



ACTIVE EMPLOYEES SFUSD 2013 HEALTH BENEFITS

Health Service System

CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

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Open Enrollment Overview

Open Enrollment takes place October 1–31, 2013. Review your options and make informed choices.

Things You Can Do During HSS Open Enrollment

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

Benefit election changes made during October 2012 Open Enrollment will be in effect from January 1, 2013 through December 31, 2013. Dependents dropped during Open Enrollment are not eligible for COBRA continuation coverage.

Open Enrollment Deadline: October 31, 2012

Completed Open Enrollment applications for the January to December 2013 plan year must be received at HSS by 5:30PM, October 31, 2012. Open Enrollment applications can be delivered to HSS in person, sent through the mail or transmitted by fax. The HSS fax number is (415) 554-1721.

Changing Benefit Elections During Open Enrollment

If you change your medical plan, the plan will issue a new medical ID card before January 1, 2013. If you do not receive your card by January 1, contact your plan. Newly enrolled Kaiser members should contact Kaiser to confirm Primary Care Physician selection. Newly enrolled Blue Shield members should contact Blue Shield to confirm Primary Care Physician and medical group selections.

If You Do Not Make Any Changes During Open Enrollment

If you do not make changes during this Open Enrollment, your current health plan elections and the eligible dependents you have covered will remain the same. Be aware your premium contributions will change, effective January 1, 2013. See pages 30–31.

What's New for January–December 2013

- Premium contribution rates will change, effective January 1, 2013. (See pages 30–31.)
- Per the federal Affordable Care Act, effective 2013 coverage for women's health services with no cost sharing is expanded for all medical plans. These services include well woman office visits, contraception, domestic violence screening and more. See www.hrsa.gov/womensguidelines.
- City Health Plan deductible and out-of-pocket maximum costs incurred from October through December 2012 will be carried over to the 2013 plan year.

Open Enrollment Events

Monday	Tuesday	Wednesday	Thursday	Friday
October 2012				
1	2	3	4	5
Start of Open Enrollment HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM HSS at 850 Bryant Room 551 8:30 AM–4:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM HSS at City Hall Room 421 8:30 AM–4:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM HSS at SFGH Main Cafeteria 8:30 AM–4:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM
8	9	10	11	12
Columbus Day	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM HSS at Laguna Honda New Hospital Conf Room P1191 8:30 AM–4:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM HSS at SFUSD 555 Franklin Street 8:30 AM–4:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM
15	16	17	18	19
HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM HSS at SFO ITB/A Training Room near SFO medical clinic 8:30 AM–4:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM
22	23	24	25	26
HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS
29	30	31		
HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS	HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS	End of Open Enrollment HSS Office Hours 1145 Market 2nd Fl 8:00 AM–5:00 PM Medical and dental vendors at HSS All applications due by 5:30 PM		

Open Enrollment FAQ

Medical Coverage	
What if I don't want to make any changes to my medical coverage?	If you do not want to choose a different medical plan, and are not adding or dropping dependents, you do not need to take any action during October 2012 Open Enrollment. Your premium contributions will change, effective January 1, 2013. (See pages 30–31.)
How do I choose different medical 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, October 31, 2012. For required eligibility documentation, see page 17.
How do I add a dependent to my medical plan?	You must submit a completed Open Enrollment application form and any required eligibility documentation to HSS no later than 5:30PM, October 31, 2012. For a list of required eligibility documentation, see page 17.
How do I drop a dependent from my medical plan?	You must submit a completed Open Enrollment application form to HSS no later than 5:30PM, October 31, 2012. No additional documentation is required when you are dropping dependent 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.
Submitting Your Open Enrollment Application	
May I fax my Open Enrollment application to HSS?	Yes, you may fax your Open Enrollment application and required eligibility documentation. The secure HSS fax number is (415) 554-1721. Please keep a copy of your fax confirmation and do not fax the same application multiple times. Faxed applications must be received by HSS by 5:30PM, October 31, 2012.
What else is required in addition to my application form?	Your application must be accompanied by any required eligibility documentation. For a list of required eligibility documentation, see page 17. Required documentation must be received by HSS no later than 5:30PM, October 31, 2012. A Social Security number is also required for each enrolled individual.
Can I get Open Enrollment materials online?	Yes, you can download the Open Enrollment application form and benefits guide from our website www.myhss.org .
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 December 2012 after the close of Open Enrollment. Note: No changes to Open Enrollment elections can be made after October 2012. HSS can only correct administrative errors based on the Open Enrollment application you submitted in October 2012.

Medical Plan Benefits Administered by HSS

These medical plan options are available to active employee members and eligible dependents. Premium contributions are deducted from the employee's paycheck.

