2022 Retirees

SAN FRANCISCO
HEALTH SERVICE SYSTEM

Health Benefits Guide

What's New for 2022

Medical, Vision and Dental

- The Health Service Board approved the addition of two new health plans available for non-Medicare eligible retirees, **Health Net CanopyCare HMO** and **Blue Shield of California PPO-Accolade**. Health Net CanopyCare HMO combines multiple Bay Area medical groups into one network that includes access to Zuckerberg General and MarinHealth Medical Center. Blue Shield of California PPO-Accolade includes 24/7 access to nurses and coordination of services and replaces the **UnitedHealthcare PPO** plan.
- Blue Shield of California Trio HMO and Access+ HMO infertility medications are now covered under the pharmacy benefit and can be obtained at any contracted CVS Specialty pharmacy. Patients can use their insurance and only need to pay their cost share at the point of sale. Prior authorization for fertility medications is no longer required.
- You can now make Open Enrollment elections and mid-year Qualifying Life Event changes online through ***eBenefits***. Go to **sfhss.org/how-to-enroll** to get started.

Well-Being

- SFHSS is constantly adding to our virtual class offerings. Visit **sfhss.org/events** for more information.
- **Get Your Flu Shot**: You can get your flu shot through an SFHSS sponsored worksite flu clinic or through your health plan. For more information on flu prevention go to **sfhss.org/well-being/flu-prevention**
- **Access CredibleMind**: Find mental health and emotional well-being content and resources online from CredibleMind, a multi-media platform featuring books, apps, videos, podcasts, assessments, articles, and online programs at **sfhss.org/crediblemind**

Step-by-Step Open Enrollment Guide

STEP 1: Review your Open Enrollment Letter for current health, dental and vision elections and new 2022 rates. **If you have no changes to your existing elections, you do not need to take any further action.**

STEP 2: Review dependent eligibility rules on our website at **sfhss.org/eligibility-rules** and the dependent(s) listed in your enclosed Open Enrollment letter. Do you need to add or drop a dependent?

- If **YES**, review the Self-Service online enrollment instructions attached to the enclosed letter to make your changes online using ***eBenefits***.
- Save and continue through all the screens and confirm at the end to submit your changes.
- Submit copies of supporting documents. New dependents must have supporting documentation submitted with their elections in order to be enrolled (e.g. birth certificate, certified marriage certificate).

STEP 3: Are you or your dependent approaching age 65 and about to become Medicare-eligible?

- If **YES,** and you are not yet enrolled in Medicare Part A & B, you must enroll through the Social Security Administration online at **ssa.gov** or by calling **(800) 772-1213**.
- If **NO,** be sure to apply for Medicare Part A & B at least three months before your 65th birthdate.
- Proof of enrollment in Medicare Part A & B are required to maintain your SFHSS benefits. Review Medicare Basics and FAQs on pages 2 to 4.
- Submit proof of Medicare enrollment by mailing a copy of your Medicare card or letter to SFHSS.

STEP 4: Are you making changes to your health plan benefits?

- If **YES**, review the Service Areas of the medical plans available to you. Non-Medicare retirees, go to page 6. Retirees with Medicare, go to page 7.
- If **NO**, proceed to **Step 5**.
- Next, review the Medical Plan benefits. Retirees without Medicare go to pages 8 to 11. Retirees with Medicare go to pages 12 to 13.
- Review your rates on the back of your enclosed Open Enrollment letter.
- Select your plan by completing the ***Choose a Medical Plan*** in ***eBenefits***.

STEP 5: Are you making changes to your vision benefits?

- If yes, review the Vision benefit options on pages 21 and 22.
- You must be enrolled in a medical plan to receive Vision benefits.
- Enrollment in the VSP Premier Plan requires that all dependents enrolled in medical coverage be enrolled in the VSP Premier Plan.
- Complete the ***Enroll in a Vision Premier Plan*** page in ***eBenefits.***

STEP 6: Are you making changes to your dental benefits?

- If **YES**, review your Dental benefit options and associated costs on page 23 to 24 and complete the ***Enroll in a Dental Plan*** page in ***eBenefits***.
- If **NO**, then you are done and you have no further action to take.

STEP 7: Complete your ***eBenefits*** elections online. Refer to the enclosed Self-Service instructions attached to your letter or go to **sfhss.org/ebenefits** to get started. Be sure to click **Save and Continue** through each screen. You must click **Submit** at the end in order to complete your enrollment. Otherwise your elections will not be recorded.

If you are unable to enroll online, download an Open Enrollment Application form and return your form and documentation by fax or mail to SFHSS. Our mailing address is **1145 Market Street, 3rd Floor, San Francisco, CA 94103** or fax to **(628) 652-4701**. To download an Open Enrollment Application form, visit **sfhss.org/oe2022**

STEP 8: You'll receive your Confirmation Statement in the mail from SFHSS in December.

Please review the Confirmation Statement to make sure your benefit elections are correct. *Changes made during Open Enrollment take effect January 1, 2022.* For more information visit **sfhss.org**

In order to serve as many members as possible, we are providing consultations by telephone only. For HELP, call San Francisco Health Service System (SFHSS) Member Services at **(628) 652-4700**.

Our telephone hours are Monday, Tuesday, Wednesday and Friday from 9am to 12pm and 1pm to 5pm and Thursday from 10am to 12pm and 1pm to 5pm PST.

Open Enrollment deadline is October 29, 2021, 5:00pm PST. No exceptions.

Executive Director's Message

I used to sew my own clothes when I was younger. I don't mean taking up the hem of my trousers or patching a hole—I followed a pattern and sewed my own clothes. It was quite common back then.

My family had a tradition of taking the scrap cloths and turning them into quilts. I realize this story dates me, but one of my fondest memories was my mom's 75th birthday. My sister organized a quilting party where three generations of women from my family gathered in a quilting circle with pillow size blocks and my mom taught us all how to create a quilt using materials and scraps from five generations of my family. We each made a pillow cover that day and I still have mine.

The COVID-19 pandemic gave me lots of time for reflection. I thought about my own family and how there's so much more I want to share with them, including the gifts my mom passed on to me. I thought about the importance of having strong foundations, not just for our families, but for our community as well. Our community, along with the entire world, was tested this past year.

When the pandemic hit, I had a front row seat allowing me to witness how all those years of community outreach, education, listening and learning from residents and building public private partnership had created a foundation of trust where our community had faith that we would get through this pandemic together. The San Francisco Bay Area vaccination rates are just remarkable compared to other urban areas in America.

We know the work can't stop here. There's always more we can do to build upon a good foundation. At the San Francisco Health Service System, we issued a health plan Request for Proposals (RFP) last year for our Active Employee and Early Retiree health benefits and we decided to add more choices and enhance our PPO plan. Please review your new choices carefully and select the plan that best meets the healthcare needs for you and your family.

As we continue our journey to pandemic recovery, I want to encourage you to reflect on the foundation of the relationships you have with your family and friends. The biggest lesson I learned after a year where I couldn't spend time with those I love is that we can all improve the quality of the time when we can spend time together. Maybe that means turning off our cell phones to give our loved ones our undivided attention or maybe it's sharing a recipe or craft, like quilting, that has been passed down from generations.

Be well,

Abbie Yant, *RN, MA*
Executive Director

This Guide includes an overview of the San Francisco Health Service System Rules, as approved by the Health Service Board. Rules can be found at **sfhss.org/san-francisco-health-service-system-member-rules** or request a copy at **(628) 652-4700**.

Medicare Basics

SFHSS requires all retirees and dependents to enroll in Medicare Part A and Part B at least three months before turning 65.

The Social Security Administration is the federal agency responsible for Medicare eligibility, enrollment and premiums. Start by downloading the *Medicare and You* handbook at **medicare.gov**.

Medicare Basics

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

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

All eligible retired members and covered eligible dependents must enroll in Medicare Part A and Part B. Failure by a member or dependent to enroll in Medicare by the required deadlines will result in a change or loss of medical coverage.

If you are not currently receiving Social Security, it is your responsibility to contact the Social Security Administration to apply for Medicare *at least three months* prior to your 65th birthday or if you become disabled. **Failure to do so could result in penalties being assessed by the Social Security Administration and the San Francisco Health Service System.**

If you have a Social Security-qualified disability or End Stage Renal Disease, you should contact the Social Security Administration immediately to apply for Medicare.

In the case where an SFHSS member and their covered dependent(s) are enrolled in a Blue Shield of California HMO plan (Access+ or Trio HMO), when either member or dependent(s) become eligible for Medicare, they must enroll in the **UnitedHealthcare Medicare Advantage PPO** plan.

Medicare Part A: Hospital Insurance

SFHSS rules require all retired members and dependents to enroll in premium-free Medicare Part A as soon as they are eligible. Most people do not pay a premium for Part A because they made sufficient contributions via payroll taxes while working.

Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals and skilled nursing facilities (but not custodial or long-term care). It also helps cover hospice care and some home healthcare. Beneficiaries must meet certain conditions to qualify for these benefits.

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 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 starts 24 to 30 months following eligibility. If you have questions about your eligibility for premium-free Medicare Part A, contact the **Social Security Administration** at **(800) 772-1213**.

All SFHSS members are required to enroll in Medicare as soon as they become eligible or face penalties.

Medicare FAQs

Medicare Part B: Medical Insurance

SFHSS 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. 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 decreases 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. 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 enrolled in Medicare.

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

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

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

A 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, the Social Security Administration may assess a late enrollment penalty for each year in which the individual was eligible but failed to enroll. SFHSS members and dependents are required to enroll in Medicare in accordance with SFHSS rules, even if they are paying a federal penalty for late Medicare enrollment.

Q **What happens if I enroll after age 65 or change SFHSS plans during Open Enrollment?**

A If you enroll in Medicare after age 65 or change Medicare plans during Open Enrollment, your plan may ask you for information about your current prescription drug coverage. If you fail to respond timely, CMS may assess a Part D Late Enrollment Penalty (LEP). Contact your new plan or SFHSS if you have questions.

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

A For Medicare-eligible SFHSS members not enrolled in Medicare or who fail to pay their Medicare premium(s), existing SFHSS medical plan coverage will be terminated and the member will be automatically enrolled in **Blue Shield of CA PPO-Accolade 20**. For Medicare-eligible dependents not enrolled in Medicare, SFHSS medical coverage will be terminated. Full SFHSS coverage for a member or dependent may be reinstated at the beginning of the next available coverage period after SFHSS receives proof of Medicare enrollment.

Blue Shield of CA PPO-Accolade 20 significantly increases premium and out-of-pocket costs. Under Accolade 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 **Blue Shield of CA PPO-Accolade 20**, yearly out-of-pocket limits increase to $10,950. For information on **Blue Shield of CA PPO-Accolade 20**, visit **sfhss.org/BSC-PPO-Accolade-20**.

Medicare FAQs

Do not enroll in a third party individual Medicare Part D prescription drug plan. Doing so will result in the termination of your SFHSS medical coverage.

Medicare Part D: Prescription Drug Insurance

There are two types of Medicare Part D prescription plans: *individual* and *group*. Individual Part D prescription drug coverage is purchased directly by an individual from an insurer or pharmacy.

