Retirees

2018 HEALTH BENEFITS

Excellent benefits for our amazing city family

SAN FRANCISCO
HEALTH SERVICE SYSTEM

Retirees

Your Open Enrollment To-Do List:

- ☐ Review your **Open Enrollment Guide and Letter!** Visit sfhss.org.
- ☐ **Premiums are changing in 2018**. Review your medical and dental plan premiums even if you are not planning to make any changes.
- ☐ Review **What's New** so you're informed about new benefits you may want to use.
- ☐ Review your dependents listed in your **Open Enrollment letter**. This is the time to add or drop dependents.
- ☐ Make your benefits elections on your SFHSS Open Enrollment form. Be sure to:
    - ☐ Select the benefits you want
    - ☐ List All dependents you're covering
    - ☐ Sign your application
    - ☐ Have the supporting documents for new dependents
- ☐ Review your **Confirmation Statement** to make sure your benefits elections are correct. You'll receive your Confirmation Statement from SFHSS in December.
- ☐ If you have questions, call **San Francisco Health Service System at 415-554-1750**.
- ☐ Open Enrollment applications and documentation **can be delivered to SFHSS in person, by mail or fax**. The SFHSS address is 1145 Market Street, 3rd Floor, San Francisco, CA 94103. The SFHSS fax number is 1-415-554-1721. Changes made during Open Enrollment take effect January 1, 2018. For more information about Open Enrollment visit sfhss.org.
- ☐ **Open Enrollment deadline is October 31, 2017, 5:00pm.**

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This guide provides an overview of the San Francisco Health Service System rules approved by the San Francisco Health Service Board. The rules can be found at sfhss.org/member_services/rules.html. To request a paper copy of the rules call 1-415-554-1750.

What's New in 2018

Blue Shield of California Offers Trio HMO Option for Actives and Non-Medicare Enrolled Retirees

In addition to Access+ HMO, Blue Shield will offer SFHSS non-Medicare members a new choice: Trio HMO. Trio HMO has the same benefits and plan design as Access+, and access to many of the same hospitals and physicians, but with lower contributions. **Current Blue Shield members whose primary care doctors are Trio HMO doctors will be automatically enrolled in the Trio HMO plan, which is the lowest cost plan, unless you complete an SFHSS Open Enrollment form electing another plan.** For more information, please go to blueshieldca.com/sfhss or call 855-747-5800.

Kaiser Permanente Extends Coverage to Retirees in Hawaii, Oregon, and Washington

Retirees will now have the option of selecting a Kaiser Permanente health plan in three other Kaiser regions, including Kaiser's Northwest, Washington and Hawaii regions. For more information, please go to sfhss.org or my.kp.org/ccsf.

Delta Dental PPO Increases Annual Benefit Maximum

The annual benefit maximum for Delta Dental PPO for Retirees will increase from $1,000 to $1,250 in 2018. The diagnostic and preventive services of two annual cleanings and two annual exams will not count toward this benefit maximum. For more information, please go to sfhss.org or deltadentalins.com/ccsf.

VSP Vision Care Adds a Premier Plan Choice

Pay a little more to enroll in the new VSP Premier Plan. You can get glasses every year with a $300 frame allowance or contacts every year with a $250 allowance. Anti-reflective and progressive lenses are covered in full with a $25 co-pay for each. See page 22 of this booklet for more information or to enroll in the Premier Plan, visit sfhss.vspforme.com or call 1-800-400-4569.

2018 Medical and Dental Plan Premium Contributions Are Changing

Review the rates for your bargaining unit at sfhss.org before making Open Enrollment decisions.

Best Doctors Expert Medical Case Review for Retirees and Dependents

This confidential service is available to all employees, retirees, spouses, domestic partners, and other dependents enrolled in a SFHSS medical plan. It provides an expert case review whenever you or covered family members face an important medical decision. Contact Best Doctors at 1-866-904-0910 to confirm a diagnosis, learn more about a prescribed medication, review a recommended treatment plan, or procedure. There is no additional cost to the member to use this service.

Increased Infertility and Reproductive Technology Benefits (Available to Non-Medicare Active and Early Retirees)

Current infertility benefits have been increased to two cycles per lifetime. Cryopreservation of reproductive tissue is being offered for up to 12 months.

SFHSS Remains a Pioneer in Gender Dysphoria Coverage and Anti-Discrimination in Health Care

In 2001, the San Francisco Health Service System became the first large public employer in the United States to include gender dysphoria care as part of its employee health design. SFHSS, in collaboration with its health plan providers, continues to champion anti-discrimination efforts and recognize medically necessary treatment options for gender dysphoria. For more information, please review the 2017 SFHSS Gender Dysphoria Policy Statement at sfhss.org.

UnitedHealthcare Offers 'Real Appeal' Weight-Loss Program

Real Appeal provides tools and support to help members lose weight, feel good, and prevent weight-related health conditions. To find out if you are eligible to participate in this program and to enroll, please go to realappeal.com, or call 1-844-344-7325.

Online Benefits Coming in 2018

SFHSS will pilot online benefits enrollment in October and will go live in 2018 offering employees the choice to go paperless.

Review Your Dependent Coverage

SFHSS Member Rules require members to immediately notify SFHSS when and enrolled dependent is no longer eligible. If you are legally separated or divorced, your spouse/former spouse is not eligible for SFHSS benefits. Dependents who are no longer a domestic partner are not eligible for SFHSS benefits. You can drop these dependents from your coverage without penalty during Open Enrollment in October.

Enrolling In Retiree Health Benefits

Learn About Retiree Health Benefits Options

Get informed about retiree plans and premium contributions by reading this Guide and visiting sfhss.org. You may also visit the San Francisco Health Service System office at 1145 Market Street, 3rd floor, San Francisco and speak with a Benefits Analyst. No appointment is necessary.

Once you are enrolled, **retiree premium contributions are deducted from pension checks** monthly. Review your pension check to verify that the correct premium contribution is being deducted. If your pension check does not cover your required premiums you must contact the San Francisco Health Service System for options on how to make your monthly payments. 2018 retiree premium contributions are listed beginning on page 35.

All Medicare-eligible retirees and dependents must maintain continuous enrollment in Medicare. To ensure 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 benefit elections for you and your eligible family members without any qualifying events. Changes made during October Open Enrollment are effective January 1, 2018.

You may only make changes to benefit elections during the plan year if there is a qualifying event. For more information about qualifying events see pages 26-27.

New Retirees: Don't Miss the 30-Day Deadline

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

Eligible new retirees must **complete enrollment in retiree health coverage within 30 calendar days** of their retirement date. If you do not enroll **within 30 days**, you can only apply for retiree benefits during the next Open Enrollment.

New retirees should plan ahead. **If you are Medicare eligible, you must be enrolled in Medicare** to enroll in benefits. The Social Security Administration may take up to three months to process Medicare enrollment so apply before your 65th birthday.

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 & County of San Francisco, San Francisco Unified School District, San Francisco City College, or San Francisco Superior Court. Other government service is not credited. If this applies to you, make sure you understand the **City Charter rules that determine your eligibility** and retiree premium contributions before finalizing your retirement date. See page 30 of this guide for more information.

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

Questions About Retiree Health Benefits

Call SFHSS Member Services at 1-415-554-1750 or visit the SFHSS office at 1145 Market Street, 3rd Floor, San Francisco. No appointment is necessary.

Medical Plans: Retirees Without Medicare

HMO

An HMO (Health Maintentance Organization) offers benefits through a network of participating physicians, hospitals and providers. For non-emergency care, you access service through your Primary Care Physician or an urgent care center.

Kaiser Permanente HMO

Traditional Plan
(No Medicare HMO)

- Must not be eligible for Medicare
- Must live in Kaiser service area
- In-network service only
- Out-of-pocket, fixed co-pays
- No deductible

Your Medicare dependents will be in Kaiser Permanente Senior Advantage.

Blue Shield of California HMO

Trio HMO
(No Medicare HMO)

Access+
(No Medicare HMO)

- Must not be eligible for Medicare
- Must live in Access+ service area
- In-network service only
- Out-of-pocket, fixed co-pays
- No deductible

Your Medicare dependents will be enrolled in United Healthcare MAPD PPO.

PPO

A PPO (Preferred Provider Organization) offers a wider choice of physicians because you can access service in-network or out-of-network. You are not assigned a Primary Care Physician so you have more responsibility for coordinating your care.

City Plan PPO

UnitedHealthcare
(No Medicare PPO)

- 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 employer coinsurance for out-of-network providers
- Reasonable and customary fee reimbursement limits

Your Medicare dependents will be enrolled in United Healthcare MAPD PPO.

Plan Features	Kaiser Permanente HMO	Blue Shield of California HMO	City Plan PPO
	Traditional NO MEDICARE HMO	**Access+ and Trio HMO** NO MEDICARE HMO	**UnitedHealthcare** NO MEDICARE CHOICE PLUS PPO
Kaiser only integrated care delivery system	■		
Bay area network of doctors and hospitals	■	■	■
National network of doctors and hospitals	Some areas in WA, OR, and HI		■
Primary Care Physician required	■	■	
No annual deductible and fixed co-pays	■	■	
Annual deductible and coinsurance			■

Note: City Plan enrollees who live in a zip code where in-network providers are not available may access out-of-area providers with the same in-network coinsurance. Your out-of-area status may change as doctors join or leave the City Plan network.

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2018. If any discrepancy exists between this guide and the EOC, the EOC will prevail. EOCs are available on sfhss.org.

Medical Plans: Retirees With Medicare

HMO

An HMO (Health Maintentance Organization) offers benefits through a network of participating physicians, hospitals and providers. For non-emergency care, you access service through your Primary Care Physician or an urgent care center.

