disclose your health information when it is required to do so by any federal, state or local law or by court order.

To Conduct Health Oversight Activities

The Health Service System may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Health Service System, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings

As permitted or required by state law, the Health Service System may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Health Service System makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information, or to obtain your consent for disclosure.

For Law Enforcement Purposes

As permitted or required by state law, the Health Service System may disclose your health information to a law enforcement official for certain law enforcement purposes, but not limited to, if the Health Service System has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety

The Health Service System may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Health Service System, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

Privacy Policy

For Specified Government Functions

In certain circumstances, federal regulations may require the Health Service System to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, Medicare and other similar entities and correctional institutions and inmates.

For Worker's Compensation

The Health Service System may release your health information to the extent necessary to comply with Workers' Compensation laws or similar programs.

Authorization To Use Or Disclose Health Information

Other than as related 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 use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights With Respect to Your Health Information

You have the following rights regarding your health information that the Health Service System maintains:

Right to Request Restrictions

You may request restrictions on certain uses and disclosures of your health information. You have the right to request in writing a limit on the Health Service System's disclosure of your health information to someone involved in the payment of your care. However, the Health Service System is not required to agree to your request.

Right to Receive Confidential Communications

You have the right to request in writing that the Health Service System communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Health Service System only communicate with you at a certain telephone number or by email. The Health Service System will make every attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information

You have the right to inspect and copy your health information. A written request to inspect and copy records containing your health information must be sent to the Health Service System. If you request a copy of your health information, the Health Service System may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information

If you believe that your health information records are inaccurate or incomplete, you may request in writing that the Health Service System amend the records. The request may be made as long as the information is maintained by the Health Service System. The Health Service System may deny the request if it does not include a reason to support the amendment. The request may be denied if your health information records were not created by the Health Service System, if the health information you are requesting to amend is not part of the Health Service System's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy or if the Health Service System determines the records containing your health information are accurate and complete.

Right to an Accounting

You have the right to request in writing a list of Health Service System disclosures of your health information for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Health Service System will provide you one accounting during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. If applicable, the Health Service System will inform you in advance of the fee.

Right to a Paper Copy of this Notice

You have a right to request in writing and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. You also may obtain a copy of the current version of this notice from the Health Service System website at www.myhss.org.

Duties of the Health Plan

The Health Service System is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Health Service System reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Health Service System changes its policies and procedures, a revised copy of this Notice will be provided to you within 60 days of the change. You have the right to express complaints to the Health Service System and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Health Service System should be made in writing. The Health Service System encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Written Authorizations and Requests

Any written authorizations or requests regarding your health information as described above should be directed to:

Health Service System
1145 Market Street, Suite 200
San Francisco, CA 94103
Attn: Privacy Officer

Effective Date

Original Effective Date: April 14, 2003
Revised January 1, 2011

Medical Plan Costs

In 2011-2012, the Health Service System will spend an estimated $694 million on health benefits for over 109,000 members and dependents. Here are things you can do to help contain healthcare costs.

Stay Healthy

- **Quit smoking.** On average, smokers die 12 years sooner than non-smokers. In 2007, the national cost to treat tobacco-related illness was over $50 billion.
- **Manage stress.** Take advantage of stress reduction classes offered by your health plan and HSS.
- **Exercise.** Incorporate 30 minutes of moderate exercise, such as walking, into your daily routine.
- **Eat more fruits, vegetables and whole grains.** Eat less sugar and saturated fat (red meat, dairy). Eliminate trans fats and fried foods.
- **Avoid heavy drinking.** National expenditures for alcohol-related illness amount to $22.5 billion. Heavy drinkers have higher healthcare costs. All HSS health plans cover alcohol abuse treatment.
- **Get an annual check-up and preventative screenings.** Most are covered at no co-pay cost.
- **Keep track of your health concerns.** Write them down; do not forget to discuss with your doctor.
- **Follow doctor's orders.** Listen to your doctor; work together to speed recovery or manage a condition.
- **Complete a Health Risk Assessment (HRA).** Identify medical needs, share results with your doctor and be proactive about your care. All HSS plans offer free, confidential HRAs.
- **Complete an Advance Directive.** You do not need a lawyer. Document your medical care wishes for your loved ones, in case you can't speak for yourself. www.ag.ca.gov/consumers/general/adv_hc_dir.htm

Work With Your Doctor and Your Health Plan

- **Compare health plans.** Service areas, provider networks and out-of-pocket costs vary, but in most cases HSS medical plans provide the same benefits. Do your research and choose the plan that's best for you.
- **Wellness education.** Your plan and/or medical group may offer free or low cost fitness seminars or classes on wellness-related topics.
- **Generic drugs, by mail order.** Take advantage of your plan's reduced costs for generic and mail order prescriptions.
- **Email your doctor.** Make use of any online tools provided by your doctor's office for communicating concerns or appointment scheduling. Some doctors may also schedule telephone consultations.
- **Pay attention to appointment reminders.** Don't skip appointments. If you must cancel, notify your doctor's office in advance.
- **Outpatient surgery.** When possible, your doctor may schedule you to have surgery on an outpatient (non-hospitalized) basis.
- **Chronic condition management programs.** These services can help you and your family become better educated and coordinate care for diabetes, asthma, heart health, cancer, obesity and other conditions.
- **Vision Service Plan (VSP) coverage for urgent eye conditions.** See a VSP network eye doctor for urgent or acute eye ailments–just a $5 co-pay.