SFHSS members should not enroll in any individual Medicare Part D plan. SFHSS members are automatically enrolled in group prescription drug coverage under Medicare Part D when they enroll in any medical plan offered through SFHSS. SFHSS medical plans offer enhanced group Medicare Part D prescription drug coverage.

UHC Medicare Advantage PPO members will receive only one card that covers medical and pharmacy services.

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

A Do not enroll in any third party Medicare Part D prescription drug plan.

If you are Medicare-eligible, enhanced group Medicare Part D drug coverage is included with your SFHSS Medicare plan.

Private insurance companies, pharmacies, and other entities may try to sell you an individual Medicare Part D prescription drug plan.

If you enroll in any private, individual Medicare Part D prescription drug plan, your Medicare coverage will be assigned to that plan and **your SFHSS group medical coverage will be terminated.**

Q Am I required to pay a premium for Medicare Part D?

A **You may be required to pay a Part D premium to the Social Security Administration if your income exceeds a certain threshold.**

If you are charged a Part D premium, but your income changes and falls below the threshold, contact Social Security to request an adjustment.

Medicare enrollees with income exceeding certain thresholds are charged a monthly Part D premium also known as the Income Related Monthly Adjusted Amount (IRMAA). In most cases, this Part D premium will be deducted from your Social Security check.

For information on Medicare Part D premiums, visit **medicare.gov/part-d/costs/premiums/drug-plan-premiums.html** or call Social Security at **(800) 772-1213**.

Q What is the SFHSS penalty if I or my dependent fail to pay a Part D premium to Social Security?

A Retirees and dependents who fail to pay a required Part D premium will result in Part D coverage being terminated by the Social Security Administration. Consequently, SFHSS medical coverage will also be terminated. SFHSS members who have lost Part D eligibility due to lack of payment will be enrolled in **Blue Shield of CA PPO-Accolade 20** member-only coverage and their dependent coverage will be terminated. Full SFHSS medical coverage for a member or dependent may be reinstated at the beginning of the next available coverage period after SFHSS receives proof of Medicare Part D reinstatement.

If you are enrolled in Medicare, do not enroll in any outside Part D plans. Prescription benefits are already included in your SFHSS medical plan. Doing so will terminate your coverage.

Enrolling in Retiree Health Benefits

NEW Retirees: Don't Miss the 30-Day Deadline. The transition of health benefits from active employee to retiree status does not happen automatically.

You must enroll in retiree health coverage as a retiree by submitting a **Retiree Enrollment Application form** and supporting documents by fax to **(628) 652-4701** or mail to SFHSS by the required deadlines. Get started by visiting **sfhss.org/benefits/getting-ready-to-retire**.

If a new Retiree does not complete enrollment in retiree health coverage within 30 calendar days of your retirement date, you will only be able to enroll in benefits during the next Open Enrollment period (unless you have a Qualifying Life Event).

New retirees should plan ahead. If you are Medicare eligible, you must be enrolled in Medicare to keep SFHSS benefits. See pages 3 and 4 for Medicare FAQs.

Your SFHSS retiree premium contributions will be deducted from your monthly pension check. Be sure to review your monthly check to verify that the correct premium contribution is being deducted. If your pension check does not cover your required premium payment, you must make payments directly through the **City of San Francisco Payment Portal**.

To create an account to make online payments, visit **sfhss.org/how-make-payment**. You can schedule recurring payments through the portal. **There are no service fees for payment by electronic check.**

For instructions on how to make online payments, go to **sfhss.org/how-make-payment**.

All Medicare-eligible retirees and dependents must maintain continuous enrollment in Medicare. To ensure that there is no break in your medical coverage, you must pay all Medicare premiums that are due to the federal government on time.

Open Enrollment is your annual opportunity to change your benefit elections for you and your eligible dependents without a qualifying event. Changes made during the October Open Enrollment period become effective January 1, 2022.

Outside of Open Enrollment, **you can only make changes to benefit elections during the plan year if there is a Qualifying Life Event.**

To be eligible for retiree health benefits, **employees hired after January 9, 2009** must have *at least* five years of credited service with a City employer: City and County of San Francisco, San Francisco Unified School District, City College of San Francisco, or Superior Court of San Francisco. Other government service is not credited.

Make sure you understand the **City Charter rules determining your eligibility** and premium contributions *before* finalizing your retirement date. See page 27 for more information.

And remember...

Depending on your retirement date, there can be a gap between when employee coverage ends and retiree coverage begins. **Setting your retirement date at the end of the month will help to avoid gaps in SFHSS coverage.**

Questions about health benefits, premium contributions or eligibility documentation?
Call (628) 652-4700.

Service Areas for Retirees *without* Medicare

County	Health Net	Blue Shield of CA		Kaiser Perm.	Blue Shield of CA	County	Health Net	Blue Shield of CA		Kaiser Perm.	Blue Shield of CA
	Canopy-Care HMO Non-Medicare HMO	Trio+ HMO Non-Medicare HMO	Access+ HMO Non-Medicare HMO	Traditional Non-Medicare HMO	PPO-Accolade Non-Medicare PPO		Canopy-Care HMO Non-Medicare HMO	Trio+ HMO Non-Medicare HMO	Access+ HMO Non-Medicare HMO	Traditional Non-Medicare HMO	PPO-Accolade Non-Medicare PPO
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				○	■
						Outside CA				◆	■

■ Available in this county
○ Available in some zip codes
◆ OR, WA, HI

Blue Shield of California PPO Accolade

Non-Medicare members and their non-Medicare dependents who lack geographic access to Trio HMO or Access+ HMO, both offered by Blue Shield of California, Health Net CanopyCare HMO, or Kaiser Permanente HMO, are eligible to enroll in **Blue Shield of California Accolade PPO** with lower premiums.

Service Areas for Retirees *with* Medicare

County	Kaiser Permanente	UnitedHealthcare	County	Kaiser Permanente	UnitedHealthcare
	Senior Advantage HMO	Medicare Advantage PPO		Senior Advantage HMO	Medicare Advantage PPO
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	○	■
			Outside CA	◆	▲

■ Available in this county
○ Available in some zip codes
◆ OR, WA, HI
▲ Service area includes all 50 states, District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands

Moving? Change of Address? Contact SFHSS (628) 652-4700 or visit sfhss.org/change-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 elections may result in non-payment of claims for services rendered.

2022 Medical Plans

	HEALTH NET CANOPYCARE CANOPYCARE HMO	BLUE SHIELD OF CALIFORNIA Trio HMO and Access+ HMO
DEDUCTIBLES		
Deductible and Out-of-Pocket Maximum (Medical)	No Deductible Annual out-of-pocket maximum $2,000/individual; $4,000/family	No Deductible Annual out-of-pocket maximum $2,000/individual; $4,000/family
PREVENTIVE CARE		
Routine Physical	No charge	No charge
Most Immunizations and Inoculations	No charge	No charge
Well Woman Exam and Family Planning	No charge	No charge
Routine Pre/Post-Partum Care	No charge	No charge visits limited; see EOC
PHYSICIAN AND OTHER PROVIDER CARE		
Office and Home Visits	$25 co-pay	$25 co-pay
Inpatient Hospital Visits	No charge	No charge
PRESCRIPTION DRUGS		
Pharmacy: Generic Drugs	$10 co-pay 30-day supply	$10 co-pay 30-day supply
Pharmacy: Brand-Name Drugs	$25 co-pay 30-day supply	$25 co-pay 30-day supply
Pharmacy: Non-Formulary Drugs	$50 co-pay 30-day supply	$50 co-pay 30-day supply
Mail Order: Generic Drugs	$20 co-pay 90-day supply	$20 co-pay 90-day supply
Mail Order: Brand-Name Drugs	$50 co-pay 90-day supply	$50 co-pay 90-day supply
Mail Order: Non-Formulary Drugs	$100 co-pay 90-day supply	$100 co-pay 90-day supply
Specialty Drugs	20% coinsurance up to $100 per prescription, 30-day supply	20% coinsurance up to $100 per prescription, 30-day supply
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	$25 co-pay in-network and out-of-network	$25 co-pay in-network
HOSPITAL/SURGERY		
Inpatient	$200 co-pay per admission	$200 co-pay per admission
Outpatient	$100 co-pay per surgery	$100 co-pay per surgery

Retirees *without* Medicare

KAISER PERMANENTE Traditional HMO	BLUE SHIELD OF CALIFORNIA PPO-ACCOLADE In-Network or Out-of-Area	 Out-of-Network
No Deductible Annual out-of-pocket maximum $1,500/individual; $3,000/family	$250 Deductible Retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $3,750/person; $7,500/Family	$500 Deductible Retiree only $1,000 Deductible + 1 $1,500 Deductible + 2 or more Annual out-of-pocket maximum $7,500/person
No charge	100% covered no deductible	50% covered after deductible
No charge	100% covered no deductible	100% covered no deductible
No charge	100% covered no deductible	50% covered after deductible
No charge visits limited; see EOC	85% covered after deductible	50% covered after deductible
$20 co-pay	85% covered after deductible	50% covered after deductible
No charge	85% covered after deductible	50% covered after deductible
$5 co-pay 30-day supply	$10 co-pay 30-day supply	$10 co-pay plus 50% coinsurance; 30-day supply
$15 co-pay 30-day supply	$25 co-pay 30-day supply	$25 co-pay plus 50% coinsurance; 30-day supply
Physician authorized only	$50 co-pay 30-day supply	$50 co-pay, plus 50% coinsurance; 30-day supply
$10 co-pay 100-day supply	$20 co-pay 90-day supply	Not covered
$30 co-pay 100-day supply	$50 co-pay 90-day supply	Not covered
Physician authorized only	$100 co-pay 90-day supply	Not covered
20% coinsurance up to $100 per prescription, 30-day supply	$50 co-pay 30-day supply	$50 co-pay, plus 50% Coinsurance; 30-day supply
No charge	85% covered after deductible	50% covered after deductible; prior notification
$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
$20 co-pay	85% covered after deductible	50% covered after deductible
$100 co-pay per admission	85% covered after deductible; notification required	50% covered after deductible; notification required
$35 co-pay	85% covered after deductible	50% covered after deductible

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions. If any discrepancy exists between the information provided in this Guide and the EOC, the EOC shall prevail. Download EOCs at **sfhss.org**.