Kaiser Permanente HMO

Senior Advantage
(Medicare Advantage HMO)

- Must be eligible for Medicare Part B
- Must live in Kaiser 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.

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

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

PPO

A PPO (Preferred Provider Organization) offers a wider choice of physicians because you can access service in-network or out-of-network. You are not assigned a Primary Care Physician so you have more responsibility for coordinating your care.

UnitedHealthcare PPO

UnitedHealthcare
(Medicare Advantage PPO)

- Must be eligible for Medicare
- Live anywhere in the USA
- One ID card for all your covered services and prescription drugs from a network of 67,000 pharmacies nationwide
- Out-of-pocket; fixed co-pay
- No deductible
- Obtain service from any willing Medicare provider in the USA

Your non-Medicare dependents may be enrolled in City Plan, Blue Shield Trio HMO, or Access+ HMO.

Plan Features	Kaiser Permanente HMO	UnitedHealthcare PPO
	Senior Advantage Medicare Advantage HMO	**UnitedHealthcare Medicare Advantage** PPO
Kaiser only integrated care delivery system	■	
Bay area network of doctors and hospitals	■	■
National network of doctors and hospitals		■
Primary Care Physician required	■	
Medicare Advantage	■	■
Excercise and fitness programs	Silver&Fit	Silver Sneakers
Enhanced coverage for diabetic supplies		■
No annual deductible and fixed co-pays	■	■
Annual deductible and coinsurance		

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2018. If any discrepancy exists between this guide and the EOC, the EOC will prevail. EOCs are available on sfhss.org.

Service Areas: Retirees Without Medicare

County	Blue Shield of California		Kaiser Permanente	United Healthcare	County	Blue Shield of California		Kaiser Permanente	United Healthcare
	Access+ NO MEDICARE HMO	**Trio+ HMO** NO MEDICARE HMO	**Traditional** NO MEDICARE HMO	**City Plan** CHOICE PLUS NO MEDICARE PPO		**Access+** NO MEDICARE HMO	**Trio+ HMO** NO MEDICARE HMO	**Traditional** NO MEDICARE HMO	**City Plan** CHOICE PLUS NO 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			❍ OR, WA, HI	■

■ = Available in this county

❍ = Available in some zip codes

Moving?

If you move out of the service area covered by your medical plan, you must elect an alternate medical plan that provides coverage in your area. Failure to change your health benefit elections may result in the non-payment of claims for services received. Contact the San Francisco Health Service System at 1-415-554-1750 to update your information and review plan options if you are changing your address.

Service Areas: Retirees With Medicare

County	Kaiser Permanente	United Healthcare	County	Kaiser Permanente	United Healthcare
	Senior Advantage MEDICARE ADVANTAGE HMO	**Medicare Advantage** PPO		**Senior Advantage** MEDICARE 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	❍	■	Yolp	❍	■
Nevada		■	Yuba	❍	■
			Outside CA	❍ OR, WA, HI	▲

■ = Available in this county

❍ = Available in some zip codes

▲ = 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?

If you move out of the service area covered by your medical plan, you must elect an alternate medical plan that provides coverage in your area. Failure to change your health benefit elections may result in the non-payment of claims for services received. Contact the San Francisco Health Service System at 1-415-554-1750 to update your information and review plan options if you are changing your address.

2018 Medical Plan Benefits-at-a-Glance

	BLUE SHIELD OF CALIFORNIA Access+ and Trio HMO	KAISER PERMANENTE Traditional 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 $1,500/person; $3,000 family
PREVENTIVE CARE		
Routine physical	No charge	No charge
Immunizations and inoculations	No charge	No charge
Well woman exam and family planning	No charge	No charge
Routine pre/post-partum care	No charge visits limited; see EOC	No charge visits limited; see EOC
PHYSICIAN and OTHER PROVIDER CARE		
Office and home visits	$25 co-pay	$20 co-pay
Inpatient hospital visits	No charge	No charge
PRESCRIPTION DRUGS		
Pharmacy: generic drugs	$10 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: brand-name drugs	$25 co-pay 30-day supply	$15 co-pay 30-day supply
Pharmacy: non-formulary drugs	$50 co-pay 30-day supply	Physician authorized only
Mail order: generic drugs	$20 co-pay 90-day supply	$10 co-pay 100-day supply
Mail order: brand-name drugs	$50 co-pay 90-day supply	$30 co-pay 100-day supply
Mail order: non-formulary drugs	$100 co-pay 90-day supply	Physician authorized only
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 within CA service area	$20 co-pay
HOSPITAL/SURGERY		
Inpatient	$200 co-pay per admission	$100 co-pay per admission
Outpatient	$100 co-pay per surgery	$35 co-pay

Retirees Without Medicare

UNITEDHEALTHCARE

City Plan Choice Plus PPO

In-Network or Out-of-Area*	Out-of-Network*
$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $3,750/person	$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $7,500/person
100% covered no deductible	50% covered after deductible
100% covered no deductible	50% covered after deductible
100% covered no deductible	50% covered after deductible
85% covered after deductible	50% covered after deductible
85% covered after deductible	50% covered after deductible
85% covered after deductible	50% covered after deductible
$5 co-pay 30-day supply	50% covered after $5 co-pay; 30-day supply
$20 co-pay 30-day supply	50% covered after $20 co-pay; 30-day supply
$45 co-pay 30-day supply	50% covered after $45 co-pay; 30-day supply
$10 co-pay 90-day supply	Not covered
$40 co-pay 90-day supply	Not covered
$90 co-pay 90-day supply	Not covered
Same as 30-day supply above limitations apply; see EOC	Same as 30-day supply above limitations apply; see EOC
85% covered after deductible	50% covered after deductible; prior notification
85% covered after deductible; if non-emergency 50% after deductible	85% covered after deductible; if non-emergency 50% after deductible
85% covered after deductible	50% covered after deductible
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible	50% covered after deductible

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2018. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Find EOCs on sfhss.org.

2018 Medical Plan Benefits-at-a-Glance

	BLUE SHIELD OF CALIFORNIA Access+ and Trio HMO	KAISER PERMANENTE Traditional HMO
REHABILITATIVE		
Physical/occupational therapy	$25 co-pay per visit	$20 co-pay authorization req.
Acupuncture/chiropractic	$15 co-pay 30 visits of each max per plan year; ASH network	$15 co-pay 30 visits combined acupuncture or chiro max per plan year; ASH network; for 25% discount see kp.org/choosehealthy
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 as authorized by PCP according to formulary
Diabetic monitoring supplies	No charge based upon allowed charges	No charge see EOC
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary
Hearing aids	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each
MENTAL HEALTH		
Inpatient hospitalization	$200 co-pay per admission	$100 co-pay per admission
Outpatient treatment	$25 co-pay non-severe and severe	$10 co-pay group $20 co-pay individual
Inpatient detox	$200 co-pay per admission	$100 co-pay per admission
Residential rehabilitation	$200 co-pay per admission	$100 co-pay per admission; physician approval required
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 when medically necessary
OUTSIDE SERVICE AREA		
Care access and limitations	Urgent care $50 co-pay; guest membership benefits for college students in some areas.	Only emergency services before condition permits transfer to Kaiser facility. Co-pays apply.

Retirees Without Medicare

UNITEDHEALTHCARE City Plan Choice Plus PPO	
In-Network or Out-of-Area*	Out-of-Network*
85% covered after deductible; 60 visits/year	50% covered after deductible; 60 visits/year
50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible; notification required	50% covered after deductible; notification required
Co-pays apply see pharmacy benefits	Co-pays apply see pharmacy benefits
85% covered after deductible; when medically necessary; notification required	50% covered after deductible; when medically necessary; notification required
85% covered after deductible; 1 aid per ear, every 36 months, up to $2,500 each	50% covered after deductible; 1 aid per ear, every 36 months, up to $2,500 each
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible; authorization required	50% covered after deductible; authorization required
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
85% covered after deductible; authorization required	50% covered after deductible; authorization required
Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. In-network and out-of-network percentages and co-pays apply.

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2018. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Find EOCs on sfhss.org.

2018 Medical Plan Benefits-at-a-Glance

	KAISER PERMANENTE **Senior Advantage** Medicare 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
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	$5 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: brand-name drugs	$15 co-pay 30-day supply	$20 co-pay 30-day supply
Pharmacy: non-formulary drugs non-preferred brands	Physician authorized only	$45 co-pay 30-day supply
Mail order: generic drugs	$10 co-pay 100-day supply	$10 co-pay 90-day supply
Mail order: brand-name drugs	$30 co-pay 100-day supply	$40 co-pay 90-day supply
Mail order: non-formulary drugs non-preferred brands	Physician authorized only	$90 co-pay 90-day supply
Specialty drugs	20% coinsurance up to $100 per prescription, 30 day supply	Same as all above limitations apply; see EOC
OUTPATIENT SERVICES		
Diagnostic X-ray and laboratory	No charge	$0 co-pay
EMERGENCY		
Hospital emergency room	$50 co-pay waive if hospitalized	$65 co-pay
Urgent care facility	$20 co-pay	$35 co-pay
HOSPITAL/SURGERY		
Inpatient	$100 co-pay per admission	$150 co-pay per admission
Outpatient	$35 co-pay	$100 co-pay

Retirees With Medicare

	KAISER PERMANENTE **Senior Advantage** Medicare Advantage HMO	UnitedHealthcare Medicare Advantage PPO
REHABILITATIVE		
Physical/Occupational therapy	$20 co-pay authorization req.	$25 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 req.	Co-pays apply authorization req.
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
Hearing aids	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each
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 of the United States and UnitedHealthcare covered United States territories will only be authorized in the case of emergency.

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2018. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Find EOCs on sfhss.org.