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**
- **Kaiser Permanente HMO**

Preferred Provider Organization (PPO)

A PPO is a medical plan that offers benefits through in-network and out-of-network healthcare providers. (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. Individual premiums are determined by the total cost of services used by the plan's group of participants. HSS offers the following PPO plan:

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

The health plans administered by HSS do not guarantee the continued participation of any particular provider, such as a doctor, hospital or medical group, during the January to December 2013 plan year. After Open Enrollment, you won't be allowed to change your health benefit elections because a doctor, hospital or medical group chooses not to participate in your plan. You will be assigned or required to select another provider.

This benefits guide does not explain all the details of your plan contract. The Evidence of Coverage (EOC) contains a complete list of benefits and exclusions in effect for each plan from January to December 2013. Review your EOC for plan details. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Download plan EOCs at www.myhss.org.

Change of Address?

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

PPO vs. HMO

QUICK COMPARISON CHART

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

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

■ = Available in this county.

○ = Available in some zip codes; verify your zip code with the plan to confirm availability.

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

Blue Shield of California: (800) 642-6155

Kaiser Permanente: (800) 464-4000

Medical Plan Benefits-at-a-Glance

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

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

Note: Out-of-pocket maximum does not include premium contributions.

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

Medical Plan Benefits-at-a-Glance

	blue  of california	KAISER PERMANENTE®	CITY HEALTH PLAN (United Healthcare Choice Plus)		
			In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
REHABILITATIVE					
Physical/Occupational therapy	\$25 co-pay	\$20 co-pay authorization required	85% covered after deductible; 60 visits max per plan year	50% covered after deductible; 60 visits max per plan year	85% covered after deductible; 60 visits max per plan year
Acupuncture	\$15 co-pay 30 visits max per plan year; ASH network only	Not covered	50% covered after deductible; \$1,000 max per plan year	50% covered after deductible; \$1,000 max per plan year	50% covered after deductible; \$1,000 max per plan year
Chiropractic	\$15 co-pay 30 visits max per plan year; ASH network only	\$15 co-pay 30 visits max calendar year; ASH network only	50% covered after deductible; \$1,000 max per plan year	50% covered after deductible; \$1,000 max per plan year	50% covered after deductible; \$1,000 max per plan year
PREGNANCY & MATERNITY					
Routine pre- and post-partum physician care; for hospital stay, see Hospital	No charge newborn must be enrolled within 30 days of birth; visits limited; see EOC	No charge newborn must be enrolled within 30 days of birth; visits limited; see EOC	85% covered after deductible; newborn must be enrolled within 30 days of birth	50% covered after deductible; newborn must be enrolled within 30 days of birth	85% covered after deductible; newborn must be enrolled within 30 days of birth
INFERTILITY					
IVF, GIFT, ZIFT and artificial insemination	50% covered limitations apply	50% covered limitations apply	50% covered after deductible; limitations apply; prior notification required	50% covered after deductible; limitations apply; prior notification required	50% covered after deductible; limitations apply; prior notification required
TRANSGENDER					
Office visits and outpatient surgery	Co-pays apply authorization req. \$75,000 lifetime max	Co-pays apply authorization req. \$75,000 lifetime max	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
DURABLE MEDICAL EQUIPMENT					
Home medical equipment	No charge	No charge as authorized by PCP according to formulary	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary	85% covered after deductible; when medically necessary; notification required	50% covered after deductible; when medically necessary; notification required	85% covered after deductible; when medically necessary; notification required
Hearing aids	Evaluation no charge 1 aid per ear every 36 months, up to \$2,500 each	Evaluation no charge 1 aid per ear every 36 months, up to \$2,500 each	85% covered after deductible; 1 aid per ear every 36 months, up to \$2,500 each	50% covered after deductible; 1 aid per ear every 36 months, up to \$2,500 each	85% covered after deductible; 1 aid per ear every 36 months, up to \$2,500 each
MENTAL HEALTH					
Inpatient hospitalization	\$200 co-pay per admission	\$100 co-pay per admission	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Outpatient treatment	\$25 co-pay non-severe and severe	\$10 co-pay group \$20 co-pay individual	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
CHEMICAL DEPENDENCY					
Inpatient detox	\$200 co-pay per admission	\$100 co-pay per admission	85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
Residential rehabilitation	\$200 co-pay per admission	\$100 co-pay per admission; physician approval required	85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
EXTENDED & END-OF-LIFE CARE					
Skilled nursing facility	No charge up to 100 days per plan year	No charge up to 100 days per benefit period	85% covered after deductible; up to 120 days per plan year; notification required; custodial care not covered	50% covered after deductible; up to 120 days per plan year; notification required; custodial care not covered	85% covered after deductible; up to 120 days per plan year; notification required; custodial care not covered
Hospice	No charge authorization required	No charge when medically necessary	85% covered after deductible; prior notification required	50% covered after deductible; prior notification required	85% covered after deductible; prior notification required

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

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

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

The Affordable Care Act mandates that many preventive services be provided at no cost to insured patients. Consult with your doctor about the types of screenings and immunizations that are right for you. For more details, including recommendations for children, see www.healthcare.gov/center/regulations/prevention/recommendations.html and www.healthcare.gov/law/resources/regulations/womensprevention.html.