2022 Medical Plans

	HEALTH NET CANOPYCARE CANOPYCARE HMO	BLUE SHIELD OF CALIFORNIA Trio HMO and Access+ HMO
REHABILITATIVE		
Physical/Occupational Therapy	$25 co-pay per visit	$25 co-pay per visit
Acupuncture/Chiropractic	$15 co-pay 30 visits of each max per plan year; ASH network	$15 co-pay 30 visits of each max per plan year; ASH network
GENDER DYSPHORIA		
Office Visits and Outpatient Surgery	Co-pays apply authorization required	Co-pays apply authorization required
DURABLE MEDICAL EQUIPMENT		
Home Medical Equipment	No charge	No charge
Diabetic Monitoring Supplies	No charge based upon allowed charges	No charge based upon allowed charges
Prosthetics/Orthotics	No charge when medically necessary	No charge when medically necessary
Hearing Aids	Evaluation no charge up to $5,000 combined for both ears, every 36 months	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each
MENTAL HEALTH		
Inpatient Hospitalization	$200 co-pay per admission	$200 co-pay per admission
Outpatient Treatment	$25 co-pay non-severe and severe	$25 co-pay non-severe and severe
Inpatient Detox	$200 co-pay per admission	$200 co-pay per admission
Residential Rehabilitation	$200 co-pay per admission	$200 co-pay per admission
EXTENDED & END-OF-LIFE CARE		
Skilled Nursing Facility	No charge up to 100 days/year	No charge up to 100 days/year
Hospice	No charge authorization required	No charge authorization required
OUTSIDE SERVICE AREA		
Care Access and Limitations	Urgent care $25 co-pay	Urgent care $50 co-pay guest membership benefits for college students in some areas

Retirees *without* Medicare

KAISER PERMANENTE Traditional HMO	BLUE SHIELD OF CALIFORNIA PPO-ACCOLADE In-Network or Out-of-Area	 Out-of-Network
$20 co-pay authorization required	85% covered after deductible; limitations may apply, see EOC	50% covered after deductible; limitations may apply, see EOC
$15 co-pay 30 visits combined acupuncture or chiro max per plan year; ASH network; for 25% discount see **kp.org/choosehealthy**	50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year
Co-pays apply authorization required	85% covered after deductible; notification required	50% covered after deductible; notification required
No charge as authorized by PCP according to formulary	85% covered after deductible; notification required	50% covered after deductible; notification required
No charge see EOC	Co-pays apply see pharmacy benefits	Co-pays apply see pharmacy benefits
No charge when medically necessary	85% covered after deductible; when medically necessary; notification required	50% covered after deductible; when medically necessary; notification required
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
$100 co-pay per admission	85% covered after deductible; notification required	50% covered after deductible; notification required
$10 co-pay group $20 co-pay individual	85% covered after deductible; notification required	50% covered after deductible; notification required
$100 co-pay per admission	85% covered after deductible; notification required	50% covered after deductible; notification required
$100 co-pay per admission; physician approval required	85% covered after deductible; authorization required	50% covered after deductible; authorization required
No charge up to 100 days/year	85% covered after deductible; up to 120 days/year; notification required; custodial care not covered	50% covered after deductible; up to 120 days/year; notification required; custodial care not covered
No charge when medically necessary	85% covered after deductible; authorization required	50% covered after deductible; authorization required
Only emergency services before condition permits transfer to Kaiser facility; co-pays apply	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

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions. If any discrepancy exists between the information provided in this Guide and the EOC, the EOC shall prevail. Download EOCs at **sfhss.org**.

2022 Medical Plans

	KAISER PERMANENTE Senior Advantage HMO	UNITEDHEALTHCARE Medicare Advantage PPO
DEDUCTIBLES		
Deductible and Out-of-Pocket Maximum	No Deductible Annual out-of-pocket maximum $1,500/individual; $3,000/family	No Deductible Annual out-of-pocket maximum $3,750/individual
PREVENTIVE CARE		
Routine Physical	No charge	$0 co-pay
Immunizations and Inoculations	No charge	$0 co-pay if covered under Part B
Well Woman Exam and Family Planning	No charge	$0 co-pay
Routine Pre/Post-Partum Care	No charge visits limited; see EOC	Cost share per type and location of service
PHYSICIAN AND PROVIDER CARE		
Office and Home Visits	$20 co-pay	$5 co-pay PCP; $15 co-pay specialist
Hospital Visits	No charge	$150 co-pay per admission
PRESCRIPTION DRUGS		
Pharmacy: Generic Drugs (Tier 1)	$5 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: Brand-Name Drugs (Tier 2)	$15 co-pay 30-day supply	$20 co-pay 30-day supply
Pharmacy: Non-Preferred Brand Drugs (Tier 3)	Physician authorized only	$45 co-pay 30-day supply
Mail Order: Generic Drugs (Tier 1)	$10 co-pay 100-day supply	$10 co-pay 90-day supply
Mail Order: Brand-Name Drugs (Tier 2)	$30 co-pay 100-day supply	$40 co-pay 90-day supply
Mail Order: Non-Preferred Brand Drugs (Tier 3)	Physician authorized only	$90 co-pay 90-day supply
Specialty Drugs (Tier 4)	20% coinsurance up to $100 per prescription, 30-day supply	$20 co-pay retail pharmacy up to 30-day supply $40 co-pay mail order pharmacy up to 90-day supply
OUTPATIENT SERVICES		
X-ray and Laboratory	No charge	$0 co-pay
EMERGENCY		
Hospital Emergency Room	$50 co-pay waived if hospitalized	$65 co-pay waived if admitted to the hospital within 24 hours
Urgent Care Facility	$20 co-pay	$20 co-pay waived if admitted to the hospital within 24 hours
HOSPITAL/SURGERY		
Inpatient	$100 co-pay per admission	$150 co-pay per admission
Outpatient	$35 co-pay	$100 co-pay

	KAISER PERMANENTE Senior Advantage HMO	UNITEDHEALTHCARE Medicare Advantage PPO
REHABILITATIVE		
Physical/Occupational Therapy	$20 co-pay authorization required	$20 co-pay
Acupuncture/Chiropractic	$15 co-pay 30 visits combined acupuncture or chiro max per plan year; ASH network; for 25% discount see **kp.org/choosehealthy**	$15 co-pay 24 visits of each max per plan year
GENDER DYSPHORIA		
Office Visits and Outpatient Surgery	Co-pays apply authorization required	Co-pays apply authorization required
DURABLE MEDICAL EQUIPMENT		
Home Medical Equipment	No charge as authorized by PCP according to formulary	$15 co-pay
Prosthetics/Orthotics	No charge when medically necessary	$15 co-pay
Diabetic Monitoring Supplies	No charge see EOC	$0 co-pay limited to certain brands
Hearing Aids	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each	Evaluation no charge $5,000 allowance for hearing aid(s), combined for both ears, every 36 months
MENTAL HEALTH		
Inpatient Hospitalization	$100 co-pay per admission	$150 co-pay per admission
Outpatient Treatment	$10 co-pay group $20 co-pay individual	$5 co-pay group $15 co-pay individual
Inpatient Detox	$100 co-pay per admission	$150 co-pay per admission
Residential Rehabilitation	$100 co-pay per admission; physician approval required	$150 co-pay per admission
EXTENDED & END-OF-LIFE CARE		
Skilled Nursing Facility	No charge up to 100 days per year	No charge up to 100 days/benefit period; no custodial care
Hospice	No charge when medically necessary	Covered by Original Medicare
OUTSIDE SERVICE AREA		
Care Access and Limitations	Only emergency Services before condition permits transfer to Kaiser facility; co-pays apply	Nationwide coverage provided Services obtained outside the United States and UnitedHealthcare PPO covered United States territories will only be authorized in the case of urgently needed services or in case of emergency

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions. If any discrepancy exists between the information provided in this Guide and the EOC, the EOC shall prevail. Download EOCs at **sfhss.org**.

Medical Plan Options: Retirees or Survivor *without* Medicare

What is a Health Maintenance Organization?

An **HMO** is a medical plan that offers benefits through a network of participating physicians, hospitals and other healthcare providers. A Primary Care Physician (PCP) must be designated to coordinate all non-emergency care and services including access to certain specialists, programs and treatments.. There is no plan year deductible before accessing your benefits. Most services are available for a fixed dollar amount (co-payment). SFHSS offers the following HMO medical plans:

- ***NEW* Health Net CanopyCare HMO:** You will have access to five prominent medical groups with 5,000+ physicians, 22 contracted hospitals/medical centers, and 42 urgent care centers. Your Primary Care Physician coordinates all medical care, across the nine Bay Area counties, to specialists across the vast CanopyCare network. You must live or work in a zip code serviced by the plan to enroll.
- **Trio HMO - Blue Shield of California:** A network of local doctors, specialists and hospitals working closely together to coordinate your care. Trio has a dedicated Concierge Service based on location. You must live or work in a zip code serviced by the plan to enroll.
- **Access+ HMO - Blue Shield of California:** Your PCP coordinates all your care and refers you to specialists and hospitals within their medical group/Independent Practice Association (IPA). Each family member can choose a different physician and medical group/IPA. You must live or work in a zip code serviced by the plan to enroll.
- **Kaiser Permanente HMO:** Most medical services are under one roof (ex. specialty care, pharmacy, lab work). No referrals required for certain specialties, like obstetrics-gynecology. You must live or work in a zip code serviced by the plan.

What is a Preferred Provider Organization?

A **PPO** is a medical plan that offers benefits through in-network and out-of-network healthcare providers. PPOs allow for a greater selection of providers however, out-of-network providers cost more. You are not assigned to a PCP, giving you more responsibility for coordinating your care. Compared to an HMO, enrolling in a PPO usually results in higher out-of-pocket costs. Unlike HMO plans, PPOs may have deductibles. Generally, you must pay a plan year deductible and a coinsurance percentage when accessing services. SFHSS offers the **Blue Shield of California PPO-Accolade** medical plan.

Health Net CanopyCare HMO

HMO Plan
(non-Medicare HMO)

- Member and dependent must not be eligible for Medicare
- Must live in a plan service area
- Out-of-pocket, fixed co-pays
- No annual deductible
- Primary Care Physician required
- Change your personal plan physician at any time for any reason

Members with **Medicare** dependents cannot enroll in Health Net CanopyCare HMO.

Blue Shield of California HMO

Trio HMO
(non-Medicare HMO)

Access+ HMO
(non-Medicare HMO)

- Must not be eligible for Medicare
- Must live in a plan service area
- In-network service only
- Out-of-pocket, fixed co-pays
- No annual deductible
- Primary Care Physician required
- Can change PCP at anytime throughout year, up to one time per month, as long as new PCP is part of a medical group in your plan

Medicare dependents enroll in **UHC MAPD PPO.**

Kaiser Permanente HMO

Traditional Plan
(non-Medicare HMO)

- Must not be eligible for Medicare
- Must live in a plan service area
- In-network service only
- Out-of-pocket, fixed co-pays
- No annual deductible
- Primary Care Physician required
- Change your personal plan physician at any time for any reason

Medicare dependents enroll in **KPSA HMO.**

Blue Shield of California PPO-Accolade

PPO Plan
(non-Medicare PPO)

- Member and dependent must not be eligible for Medicare
- Live anywhere in the world
- Access covered services worldwide
- Annual deductible must be reached before coverage begins
- Out-of-pocket coinsurance
- Lower rate of plan paid coinsurance for out-of-network providers
- Reasonable and customary fee reimbursement limits

Members with **Medicare** dependents can enroll in UHC Companion PPO or UHC Medicare Advantage PPO.

Medical Plan Options: Retirees or Survivor *with* Medicare

What is a Health Maintenance Organization?

An **HMO** is a medical plan that offers benefits through a network of participating physicians, hospitals and other healthcare providers. A Primary Care Physician (PCP) must be designated to coordinate all non-emergency care and services including access to certain specialists, programs and treatments.. There is no plan year deductible before accessing your benefits. Most services are available for a fixed dollar amount (co-payment).