2018 Medical Plan Benefits-at-a-Glance

	BLUE SHIELD OF CALIFORNIA Access+ and Trio HMO	KAISER PERMANENTE Traditional 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 $1,500/person; $3,000 family
PREVENTIVE CARE		
Routine physical	No charge	No charge
Immunizations and inoculations	No charge	No charge
Well woman exam and family planning	No charge	No charge
Routine pre/post-partum care	No charge visits limited; see EOC	No charge visits limited; see EOC
PHYSICIAN and OTHER PROVIDER CARE		
Office and home visits	$25 co-pay	$20 co-pay
Inpatient hospital visits	No charge	No charge
PRESCRIPTION DRUGS		
Pharmacy: generic drugs	$10 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: brand-name drugs	$25 co-pay 30-day supply	$15 co-pay 30-day supply
Pharmacy: non-formulary drugs	$50 co-pay 30-day supply	Physician authorized only
Mail order: generic drugs	$20 co-pay 90-day supply	$10 co-pay 100-day supply
Mail order: brand-name drugs	$50 co-pay 90-day supply	$30 co-pay 100-day supply
Mail order: non-formulary drugs	$100 co-pay 90-day supply	Physician authorized only
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 within CA service area	$20 co-pay
HOSPITAL/SURGERY		
Inpatient	$200 co-pay per admission	$100 co-pay per admission
Outpatient	$100 co-pay per surgery	$35 co-pay

Retirees Without Medicare

UNITEDHEALTHCARE

City Plan Choice Plus PPO

In-Network or Out-of-Area*	Out-of-Network*
$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $3,750/person	$250 Deductible retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket maximum $7,500/person
100% covered no deductible	50% covered after deductible
100% covered no deductible	50% covered after deductible
100% covered no deductible	50% covered after deductible
85% covered after deductible	50% covered after deductible
85% covered after deductible	50% covered after deductible
85% covered after deductible	50% covered after deductible
$5 co-pay 30-day supply	50% covered after $5 co-pay; 30-day supply
$20 co-pay 30-day supply	50% covered after $20 co-pay; 30-day supply
$45 co-pay 30-day supply	50% covered after $45 co-pay; 30-day supply
$10 co-pay 90-day supply	Not covered
$40 co-pay 90-day supply	Not covered
$90 co-pay 90-day supply	Not covered
Same as 30-day supply above limitations apply; see EOC	Same as 30-day supply above limitations apply; see EOC
85% covered after deductible	50% covered after deductible; prior notification
85% covered after deductible; if non-emergency 50% after deductible	85% covered after deductible; if non-emergency 50% after deductible
85% covered after deductible	50% covered after deductible
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible	50% covered after deductible

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2018. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Find EOCs on sfhss.org.

2018 Medical Plan Benefits-at-a-Glance

	BLUE SHIELD OF CALIFORNIA Access+ and Trio HMO	KAISER PERMANENTE Traditional HMO
REHABILITATIVE		
Physical/occupational therapy	$25 co-pay per visit	$20 co-pay authorization req.
Acupuncture/chiropractic	$15 co-pay 30 visits of each max per plan year; ASH network	$15 co-pay 30 visits combined acupuncture or chiro max per plan year; ASH network; for 25% discount see kp.org/choosehealthy
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 as authorized by PCP according to formulary
Diabetic monitoring supplies	No charge based upon allowed charges	No charge see EOC
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary
Hearing aids	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each
MENTAL HEALTH		
Inpatient hospitalization	$200 co-pay per admission	$100 co-pay per admission
Outpatient treatment	$25 co-pay non-severe and severe	$10 co-pay group $20 co-pay individual
Inpatient detox	$200 co-pay per admission	$100 co-pay per admission
Residential rehabilitation	$200 co-pay per admission	$100 co-pay per admission; physician approval required
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 when medically necessary
OUTSIDE SERVICE AREA		
Care access and limitations	Urgent care $50 co-pay; guest membership benefits for college students in some areas.	Only emergency services before condition permits transfer to Kaiser facility. Co-pays apply.

Retirees Without Medicare

UNITEDHEALTHCARE

City Plan Choice Plus PPO

In-Network or Out-of-Area*	Out-of-Network*
85% covered after deductible; 60 visits/year	50% covered after deductible; 60 visits/year
50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible; notification required	50% covered after deductible; notification required
Co-pays apply see pharmacy benefits	Co-pays apply see pharmacy benefits
85% covered after deductible; when medically necessary; notification required	50% covered after deductible; when medically necessary; notification required
85% covered after deductible; 1 aid per ear, every 36 months, up to $2,500 each	50% covered after deductible; 1 aid per ear, every 36 months, up to $2,500 each
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible; notification required	50% covered after deductible; notification required
85% covered after deductible; authorization required	50% covered after deductible; authorization required
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
85% covered after deductible; authorization required	50% covered after deductible; authorization required
Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. In-network and out-of-network percentages and co-pays apply.

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2018. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Find EOCs on sfhss.org.

2018 Medical Plan Benefits-at-a-Glance

	KAISER PERMANENTE **Senior Advantage** Medicare 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
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	$5 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: brand-name drugs	$15 co-pay 30-day supply	$20 co-pay 30-day supply
Pharmacy: non-formulary drugs non-preferred brands	Physician authorized only	$45 co-pay 30-day supply
Mail order: generic drugs	$10 co-pay 100-day supply	$10 co-pay 90-day supply
Mail order: brand-name drugs	$30 co-pay 100-day supply	$40 co-pay 90-day supply
Mail order: non-formulary drugs non-preferred brands	Physician authorized only	$90 co-pay 90-day supply
Specialty drugs	20% coinsurance up to $100 per prescription, 30 day supply	Same as all above limitations apply; see EOC
OUTPATIENT SERVICES		
Diagnostic X-ray and laboratory	No charge	$0 co-pay
EMERGENCY		
Hospital emergency room	$50 co-pay waive if hospitalized	$65 co-pay
Urgent care facility	$20 co-pay	$35 co-pay
HOSPITAL/SURGERY		
Inpatient	$100 co-pay per admission	$150 co-pay per admission
Outpatient	$35 co-pay	$100 co-pay

Retirees With Medicare

	KAISER PERMANENTE **Senior Advantage** Medicare Advantage HMO	UnitedHealthcare Medicare Advantage PPO
REHABILITATIVE		
Physical/Occupational therapy	$20 co-pay authorization req.	$25 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 req.	Co-pays apply authorization req.
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
Hearing aids	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each
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 of the United States and UnitedHealthcare covered United States territories will only be authorized in the case of emergency.

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions for 2018. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. Find EOCs on sfhss.org.

Medicare and San Francisco Health Service System Benefits

The San Francisco Health Service System requires all eligible retiree members and dependents to enroll in Medicare Part A and Part B.

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

Medicare Basics

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

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

All eligible retired members and covered eligible dependents must enroll in Medicare Part A and Part B. Failure by a member or dependent to enroll in Medicare by 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 when 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.

A SFHSS member and his or her covered dependents may not all be eligible for Medicare. In that case, whoever is eligible for Medicare will be covered under either the Kaiser Permanente Senior Advantage Plan (if the member under 65 is in the Kaiser Permanente HMO) or under the UnitedHealthcare Medicare Advantage PPO Plan (if the member under 65 is in either the Blue Shield or City 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 begins 24 to 30 months following eligibility. If you have questions about your eligibility for premium-free Medicare Part A, contact the Social Security Administration at 1-800-772-1213.

Medicare and San Francisco Health Service System Benefits

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 failing to pay Medicare premiums after enrollment?

A For Medicare-eligible SFHSS members without Medicare, existing SFHSS medical plan coverage will be terminated and the member will be automatically enrolled in City Plan 20. For eligible dependents without 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.

Q What is the City Plan 20 for Medicare-eligible SFHSS members who do not enroll in Medicare or who fail to pay Medicare premiums?

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

Medicare and San Francisco Health Service System Benefits

Do not enroll in any individual Medicare Part D plan. Doing so could 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 an individual Medicare Part D prescription drug plan. If you are Medicare-eligible, enhanced group Medicare Part D drug coverage is included with your SFHSS medical 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 Most people are not required to pay a Medicare Part D premium. However, if your income exceeds a certain threshold, you may be required to pay a Part D premium to the Social Security Administration (See medicare.gov).

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 quarterly 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 or call Social Security at 1-800-772-1213.

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 automatically enrolled in City Plan 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.

Medical Coverage If You Travel or Reside Outside of the United States

For Medicare and Non-Medicare Members

Traveling Outside of the Service Area of Your Health Plan

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 travelling outside of the United States:

- Blue Shield of California HMO for retirees without Medicare only covers emergency services outside of California service areas.
- Kaiser Permanente HMO plans only cover emergency services outside of their service areas.
- The UnitedHealthcare Medicare Advantage PPO covers emergency services outside of the United States.
- Pre-Medicare retirees in the UnitedHealthcare City Plan Choice Plus PPO are covered outside of the United States. If you obtain service outside of the United States, you will pay out-of-area 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-need-health-care-outside-us.html.

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 the San Francisco Health Service System.

Retirees Residing Permanently Outside the of United States

Non-Medicare Retiree (under 65) members who reside permanently outside of the United States must either enroll in the UnitedHealthcare City Plan Choice Plus PPO 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 a foreign resident, please contact the Social Security Administration for more information before choosing to disenroll from Medicare. The federal government may charge you significant penalties if you disenroll from Medicare now but decide to re-enroll in the future.

Nurseline and Urgent Care

Save Time and Money.
Call for Nurse Advice. Visit an Urgent Care Center. Email Your Doctor.

Call a free nurse advice line and speak to a registered nurse. Get answers to your questions about health problems, illness or injury. The nurse can also help you decide if you need routine, urgent or emergency service.

Visit an urgent care center when your physician is not available, after hours and on weekends. Urgent care offers the convenience of same-day appointments and walk-in service. Use urgent care when you need prompt attention for an illness or injury that is not life-threatening.