Additional Wellness Benefits

Health Plan Wellness Tools

Blue Shield of California

The Healthy Lifestyle Rewards Program provides financial incentives for completion of a Health Risk Assessment and condition management programs:

www.blueshieldca.com/hw/

Wellness discounts and savings:

www.blueshieldca.com/bsc/hw/hw_375.jhtml

Quit For Life smoking cessation:

(866) 784-8454

www.quitnow.net

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

Conditions A–Z, online symptom checker, Health Risk Assessment and more:

www.myuhc.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

Weight Watchers

Weight Watchers provides a supportive way to lose weight. Weekly group meetings focus on practical strategies to help you reach your goals. You may attend one informational meeting at no cost. Sign up for a discounted monthly pass at wellness.weightwatchers.com. Enter company number 54552 and company passcode WW54552. Note: if you sign-up online, you will be charged automatically each month until you cancel.

24/7 Nurse Hotlines

Talk with a registered nurse 24/7 seven days a week.

Kaiser San Francisco Nurse Advice:

English (415) 833-2200

Chinese (415) 833-2239

Spanish (415) 833-2203

For other Kaiser locations go to www.kp.org and click Locate Our Services.

Blue Shield NurseHelp 24/7:

English or Spanish (877) 304-0504

Brown & Toland Ask-A-Nurse:

Brown & Toland patients only (855) 423-9974

UnitedHealthcare Nurseline:

(800) 237-4936

HSS Member Fitness Club Discounts

24 Hour Fitness

One Club Sport \$24.99 per month; All Club Sport \$29.99 per month; All Club Super \$44.99 per month. No initiation fee; month-to-month, no contract. Go to www.24hourfitness.com/corp/sanfranemp and enter code100961.

Crunch

One-time enrollment fee \$59.00 per person; unlimited California club access \$54.99 per month. Month-to-month, no contract: (415) 602-6193.

Live Fit Gym

Basic gym \$47 per month; gym and unlimited classes \$67 per month; gym, unlimited classes and monthly massage \$85 per month. Other packages available. Month-to-month; no contract: (415) 525-4364.

Planet Fitness

\$15 per month San Francisco only; \$29 sign-up fee and \$30 annual lock-in rate. \$19.99 per month multi-club; no sign-up fee; \$39.99 annual lock-in. Month-to-month; no contract: (415) 433-3033.

This is a partial list. For a complete list of the most current fitness club discounts visit www.myhss.org.

Vision Plan Benefits Administered by HSS

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, per 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*
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
Savings and Discounts		
Non-covered lens options (progressives, anti-reflective coating, photochromic, polycarbonate)	Average 20–25% off Of provider's usual and customary charges; every 24 months*	Not applicable
Laser Vision Correction	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities	Not applicable

*Based on your last date of service.

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 members of the Health Service System and which dependents may be eligible for coverage.

Member Eligibility

The following are eligible to participate in the Health Service System as members, per San Francisco Administrative Code Section 16.700:

- City and County Employees
 - All permanent employees of the City and County of San Francisco whose normal work week is not less than 20 hours;
 - All regularly scheduled provisional employees of the City and County of San Francisco whose normal work week is not less than 20 hours;
 - All other employees of the City and County of San Francisco, including temporary exempt or “as needed” employees, who have worked more than 1,040 hours in any consecutive 12-month period and whose normal work week is not less than 20 hours.
- Elected Officials of the City & County of San Francisco
- All members of designated boards and commissions during their time in service to the City and County of San Francisco as defined in San Francisco Administrative Code Section 16.700(c).
- All officers and employees as determined eligible by the governing bodies of the San Francisco Transportation Authority, San Francisco Parking Authority, Treasure Island Development Authority, San Francisco Superior Court and any other employees as determined eligible by ordinance.

Dependent Eligibility

Spouse or Domestic Partner

A member’s legal spouse or domestic partner may be eligible for HSS healthcare coverage. Proof of marriage or registered domestic partnership is required, as well as the dependent’s Social Security number. Proof of Medicare enrollment must also be provided for a same-sex spouse or domestic partner (of either gender) who is age 65 or older, or who is Medicare-eligible due to a 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 coverage period 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, adopted child (including child placed for adoption), and the natural or adopted child of a member’s enrolled domestic partner are eligible for coverage up to 26 years of age. Coverage terminates at the end of the coverage period in which the child turns 26. Eligibility documentation is required upon initial enrollment.