SFHSS offers the following HMO medical plans:

- **Kaiser Permanente Senior Advantage HMO**

What is a Preferred Provider Organization?

A **PPO** is a medical plan that offers benefits through in-network and out-of-network healthcare providers. PPOs allow for a greater selection of providers however, for some PPO plans, out-of-network providers cost more.

You are not assigned to a Primary Care Physician, giving you more responsibility for coordinating your care.

SFHSS offers the following Medicare PPO plan:

- **UnitedHealthcare Medicare Advantage PPO**

For most services offered through the United Healthcare Medicare Advantage PPO plan, members will be responsible for co-pays, versus a coinsurance percentage.

Additionally, receiving services from out-of-network providers will not cost you more.

Kaiser Permanente Senior Advantage HMO

Senior Advantage
(Medicare Advantage HMO)

- Must be eligible for Medicare Part B
- Must live in a plan service area
- In-network service only
- Out-of-pocket, fixed co-pays
- No deductible
- One ID card for all your covered services and prescription drugs
- Primary Care Physician required
- Medicare Advantage Plan
- ***Silver&Fit*** fitness program

Your **Medicare** dependents will be in **Kaiser Permanente Senior Advantage.**

Your **non-Medicare** dependents will be enrolled in **Kaiser Permanente's Traditional HMO Plan.**

UnitedHealthcare Medicare Advantage PPO

UnitedHealthcare
(Medicare Advantage PPO)

- Must be eligible for Medicare
- Live anywhere in the USA
- Obtain service from any willing Medicare provider in the USA
- One ID card for all your covered services and prescription drugs from a network of thousands of pharmacies nationwide
- Out-of-pocket; fixed co-pay
- No deductible
- Medicare Advantage Plan
- ***Silver Sneakers*** fitness program
- Enhanced coverage for diabetic supplies
- UHC Hearing - 5,000+ nationwide locations which offers hundreds of name brand and private-labeled hearing aids from the leading manufacturers, providing up to 80% off industry prices

Your **non-Medicare** dependents may be enrolled in **Blue Shield of CA Trio HMO, Blue Shield of CA Access+ HMO,** or **UnitedHealthcare Companion PPO (Non-Medicare).**

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions. If any discrepancy exists between this Guide and the EOC, the EOC shall prevail. EOCs are available for download at **sfhss.org**.

2022 Medical Premiums: Retiree or Survivor *without* Medicare (California)

Retirees hired BEFORE January 9, 2009

Medical Premiums (Monthly)	Health Net CanopyCare HMO		Blue Shield of California Trio HMO		Blue Shield of California Access+ HMO		Kaiser Permanente HMO		Blue Shield of CA PPO-Accolade	
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$1,932.17	$50.85	$1,855.55	$29.79	$2,063.94	$87.06	$1,437.79	$0	$1,507.60	$289.94
Retiree/Survivor +1 Dependent *without* Medicare	$2,377.24	$495.93	$2,278.72	$452.96	$2,546.67	$569.80	$1,794.29	$356.49	$1,910.85	$693.19
Retiree/Survivor +2 or More Dependents *without* Medicare	$2,377.24	$1,206.41	$2,278.72	$1,128.48	$2,546.67	$1,340.42	$1,794.29	$948.26	$1,910.85	$1,337.08
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	-	-	$2,071.15	$245.38	$2,279.54	$302.65	$1,594.66	$156.86	UHC Companion PPO $1,723.20	$505.53
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	-	-	$2,071.15	$920.90	$2,279.54	$1,073.27	$1,594.66	$748.63	$1,723.20	$1,149.42

Retirees hired AFTER January 9, 2009[1] with *at least* 10 years but *less than* 15 years of service

Medical Premiums (Monthly)	Health Net CanopyCare HMO		Blue Shield of California Trio HMO		Blue Shield of California Access+ HMO		Kaiser Permanente HMO		Blue Shield of CA PPO-Accolade	
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$966.09	$1,016.93	$927.78	$957.56	$1,031.97	$1,119.03	$718.90	$718.89	$753.80	$1,043.74
Retiree/Survivor +1 Dependent *without* Medicare	$1,188.62	$1,684.55	$1,139.36	$1,592.32	$1,273.34	$1,843.13	$897.15	$1,253.63	$955.43	$1,648.61
Retiree/Survivor +2 or More Dependents *without* Medicare	$1,188.62	$2,395.03	$1,139.36	$2,267.84	$1,273.34	$2,613.75	$897.15	$1,845.40	$955.43	$2,292.50
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	-	-	$1,035.58	$1,280.95	$1,139.77	$1,442.42	$797.33	$954.19	UHC Companion PPO $861.60	$1,367.13
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	-	-	$1,035.58	$1,956.47	$1,139.77	$2,213.04	$797.33	$1,545.96	$861.60	$2,011.02

[1]**Retirees or survivors of retirees with at least 5 years of service but less than 10 years of service have no City contribution and must pay the full premium rate**.

Required Retiree/Survivor premium contributions, if any, will be deducted from the member's monthly pension check. If the pension check does not fully cover premium payments, the member must contact SFHSS to make payment arrangements.

2022 Medical Premiums: Retiree or Survivor *without* Medicare (Outside of California)

Retirees hired BEFORE January 9, 2009

Medical Premiums (Monthly)	Kaiser Permanente HMO						Blue Shield of CA PPO Accolade	
	Northwest		Washington		Hawaii			
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$1,154.04	$0	$1,563.01	$0	$857.73	$0	$1,710.48	$87.06
Retiree/Survivor +1 Dependent *without* Medicare	$1,729.57	$575.53	$2,343.03	$780.01	$1,285.11	$427.37	$2,113.73	$490.31
Retiree/Survivor +2 or More Dependents *without* Medicare	$1,729.57	$1,530.88	$2,343.03	$2,074.83	$1,285.11	$1,136.81	$2,113.73	$1,134.20
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$1,366.14	$212.09	$1,715.89	$152.87	$1,039.42	$181.68	UHC Companion PPO	
							$1,926.08	$302.65
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$1,366.14	$1,167.44	$1,715.89	$1,447.69	$1,039.42	$891.12	$1,926.08	$946.54

Retirees hired AFTER January 9, 2009[1] with *at least* 10 years but *less than* 15 years of service

Medical Premiums (Monthly)	Kaiser Permanente HMO						Blue Shield of CA PPO Accolade	
	Northwest		Washington		Hawaii			
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$577.02	$577.02	$781.51	$781.50	$428.87	$428.86	$855.24	$942.30
Retiree/Survivor +1 Dependent *without* Medicare	$864.79	$1,440.31	$1,171.52	$1,951.52	$642.56	$1,069.92	$1,056.87	$1,547.17
Retiree/Survivor +2 or More Dependents *without* Medicare	$864.79	$2,395.66	$1,171.52	$3,246.34	$642.56	$1,779.36	$1,056.87	$2,191.06
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$683.07	$895.16	$857.95	$1,010.81	$519.71	$701.39	UHC Companion PPO	
							$963.04	$1,265.69
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$683.07	$1,850.01	$857.95	$2,305.63	$519.71	$1,410.83	$963.04	$1,909.58

[1]**Retirees or survivors of retirees with at least 5 years of service but less than 10 years of service have no City contribution and must pay the full premium rate.**

2022 Medical Premiums: Retiree or Survivor *without* Medicare in California and No Access to Either Kaiser Permanente HMO or Blue Shield of California HMOs

Retirees hired BEFORE January 9, 2009

Medical Premiums (Monthly)	Health Net CanopyCare HMO		Blue Shield of California Trio HMO		Blue Shield of California Access+ HMO		Kaiser Permanente HMO		Blue Shield of CA PPO Accolade	
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$1,932.17	$50.85	$1,855.55	$29.79	$2,063.94	$87.06	$1,437.79	$0	$1,710.48	$87.06
Retiree/Survivor +1 Dependent *without* Medicare	$2,377.24	$495.93	$2,278.72	$452.96	$2,546.67	$569.80	$1,794.29	$356.49	$2,113.73	$490.31
Retiree/Survivor +2 or More Dependents *without* Medicare	$2,377.24	$1,206.41	$2,278.72	$1,128.48	$2,546.67	$1,340.42	$1,794.29	$948.26	$2,113.73	$1,134.20
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	-	-	$2,071.15	$245.38	$2,279.54	$302.65	$1,594.66	$156.86	UHC Companion PPO $1,926.08	$302.65
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	-	-	$2,071.15	$920.90	$2,279.54	$1,073.27	$1,594.66	$748.63	$1,926.08	$946.54

Retirees hired AFTER January 9, 2009[1] with *at least* 10 years but *less than* 15 years of service

Medical Premiums (Monthly)	Health Net CanopyCare HMO		Blue Shield of California Trio HMO		Blue Shield of California Access+ HMO		Kaiser Permanente HMO		Blue Shield of CA PPO Accolade	
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$966.09	$1,016.93	$927.78	$957.56	$1,031.97	$1,119.03	$718.90	$718.89	$855.24	$942.30
Retiree/Survivor +1 Dependent *without* Medicare	$1,188.62	$1,684.55	$1,139.36	$1,592.32	$1,273.34	$1,843.13	$897.15	$1,253.63	$1,056.87	$1,547.17
Retiree/Survivor +2 or More Dependents *without* Medicare	$1,188.62	$2,395.03	$1,139.36	$2,267.84	$1,273.34	$2,613.75	$897.15	$1,845.40	$1,056.87	$2,191.06
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	-	-	$1,035.58	$1,280.95	$1,139.77	$1,442.42	$797.33	$954.19	UHC Companion PPO $963.04	$1,265.69
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	-	-	$1,035.58	$1,956.47	$1,139.77	$2,213.04	$797.33	$1,545.96	$963.04	$1,909.58

[1]**Retirees or survivors of retirees with at least 5 years of service but less than 10 years of service have no City contribution and must pay the full premium rate**.

Required Retiree/Survivor premium contributions, if any, will be deducted from the member's monthly pension check. If the pension check does not fully cover premium payments, the member must contact SFHSS to make payment arrangements.