If available, take advantage of your doctor's online patient portal. Email your physician, view lab results, make appointments and renew your prescriptions online.

City Plan PPO	Blue Shield of California HMO	Kaiser Permanente HMO	New City Plan PPO
Non-Medicare Only	**Non-Medicare Only**	**Medicare and Non-Medicare**	**Medicare Only**
Nurseline 24/7 1-800-846-4678	**NurseHelp 24/7** Access+: 1-877-304-0504 Trio HMO: 1-877-304-0504	**Nurse Advice 24/7** 1-866-454-8855 **Urgent Care** 1-866-454-8855	**Nurseline** 1-877-365-7949
Urgent After Hours Care San Francisco Golden Gate Urgent Care 1-415-746-1812 Hayward St. Francis Urgent Care 1-510-780-9400 Rohnert Park Concentra 1-866-944-6046 For more current and additional urgent care facilities call 1-866-282-0125 or visit welcometouhc.com/sfhss.	**Urgent After Hours Care** For the urgent after hours care nearest you contact Blue Shield: Access+: 1-855-256-9404 blueshieldca.com Trio HMO: 1-855-747-5800 blueshieldca.com/triosfhss	**Urgent After Hours Care** San Francisco 1-415-833-2200 Oakland 1-510-752-1190 Redwood City 1-650-299-2015 Walnut Creek 1-925-295-4070 San Rafael 1-415-444-2940 This is a partial list. For additional Kaiser urgent care facilities call 1-866-454-8855.	**Urgent After Hours Care** For urgent care facilities call UnitedHealthcare at 1-877-259-0493 welcometouhc.com/sfhss

Mental Health and Substance Abuse Benefits

Under federal law, there is no yearly or lifetime dollar limit for essential mental health benefits. Mental health benefits—including deductibles, co-payments, coinsurance, out-of-pocket limits, number of days or visits covered, and any pre-authorization of treatment—must be the same as those for medical/surgical services.

Mental Health and Substance Abuse Services

For urgent mental health issues, members should call 911, or go to the nearest emergency department.

Kaiser Permanente HMO	UHC - City Plan PPO	UHC Medicare Advantage PPO Plan
Medicare and Non-Medicare	**Non-Medicare**	**Medicare Only**
Call 1-800-464-4000 to make an appointment or contact your Primary Care Physician. You can make an appointment to see a therapist without a referral from your primary care physician.	Call 1-866-282-0125 to make an appointment. Telemental Health services are available with participating providers. To find providers online, go to www.liveandworkwell.com or welcometouhc.com/sfhss.	Call 1-877-259-0493 to make an appointment or contact your Primary Care Physician.

Mental Well-being Services

What is mental well-being? Being satisfied with your life, having positive relationships, coping with stress, and working productively. The San Francisco Health Service System and your health plans offer mental well-being services. To learn more visit sfhss.org/well-being/peaceofmind.

Kaiser Permanente HMO	UHC - City Plan PPO	UHC Medicare Advantage PPO Plan
Medicare and Non-Medicare	**Non-Medicare**	**Medicare Only**
Counseling: Call 1-800-464-4000 **Classes, Support Groups:** Contact your local Kaiser facility for a calendar or visit kp.org/mentalhealth. **Telephone/Online Coaching:** Call 1-866-251-4514 or visit kp.org and search for HealthMedia Relax. **Tobacco Cessation:** Contact your local Kaiser facility for classes. Call 1-866-251-4514 for a telephonic coach. For HealthMedia Breathe and other resources visit kp.org/quitsmoking. **Home Health Care:** There are many excellent resources to assist you in your caregiving role. Ask your doctor about Kaiser Permanente resources for caregivers or visit kp.org for resources and classes.	**Tobacco Cessation** www.liveandworkwell.com for information on quitting. Smoking Cessation drugs are covered at no cost to members. Restrictions apply. Visit welcometouhc.com/sfhss for the online smoking cessation information.	**Solutions for Caregivers** The Solutions for Caregivers case managers can help with making difficult decisions about various topics including living arrangements and care needs. Services include: • In-person assessment • Telephone consultation • Toll-free access to caregiver coaches with a list of local resources • Personalized care plan • Caregiver coaches act as an advocate • Coordination of services Services are available for members and those who care for members. A Medicare Advantage member number is needed to obtain services. Call 1-866-896-1895 8:00 a.m.-5:00 p.m. CT Monday-Friday **Counseling/Therapy** Individual and group therapy, screenings, and education. Call 1-877-259-0493.

Prevention

If everyone in the United States received recommended clinical preventive care, 100,000 lives would be saved each year.

Most preventive care services are covered 100% through your heath plan. This means you pay nothing for regular checkups, screenings, vaccinations, and healthy lifestyle programs. Preventive care and healthy lifestyle choices are small steps you can take to help improve your well-being. For example, with appropriate preventive care you could avoid or delay the onset of a negative health condition. Early diagnosis—another benefit of regular preventive care—increases the probability of finding an effective treatment. Getting regular preventive care is one way members can keep the cost of their own care down and help SFHSS manage costs overall.

Get Started With Your Preventive Care

1. Go to cdc.gov/prevention, enter your gender and age to receive a personalized list of recommended preventive care.
2. Contact your health care provider to schedule your preventive care, and learn about services they offer to help you live a healthy lifestyle. Don't forget to take advantage of preventative dental care and vision screenings.

Preventive vs. Diagnostic

Generally, services are considered preventive and are covered without a co-pay when:

- You don't have symptoms **AND**
- They are recommended for people of your age and gender

Services may be considered diagnostic and will require a co-pay when:

- You have symptoms **OR**
- They are performed more frequently than recommended because of specific risk factors

Example:

Lisa, age 45, sees her doctor for her routine office visit and has age-appropriate screenings during her annual physical. Her doctor orders a lipid screening, urinalysis, and full blood chemistry panel. The office visit and the lipid screening, recommended by the United States Preventive Services Task Force (USPSTF), are covered 100%. However, the urinalysis and full blood chemistry panel are not considered preventive. They are covered under the medical benefit as outlined by Lisa's plan design. Why? These services are not recommended preventive services as outlined by the USPSTF. So, for these tests, Lisa would be subject to any copay, deductible, and coinsurance under her plan.

Best Doctors: Expert Medical Review

Expert physicians provide free and confidential case review when you or a family member faces any important medical decision.

In-depth medical review by a world-renowned expert is available for medical services or treatments plans that concern you. Consider using Best Doctors if you or an eligible family member needs to:

- Confirm a diagnosis
- Decide if a recommended surgery is necessary
- Review a recommended treatment plan for a life-threatening illness like cancer or heart disease
- Learn more about a prescribed medication or medication interactions
- Evaluate options for treating chronic joint pain or back pain
- Manage a complex chronic condition or multiple conditions

The Best Doctors benefit includes:

In-Depth Medical Case Review

At your request, Best Doctors collects and reviews your medical records, including images and tests. Expert physicians review your information and you receive a detailed report and a confidential recommendation about your diagnosis and treatment plan. Best Doctors will discuss this report with you and with your treating physician if you request it. This service helps you make the treatment decisions that are right for you.

Ask the Expert

If you have a basic question about a diagnosis or treatment options, you can obtain personalized guidance from a physician with specific expertise.

Critical Care

If you or your dependent family member is admitted to an emergency room with a traumatic injury requiring critical care, or neonatal unit for an acute medical event, Best Doctors' emergency medical experts can provide early intervention along with your treating medical team. If necessary, Best Doctors will coordinate with a local Nurse Case Manager to assist with medical record collection.

Find a Doctor

Best Doctors provides you with a list of doctors who match your criteria, giving you the flexibility to choose the right physician and schedule an appointment at your convenience.

Medical Records eSummary

Best Doctors can collect and organize all your medical records along with a personal health summary from a Best Doctor and provide them to you on an easily accessible USB drive.

Treatment Decision Support

You have free access to one-on-one coaching as well as interactive online educational modules featuring in-depth, easy to follow information about your specific condition. By completing the program, you will be more educated on your condition and all of the treatment options available to you.

Contact Best Doctors

To get started, call Best Doctors at 1-866-904-0910 or visit members.bestdoctors.com. You will be assigned a Best Doctors clinician to help you through the process and to select the best option for you. With your permission Best Doctors will gather and review your medical records, including images, lab results, and pathology slides to make their recommendations.

Vision Plan Benefits

All SFHSS members and dependents who are enrolled in an SFHSS medical plan are automatically enrolled in the Basic Vision Plan. You can choose to enroll yourself and your dependents in the Premier Vision Plan.

Vision Plan Basic Benefits

SFHSS members and dependents enrolled in a medical plan adminstered by SFHSS have basic vision coverage through VSP Vision Care. You may use a VSP Vision Care network doctor or a non-VSP doctor. To locate a VSP network doctor visit vsp.com or contact Member Services at 1-800-877-7195.

Accessing Your Vision Benefits

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

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

Basic Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses are available every other calendar year. 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, will cost you more.

Vision Plan Expenses Not Covered

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

Premier Vision Plan

You now have choices—stay enrolled in the Basic Plan or choose the Premier Plan for enhanced benefits, such as a $300 allowance on frames or a $250 allowance on contacts. One set of contacts or eyeglasses every calendar year. Anti-reflective and Progressive lenses are covered in full with a $25 co-pay for each. For more information and to enroll, call VSP at 1-800-400-4569 or go to sfhss.vspforme.com.

VSP Vision Care Member Extras

VSP Vision Care offers exclusive special offers and discounts, including an extra $20 on featured frame brands and rebates on popular contact lenses. Discounts are also available for 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.