Legal Guardianships and Court-Ordered Children

Children under 19 years 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. Coverage terminates at the end of the coverage period in which the child turns 19. The member must provide HSS with proof of guardianship, court order or decree by required deadlines.

Adult Disabled Children

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

1. Adult child was enrolled in an HSS medical plan on the child’s 19th birthday and continuously 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 employee 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

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

REQUIRED ELIGIBILITY DOCUMENTATION

	EVIDENCE OF HIRE	BENEFIT AUTH. FORM	MARRIAGE CERTIFICATE	DOMESTIC PARTNER CERT	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	PROOF OF PLACEMENT	COURT ORDER OR DECREE	MEDICAL EVIDENCE	SOCIAL SECURITY #
Employee: Permanent/Provisional	■									■
Employee: Temporary/Exempt		■								■
Spouse			■							■
Domestic Partner				■						■
Child: Natural					■					■
Stepchild: Spouse			■		■					■
Stepchild: Domestic Partner				■	■					■
Child: Adopted						■				■
Child: Placed for Adoption							■			■
Child: Legal Guardianship								■		■
Child: Court Ordered								■		■
Adult Child: Disabled									■	■

Note: Proof of Medicare enrollment is also required for a Medicare-eligible same-sex spouse, domestic partner or disabled child.

Temporary Employee Eligibility

Take note of this important information for temporary teachers, speech therapists, psychologists, nurses, substitutes and all other SFUSD temporary employees.

Temporary Certificated Employees

Temporary certificated employees with contracts that end June 30, 2013 are as follows:

- Emergency Teachers (ETs)
- Categorical Teachers (CTCs)
- University Interns (ITs)

If you are a Temporary Certificated employee your last day of coverage will be June 30, 2013. Effective July 1, 2013, you may elect to continue coverage under the COBRA provision. Please see pages 26–27 of this guide for more information.

Temporary School-Term Biweekly Employees

Temporary School-Term Biweekly Employees include but are not limited to:

- Clerical Workers
- Paraprofessionals
- Security Aides

If you are a Temporary School-Term Biweekly employee your last day of coverage will be June 4, 2013. Effective June 5, 2013, you may elect to continue coverage under the COBRA provision. Please see pages 26–27 of this guide for more information about COBRA.

School-Term Employees who make open enrollment changes with HSS must notify the SFUSD Benefits Office so double deductions can be adjusted. Please fax a copy of your HSS open enrollment form immediately to SFUSD at (415) 241-6375.

Rehired in the Fall?

If you are rehired in the fall with an eligible SFUSD assignment, you must re-enroll for healthcare benefits through HSS and SFUSD.

Benefits Administered by SFUSD

SFUSD employees may be eligible for benefits through SFUSD, such as dental coverage, Flexible Spending Accounts and disability insurance. Contact the SFUSD Benefits Office for details.

Dental Plan (Delta Premier)

As an eligible employee of the San Francisco Unified School District, SFUSD offers you dental coverage through Delta Dental Premier Plan. Contact the SFUSD Benefits Office at (415) 241-6101 for dental plan enrollment information.

Please refer to page 32 of this guide for the Delta Dental group number and contact telephone number. The plan document (Evidence of Coverage) provided by Delta Dental gives a detailed list of the covered expenses, exclusions and limitations under this plan.

Flexible Spending Accounts (FSAs)

Healthcare and Dependent Care Flexible Spending Accounts are offered through AFLAC (American Family Life Assurance Company). Contact the SFUSD Benefits Office for FSA eligibility and enrollment information.

Participation in an FSA program allows a portion of your salary to be redirected on a pre-tax basis to provide reimbursement for certain types of expenses. Participation in one or both FSAs can save you money by reducing your taxable income. Taxes will be calculated after the elected amount is deducted from your salary. Your taxable income will be reduced for Social Security purposes; therefore, there may be a corresponding reduction in Social Security benefits.

Please see page 32 of this guide of this guide for FSA administrator contact information. Refer to your FSA participant handbook for a detailed list of covered expenses, exclusions and limitations under this plan.

Short-Term Disability Insurance, Tax Shelter Investments and Pre-Paid Legal Plans

Refer to the SFUSD website at www.sfusd.edu and/or your SFUSD Employees' Summary of Benefits packet for a list of additional voluntary supplemental benefit programs available through SFUSD.

Questions about Other Benefits?

To verify your eligibility for other SFUSD benefits contact the SFUSD Benefits Office at (415) 241-6101 or visit www.sfusd.edu.

Changing Elections Outside of Open Enrollment

A member may make a benefits election change due to a qualifying event a maximum of two times during the January–December 2013 plan year. For changes to benefit elections due to a qualifying event the member must notify the Health Service System and complete the enrollment process. This includes the submission of all required documentation **no later than 30 calendar days** after the qualifying event. A Social Security number is required for all newly enrolled individuals.