2022 Medical Premiums: Retiree or Survivor *with* Medicare Part A and Part B (California)

Retirees hired BEFORE January 9, 2009

Medical Premiums (Monthly)	Kaiser Permanente Senior Advantage HMO		UHC Medicare Advantage PPO with Non-Medicare Dependent(s) in Blue Shield HMO				UHC Medicare Advantage PPO with Non-Medicare Dependent(s) in UHC Companion Plan	
			Blue Shield of CA Trio HMO		Blue Shield of CA Access+ HMO			
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$316.71	$0	$434.17	$0	$434.17	$0	$434.17	$0
Retiree/Survivor +1 Dependent *without* Medicare	$673.21	$356.49	$857.34	$423.17	$916.90	$482.74	$837.42	$403.25
Retiree/Survivor +2 or More Dependents *without* Medicare	$673.21	$948.26	$857.34	$1,098.69	$916.90	$1,253.36	$837.42	$1,047.14
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$473.58	$156.86	$649.77	$215.59	$649.77	$215.59	$649.77	$215.59
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$473.58	$748.63	$649.77	$891.11	$649.77	$986.21	$649.77	$859.48

Retirees hired AFTER January 9, 2009[1] with *at least* 10 years but *less than* 15 years of service

Medical Premiums (Monthly)	Kaiser Permanente Senior Advantage HMO		UHC Medicare Advantage PPO with Non-Medicare Dependent(s) in Blue Shield HMO				UHC Medicare Advantage PPO with Non-Medicare Dependent(s) in UHC Companion Plan	
			Blue Shield of CA Trio HMO		Blue Shield of CA Access+ HMO			
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$158.36	$158.35	$217.09	$217.08	$217.09	$217.08	$217.09	$217.08
Retiree/Survivor +1 Dependent *without* Medicare	$336.61	$693.09	$428.67	$851.84	$458.45	$941.19	$418.71	$821.96
Retiree/Survivor +2 or More Dependents *without* Medicare	$336.61	$1,284.86	$428.67	$1,527.36	$458.45	$1,711.81	$418.71	$1,465.85
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$236.79	$393.65	$324.89	$540.47	$324.89	$540.47	$324.89	$540.47
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$236.79	$985.42	$324.89	$1,215.99	$324.89	$1,311.09	$324.89	$1,184.36

[1]**Retirees or survivors of retirees with at least 5 years of service but less than 10 years of service have no City contribution and must pay the full premium rate.**

2022 Medical Premiums: Retiree or Survivor *with* Medicare Part A and Part B (Outside of California)

Retirees hired BEFORE January 9, 2009

Medical Premiums (Monthly)	Kaiser Permanente Senior Advantage HMO						UHC Medicare Advantage PPO with Non-Medicare Dependent(s) in UHC Companion Plan	
	Northwest		Washington		Hawaii			
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$427.17	$0	$308.73	$0	$366.35	$0	$434.17	$0
Retiree/Survivor +1 Dependent *without* Medicare	$1,002.70	$575.53	$1,088.75	$780.01	$793.73	$427.37	$837.42	$403.25
Retiree/Survivor +2 or More Dependents *without* Medicare	$1,002.70	$1,530.88	$1,088.75	$2,074.83	$793.73	$1,136.81	$837.42	$1,047.14
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$639.27	$212.09	$461.61	$152.87	$548.04	$181.68	$649.77	$215.59
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$639.27	$1,167.44	$461.61	$1,447.69	$548.04	$891.12	$649.77	$859.48

Retirees hired AFTER January 9, 2009[1] with *at least* 10 years but *less than* 15 years of service

Medical Premiums (Monthly)	Kaiser Permanente Senior Advantage HMO						UHC Medicare Advantage PPO with Non-Medicare Dependent(s) in UHC Companion Plan	
	Northwest		Washington		Hawaii			
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree/Survivor Only	$213.59	$213.58	$154.37	$154.36	$183.18	$183.17	$217.09	$217.08
Retiree/Survivor +1 Dependent *without* Medicare	$501.35	$1,076.88	$544.38	$1,324.38	$396.87	$824.23	$418.71	$821.96
Retiree/Survivor +2 or More Dependents *without* Medicare	$501.35	$2,032.23	$544.38	$2,619.20	$396.87	$1,533.67	$418.71	$1,465.85
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B	$319.64	$531.72	$230.81	$383.67	$274.02	$455.70	$324.89	$540.47
Retiree/Survivor +1 Dependent *with* Medicare Parts A&B +1 or more non-Medicare Dependent(s)	$319.64	$1,487.07	$230.81	$1,678.49	$274.02	$1,165.14	$324.89	$1,184.36

[1]**Retirees or survivors of retirees with at least 5 years of service but less than 10 years of service have no City contribution and must pay the full premium rate.**

Vision Plans

Retirees and dependents enrolled in a medical plan are automatically enrolled in vision benefits.

Vision Plan Benefits

SFHSS members and dependents enrolled in medical coverage automatically receive vision coverage through VSP Vision Care. If you elect to enroll in the VSP Premier plan and you have dependents enrolled in SFHSS medical coverage, your covered dependents will also be enrolled in the VSP Premier Plan. You may go to a VSP network or out-of-network provider. Visit **www.vsp.com** for a complete list of network providers.

Accessing Your Vision Benefits

To receive services from a network provider, contact the provider and identify yourself as a VSP Vision Care member *before* your appointment. VSP Vision Care will provide benefit authorization directly to the provider. Services must be received prior to the benefit authorization expiration date.

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

Basic Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every other calendar year unless enrolled in the VSP Premier Plan. If examination reveals prescription change of 0.50 diopter or more after 12 months, replacement lenses are covered.
- Eligible dependent children are covered in full for polycarbonate prescription lenses.
- Cosmetic extras, including progressive, tinted or oversize lenses, cost more.

Expenses Not Covered by Plan

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

VSP Basic and Premier Vision Plans

You now have a choice. As a new hire or during Open Enrollment, you can remain in the VSP Basic Plan or enroll in the VSP Premier Plan for enhanced benefits.

Computer Vision Care Benefit (VDT)

Some union contracts provide employer-paid computer vision (VDT) benefits. Coverage includes an annual computer vision exam, $75 in-network retail frame allowance every 24 months and single vision, bifocal, and trifocal lenses.

VSP Vision Care Member Extras

VSP Vision Care offers exclusive special offers and discounts and rebates on popular contact lenses.

VSP also provides savings on *hearing aids* through TruHearing® for you, covered dependents and extended family including parents and grandparents.

No Medical Plan = No Vision Benefits

If you do not enroll in a medical plan, you and your dependents cannot access VSP Vision Care benefits.

Vision Plan Benefits-at-a-Glance

Covered Services	VSP Basic[1]	VSP Premier
Well Vision Exam	$10 co-pay every calendar year	$10 co-pay every calendar year
Single Vision Lenses	$25 co-pay every other calendar year[2]	$0 every calendar year
Lined Bifocal Lenses	$25 co-pay every other calendar year[2]	$0 every calendar year
Lined Trifocal Lenses	$25 co-pay every other calendar year[2]	$0 every calendar year
Standard Progressive Lenses	100% coverage every other calendar year	100% coverage every calendar year
Premium Progressive Lenses	$95–$105 co-pay every other calendar year	$25 co-pay every calendar year
Custom Progressive Lenses	$150–$175 co-pay every other calendar year	$25 co-pay every calendar year
Standard Anti-Reflective Coating	$41 co-pay every other calendar year	$25 co-pay every calendar year
Premium Anti-Reflective Coating	$58–$69 co-pay every other calendar year	$25 co-pay every calendar year
Custom Anti-Reflective Coating	$85 co-pay every other calendar year	$25 co-pay every calendar year
Scratch-Resistant Coating	Fully covered every other calendar year[2]	Fully Covered every calendar year
Frames	$150 allowance for a wide selection of frames $170 allowance for featured frames $80 allowance use at Costco® $25 co-pay applies; 20% savings on amount over the allowance; every other calendar year	$300 allowance for a wide selection of frames $320 allowance for featured frames $165 allowance at Costco® No additional co-pay; 20% savings on the amount over your allowance every calendar year
Contacts *(instead of glasses)*	$150 allowance every other calendar year[2]	$250 allowance every calendar year
Contact Lens Exam	Up to $60 co-pay every other calendar year2	Up to $60 co-pay every calendar year
Primary Eye Care *(for the treatment of urgent or acute ocular conditions)*	$5 co-pay	$5 co-pay

Vision Care Discounts		
Laser Vision Correction	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities

Vision Care Premium Rates	VSP Basic Plan	Retiree/Survivor Monthly Contribution
	Included with your medical premium.	**Retiree/Survivor Only $10.50** **Retiree/Survivor + 1 Dependent $15.92** **Retiree/Survivor + Family $32.79**

Your Coverage with Out-of-Network Providers

Visit **vsp.com** if you plan to see a provider other than a VSP network provider.

Exam	Up to $50	**Single Vision Lenses**	Up to $45	**Lined Trifocal Lenses**	Up to $85	**Contacts**	Up to $105
Frame	Up to $70	**Lined Bifocal Lenses**	Up to $65	**Progressive Lenses**	Up to $85		

[1]VSP Basic Plan coverage is included with your medical premium.

[2]Under the VSP Basic plan, new lenses may be covered the next year if Rx change is more than .50 diopters.

In the instance where information in this chart conflicts with the plan's Evidence of Coverage, the plan's Evidence of Coverage shall prevail.

Dental Plans

Dental benefits are a valuable part of your healthcare coverage and fundamental to your overall good health.

PPO Dental Plans

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

SFHSS offers the following PPO dental plan:

- Delta Dental PPO

Save Money By Choosing Network PPO Dentists

Delta Dental PPO has two different networks. Ask your dentist if they are a Delta Dental PPO network or Premier network dentist. When you use Delta Dental's network dentists, you are only responsible to pay your cost-share for covered services (i.e. deductible and co-insurance, within applicable benefit maximums). Delta Dental's network dentists are not allowed to charge you more for covered services beyond the negotiated rates and fees (Balance Billing), and your applicable cost-share. If you believe a Network Provider has charged you more, please call Delta Dental using the telephone numbers indicated under **Key Contacts** this guide.

If you want to know what you are responsible for paying, please ask your Delta Dental dentist for a pre-treatment estimate before receiving covered services. You can also choose a dentist outside of the PPO and Premier networks. Covered service received by Non-Delta Dental dentists will cost you more, and you may be subject to Balance Billing.

DHMO Dental Plans

Similar to medical HMOs, Dental Health Maintenance Organization (DHMO) plans require that you receive all of your dental care from within a network of participating dental offices. These networks are generally smaller than dental PPO networks.

Before you elect a DHMO plan, make sure that the plan's network includes the dentist of your choice.

Under these plans, services are covered either at no cost or a fixed co-pay. Out-of-pocket costs for these plans are generally lower than PPO plans.

SFHSS offers the following DHMO plans:

- DeltaCare USA DHMO
- UnitedHealthcare Dental DHMO

Delta Dental PPO Support for Chronic Conditions

Delta Dental PPO's ***SmileWay*** program features 100% coverage for one annual periodontal scaling and root planing procedure and four of the following (any combination) per calendar or contract year: teeth cleaning and/or periodontal maintenance services for members with specific chronic conditions. Calendar Year Benefit Maximums and Deductibles do not apply. To enroll, call Delta Dental PPO directly at **(888) 335-8227**.