2018 VSP Vision Care

New Premier Plan Choice

Members and dependents enrolled in medical coverage are also enrolled in VSP Vision Care Basic benefits. Once enrolled, you have the choice of using a VSP in-network provider or a licensed, out-of-network provider. Locate a VSP in-network provider by visiting vsp.com. No ID cards are issued for vision benefits. If you receive service from a provider outside of the VSP network (including Kaiser) you must pay in full and submit a bill to VSP for reimbursement. **You now have choice—stay enrolled in the Basic Plan or choose the Premier Plan for enhanced benefits - see below for details and to enroll contact sfhss.vspforme.com or call 1-800-400-4569.** Visit vsp.com/optical-discounts.html for a detailed list of VSP Vision Care discounts, including hearing aid reimbursement.

Covered Services	Basic	Premier
Well vision exam	$10 co-pay every calendar year	$10 co-pay every calendar year
Single vision lenses Lined bifocal lenses Lined trifocal lenses	$25 co-pay every other calendar year $25 co-pay every other calendar year $25 co-pay every other calendar year	$0 every calendar year $0 every calendar year $0 every calendar year
Standard progressive lenses Premium progressive lenses Custom progressive lenses	$55 co-pay $95–$105 co-pay $150–$175 co-pay every other calendar year	$25 co-pay every calendar year
Standard anti-reflective coating Premium anti-reflective coating Custom anti-reflective coating	$41 co-pay every other calendar year $58-$69 co-pay every other calendar year $85 co-pay every other calendar year	$25 co-pay every calendar year
Scratch-resistant coating	Fully covered every other calendar year	Fully covered every calendar year
Frames	$150 allowance for a wide selection of frames $170 allowance for featured frames $80 allowance at Costco $25 co-pay applies; 20% savings on amount over the allowance; every other calendar year	$300 allowance for a selection $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	$250 allowance every calendar year
Contact lens exam	Up to $60 co-pay fitting and evaluation exam covered; every other calendar year	Up to $60 co-pay every calendar year
Primary eye care	$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
	Retiree/Survivor Monthly Contribution	**Retiree/Survivor Monthly Contribution**
	Included in medical premium	Retiree/Survivor Only $10.86 Retiree/Survivor + 1 Dependent $15.54 Retiree/Survivor + 2 or More Dependents $30.82

Your Coverage with Out-of-Network Providers

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

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

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 Plan Options

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

PPO-Style Dental Plans

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

SFHSS offers the following PPO-style dental plan:

- Delta Dental PPO

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

The Delta Dental plan has two different networks. Ask your dentist if he or she is a Delta Dental PPO or Premier dentist. Both networks are held to the same quality standards. But choosing a PPO dentist will save you money. You can also choose any dentist outside of the PPO and Premier networks. However, many services may be covered at a lower percentage, so you pay more. Also, payment is based on reasonable and customary fees for the geographic area. Diagnostic and preventive do not count towards the annual maximum.

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

HMO-Style Dental Plans

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

Under these plans, services are covered either at no cost or a fixed co-pay. So there are generally lower out-of-pocket costs for these plans compared to the PPO style dental plan.

SFHSS offers the following DMO plans:

- DeltaCare USA
- UnitedHealthcare Dental

Dental Plan Quick Comparison

	Delta Dental PPO	DeltaCare USA DMO	UnitedHealthcare Dental DMO
Can I receive service from any dentist?	Yes. You can use any dental provider. You pay less when you choose a PPO in-network provider.	No. All services must be received from a contracted network dentist.	No. All services must be received from a contracted network dentist.
Do I need a referral for specialty dental care?	No.	Yes.	Yes.
Will I pay a flat rate for most services?	No. You pay a percentage of applicable charges.	Yes.	Yes.
Must I live in a certain service area to enroll?	No.	Yes. You must live in this DMO's service area.	Yes. You must live in this DMO's service area.

2018 Dental Plan Benefits-at-a-Glance

	Delta Dental			Deltacare USA	UnitedHealthcare
Choice of dentist	You may choose any licensed dentist. You will receive a higher level of benefit and lower out-of-pocket costs when using a Delta Dental PPO dentist.			DeltaCare dental network only	UnitedHealthcare dental network only
Annual deductible	$50 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 year, excluding preventive cleanings and exams			None	None
Covered Services	**PPO Dentists**	**Premier Dentists**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
Cleanings and exams	100% covered 1 every 6 months;	80% covered 2x/year; pregnant women 3x/year	80% covered 2x/year; pregnant women 3x/year	100% covered 1 every 6 months	100% covered 1 every 6 months
X-rays	100% covered full mouth 1x/5 years; bitewing 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-$95 co-pay
Crowns	50% covered	50% covered	50% covered	100% covered Limitations apply to resin materials	$20-$100 co-pay
Dentures, pontics, and bridges	50% covered	50% covered	50% covered	100% covered Full and partial dentures 1x/5 years; fixed bridge-work, limitations apply	$90-$100 co-pay
Endodontic/ Root Canals	50% 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	Co-pays vary
Implants	50% 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; limits apply	Member pays: $2,000/child $2,000/adult $350 startup fee; limits apply

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

Changing Benefit Elections: Qualifying Events

You may change health benefit elections outside of Open Enrollment if there is a qualifying event.

To change benefit elections, you must complete the election change process, including the submission of all required documentation, no later than **30 calendar days** after the qualifying event occurs. If the election change process is not completed **within 30 days** of the date of the qualifying event, you must wait until the next Open Enrollment to make the change. **Note:** an individual with End Stage Renal Disease may be prohibited from changing medical plans.

Marriage or Domestic Partnership

To enroll a new spouse/domestic partner and eligible children of a spouse/partner in San Francisco Health Service System (SFHSS) healthcare coverage, submit a completed SFHSS enrollment application, a copy of a marriage certificate or certificate of domestic partnership, and a birth certificate for each child to SFHSS **within 30 days** of the legal date of the marriage or partnership. Certificates of marriage or partnership must be issued in the United States. A Social Security number must be provided for each of the family members being enrolled. Proof of Medicare enrollment is also required for a domestic partner who is Medicare-eligible due to age or disability. Coverage for your spouse or domestic partner and their eligible children will be effective the first day of the coverage period following the submission of the required application and documentation.

Birth or Adoption

To enroll your newborn or newly adopted child, you must submit a completed SFHSS enrollment application and a copy of the birth certificate or adoption documentation **within 30 days** from the date of birth or placement for adoption. Coverage for an enrolled newborn child will be effective on the child's date of birth. Coverage for an enrolled adopted child will be effective on the date the child is placed. A Social Security number must be provided within six months of the date of birth or adoption or your child's coverage may be terminated.

Legal Guardianship or Court Order

Coverage for a child under legal guardianship is effective the date guardianship takes effect if all documentation 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.

Divorce, Separation, Dissolution, Annulment

By law, you must disenroll ineligible dependents **within 30 days** from the date of a divorce, legal separation, annulment or dissolution of partnership. Submit a completed SFHSS application with a copy of the legal documentation of your family status change. Coverage for an ex-spouse, domestic partner, and stepchildren will terminate on the last day of the coverage period in which the divorce, legal separation, annulment, or dissolution of domestic partnership occurred provided you complete disenrollment **within 30 days**. Failure to notify SFHSS can result in significant financial penalties equal to the total cost of benefits and services provided for any ineligible dependents.

Loss of Other Health Coverage

SFHSS members and eligible dependents who lose other coverage may enroll by submitting a completed application and proof of loss of coverage **within 30 days** of the date other coverage terminates. Coverage can be lost due to termination of employment, change from full-time to part-time work, dropping other employer coverage during Open Enrollment, ineligibility for Medicare or Medicaid, unpaid leave of absence, or return from military service. Documentation of lost coverage must state the date other coverage ends and the names of individuals losing coverage. If required documentation is submitted, SFHSS coverage will be effective on the first day of the next coverage period. There may be a break in coverage between the date other coverage terminates and the date SFHSS coverage begins.

Obtaining Other Health Coverage

You may waive SFHSS coverage for yourself or a dependent who enrolls in other health coverage (if you waive coverage for yourself, coverage for all your enrolled dependents must also be waived). Submit a completed SFHSS application and proof of enrollment **within 30 days** of the date of enrollment in the other health plan. Proof of coverage must indicate the effective date of coverage and the names of enrolled individuals. After all required documentation is submitted, SFHSS coverage will terminate on the last day of the coverage period. There may be an overlap of coverage between the date the other coverage begins and the date SFHSS coverage terminates. You must pay premium contributions up to the termination date of SFHSS coverage.

Moving Out of Your Plan's Service Area

If you move your primary residence to a location outside your health plan's service area, you cannot obtain services through that plan. Don't risk termination of coverage. You must enroll in a different SFHSS plan that offers service based on your new address. Complete an SFHSS application to elect a new plan **within 30 days** of your move. Coverage under the new plan will be effective the first day of the coverage period following the date SFHSS receives your enrollment application and any required documentation.

Death of a Dependent

If an enrolled dependent dies, notify SFHSS as soon as possible and submit a copy of the death certificate **within 30 days** of the date of death. Coverage terminates the day after the dependent's death.

Death of a Member

In the event of a member's death, the surviving dependent or survivor's designee should contact SFHSS to obtain information about eligibility for survivor health benefits. To be eligible for health benefits, the surviving spouse or domestic partner of a retiree must have been married to the member, or registered as the member's domestic partner, for at least one year prior to the death of the member.

The surviving spouse or domestic partner of a retiree member hired after January 9, 2009, may not be eligible for SFHSS benefits. Other restrictions apply.

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

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

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

Responsibility for Premium Contributions

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

Eligibility

These rules govern which retirees and dependents may be eligible for San Francisco Health Service System 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. Service requirements vary. If hired on or after January 9, 2009, Proposition B applies (see page 30). If a retiree chooses to take a lump sum pension distribution, retiree health premium contributions will be unsubsidized and paid at full cost. Other restrictions may apply. For an assessment of eligibility for retiree health benefits contact the San Francisco Health Service System.