For more information about HSS finances and membership demographics, visit www.myhss.org/finance.

Rates: Retiree Not Eligible for Medicare

MONTHLY CONTRIBUTIONS EFFECTIVE JULY 1, 2011 - JUNE 30, 2012

MEDICAL	BLUE SHIELD HMO		KAISER HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	1,265.71	42.73	1,014.23	0.64	984.26	303.46
Retiree + 1 Dependent with no Medicare	1,559.92	336.93	1,266.33	252.74	1,606.56	925.75
Retiree + 2 or More Dependents with no Medicare	1,559.92	825.29	1,266.33	671.23	1,606.56	1,802.84
Retiree + 1 Dependent with Medicare Part A Only	1,559.92	336.93	1,266.33	252.74	1,525.54	844.73
Retiree + 1 Dependent with Medicare Part B Only	1,559.92	336.93	1,266.33	252.74	1,240.99	560.18
Retiree + 1 Dependent with Medicare Part A and Part B	1,454.61	231.62	1,191.29	177.69	1,158.15	477.34
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,559.92	825.29	1,266.33	671.23	1,525.54	1,721.82
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,559.92	825.29	1,266.33	671.23	1,240.99	1,437.27
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,454.61	719.98	1,191.29	596.18	1,158.15	1,354.43

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	39.87	0	16.47	0	31.70
Retiree + 1 Dependent	0	79.80	0	27.20	0	52.31
Retiree + 2 or More Dependents	0	120.54	0	40.22	0	77.37

All rates that appear in this Benefits Guide are subject to final approval by the San Francisco Board of Supervisors.

Rates: Retiree Eligible for Medicare Part A & Part B

MONTHLY CONTRIBUTIONS EFFECTIVE JULY 1, 2011 - JUNE 30, 2012

MEDICAL	BLUE SHIELD HMO		KAISER HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	378.81	0	355.13	0	381.89	0
Retiree + 1 Dependent with no Medicare	673.02	294.20	607.23	252.10	1,004.19	622.29
Retiree + 2 or More Dependents with no Medicare	673.02	782.56	607.23	670.59	1,004.19	1,499.38
Retiree + 1 Dependent with Medicare Part A Only	673.02	294.20	607.23	252.10	923.17	541.27
Retiree + 1 Dependent with Medicare Part B Only	673.02	294.20	607.23	252.10	638.62	256.72
Retiree + 1 Dependent with Medicare Part A and Part B	567.71	188.89	532.19	177.05	555.78	173.88
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	673.02	782.56	607.23	670.59	923.17	1,418.36
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	673.02	782.56	607.23	670.59	638.62	1,133.81
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	567.71	677.25	532.19	595.54	555.78	1,050.97

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	39.87	0	16.47	0	31.70
Retiree + 1 Dependent	0	79.80	0	27.20	0	52.31
Retiree + 2 or More Dependents	0	120.54	0	40.22	0	77.37

All rates that appear in this Benefits Guide are subject to final approval by the San Francisco Board of Supervisors.

Rates: Retiree Eligible for Medicare Part A Only

MONTHLY CONTRIBUTIONS EFFECTIVE JULY 1, 2011 - JUNE 30, 2012

MEDICAL	BLUE SHIELD HMO		KAISER HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	1,265.71	42.73	1,014.23	0.64	822.17	303.46
Retiree + 1 Dependent with no Medicare	1,559.92	336.93	1,266.33	252.74	1,444.47	925.75
Retiree + 2 or More Dependents with no Medicare	1,559.92	825.29	1,266.33	671.23	1,444.47	1,802.84
Retiree + 1 Dependent with Medicare Part A Only	1,559.92	336.93	1,266.33	252.74	1,363.45	844.73
Retiree + 1 Dependent with Medicare Part B Only	1,559.92	336.93	1,266.33	252.74	1,078.90	560.18
Retiree + 1 Dependent with Medicare Part A and Part B	1,454.61	231.62	1,191.29	177.69	996.06	477.34
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,559.92	825.29	1,266.33	671.23	1,363.45	1,721.82
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,559.92	825.29	1,266.33	671.23	1,078.90	1,437.27
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,454.61	719.98	1,191.29	596.18	996.06	1,354.43

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	39.87	0	16.47	0	31.70
Retiree + 1 Dependent	0	79.80	0	27.20	0	52.31
Retiree + 2 or More Dependents	0	120.54	0	40.22	0	77.37

All rates that appear in this Benefits Guide are subject to final approval by the San Francisco Board of Supervisors.