2022 Dental Premiums: All Retirees (and Survivors)

2022 MONTHLY DENTAL PREMIUMS	DELTA DENTAL PPO		DELTACARE USA DHMO		UNITEDHEALTHCARE DENTAL DHMO	
	City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Retiree Only	$0	$45.73	$0	$32.22	$0	$14.38
Retiree +1 Dependent	$0	$90.96	$0	$53.17	$0	$23.74
Retiree +2 or More Dependents	$0	$135.75	$0	$78.65	$0	$35.11

Dental Plan Benefits-at-a-Glance

	Delta Dental PPO			DeltaCare USA DHMO	UnitedHealthcare Dental DHMO
Choice of Dentist	You may choose any licensed dentist. You will receive a higher level of benefit and lower out-of-pocket costs with Delta Dental PPO or Premier network dentists.			DeltaCare USA **network only**	UHC Dental **network only**
Deductible	$75 per person; $150 for family for Premier and out-of-network services, excluding diagnostic and preventive care			None	None
Plan Year Maximum	$1,250 per person Per calendar year, excluding orthodontia benefits, diagnostic and preventive care			None	None
Covered Services	**PPO Dentists**	**Premier Dentists**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
Cleanings[1] and Exams	100% covered annual - 2x/yr.; pregnancy - 3x/yr.	80% covered annual - 2x/yr.; pregnancy - 3x/yr.	80% covered annual - 2x/yr.; pregnancy - 3x/yr.	100% covered 1 every 6 months	100% covered 1 every 6 months
X-rays	100% covered full mouth 1x/5 years; bitewing 1x year over age 18; not subject to annual maximum	80% covered full mouth 1x/5 years; bitewing 1x year over age 18; not subject to annual maximum	80% covered full mouth 1x/5 years; bitewing 1x year over age 18; not subject to annual maximum	100% covered some limitations apply	100% covered some limitations apply
Extractions	80% covered	80% covered	80% covered	100% covered	$5-$25 co-pay
Fillings	80% covered	80% covered	80% covered	100% covered limitations apply to resin materials	$5-$25 co-pay
Crowns	60% covered	50% covered	50% covered	100% covered limitations apply to resin materials	100% covered limitations apply
Dentures, Pontics, and Bridges	60% covered	50% covered	50% covered	100% covered full and partial dentures 1x/5yrs.; fixed bridgework, limitations apply	$90-$100 co-pay
Endodontic/ Root Canals	60% covered	50% covered	50% covered	100% covered excluding the final restoration	$15-$60 co-pay
Oral Surgery	80% covered	80% covered	80% covered	100% covered authorization required	Co-pays vary
Implants	60% covered	50% covered	50% covered	Not covered	Covered Refer to co-pay schedule
Orthodontia	Not Covered	Not Covered	Not Covered	Member pays: $1,600/child $1,800/adult $350 startup fee; limitations apply	Member pays: $2,000/child $2,000/adult $350 startup fee; limitations apply
Night Guards	80% covered (1x3yr.)	80% covered (1x3yr.)	80% covered (1x3yr.)	$100 co-pay	100% covered

[1]Members with Chronic Conditions (diabetes, heart disease, HIV/AIDS, rheumatoid arthritis and stroke) may receive up to 4 cleanings per year. In any instance where information in this chart conflicts with a plan's Evidence of Coverage (EOC), the plan's EOC shall prevail.

Eligibility

The following rules govern which retirees and dependents may be eligible for SFHSS health coverage.

Retiree Member Eligibility

- An employee must meet age and minimum service requirements *and* have been enrolled in SFHSS health benefits at some time during active employment to be eligible for retiree health coverage. SFHSS calculates service eligibility (requirements may vary).
- **If hired on or after January 9, 2009, Proposition B applies.**
- If a retiree chooses to take a lump sum pension distribution, retiree health premium contributions will not be *subsidized* and the retiree will be responsible for the *full cost of the premiums* (other restrictions may apply). Contact SFHSS for an eligibility assessment of retiree health benefits.
- **Newly eligible retirees must enroll in retiree medical and/or dental coverage within 30 days of their effective retirement date.**
- To enroll, submit a completed Enrollment Application form and copies of your required eligibility documentation and retirement system paperwork by fax or mail. To download an Enrollment Application form, visit **sfhss.org/benefits/retirees-with-medicare** or **sfhss.org/benefits/retirees-without-medicare**.
- Members eligible for Medicare at the time of retirement must also provide proof of Medicare enrollment. **Medicare applications take three to four months to process**, so plan ahead *before* your 65th birthday. **If you fail to meet required deadlines, you must wait until the next Open Enrollment period to enroll in benefits.**
- 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 your employee coverage ends and retiree coverage begins. **Setting a retirement date at the end of the month will help avoid a gap in your coverage.**
- Contact SFHSS Member Services at **(628) 652-4700** *at least three months* before your retirement date to prepare for enrollment in retiree benefits. **You must notify SFHSS, even if you are not planning to elect SFHSS coverage on your retirement date**.

Dependent Eligibility

Spouse and Domestic Partners

A member's spouse or registered domestic partner may be eligible for SFHSS health coverage. Proof of legal marriage or domestic partnership is required, as well as the dependent's Social Security number.

Enrollment in SFHSS benefits must be completed **within 30 days** of the date of marriage or partnership. A spouse or registered domestic partner can also be added during the Open Enrollment period in October.

Natural Children, Stepchildren, Adopted Children

A member's natural child, legally adopted child, or child placed in adoption with member and any stepchild who is the natural child, legally adopted child or child placed for adoption with a member's enrolled spouse or domestic partner are eligible for coverage up to the age of 26. Coverage ends at the end of the coverage period when the child turns 26. Enrollment and eligibility documentation must be submitted to SFHSS **within 30 days** of birth, adoption, Qualifying Life Event or otherwise submitted during Open Enrollment to enroll the child for the subsequent plan year. See Sec. B.3.a of the San Francisco Health Service System Member Rules for more details.

Legal Guardianships and Court-Ordered Children

Children under 19 years of age placed under the legal guardianship of an enrolled member, a member's spouse, or domestic partner are eligible for coverage.

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 proof of guardianship, court order, or decree in addition to any other required document(s) and/or timely submission requirements established in the San Francisco Health Service System Member Rules.

Adult Disabled Children

To qualify a disabled adult child ("Adult Child") as a dependent, the Adult Child must be incapable of self-support because of a mental or physical condition that existed prior to age 26, continuously live with disability after turning 26, *and* meet each of the following criteria:

1. Adult Child is enrolled in an SFHSS medical plan on their 26th birthday; *and*
2. Adult Child has met the requirements of being an eligible dependent child under SFHSS member Rules Section B.3 before turning 26; *and*
3. Adult Child must have been physically or mentally disabled on the date coverage would have otherwise terminated due to age (turning 26), and continue to be disabled from age 26 on; *and*
4. An Adult Child who qualifies for Medicare due to a disability is required to enroll in Medicare (*see SFHSS Member Rules Section J*). Members must notify SFHSS of the Adult Child's eligibility for Medicare, as well as the Adult Child's subsequent enrollment in Medicare.
5. Adult Child is incapable of self-sustaining employment due to the physical or mental disability; *and*
6. Adult Child is dependent on SFHSS member for substantially all of their economic support, *and* is declared as an exemption on member's federal income tax return;
7. Member is required to comply with their enrolled medical plan's disabled dependent certification process and annual recertification process thereafter or upon request.
8. To maintain ongoing eligibility after the Adult Child has been enrolled, the Member must continuously enroll the Adult Child in an SFHSS medical plan without interruption and must ensure that the Adult Child remains continuously enrolled with Medicare A/B (if eligible) without interruption.

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 and dental coverage in certain instances where coverage would otherwise end. These include:

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

For more information about COBRA, visit **sfhss.org/benefits/cobra** or contact us at **(628) 652-4700.**

Eligibility Under City Charter

City Charter provisions regarding retiree health benefits for employees hired after January 9, 2009.

Retirees and Proposition B

Proposition B (approved by San Francisco voters in 2008), amended the City Charter provisions relating to retiree health benefits.

To be eligible for retiree health benefits, employees hired *after* January 9, 2009 must have *at least* 5 years of credited service with a City employer: City and County of San Francisco, San Francisco Unified School District, City College of San Francisco or San Francisco Superior Court. Other government employment is not credited.

Under the Charter amendment, employees hired *after* January 9, 2009 must retire within 180 days of separation from employment to be eligible for retiree health benefits. That means an employee must have the credited service *and* the age required for retirement at the time of separation from service to qualify for retiree health benefits.

A surviving dependent may be eligible for retiree health benefits if a deceased employee had 10 or more years of credited service with a City employer.

Different premium contribution rates apply for employees hired *after* January 9, 2009, based on eligibility and years of credited service.

- **With at least 5 years** but *less than 10 years* of credited service, the retiree member must pay the full premium rate and does not receive any employer premium contribution.
- **With at least 10 years** but *less than 15 years* of credited service, the retiree will receive 50% of the total employer premium contribution.
- **With at least 15 years** but *less than 20 years* of credited service, the retiree will receive 75% of the total employer premium contribution.
- **With 20 or more years of credited service**, or disability retirement, the retiree will receive 100% of the total employer premium contribution.

2011 Proposition C: Employees Separated From Service Before June 30, 2001 and Retired After January 6, 2012

Employees who separated service from a City employer before June 30, 2001 and retire after January 6, 2012 will receive the employer health premium contributions in effect at the time of their separation.

If enrolled in SFHSS retiree health benefits administered by SFHSS:

- The retiree member receives 100% of the employer premium contribution as defined by the City Charter.
- The retiree pays the full premium for any other enrolled dependents. There is no employer premium contribution.

Changing Benefit Elections: Qualifying Life Events

You may change health benefits elections outside of Open Enrollment if you have a Qualifying Life Event.

Certain life events count as a "Qualifying Life Event" where you can modify your benefits elections. If you have a Qualifying Life Event, you can change your elections and required documentation online using *eBenefits*, which you can access from the *Life Events* link under *Employee Links* on the City's Employee Portal. Visit sfhss.org/how-to-enroll to get started. Or you can submit your Enrollment Application form and documentation by fax to (628) 652-4701 or mail to SFHSS no later than 30 calendar days after the Qualifying Life Event occurs.

New Spouse or Domestic Partnership

Enroll a new spouse or domestic partner and eligible children of spouse or domestic partner online using ***eBenefits*** on the San Francisco Employee Portal. Visit **sfhss.org/how-to-enroll** to get started. Be sure to upload copies of your certified marriage certificate, certificate of domestic partnership and birth certificate for each child. Your election and required documents must be submitted **within 30 days** of the legal date of the marriage or partnership. You can also submit an Enrollment Application form and copies of required documentation by fax or mail. Certificates of domestic partnership must be issued in the United States. A Social Security number must be provided for each enrolling family member. Proof of Medicare is also required for a domestic partner who is Medicare-eligible due to age or disability. Coverage for your spouse or domestic partner is effective the first day of the coverage period following receipt and approval of required documentation.

Newborn or Newly Adopted Child

Coverage for an enrolled newborn child begins on the child's date of birth. Your election and required documents must be submitted **within 30 days** of the birth or date of legal adoption. Coverage for an enrolled adopted child will be effective on the date the child is placed. SFHSS provides a one-time benefit reimbursement of up to $15,000 to an eligible employee or eligible retiree for qualified expenses incurred from an eligible adoption or eligible surrogacy. For more details, visit **sfhss.org/surrogacy-and-adoption**. A Social Security number must be provided to SFHSS **within six months** of the date of birth or adoption, or your child's coverage may be terminated. Use ***eBenefits*** to submit documentation and enroll online.