Newly eligible retirees must enroll in retiree medical and/or dental coverage **within 30 days** of their retirement effective date. To enroll you must provide SFHSS with a completed enrollment application and all required eligibility documentation, including retirement system paperwork. 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 by Social Security, so plan ahead before your 65th birthday. If you fail to meet required deadlines, you must wait until the next Open Enrollment.

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

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

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

Dependent Eligibility

Spouse or Registered Domestic Partner

A member's spouse or registered domestic partner may be eligible for SFHSS healthcare coverage. Proof of 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. In that case, coverage begins on the first day of the coverage period after a completed application and eligibility documentation is filed with SFHSS. A spouse or registered domestic partner can also be added to a member's coverage during Open Enrollment. Proof of Medicare enrollment must be provided for a spouse or registered domestic partner who is Medicare-eligible due to age or disability. Medicare applications take three to four months to process by Social Security, so plan ahead.

Natural Children, Stepchildren, Adopted Children

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

Legal Guardianship and Court-Ordered Children

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

Eligibility

Adult Disabled Children

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

1. Adult child is enrolled in a San Francisco Health Service System medical plan on the child's 26th birthday.
2. Disabled child must meet the requirements of being an eligible dependent child in SFHSS Member Rules Section B.3 before turning 26.
3. Adult child must have been physically or mentally disabled on the date coverage would otherwise end because of age and continue to be disabled since age 26.
4. Adult child is incapable of self-sustaining employment due to the physical or mental disability.
5. Adult child is dependent on the member for substantially all of their economic support and is declared as an exemption on the member's federal income tax.
6. Member is required to comply with their enrolled medical plan's disabled dependent certification process and recertification process every year thereafter and upon request.
7. All enrolled dependents who qualify for Medicare due to a disability are required to enroll in Medicare (see SFHSS Member Rules Section J). Members must notify the San Francisco Health Service System of any dependent's eligibility for, and enrollment in, Medicare.
8. Once enrolled, the member must continuously enroll the disabled adult child with the San Francisco Health Service System and Medicare (if eligible) to maintain future eligibility.

COBRA Continuation Coverage

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

- Children who are aging out of 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.html or call SFHSS at 1-415-554-1750.

Medicare Enrollment is Required

Retiree members and dependents covered on a San Francisco Health Service System plan must be enrolled in Medicare as soon as they are eligible due to age, disability, or End Stage Renal Disease (ESRD).

Financial Penalties for Failing to Disenroll Ineligible Dependents

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

Eligibility

City Charter Amendments and Retiree Benefits

2008 Proposition B: Employees Hired After January 9, 2009

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 & County of San Francisco, San Francisco Unified School District, San Francisco City College, or San Francisco Superior Court. Other government service is not credited.

Also under this 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 be eligible for retiree health benefits.

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

If eligible, different premium contribution rates apply for employees hired after January 9, 2009, based on years of credited service with the City employers. See pages 40–43 for retiree premium contributions based on Proposition B.

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 employer premium contribution for themselves and eligible dependents.
- With at least 15 years, but less than 20 years of credited service, the retiree will receive 75% of the employer premium contribution for themselves and eligible dependents.
- With 20 or more years of credited service or disability retirement, the retiree will receive 100% of the employer premium contribution for themselves and eligible dependents.

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 receive the employer health premium subsidies in effect at the time of their separation.

View retiree premium contribution amounts based on Proposition C: sfhss.org/benefits/retirees.html.

If enrolled in retiree health benefits administered by the San Francisco Health Service System:

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

Getting Ready to Retire?

Make an informed decision. First, confirm your years of credited service with a City employer with your retirement system (SFERS, CalPERS, CalSTRS, or PARS). Remember–if you were hired after January 9, 2009, other government service is not credited for retiree health benefits eligibility.

Then, contact the San Francisco Health Service System. A benefits analyst will review your service credits, health benefits eligibility, retiree health plan options, and premium contributions.

If you are Medicare-eligible due to age or disability, you must contact the Social Security Administration to apply for Medicare before you retire. Plan ahead. It can take Social Security up to three months to complete processing of your Medicare enrollment.

Glossary of Healthcare Terms

Accountable Care Organization
A payment and healthcare delivery model that aligns medical group reimbursements with meeting coordinating care and quality and cost targets. Also called an ACO.

Ambulatory Care
Care provided in outpatient setting.

Benefits Coverage Period
Dates when your health insurance coverage begins and ends.

Brand-Name Drug
FDA-approved prescription drugs marketed under a specific brand name by the manufacturer.

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

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

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

Covered California
California state health insurance exchange where people can purchase affordable insurance if they lose coverage: coveredca.com.

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

Dependent
A family member who meets the eligibility criteria established by SFHSS for health plan enrollment.

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

Effective Date
The calendar date your healthcare coverage begins. You are not covered until the effective date.

Employee Premium Contribution
The amount you must pay toward health plan premiums.

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

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

Enrollee
Individual enrolled in a health plan.

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

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

Exclusions
The list of conditions, injuries, or treatments that are not covered under your health insurance policy. Exclusions are listed in the Evidence of Coverage.

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

Generic Drug
The FDA-approved therapeutic equivalent to a brand-name prescription drug containing the same active ingredient and costing less than the brand-name drug.

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

Imputed Income
IRS regulations require that the value of non-cash compensation, including employer contribution toward health premiums for an employee's domestic partner, be reported as taxable income on federal tax returns.

In-Network
Providers or facilities that contract with a health plan to provide services at pre-negotiated fees. Enrollees usually pay less when using an in-network provider.

In-Patient
Services that are provided in a hospital and require admission and an overnight stay.

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

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

Non-Formulary Drug
A drug that is not on the insurer's list of approved medications. Can only be prescribed with a physician's special authorization.

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

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

Out-of-Network
Providers or facilities that are not in your health plan's provider network. Some plans do not cover out-of-network services. Others charge a higher coinsurance.

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

Out-of-Pocket Maximum
The highest total amount you will spend in a year on out-of-pocket medical costs. Once you reach out-of-pocket maximum, your plan pays 100% of covered service costs.

Out-Patient
Services that are provided in a clinic or doctor's office and do not require overnight admission to the hospital.

Preferred Provider Organization (PPO)
Provides in-network services to subscribers at negotiated rates but allows subscribers to seek service from out-of-network providers often at a higher cost.

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

Primary Care Physician (PCP)
Doctor (or nurse practitioner) who coordinates all your medical care. HMOs require all plan participants to be assigned to a PCP.

Privacy
SFHSS complies with federal and state laws that protect personal health information. For details: sfhss.org/health_service_board/privacy_policy.html

Qualifying Event
A life event that allows you to make a change in your benefit elections outside of Open Enrollment. Includes marriage, domestic partnership, separation, divorce or dissolution of partnership, birth or adoption of a child, death of a dependent, and obtaining or losing other health coverage.

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

Same Day Surgery
Surgery procedures performed at an ambulatory care center or in-patient hospital without an admission or over night stay.

Specialty Drug
New types of drugs to treat specific illnesses.

Legal Notices About Health Benefits

Notice of Medicare Part D Creditable Coverage

If you are Medicare-eligible and enrolled in a medical plan through the San Francisco Health Service System, your prescription drug coverage is better than the standard level of coverage set by the federal government under Medicare Part D. This qualifies as creditable coverage under Medicare Part D.

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

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

If a person loses creditable prescription drug coverage through no fault of his or her own, that person may also be eligible for a Special Enrollment Period (SEP) to join a Medicare drug plan.

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

The San Francisco Health Service System 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, the San Francisco Health Service System will not disclose your health information without your written authorization:

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

If you authorize the San Francisco Health Service System to disclose your health information, you may revoke that authorization in writing at any time.

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

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

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

Health Service Board Achievements

Randy Scott
Appointee
President

Wilfredo Lim
Elected
Employee
Vice President

Karen Breslin
Elected
Retiree

Jeff Sheehy
Appointee
Board of
Supervisors

Sharon Ferrigno
Elected
Retiree

Stephen
Follansbee, MD
Appointee

Gregg Sass
Appointee

Steps to Improve and Maintain Affordable Benefits:

1. Approved active and early retiree rates overall below 4% for 2018. This required allocation of $4.53M from the City Plan Stabilization Reserve to reduce 2018 City Plan premiums for employees and early retirees. This allocation reduced premium rates and will reduce the base rate used to calculate the 40% federal excise tax in 2020.
2. Continued flex-funding of the Blue Shield of California plan allowing the San Francisco Health Service System to reduce insurance costs by paying hospital, pharmacy, and physician costs directly.
3. Approved a proposal to implement the Blue Shield of California Trio Plan for actives and early retirees for plan year 2018. This plan will be offered in addition to the current Blue Shield of California Access+ plan with identical benefits but with a narrow network of hospitals. The premiums are 5.9% lower than the existing Access+ plan.
4. Through the Health Service Board Education Policy, the Board continues to be fully committed to being knowledgeable and apply understanding to business principles and practices of the San Francisco Health Service System and the Health System Trust.
5. Maintaining oversight and providing guidance for the recruitment of the San Francisco Health Service System Executive Director.
6. Adopted a policy statement on Gender Dysphoria stating San Francisco Health Service System and the Health Service Board will fully recognize medically necessary treatment for gender dysphoria as part of the full scope of benefits offered to members.