FAMILY STATUS	Enrollment Change	Documentation	Coverage
Marriage Legal Domestic Partnership	Add new spouse or partner to medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • Marriage certificate or certificate of partnership • Proof of Medicare enrollment for Medicare-eligible same-sex spouse or domestic partner (of either gender) 	Coverage is effective the first day of the coverage period following submission of required documentation by 30-day deadline.
	Add new stepchild to medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • Marriage certificate or certificate of partnership • Child's birth certificate 	Coverage is effective the first day of the coverage period following submission of required documentation by 30-day deadline.
	Waive member's medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • Marriage certificate or certificate of partnership • Proof of member enrollment in other coverage 	Coverage terminates the first day of the coverage period following submission of required documentation by 30-day deadline.
Divorce Legal Separation Dissolution of Partnership Annulment	Drop former spouse, partner and associated stepchildren from medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • Divorce decree or legal documents proving separation, dissolution of partnership or annulment 	These individuals are no longer eligible for HSS coverage; failure to drop may result in penalties. Coverage terminates the first day of the coverage period following submission of required documentation.
Birth of a Child Adoption of a Child Child Placed for Adoption	Add child to medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • If newborn, birth verification letter from hospital; birth certificate when issued • If adopted, adoption certificate or proof of adoption 	Coverage is effective the day of the child's birth, if documentation is submitted by 30-day deadline.
Legal Guardianship of a Child	Add child to medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • Court decree 	Coverage effective the date guardianship takes effect, if documentation submitted by 30-day deadline.
Court-Ordered Coverage for a Child	Add child to medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • Court order to add child 	Coverage effective the date of court order, if documentation submitted by 30-day deadline.
	Drop child from medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • Court order for other coverage • Proof child has other coverage 	Coverage terminates the first day of the coverage period following submission of required documentation by 30-day deadline.

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

LOSS OF COVERAGE	Enrollment Change	Documentation	Coverage
Member Loses Other Coverage	Enroll member (and dependents who also lost coverage) in medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • Proof of loss of coverage 	Coverage is effective the first day of the coverage period following submission of required documentation by 30-day deadline.
Spouse or Partner Loses Other Coverage	Enroll spouse or partner in medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • Proof of loss of coverage • Marriage certificate or certification of legal partnership 	Coverage is effective the first day of the coverage period following submission of required documentation by 30-day deadline.
Dependent Child or Stepchild Loses Other Coverage	Enroll child or stepchild in medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • Proof of loss of coverage • Child's birth certificate • Marriage certificate or certification of legal partnership (if stepchild) 	Coverage is effective the first day of the coverage period following submission of required documentation by 30-day deadline.

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

GAIN OF COVERAGE	Enrollment Change	Documentation	Coverage
Member Gains Other Coverage	Waive member medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • Proof of other coverage 	Coverage terminates the first day of the coverage period following submission of required documentation by 30-day deadline.
Spouse or Partner Gains Other Coverage	Drop spouse or partner from medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • Proof of other coverage 	Coverage terminates the first day of the coverage period following submission of required documentation by 30-day deadline.
Dependent Child or Stepchild Gains Other Coverage	Drop child or stepchild from medical coverage	<ul style="list-style-type: none"> • HSS enrollment application • Proof of other coverage 	Coverage terminates the first day of the coverage period following submission of required documentation by 30-day deadline.

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Changing Elections Outside of Open Enrollment

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 an employee 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 death date of death:

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

A surviving spouse or partner who is not enrolled on the deceased member's health plan at the time of the member's death may be eligible for coverage, but must wait until Open Enrollment to enroll. Surviving dependent children of a member must meet eligibility requirements for dependent children. (See pages 26–27.) Eligible surviving dependent children may be enrolled, but do not qualify for employer-subsidized benefits.

Moving Out of a Plan's Service Area

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

Financial Penalties for Failing to Disenroll Ineligible Dependents

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

Domestic Partner and Same-Sex Spouse Taxation

Health coverage for your domestic partner, same-sex spouse, and children of that partner or spouse through an HSS plan is typically a taxable benefit.

Tax Treatment of Health Benefits

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

IRS Exemption for Enrolled Health Plan Dependents Who Meet Certain Requirements

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

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

If an enrolled dependent meets all these requirements the employee may submit an annual declaration to HSS, and there will be no imputed income for

the employer contribution to dependent health premiums and employee premium contributions will be paid pre-tax. To take advantage of this favorable tax treatment, you must file the HSS declaration annually with HSS by required deadlines.

Equitable California State Tax Treatment

If your dependent does not meet the IRS code section 152 requirements for favorable tax treatment under federal law, you may still take advantage of equitable California state tax treatment if your dependent qualifies under California state law. (This California law only applies to same-sex domestic partners and same-sex spouses—not opposite-sex domestic partners.) To obtain equitable tax treatment under California state law, you are required to have either a valid California marriage license or a Declaration of Domestic Partnership issued by the Secretary of the State of California. In this case, you will need to deduct the value of the employer-paid health insurance premiums for your same-sex domestic partner or same-sex spouse, and his or her children, when filing your California state income tax return.