Legal Guardianship or Court Order

Coverage for a child under legal guardianship or court order shall begin upon effective date of guardianship or court order is submitted by the **30-day deadline.** Coverage for a dependent per a court order will be effective the date of court order, if all documentation is submitted to SFHSS by the **30-day deadline**. Use ***eBenefits*** to submit documentation and enroll online.

Divorce, Separation, Dissolution, Annulment

A member must **immediately** notify SFHSS and provide documentation in writing when the legal separation, divorce or final dissolution of marriage or termination of domestic partnership has been granted. Coverage of an ex-spouse, step-children, domestic partner and children of domestic partner will terminate on the last day of the coverage period of the event date. Use ***eBenefits*** to submit documentation and dis-enroll any former dependent(s) online.

Loss of Other Health Coverage

SFHSS members and eligible dependents who lose other health care coverage may enroll within 30 days in SFHSS benefits. Once required proof of loss of other health coverage documentation is submitted to and processed by SFHSS, coverage will be effective on the first day of the next coverage period. Use ***eBenefits*** to submit documentation and enroll online.

Obtaining Other Health Coverage

You may waive SFHSS coverage for yourself or a dependent who enrolls in other health coverage by providing proof of alternate coverage on official letterhead within 30 days of the event. If you waive coverage, all coverage for enrolled dependents will also be waived. After submitting the required documentation is submitted, your SFHSS coverage will terminate on the last day of the coverage period. Use ***eBenefits*** to submit documentation and update your elections online.

Moving Out of Your Plan's Service Area

If you move your residence to a location outside of your plan's service area, you can enroll in an SFHSS plan that offers service where your new address is located **within 30 days**. Coverage will be effective the first day of the coverage period following receipt and approval of required documentation. Therefore, it is important to notify SFHSS before you move. If you do not contact us in advance of your move, a lapse in coverage may occur from the date you notify SFHSS and the effective coverage date. Please note that if your new residence remains within your current SFHSS plan's service area, you cannot enroll in a different SFHSS Plan, as a result of the change in residence.

Death of a Dependent

In the event of the death of a dependent, notify SFHSS as soon as possible and submit a copy of the death certificate **within 30 days** of the event to disenroll the deceased dependent.

Death of a Member

In the event of a member's death, the **surviving dependent** or **survivor's designee** should contact SFHSS to obtain information about eligibility for survivor health benefits.

Upon notification, SFHSS will mail instructions to the spouse or partner, including a list of required documents for enrolling in surviving dependent health coverage.

If the deceased member qualifies for retiree benefits, the **surviving dependent** or **survivor's designee** may be eligible to continue benefits as a surviving spouse or will have to take COBRA.

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 to enroll during the next Open Enrollment period.

Responsibility for Premium Contributions

Changes in coverage due to a qualifying event may change premium contributions. **If your premium is deducted from your pension check, review your pension check statement to make sure premium deductions are correct. If your premium deduction is incorrect, contact SFHSS.** You must pay any premiums that are owed. Unpaid premium contributions will result in termination of coverage.

Failure to notify SFHSS of your dependent(s) ineligibility can result in significant financial penalties equal to the total cost of benefits and services provided to ineligible dependent(s).

Retirees Living or Traveling Outside of the United States

For Medicare and non-Medicare Members.

Traveling Outside of Your Plan's Service Area

Contact your health plan *before* traveling to determine available coverage and for information about how to contact your plan from outside of the United States.

In general, if you are traveling outside of the United States:

- **Health Net CanopyCare HMO** for retirees without Medicare, only covers urgent and emergency services when outside of the service area.
- **Blue Shield of California's Trio HMO** and **Access+ HMO** for retirees without Medicare only covers *emergency services* outside of California service areas.
- **UnitedHealthcare Medicare Advantage PPO plan only covers urgent and emergency services outside of the service area.**
- **Kaiser Permanente HMO** and **Kaiser Permanente's Senior Advantage HMO** plans only cover *urgent and emergency services* outside of their service areas.
- **Blue Shield of California PPO-Accolade for retirees without Medicare** are covered outside of the United States. If you obtain service outside of the United States, you will pay out-of-network coinsurance.

In most cases, Medicare does *not* provide coverage for healthcare services obtained outside of the United States. For more information visit: **medicare.gov/coverage/travel**.

Before you drop Medicare, read this!
Before you disenroll in Medicare, the federal government may charge you significant penalties if you disenroll from Medicare and decide to re-enroll in the future.

Medicare Enrollment is Required for Retirees Traveling or Residing Temporarily Outside of the United States

To ensure continued healthcare coverage when you return to the United States, **you must maintain your Medicare Part B and Part D enrollment while you are out of the country**. If you choose to cancel your Medicare Part B and/or Part D, or if you are dropped because you have not paid Medicare premiums, you may have a penalty assessed when you re-enroll with Social Security. **Failure to maintain continuous enrollment in Medicare will also disrupt the coverage you have through SFHSS**.

Retirees Residing Permanently Outside of the United States

Non-Medicare retiree members (under age 65) who reside *permanently* outside of the United States must either enroll in the **Blue Shield of CA PPO-Accolade** or waive San Francisco Health Service System coverage.

Medicare enrollment is not required for retired members over 65 residing outside of the United States (foreign residents). However, healthcare services within the United States will not be covered for foreign residents who are not enrolled in Medicare.

Members who choose to not enroll in Medicare must complete an SFHSS form certifying that they are waiving Medicare enrollment and waiving health coverage within the United States.

If you are currently enrolled in a Medicare plan offered through SFHSS, and you are planning to move outside of the continental United States, you must contact SFHSS Member Services at **(628) 652-4700** for information on other health plan options that may be available to you which are different than those available in the United States.

Legal Notices

Summary of Benefits and Coverage (SBCs)

The Affordable Care Act requires each insurer provide a standardized summary of benefits and coverage to assist people in comparing medical plans. Federally mandated SBCs are available online at **sfhss.org**

Infertility Services

Whether you're starting a family now or in the future, SFHSS has in fertility treatment coverage available to all members regardless of age, race, relationship status or sexual orientation on all non-Medicare medical plans. Members must first consult their obstetrician or gynecologist to develop a plan to move forward with obtaining these benefits.

Women's Health and Cancer Rights Notice

The Women's Health and Cancer Rights Act of 1998 requires that your medical plan provide benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Contact your medical plan for details.

Use and Disclosure of Your Personal Health Information

SFHSS maintains policies to protect your personal health information in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA). Other than the uses listed below, SFHSS will not disclose your health information without your written authorization:

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

If you authorize SFHSS to disclose your health information, you may revoke that authorization in writing at any time.

You have the right to express complaints to SFHSS and the Federal Health and Human Services Agency if you feel your privacy rights have been violated.

Any privacy complaints made to SFHSS should be made in writing. This is a summary of a legal notice that details SFHSS privacy policy. The full legal notice of our privacy policy is available at **sfhss.org/sfhss-privacy-policy-and-forms**. You may also contact SFHSS to request a written copy of the full legal notice.

Patient Protection Provider Choice Notice

Participating SFHSS HMO plans require the designation of a primary care provider (PCP).

You have the right to designate any primary care provider who participates in the health plan's network and who is available to accept you or your family members.

Until you make a PCP designation, the HMO insurance provider you elect may designate one for you.

For information on how to select a PCP, and for a list of the participating PCPs, contact your health plan or visit their website.

For children, you may designate a pediatrician as the PCP. You do not need prior authorization from your health plan or from any other person (including your PCP) in order to obtain access to obstetrical or gynecological care from a health care professional within your PCP's medical group who specializes in obstetrics or gynecology.

The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, visit **my.kp.org/ccsf**, **blueshieldca.com/sfhss**, **healthnet.com/sfhss**, or contact the number on the back of your insurance card.

Medicare Creditable Coverage

Medicare Part D Prescription Drug Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with San Francisco Health Service System (SFHSS) and about your options under Medicare's prescription drug coverage.

This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. SFHSS has determined that the prescription drug coverage offered by the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Drug Plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you do decide to join a Medicare drug plan, your SFHSS coverage will be affected. Benefits will not be coordinated with a Medicare Part D plan. If you do decide to join a Medicare drug plan and drop your SFHSS prescription drug coverage, be aware that you may not be able to get this coverage back (does not apply to active employees or dependents).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your coverage with SFHSS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium.

You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following Open Enrollment period in October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact SFHSS at **(628) 652-4700** for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, or if this coverage through SFHSS changes. You also may request a copy at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. If Medicare-eligible, you'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage, visit **medicare.gov** or call your **State Health Insurance Assistance Program** (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. They can be reached at **1-(800)-MEDICARE (1-800-633-4227)**. TTY users should call **(877) 486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit Social Security at **ssa.gov** or call **(800) 772-1213. (TTY: 1 (800) 325-0778)**.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty). Visit **sfhss.org/creditable-coverage** for more details.

Most Preventive Care is 100%[1] FREE.

Schedule your annual check-ups today.

Why wait for illness or injury to see your doctor when preventive care is FREE? **No co-pays or deductibles.** Get on your health care provider's calendar today. For more information about your benefits, visit **sfhss.org** or contact **SFHSS** at **(628) 652-4700** or toll-free at **(800) 542-2266**.

Annual Preventive Care Exams

	Medical	Dental	Vision
Type of Appointment	■ Annual Physical/Well-Check/Well-woman exam ■ Vaccinations recommended by your Primary Care Physician ■ Cancer Screenings recommended by your Primary Care Physician	■ Dental Exam and Cleaning Every 6 Months *(limit of two (2) dental exams and two (2) cleanings per calendar year)*	■ Annual Vision Exam
Make an Appointment	**Health Net CanopyCare HMO: Contact your Primary Care Physician listed on your ID card.** **Kaiser Permanente HMO: (800) 464-4000** **Kaiser Permanente Senior Advantage HMO:** ■ **In CA: (800) 443-0815** ■ **In NW: (877) 221-8221** ■ **In WA: (888) 901-4636** ■ **In HI: (800) 805-2739** **Blue Shield of California** ■ **Trio HMO: (855) 747-5800** ■ **Access+ HMO: (855) 256-9404** ■ **PPO-Accolade: (866) 336-0711** **UHC Medicare Advantage PPO (877) 259-0493**	**Delta Dental PPO: (888) 335-8227, or request a consultation with a PPO dentist from your home by visiting: www1.deltadental-ins.com/virtual-consult** **DeltaCare USA DHMO: (800) 422-4234** **UnitedHealthcare Dental DHMO: (800) 999-3367**	**VSP Vision Care: (800) 877-7195**

Mental Health and Substance Abuse Benefits

Health Plans: Mental Health, Well-Being and Substance Abuse Benefits[1]

Health Net CanopyCare HMO	Blue Shield of California HMO and PPO-Accolade	Kaiser Permanente HMO	UHC Medicare Advantage PPO
Call Health Net's behavioral health administrator, MHN at **(833) 996-2567** to obtain referrals for mental health and substance use disorder treatment services. You can also access outpatient providers through the MHN website at **www.mhn.com/members**. No authorization required for psychotherapy or medication support services.	**Trio HMO and Access+ HMO:** Call **(877) 263-9952** to find a provider and schedule an appointment with *Blue Shield's Mental Health Service Administrator.* **PPO-Accolade:** Call **(866) 336-0711** to access mental health services.	Traditional HMO members call **(800) 464-4000**. Senior Advantage members call **(800) 443-0815**. **Apps:** Members can access self-care apps, *Calm* and *myStrength*, through **kp.org/selfcareapps**.	UHC Medicare Advantage PPO members call **(877) 259-0493**. **Telemental Health:** To learn more, go to **whyuhc.com/sfhss** or sign in to your account at **UHCRetiree.com/sfhss**