Benefit Additions:

- Approved the Blue Shield Trio HMO. Trio HMO has the same benefits and plan design as Access+ HMO with lower premium contributions and access to many of the same hospitals and physicians.
- Approved the new VSP Premier Plan. For an increased premium, members will gain the benefit of increased allowances for frames and contacts as well as being able to obtain coverage once a calendar year versus once every 48 months.
- Approved increase of Infertility and Reproductive Technology benefits through existing medical plans offered through SFHSS. Current infertility benefits have been increased to two cycles per lifetime. Cryopreservation of reproductive tissue is being offered for up to 12 months.
- UnitedHealthcare Offers 'Real Appeal' Weight-loss Program. Free and available to all SFHSS members, Real Appeal provides tools and support to help members lose weight, feel good, and prevent weight-related health conditions.
- Approved Kaiser Permanente extension of coverage to Retirees in Hawaii, Oregon, and Washington. Retirees will now have the option of selecting a Kaiser Permanente health plan in three other Kaiser regions, including Kaiser's Northwest, Washington, and Hawaii regions.
- Approved Delta Dental PPO increase of Annual Benefit Maximum for Retirees. The annual benefit maximum for Delta Dental PPO for Retirees will increase from $1,000 to $1,250 in 2018.

2018 Medical Premiums: Retiree or Survivor of Retiree Without Medicare Residing in California

RETIREES OR SURVIVORS OF RETIREES HIRED BEFORE JANUARY 9, 2009

2018 Monthly Medical Premiums	Blue Shield of California				Kaiser Permanente HMO		UHC City Plan PPO	
	Trio HMO		Access+ HMO					
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$1,601.54	$29.44	$1,750.74	$70.44	$1,229.20	$0	$1,072.43	$117.64
Retiree/Survivor +1 Dependent with no Medicare	$1,967.37	$395.26	$2,159.21	$478.92	$1,533.78	$304.57	$1,642.37	$687.58
Retiree/Survivor +2 or More Dependents with no Medicare	$1,967.37	$979.28	$2,159.21	$1,131.01	$1,533.78	$810.17	$1,642.37	$1,535.76
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$1,790.61	$218.50	$1,939.81	$259.50	$1,418.88	$189.68	$1,261.50	$306.70
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$1,790.61	$802.52	$1,939.81	$911.59	$1,418.88	$695.28	$1,261.50	$1,154.88

RETIREES OR SURVIVORS OF RETIREES HIRED AFTER JANUARY 9, 2009 WITH MORE THAN 5 AND LESS THAN 10 YEARS OF SERVICE

2018 Monthly Medical Premiums	Blue Shield of California				Kaiser Permanente HMO		UHC City Plan PPO	
	Trio HMO		Access+ HMO					
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$0	$1,630.98	$0	$1,821.18	$0	$1,229.20	$0	$1,190.07
Retiree/Survivor +1 Dependent with no Medicare	$0	$2,362.63	$0	$2,638.13	$0	$1,838.35	$0	$2,329.95
Retiree/Survivor +2 or More Dependents with no Medicare	$0	$2,946.65	$0	$3,290.22	$0	$2,343.95	$0	$3,178.13
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$0	$2,009.11	$0	$2,199.31	$0	$1,608.56	$0	$1,568.20
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$0	$2,593.13	$0	$2,851.40	$0	$2,114.16	$0	$2,416.38

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.

2018 Medical Premiums: Retiree or Survivor of Retiree With Medicare Part A & Part B Residing in California

RETIREES HIRED BEFORE JANUARY 9, 2009

2018 Monthly Medical Premiums	Kaiser Permanente HMO		UHC Medicare Advantage PPO		UHC Medicare Advantage PPO with Non Medicare Dependents in Blue Shield of California Trio HMO		UHC Medicare Advantage PPO with Non Medicare Dependents in Blue Shield of California Access+ HMO	
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$383.74	$0	$382.51	$0	$382.51	$0	$382.51	$0
Retiree/Survivor +1 Dependent with no Medicare	$688.32	$304.57	$952.45	$569.94	$748.34	$365.82	$790.98	$408.48
Retiree/Survivor +2 or More Dependents with no Medicare	$688.32	$810.17	$952.45	$1,418.12	$748.34	$949.84	$790.98	$1,060.57
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$573.42	$189.68	$571.58	$189.06	-	-	-	-
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$573.42	$695.28	$571.58	$1,037.24	$571.58	$773.08	$571.58	$841.15

RETIREES HIRED AFTER JANUARY 9, 2009 WITH MORE THAN 5 AND LESS THAN 10 YEARS OF SERVICE

2018 Monthly Medical Premiums	Kaiser Permanente HMO		UHC Medicare Advantage PPO		UHC Medicare Advantage PPO with Non Medicare Dependents in Blue Shield of California Trio HMO		UHC Medicare Advantage PPO with Non Medicare Dependents in Blue Shield of California Access+ HMO	
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$0	$383.74	$0	$382.51	$0	$382.51	$0	$382.51
Retiree/Survivor +1 Dependent with no Medicare	$0	$992.89	$0	$1,522.39	$0	$1,114.16	$0	$1,199.46
Retiree/Survivor +2 or More Dependents with no Medicare	$0	$1,498.49	$0	$2,370.57	$0	$1,698.18	$0	$1,851.55
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$0	$763.10	$0	$760.64	-	-	-	-
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$0	$1,268.70	$0	$1,608.82	$0	$1,344.66	$0	$1,412.73

2018 Medical Premiums: Retiree or Survivor of Retiree Without Medicare Residing Outside of California

RETIREES OR SURVIVORS OF RETIREES HIRED BEFORE JANUARY 9, 2009

2018 Monthly Medical Premiums	Kaiser Permanente HMO						UHC City Plan PPO	
	Northwest		Washington		Hawaii			
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$1,384.01	$0	$1,232.56	$0	$845.18	$0	$1,072.43	$117.64
Retiree/Survivor +1 Dependent with no Medicare	$2,073.83	$689.81	$1,846.65	$614.09	$1,265.58	$420.39	$1,642.37	$687.58
Retiree/Survivor +2 or More Dependents with no Medicare	$2,073.83	$1,834.89	$1,846.65	$1,633.47	$1,265.58	$1,118.24	$1,642.37	$1,535.76
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$1,577.43	$193.41	$1,387.91	$155.34	$1,022.51	$177.32	$1,261.50	$306.70
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$1,577.43	$1,455.42	$1,387.91	$1,174.72	$1,022.51	$946.30	$1,261.50	$1,154.88

RETIREES OR SURVIVORS OF RETIREES HIRED AFTER JANUARY 9, 2009 WITH MORE THAN 5 AND LESS THAN 10 YEARS OF SERVICE

2018 Monthly Medical Premiums	Kaiser Permanente HMO						UHC City Plan PPO	
	Northwest		Washington		Hawaii			
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$0	$1,384.01	$0	$1,232.56	$0	$845.18	$0	$1,190.07
Retiree/Survivor +1 Dependent with no Medicare	$0	$2,763.64	$0	$2,460.74	$0	$1,685.97	$0	$2,329.95
Retiree/Survivor +2 or More Dependents with no Medicare	$0	$3,908.72	$0	$3,480.12	$0	$2,383.82	$0	$3,178.13
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$0	$1,770.84	$0	$1,543.25	$0	$1,199.83	$0	$1,568.20
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$0	$3,032.85	$0	$2,562.63	$0	$1,968.81	$0	$2,416.38

2018 Medical Premiums: Retiree or Survivor of Retiree With Medicare Part A and Part B Residing Outside of California

RETIREES OR SURVIVORS OF RETIREES HIRED BEFORE JANUARY 9, 2009

2018 Monthly Medical Premiums	Kaiser Permanente Senior Advantage HMO						UHC Medicare Advantage PPO	
	Northwest		Washington		Hawaii			
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$391.21	$0	$315.07	$0	$359.03	$0	$382.51	$0
Retiree/Survivor +1 Dependent with no Medicare	$1,081.03	$689.81	$929.16	$614.09	$779.44	$420.39	$952.45	$569.94
Retiree/Survivor +2 or More Dependents with no Medicare	$1,081.03	$1,834.89	$929.16	$1,633.47	$779.44	$1,189.37	$952.45	$1,418.12
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$584.63	$193.41	$470.42	$155.34	$536.36	$177.32	$571.58	$189.06
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$584.63	$1,455.42	$470.42	$1,174.72	$536.36	$1,017.43	$571.58	$1,037.24

RETIREES OR SURVIVORS OF RETIREES HIRED AFTER JANUARY 9, 2009 WITH MORE THAN 5 AND LESS THAN 10 YEARS OF SERVICE

2018 Monthly Medical Premiums	Kaiser Permanente Senior Advantage						UHC Medicare Advantage PPO	
	Northwest		Washington		Hawaii			
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$0	$391.21	$0	$315.07	$0	$359.03	$0	$382.51
Retiree/Survivor +1 Dependent with no Medicare	$0	$1,770.84	$0	$1,543.25	$0	$1,199.83	$0	$1,522.39
Retiree/Survivor +2 or More Dependents with no Medicare	$0	$2,915.92	$0	$2,562.63	$0	$1,968.81	$0	$2,370.57
Retiree/Survivor +1 Dependent with Medicare Part A and Part B	$0	$778.04	$0	$625.76	$0	$713.68	$0	$760.64
Retiree/Survivor +1 Dependent with Medicare Part A and B +1 or more Dependents	$0	$2,040.05	$0	$1,645.14	$0	$1,553.79	$0	$1,608.82

2018 Dental Premiums: All Retirees / Survivors

2018 Monthly Dental Premiums	Delta Dental PPO		DeltaCare USA DMO		UnitedHealthcare Dental DMO	
	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost	City Contribution	Retiree/ Survivor Cost
Retiree/Survivor Only	$0	$45.77	$0	$32.85	$0	$16.47
Retiree/Survivor +1 Dependent	$0	$91.04	$0	$54.21	$0	$27.20
Retiree/Survivor +2 or More Dependents	$0	$135.88	$0	$80.19	$0	$40.22