Consult with Your Tax Advisor

This is a brief overview regarding the tax treatment of health benefits for domestic partners, same-sex spouses and their children. Please consult with a professional tax advisor before taking any action. You remain subject to all state and federal tax law and will be responsible for any consequences that result from the forms, documents or declarations you submit to the Health Service System.

Learn more online:

www.myhss.org/member_services

Leaves of Absence and Health Coverage

Type of Leave	Eligibility	Your Responsibilities
<p>Family and Medical Leave (FMLA)</p> <p>Worker’s Compensation Leave</p> <p>Family Care Leave</p> <p>Military Leave</p>	<p>If you notify HSS within 30 days of when your leave begins, you may be eligible to continue or discontinue (waive) your healthcare coverage for the duration of your approved leave of absence.</p> <p>You may have additional rights under an approved FMLA leave. Contact your departmental personnel representative for details.</p>	<ol style="list-style-type: none"> 1. Notify your department’s personnel officer. They will provide HSS with important information about your leave. 2. Contact HSS within 30 days of when leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits. 3. Contact HSS immediately (within 30 days of return to work) to request that premium contributions return to active status.
<p>Personal Leave Following Family Care Leave</p>	<p>If you have been on an approved Family Care Leave and elect to extend your leave period as a Personal Leave, you may be eligible to continue (or waive) your healthcare coverage for the duration of your approved Personal Leave, if:</p> <ul style="list-style-type: none"> - The reason for the Personal Leave is the same as the reason for the prior Family Care Leave. - Your required employee premium contribution payments, if any, are current. - You notify HSS before your leave begins. 	<ol style="list-style-type: none"> 1. Notify your department’s personnel officer. They will provide HSS with important information about your leave. 2. Contact HSS within 30 days of when leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits. 3. Contact HSS immediately (within 30 days of return to work) to request that premium contributions return to active status.
<p>Educational Leave</p> <p>Personal Leave</p> <p>Leave for Employment as an Employee Organization Officer or Representative</p>	<p>If you notify HSS within 30 days of when your leave begins, you may be eligible to continue (or waive) your healthcare coverage for the duration of your approved leave of absence.</p>	<ol style="list-style-type: none"> 1. Notify your department’s personnel officer. They will provide HSS with important information about your leave. 2. Contact HSS within 30 days of when leave begins to either waive coverage or arrange for payment of employee premium contributions while you are on leave. Failure to do so can result in termination of your health benefits. 3. If your leave lasts beyond 12 weeks, you must pay the total cost of medical coverage for yourself and any covered dependents. This includes your employee premium contribution amount plus the City and your employer’s contribution. Contact HSS for details. 4. Contact HSS immediately (within 30 days of return to work) to request that premium contributions return to active status.

Approaching Retirement

Transition to Retirement

The transition of health benefits from active to retiree status does not happen automatically. You must elect to continue retiree healthcare coverage by submitting the required retiree enrollment form and supporting documents to HSS. Contact HSS Member Services at (415) 554-1750 three months before your retirement date to learn about enrolling in retiree benefits. You are required to notify HSS of your retirement even if you are not planning to elect HSS coverage on your retirement date.

Depending on your retirement date, there can be a gap between when active employee coverage ends and retiree coverage begins. Call HSS Member Services at (415) 554-1750 to review your options before deciding on your retirement date.

If you choose to continue health coverage through HSS after you retire, retiree premium contributions may be higher than your active employee contributions. Costs will depend on your plan choices, number of dependents covered and your Medicare status. Health premium contributions will be taken from your pension check. If required monthly contributions are greater than the total amount of your pension check, you must contact HSS to make payment arrangements. Premium contribution rates may change, as specified during Open Enrollment.

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

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

Medicare Enrollment Requirements for Employees and Dependents

Active Employees and Opposite-Sex Spouses Medicare Enrollment Optional

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

Same-Sex Spouses and Domestic Partners Medicare Enrollment Required

A same-sex spouse or domestic partner (of either gender) of an active employee must enroll, and remain enrolled, in both premium-free Medicare Part A and Medicare Part B upon reaching age 65. Proof of Medicare enrollment, such as a copy of the Medicare card, must be provided to HSS. Your spouse or partner will then be enrolled in the appropriate Medicare Advantage or Medicare Coordinated plan from your insurer. A same-sex spouse or domestic partner who is age 65 or older and eligible for Medicare but not enrolled in Part A and Part B cannot be enrolled in HSS coverage. If enrolled in HSS medical coverage without Medicare, spouse or partner benefits can be terminated. The federal government charges a premium for Medicare Part B, and in some cases for group employer Part D. All Medicare premium payments must be paid to maintain Medicare enrollment. Also, a same-sex spouse or domestic partner who fails to enroll in Medicare Part B as soon as he or she is eligible may be charged penalties by the federal government.