Well-Being Services

To learn more, visit **sfhss.org/Using-Your-Benefits/using-your-benefits-retirees.**

Health Net CanopyCare HMO	Blue Shield of California HMO	Kaiser Permanente HMO	UHC Medicare Advantage PPO
Non-Medicare Plan Only	Non-Medicare Plans Only	Medicare and Non-Medicare Plans	Medicare Plan Only
Weight management, Healthy Eating and Nutrition Services. **On-Line and Health Coaching Programs:** ■ Reach a Health Weight ■ Improve Your Diet ■ Be More Active **Tobacco Cessation coaching programs** **Diabetes Prevention:** ■ Omada Prevention **Acupuncture and Chiropractic:** ■ 30 visits/year combined for Acupuncture and Chiropractic Choose Healthy discount program for additional visits after the initial 30 visits. **Discounts:** ■ Hearing screenings and hearing aids ■ Weight-loss programs	**Gym Discounts:** Get started with discounts through *Fitness Your Way.* Trio HMO members can call **(855) 747-5800**. Access+ HMO members can call **(855) 256-9404**. **PPO-Accolade:** Call **(866) 336-0711** **Weight Management Programs**: Make lasting lifestyle through **Wellvolution.com**. **Chiropractic & Acupuncture Benefits:** Services are provided through the *American Specialty Health Network* with a $15 co-pay per visit. To find a practitioner, call **(800) 678-9133**.	**Silver&Fit Program (Medicare only):** Join a fitness facility and stay fit with Home Fitness kits. Get online resources, rewards and be physically active. Visit **kp.org/silverandfit** or call **(877) 750-2746**. **Medical Weight Management Program:** A health-conscious solution that is based on treating the whole you, not just your weight. Visit **kphealthyweight.com**, or call **(866) 454-3480**. **Active & Fit Direct Discount Program:** Flexible, low-cost fitness program, product & specialty provider discounts. Visit **choosehealthy.com** or call **(877) 335-2746** for more details. **Chiropractic & Acupuncture Benefits:** Available through *ASH Network*. Visit **my.kp.org/ccsf/chiroandacu** or call **(800) 678-9133** for more details. **Programs and Classes:** Visit **my.kp.org/ccsf/healthy-extra** for more details.	**Silver Sneakers:** Memberships to participating gyms (in-network) and fitness classes for all adults 65+ and of all abilities. Visit **silversneakers.com** or call **(888) 423-4632** for more details. **Real Appeal Program:** A practical solution for members at risk of obesity-related diseases and those who want to maintain a healthy lifestyle. Enroll at **uhc.realappeal.com** or **(844) 924-7325.** **Chiropractic & Acupuncture Benefits:** Self-refer to a licensed practitioner. Find a practitioner at **whyuhc.com/sfhss**.

[1]As a result of mental health parity law, there is no yearly, or lifetime dollar amounts for mental health benefits.

Stephen Follansbee, M.D.
President
Appointed by
Mayor Breed

Chris Canning
Vice-President
Elected by SFHSS
Membership

Karen Breslin
Elected by SFHSS
Membership

Claire Zvanski
Elected by SFHSS
Membership

Randy Scott
Appointed by
Controller's Office

Mary Hao
Appointed by
Mayor Breed

Connie Chan
Appointed by the
Board of Supervisors

Health Service Board Achievements

Throughout the shelter-in-place public health order due to the COVID-19 pandemic, the Health Service Board maintained public meetings in a safe and virtual environment and are commended for their diligence in navigating digital platforms. Monthly Board meetings were publicly broadcast with the support of SFGov TV.

Health Service System Support of Citywide Mandates

In December 2020, the Health Service Board approved the SFHSS Racial Equity Action Plan in accordance with the citywide mandate. The Board endorsed and approved the design and development of Phase 1 to advance racial equity throughout 2021-2023. Consistent with the SFHSS Strategic Plan, this includes education and awareness training to better understand how distinct social, environmental, and demographic factors can impact whole-person health and well-being. All Board members completed the required biennial Implicit Bias Training.

Health Service Board Annual Self Evaluation and Education Plan

The Board completed their annual self-evaluation in December 2020 and worked with the Health Service Board Governance Committee to review the results and prepared the final report which was presented to the full Board at the February 11, 2021 regular meeting. The Board Secretary tracked the outlined areas of improvement and provided an update to the Governance Committee mid-year to support progress and alignment to the Board's evaluation goals. The Governance Committee also presented the Board 2021 Education Plan outlining focused topics for the year.

Health Service Board Commissioner Resignations, Appointments and Orientation

Supervisor Dean Preston resigned from the Health Service Board in February 2020 and was generously thanked by the SFHSS staff and Commissioners for his contributions. At the May 13, 2021 Board meeting, the Board welcomed Supervisor Connie Chan to the Health Service Board. Supervisor Chan represents District 1 and serves on several Board of Supervisor Committees. SFHSS Leadership provided Board orientation materials digitally to newly appointed Supervisor Chan. Orientation materials included the Board Commissioner role as a governing body, overall Board responsibilities, the Rates and Benefits Cycle and a comprehensive overview of the SFHSS departments and roles.

Health Service Board Approval of New Health Plan Offerings

On February 11, 2020 the Board approved new medical plans for active employees and early retirees for Plan Year 2022. The New Health Plan Request for Proposal (RFP) achieved its goals to provide more choice amongst HMO plans, secure a sustainable PPO plan, create competition between carriers, manage risk and costs through innovation and transparency while advancing whole person health and well-being for Members. New plans include Health Net CanopyCare HMO and Blue Shield of California PPO-Accolade. The Board is commended for its review and approval of new health plans that provide outstanding health and other employee benefits to its members while adhering to the highest standards of care.

Health Service Board Approval on Benefit and Plan Enhancements

Health Net CanopyCare HMO rate cards approved (new plan).

A rate increase of 4.96% for Kaiser HMO – Actives.

A rate decrease of 4.7% for Kaiser HMO Multi-Region – Early Retirees-across OR/WA/HI.

A rate decrease of 2.7% for Kaiser HMO Multi-Region – Medicare Retirees-across OR/WA/HI.

A rate increase of 2% for BSC Trio HMO.

A rate increase of 0.8% for BSC Access+ HMO.

A rate increase of 2.7% for BSC PPO-Accolade (plan administered by UHC in 2021).

A rate increase of 1.2% for UHC Medicare Advantage PPO.

A rate decrease of 10.83% for Kaiser Medicare Senior Advantage.

A rate decrease of 10% for UnitedHealthcare Dental DHMO for retirees.

A rate decrease of 14.4% for Delta Dental PPO for actives.

A rate decrease of 10% for UHC Insured Dental DHMO for actives.

No change for Delta Care USA fully Insured Dental DHMO for actives.

A rate decrease of 14.4% for Delta Dental PPO for Actives.

A rate increase of 4.17% for Delta Dental PPO for retirees.

A rate increase of 4.17% for Delta Dental USA DHMO for retirees.

VSP Vision renewed with no total rate/member contributions changes.

The Hartford life insurance, AD&D, and long-term disability plans renewed with no total rate/or member contribution changes.

Key Contacts

SFHSS
1145 Market Street, 3rd Floor
San Francisco, CA 94103
Tel: (628) 652-4700
Toll Free: (800) 541-2266
Fax: (628) 652-4701
sfhss.org

Telephone hours: Monday, Tuesday, Wednesday and Friday from 9am-12pm and 1pm to 5pm and Thursday from 10am to 12pm and 1pm to 5pm.

Well-Being
Catherine Dodd Wellness Center
1145 Market Street, 1st Floor
San Francisco, CA 94103
Tel: (628) 652-4650
Fax: (628) 652-4601
wellbeing@sfgov.org
sfhss.org/well-being

Health Service Board
Attn. Board Secretary
1145 Market Street, 3rd Floor
San Francisco, CA 94103
Tel: (628) 652-4719
Fax: (628) 652-4702
health.service.board@sfgov.org
sfhss.org/health-service-board

PENSION BENEFITS

SFERS
Employees' Retirement System
(415) 487-7000
mysfers.org

CalPERS
(888) 225-7377
calpers.ca.gov

CalSTRS
(800) 228-5453
calstrs.org

PARS
(800) 540-6369
parsinfo.org

NON-MEDICARE PLANS

Health Net CanopyCare HMO
(833) 448-2042
healthnet.com/sfhss
Group G0727A

Blue Shield of CA Trio HMO
(855) 747-5800
blueshieldca.com/sites/imce/trio.sp
Group W0051448

Blue Shield of CA Access+ HMO
(855) 256-9404
blueshieldca.com/sfhss
Group W0051448

Blue Shield of California PPO-Accolade
(866) 336-0711
member.accolade.com
Group W0072990

Kaiser Permanente Traditional HMO
my.kp.org/ccsf

In CA: (800) 464-4000
North CA - Group 888
South CA - Group 231003

In NW: (800) 813-2000
Group 21227

In WA: (206) 630-4636
Group 25512

In HI: (800) 966-5955
Group 10119

UHC Companion Plan PPO
(866) 282-0125
welcometouhc.com/sfhss
Group 752103

MEDICARE ADVANTAGE PLANS

UHC Medicare Advantage PPO
(877) 259-0493
uhcretiree.com/sfhss
Group 13694 | Group 12786 Part B Only

Kaiser Permanente Sr. Advantage HMO
my.kp.org/ccsf

In CA: (800) 443-0815
North CA - Group 888
South CA - Group 231003

In NW: (877) 852-5081
Group 21227

In WA: (206) 630-4600
Group 25512

In HI: (877) 852-5081
Group 10119

MEDICARE ADVANTAGE FITNESS PLANS

SilverSneakers **Fitness Program**
(UHC Medicare Advantage PPO)
(888) 423-4632
silversneakers.com

Silver&Fit **Fitness Program**
(Kaiser Senior Advantage HMO)
(877) 750-2746
silverandfit.com

DENTAL AND VISION PLANS

Delta Dental PPO
(888) 335-8227
deltadentalins.com/ccsf
Group 01673

DeltaCare USA DHMO
(800) 422-4234
deltadentalins.com/ccsf
Group 71797-0001

UHC Dental DHMO
(800) 999-3367
welcometouhc.com/sfhss
Group 275550

VSP Vision Care
(800) 877-7195
www.vsp.com
Group 12145878

OTHER AGENCIES

Social Security
Medicare Enrollment
(800) 772-1213
(800) 325-0778 (TTY)
ssa.gov

Medicare
Medicare Administration
(800) 633-4227
(877) 486-2048 (TTY)
medicare.gov

Health Insurance Exchange
Covered California
(888) 975-1142
coveredca.com

Sign up for eNews at **sfhss.org/sign-enews**