2018 VSP Premier Premiums: All Retirees / Survivors

	2018 Monthly Vision Premiums
Retiree/Survivor Only	$10.86
Retiree/Survivor +1 Dependent	$15.54
Retiree/Survivor +2 or More Dependents	$30.82

Key Contacts

HEALTH SERVICE SYSTEM

Member Services

1145 Market Street, 3rd Floor
San Francisco, CA 94103

Tel: 1-415-554-1750
1-800-541-2266
Fax: 1-415-554-1721
sfhss.org

Well-being Program

1145 Market Street, 1st Floor
San Francisco, CA 94103

Tel: 1-415-554-0643
wellness@sfgov.org

Health Service Board

Tel: 1-415-554-0662
health.service.board@sfgov.org

MEDICAL PLANS			
Blue Shield of California Access+ Non-Medicare Trio HMO Non-Medicare	Access+: 1-855-256-9404 Trio HMO: 1-855-747-5800	Access+: blueshieldca.com Trio HMO: blueshieldca.com/triosfhss	Group W0051448 (Access+ and Trio HMO)
Kaiser Permanente Senior Advantage and Traditional	1-800-443-0815 CA 1-800-813-0000 NW 1-888-901-4636 WA 1-888-597-5310 HI	kp.org	Group 888 Northern California Group 231003 Southern California Group 21227 Northwest Group 25512 Washington Group 10119 Hawaii
City Plan UnitedHealthcare Non-Medicare	1-866-282-0125	welcometouhc.com/sfhss	Group 752103
UnitedHealthcare Medicare Advantage PPO	1-877-259-0493	welcometouhc.com/sfhss	Group 13694 Group 12786 Part B Only
DENTAL and VISION PLANS			
Delta Dental	1-888-335-8227	deltadentalins.com	Group 1673-0001
DeltaCare USA	1-800-422-4234	deltadentalins.com	Group 71797-0003
UnitedHealthcare Dental formerly Pacific Union Dental	1-800-999-3367	welcometouhc.com/sfhss	Group 275550
VSP Vision Care	1-800-877-7195	vsp.com	Group 12145878
COBRA			
P&A Group	1-800-688-2611	padmin.com	
MEDICAL CASE REVIEW			
Best Doctors	1-866-904-0910	members.bestdoctors.com	
OTHER AGENCIES			
SFERS	1-415-487-7000	mysfers.org	Pension benefits
CalPERS	1-888-225-7377	calpers.ca.gov	
CalSTRS	1-800-228-5453	calstrs.org	
PARS	1-800-540-6369	parsinfo.org	
Social Security	1-800-772-1213 TTY 1-800-325-0778	ssa.gov	Medicare enrollment
Medicare	1-800-633-4227 TTY 1-877-486-2048	medicare.gov	Medicare administration
Covered California	1-888-975-1142	coveredca.com	State insurance exchange

October 2017 Special Events

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
2 **PUC HEADQUARTERS**** 525 Golden Gate O'Shaughnessy Room 8:00AM–3:00PM Meet a Benefits Analyst Get a Free Flu Shot	**3** **MTA PRESIDIO*** 10:00AM–3:00PM Meet a Benefits Analyst Get a Free Flu Shot	**4** **DPW HEALTH FAIR*** Cesar Chavez Yard 10:00AM–1:00PM Meet a Benefits Analyst **MISSION CORRIDOR** 1650 Mission, 5th Floor 9:00AM–4:00PM Meet a Benefits Analyst Get a Free Flu Shot	**5** **POLICE HEADQUARTERS** 1245 3rd Street Room 3111 9:00AM–4:30PM Meet a Benefits Analyst Get a Free Flu Shot	**6** **SFUSD HEALTH FAIR*** John O'Connell High School 2355 Folsom Street 4:00PM–8:00PM Meet a Benefits Analyst Meet Plan Vendors Get a Free Flu Shot
9 Columbus Day Holiday	**10** **HALL OF JUSTICE** 850 Bryant Street Room 551 9:00AM–4:30PM Meet a Benefits Analyst Get a Free Flu Shot	**11** **RETIRED EMPLOYEES OF CCSF HEALTH FAIR** Scottish Rite Masonic Center 2850 19th Avenue 10:00AM–12:00PM Meet a Benefits Analyst Meet Plan Vendors Get a Free Flu Shot	**12** **SFO HEALTH FAIR** Aviation Museum 11:30AM–3:30PM Meet Plan Vendors **SFO OPEN ENROLLMENT** ITBA Training Room 9:00AM–4:30PM Meet a Benefits Analyst Voluntary Benefits Info	**13** **ONE SOUTH VAN NESS BENEFITS FAIR** 2nd Floor Atrium 9:00AM–4:00PM Meet a Benefits Analyst Voluntary Benefits Info Meet Plan Vendors Get a Free Flu Shot
16 **1235 MISSION** 3rd Floor Flu Shots Only* 9:00AM–1:00PM Get a Free Flu Shot	**17** **HETCH HETCHY** 1 Lakeshore Dr. Mocassin, CA Moccasin Great Room 7:30AM–12:00PM Meet a Benefits Analyst Voluntary Benefits Info Get a Free Flu Shot **Zuckerberg San Francisco General** Cafeteria 9:00AM–4:30PM Meet a Benefits Analyst	**18** **CITY HALL BENEFITS FAIR** 1 Dr. Carlton B. Goodlett Pl. South Light Court 9:00AM–4:30PM Meet a Benefits Analyst Voluntary Benefits Info Meet Plan Vendors Get a Free Flu Shot	**19**	**20** **Laguna Honda Hospital** 375 Laguna Honda Blvd. Conf. Rm. 2, P1191 9:00AM–4:30PM Meet a Benefits Analyst **SF PUBLIC LIBRARY** 100 Larkin St. Latino Hispanic Room 10:00AM–1:00PM Meet a Benefits Analyst Get a Free Flu Shot
23	**24**	**25**	**26**	**27**
Vendor Week				
SFHSS OPEN HOUSE 1145 Market Street, 1st Floor 8:00AM–5:00PM				
	MTA MME DIVISION* 601 25th Street Room 235 A/B 11:00AM–4:00PM Get a Free Flu Shot	**PUC-PHELPS** 750 Phelps St. Administration Building, 930 Conference Room 8:00AM–12:00PM Get a Free Flu Shot	**DEPT. OF EMERGENCY MANAGEMENT*** 1011 Turk Street 1st Floor 5:00AM–9:00AM 11:00AM–5:00PM Get a Free Flu Shot	**WAR MEMORIAL** 401 Van Ness Room 302 10:00AM–2:00PM Get a Free Flu Shot
30 **PUC MILLBRAE** 1000 El Camino Real San Mateo Conf Room 8:00AM–1:00PM Meet a Benefits Analyst 7:00AM–12:00PM Get a Free Flu Shot	**31** **SFHSS WELLNESS CENTER** 1145 Market Street 1st Floor 8:00AM–5:00PM Meet a Benefits Analyst 8:00AM–1:00PM Get a Free Flu Shot			

Open Enrollment applications are due by Tuesday, October 31, 2017, 5:00PM.

The San Francisco Health Service System is open 8:00AM–5:00PM, Monday to Friday, except Columbus Day Holiday. Benefit Analysts will be available all month on the 1st floor to accept applications. No appointment necessary. For more information about Open Enrollment and flu shot clinics visit sfhss.org.

Free flu shot events are for adults only, first come, first served. Supplies are limited.

*Events are for employees/retirees with location access only.
**This event is for active city employees only.

10 Things Retirees Should Know...

The San Francisco Health Service System is Your Trusted Resource for Health Benefits Information

If you have questions about your benefits contact the San Francisco Health Service System at 1-415-554-1750 or 1-800-541-2266. Visit our website at sfhss.org.

Retiree Health Benefits Eligibility Is Determined by the San Francisco City Charter

Eligibility for retiree health benefits and retiree premium contributions vary depending upon an individual's hire date, years of credited service, time of retirement and other factors.

Retiree Health Benefits Are Different Than Employee Health Benefits

Review retiree benefits options carefully. Retiree medical and dental plans are not the same as active employee plans. Premium contributions are also different.

New Retirees: There Is A 30 Day Deadline to Enroll In Retiree Health Benefits

You must complete enrollment in retiree benefits within 30 days of your retirement date. If you miss the 30 day deadline, you must wait until Open Enrollment to enroll in retiree health benefits.

Retirees and Dependents Must Enroll In Medicare Part A and Part B As Soon As Eligible

Retirees and dependents who are Medicare-eligible due to age or disability must enroll in premium-free Medicare Part A hospital insurance and Medicare Part B medical insurance.

Do Not Enroll In Any Individual Medicare Part D Prescription Drug Plan

All Health Service System retiree medical plans include enhanced group Medicare Part D coverage. You must not enroll in an individual Part D plan offered through pharmacy, organization or insurer.

Medicare-eligible Retirees Must Pay Premiums to the Federal Government

You must pay Medicare premiums to maintain continuous enrollment in Medicare. There is a premium for Medicare Part B. You may also be required to pay a premium for your group Medicare Part D.

Health Service Premium Contributions Must Also Be Paid

Any premium contributions due to the San Francisco Health Service System must be paid to maintain your enrollment in health coverage provided through the San Francisco Health Service System.

You Must Disenroll Ineligible Family Members Within 30 Days

Divorce or dissolution of partnership? Your ex-spouse, partner or stepchild is no longer eligible for health coverage. Don't risk paying significant penalties. Contact SFHSS and drop ineligible dependents.

If You Change Your Home Address, Contact the San Francisco Health Service System

Your retirement system does not update your address with the San Francisco Health Service System. If you move, make sure to notify SFHSS about your change of address, so we can keep you informed about your benefits.