COBRA Coverage

Employees and covered dependents who lose access to HSS health benefits may be eligible for COBRA coverage.

COBRA Continuation Coverage

COBRA, a federal law enacted in 1986, allows employees and their covered dependents to elect a temporary extension of healthcare coverage in certain instances where coverage would otherwise end. COBRA is administered by Fringe Benefits Management Company, a Division of WageWorks.

COBRA Qualifying Events

Under COBRA, employees may elect to continue healthcare coverage if it is lost due to any of the following qualifying events:

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

Covered spouses or domestic partners may elect COBRA coverage if healthcare coverage is lost due to any of the following qualifying events:

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

Covered dependent children may elect COBRA coverage if healthcare coverage is lost due to any of the following qualifying events:

- Loss of dependent child status under the plan rules.
- Voluntary or involuntary termination of the employee's employment (except for gross misconduct).
- Hours of employment reduced, making the employee ineligible for employer health coverage.

- Parent's divorce, legal separation or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

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

COBRA Notification and Time Limits for COBRA Elections

When a qualifying event occurs, the COBRA Administrator will notify you of the opportunity to elect COBRA coverage. You have 60 days from the notification date to complete enrollment for yourself and any dependents who were covered on your employer-provided plan at the time of your termination. 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 any newly eligible dependent (spouse, domestic partner, newborn or adopted child) to your COBRA coverage based on the date of the qualifying event (marriage, partnership, birth, adoption). If a dependent loses coverage (due to divorce or aging out of a plan) the employee or dependent must notify the COBRA Administrator within 30 days of the qualifying event.

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. (Employees and dependents who are eligible for less than 36 months of federal COBRA may be eligible for Cal-COBRA. Continuation coverage under both federal and California state COBRA will not exceed 36 months.)

Employees who are disabled on the date of their qualifying event, or at any time during the first 60 days of COBRA coverage, are eligible for 29 months of coverage. Beginning the 19th month of coverage, the cost will rise to 150 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 premium rate information, contact HSS at (415) 554-1750 or visit www.myhss.org.

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

Federal Legislation and COBRA

This information may not reflect changes to COBRA resulting from federal legislation. For the most up-to-date information about how federal legislation may impact COBRA benefits, please contact Fringe Benefits Management Company, a Division of WageWorks, at (800) 342-8017.

Continuing Dental Coverage

SFUSD employees who wish to continue dental coverage under COBRA must contact the SFUSD Benefits Office. HSS does not administer dental benefits for SFUSD employees.

Privacy Policy

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

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.

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, 2012

SFUSD Employees January–December 2013

EMPLOYEE ONLY MEDICAL PLAN PREMIUM CONTRIBUTIONS

	BLUE SHIELD HMO			KAISER PERMANENTE HMO			CITY HEALTH PLAN PPO		
	SFUSD Pays	Employee Pays	Total Premium	SFUSD Pays	Employee Pays	Total Premium	SFUSD Pays	Employee Pays	Total Premium
BIWEEKLY									
Craft Unions Local 4, 6, 22, 38, 39, 40, 66, 104, 261, 377, 718, 853, 1414	253.02	45.67	298.69	246.83	1.03	247.86	246.83	334.23	581.06
Board Designated Confidential or Unrepresented and SEIU Local 1021	253.02	45.67	298.69	246.83	1.03	247.86	276.92	304.14	581.06
Board Designated Classified Managerial	253.02	45.67	298.69	246.83	1.03	247.86	246.83	334.23	581.06
IFPTE Local 21	253.02	45.67	298.69	246.83	1.03	247.86	246.83	334.23	581.06
UESF Paraprofessionals	253.02	45.67	298.69	246.83	1.03	247.86	246.83	334.23	581.06
MONTHLY									
UASF, BOE, Cabinet (Unrepresented Certificated Management)	548.21	98.95	647.16	534.78	2.24	537.02	534.78	724.19	1,258.97
UESF Certificated	548.21	98.95	647.16	534.78	2.24	537.02	534.78	724.19	1,258.97