Rates: Retiree Eligible for Medicare Part B Only

MONTHLY CONTRIBUTIONS EFFECTIVE JULY 1, 2011 - JUNE 30, 2012

MEDICAL	BLUE SHIELD HMO		KAISER HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	1,308.44	0	1,014.87	0.00	556.67	0
Retiree + 1 Dependent with no Medicare	1,602.65	294.20	1,266.97	252.10	1,178.97	622.29
Retiree + 2 or More Dependents with no Medicare	1,602.65	782.56	1,266.97	670.59	1,178.97	1,499.38
Retiree + 1 Dependent with Medicare Part A Only	1,602.65	294.20	1,266.97	252.10	1,097.95	541.27
Retiree + 1 Dependent with Medicare Part B Only	1,602.65	294.20	1,266.97	252.10	813.40	256.72
Retiree + 1 Dependent with Medicare Part A and Part B	1,497.34	188.89	1,191.93	177.05	730.56	173.88
Retiree + 1 Dependent with Medicare Part A Only + 1 or more Dependents	1,602.65	782.56	1,266.97	670.59	1,097.95	1,418.36
Retiree + 1 Dependent with Medicare Part B Only + 1 or more Dependents	1,602.65	782.56	1,266.97	670.59	813.40	1,133.82
Retiree + 1 Dependent with Medicare Part A and B + 1 or more Dependents	1,497.34	677.25	1,191.93	595.54	730.56	1,050.97

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	39.87	0	16.47	0	31.70
Retiree + 1 Dependent	0	79.80	0	27.20	0	52.31
Retiree + 2 or More Dependents	0	120.54	0	40.22	0	77.37

All rates that appear in this Benefits Guide are subject to final approval by the San Francisco Board of Supervisors.

Rates: Eligible Surviving Spouse/Domestic Partner

MONTHLY CONTRIBUTIONS EFFECTIVE JULY 1, 2011 - JUNE 30, 2012

MEDICAL	BLUE SHIELD HMO		KAISER HMO		CITY HEALTH PLAN PPO	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Survivor Not Eligible for Medicare	1,265.71	42.73	1,014.23	0.64	984.26	303.46
Survivor + 1 Dependent with no Medicare	1,265.71	631.14	1,014.23	504.84	984.26	1,548.05
Survivor + 1 Dependent with Medicare Part A and Part B	1,265.71	420.52	1,014.23	354.75	984.26	651.23
Survivor + 2 or More Dependents with no Medicare	1,265.71	1,119.50	1,014.23	923.33	984.26	2,425.14
	BLUE SHIELD HMO		**KAISER HMO**		**CITY HEALTH PLAN PPO**	
Survivor with Medicare Part A and B	378.81	0	355.13	0	381.89	0
Survivor with Medicare A&B + 1 Dependent with no Medicare	378.81	588.41	355.13	504.20	381.89	1,244.59
Survivor with Medicare A&B + 1 Dependent with Medicare A&B	378.81	377.79	355.13	354.11	381.89	347.77
Survivor with Medicare A&B + 2 or more Dependents with no Medicare	378.81	1,076.77	355.13	922.69	381.89	2,121.68

DENTAL	DELTA DENTAL		PACIFIC UNION DENTAL		DELTACARE USA	
	City Pays	Retiree Pays	City Pays	Retiree Pays	City Pays	Retiree Pays
Retiree Only	0	39.87	0	16.47	0	31.70
Retiree + 1 Dependent	0	79.80	0	27.20	0	52.31
Retiree + 2 or More Dependents	0	120.54	0	40.22	0	77.37

All rates that appear in this Benefits Guide are subject to final approval by the San Francisco Board of Supervisors.

Key Contact Information

HEALTH SERVICE SYSTEM

Member Services
1145 Market Street, 2nd Floor
San Francisco, CA 94103
(Civic Center Station between 7th and 8th)
Tel: (415) 554-1750
(800) 541-2266 (outside 415 area code)
Fax: (415) 554-1721
www.myhss.org

MEDICAL PLANS

City Health Plan PPO (UnitedHealthcare)
Tel: (866) 282-0125
Group No. 705287
www.myuhc.com

Blue Shield of California 65 Plus (Medicare Advantage) HMO
Tel: (800) 776-4466
Group No. MA0002
www.blueshieldca.com/sfhss

Blue Shield of California Access+ HMO
Tel: (800) 642-6155
Group No. H11054
www.blueshieldca.com/sfhss

Kaiser Permanente HMO
Tel: (800) 464-4000
Group No. 888
my.kp.org/ca/cityandcountyofsanfrancisco

VISION PLAN

Vision Service Plan (VSP)
Tel: (800) 877-7195
Group No. 12145878
www.vsp.com

DENTAL PLANS

Delta Dental
Tel: (888) 335-8227
Group No. 1673-0001
www.deltadentalins.com/ccsf

DeltaCare USA Dental
Tel: (800) 422-4234
Group No. 1797-0003
www.deltadentalins.com/ccsf

Pacific Union Dental
Tel: (800) 999-3367
(925) 363-6000
Group No. 705287-0048
www.myuhcdental.com

COBRA

Fringe Benefits Management Company (FBMC)
Tel: (800) 342-8017
www.myfbmc.com

CITY AGENCIES

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

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

FEDERAL AGENCIES

Social Security Administration
Tel: (800) 772-1213
www.ssa.gov

Medicare
Tel: (800) 633-4227
www.medicare.gov