EMPLOYEE PLUS ONE MEDICAL PLAN PREMIUM CONTRIBUTIONS

	BLUE SHIELD HMO			KAISER PERMANENTE HMO			CITY HEALTH PLAN PPO		
	SFUSD Pays	Employee Pays	Total Premium	SFUSD Pays	Employee Pays	Total Premium	SFUSD Pays	Employee Pays	Total Premium
BIWEEKLY									
Craft Unions Local 4, 6, 22, 38, 39, 40, 66, 104, 261, 377, 718, 853, 1414	556.98	39.47	596.45	493.74	1.03	494.77	585.72	555.96	1,141.68
Board Designated Confidential or Unrepresented and SEIU Local 1021	548.88	47.57	596.45	481.75	13.02	494.77	555.62	586.06	1,141.68
Board Designated Classified Managerial	363.06	233.39	596.45	350.67	144.10	494.77	350.67	791.01	1,141.68
IFPTE Local 21	363.06	233.39	596.45	350.67	144.10	494.77	350.67	791.01	1,141.68
UESF Paraprofessionals	362.47	233.98	596.45	350.08	144.69	494.77	350.08	791.60	1,141.68
MONTHLY									
UASF, BOE, Cabinet (Unrepresented Certificated Management)	785.36	506.95	1,292.31	758.50	313.51	1,072.01	758.50	1,715.13	2,473.63
UESF Certificated	785.36	506.95	1,292.31	758.50	313.51	1,072.01	758.50	1,715.13	2,473.63

EMPLOYEE PLUS 2 MEDICAL PLAN PREMIUM CONTRIBUTIONS

	BLUE SHIELD HMO			KAISER PERMANENTE HMO			CITY HEALTH PLAN PPO		
	SFUSD Pays	Employee Pays	Total Premium	SFUSD Pays	Employee Pays	Total Premium	SFUSD Pays	Employee Pays	Total Premium
BIWEEKLY									
Craft Unions Local 4, 6, 22, 38, 39, 40, 66, 104, 261, 377, 718, 853, 1414	603.27	240.32	843.59	585.72	114.00	699.72	585.72	1,024.94	1,610.66
Board Designated Confidential or Unrepresented and SEIU Local 1021	573.20	270.39	843.59	555.62	144.10	699.72	555.62	1,055.04	1,610.66
Board Designated Classified Managerial	379.75	463.84	843.59	362.21	337.51	699.72	362.21	1,248.45	1,610.66
IFPTE Local 21	379.75	463.84	843.59	362.21	337.51	699.72	362.21	1,248.45	1,610.66
UESF Paraprofessionals	390.70	452.89	843.59	373.15	326.57	699.72	373.20	1,237.46	1,610.66
MONTHLY									
UASF, BOE, Cabinet (Unrepresented Certificated Management)	846.51	981.26	1,827.77	808.50	707.55	1,516.05	808.50	2,681.27	3,489.77
UESF Certificated	846.51	981.26	1,827.77	808.50	707.55	1,516.05	808.50	2,681.27	3,489.77

All rates published in this guide are subject to approval by the Health Service Board, the San Francisco Board of Supervisors and/or the respective employers. Rate updates will available on www.myhss.org.

Key Contact Information

SAN FRANCISCO UNIFIED SCHOOL DISTRICT

Benefits Office

555 Franklin Street, 2nd Floor
San Francisco, CA 94102
Tel: (415) 241-6101 x3243, x3389, x3250
or x3250
Fax: (415) 241-6375
www.sfusd.edu

DENTAL PLAN

Delta Dental Premier Plan

PO Box 7736
San Francisco, CA 94120
Tel: (888) 335-8227
Group No. 652-0011 (monthly employees)
Group No. 652-0016 (biweekly employees)
Group No. 652-0012 (paraprofessionals)
Email: cms@delta.org
www.deltadentalins.com

GROUP LIFE AND LONG-TERM DISABILITY INSURANCE

The Standard Insurance

PO Box 2800
Portland, OR 97208-2800

Group Life/AD&D

Tel: (800) 628-8600

Long-Term Disability

Tel: (800) 368-1135

FLEXIBLE SPENDING ACCOUNTS

American Family Life Assurance Company

1932 Wynnton Road
Columbus, GA 31999
Tel: (877) 353-9487
www.aflac.com

HEALTH SERVICE SYSTEM

Member Services

1145 Market Street, Suite 200
San Francisco, CA 94103
(Civic Center Station between 7th and 8th)
Tel: (415) 554-1750
(800) 541-2266 (outside 415)
Fax: (415) 554-1721
www.myhss.org

MEDICAL PLANS

City Health Plan (UnitedHealthcare)

Tel: (866) 282-0125
Group Number 705287
www.myuhc.com

Blue Shield of California

Tel: (800) 642-6155
Group Number H11054
www.blueshieldca.com/sfhss

Kaiser Permanente

Tel: (800) 464-4000
Group No. 888 (Northern California)
Group No. 231003 (Southern California)
my.kp.org/ca/cityandcountyofsanfrancisco

VISION PLAN

Vision Service Plan (VSP)

Tel: (800) 877-7195
Group No. 12145878
www.vsp.com

COBRA

Fringe Benefits Management Company (FBMC)

Tel: (800) 342-8017
www.myfbmc.com