

SFUSD Employees



Benefits Guide

2010-2011

Health Service System
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

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Things You Can Do During Open Enrollment

- Elect a different medical plan.
- Add or drop eligible dependents from medical coverage.

Open Enrollment Events

Health Service System

April 1-16, 2010

Monday - Friday

8^{AM} to 5^{PM}

April 19-30, 2010

Plan vendors on-site

Monday - Friday

7:30^{AM} to 5:30^{PM}

1145 Market Street, 2nd Floor

San Francisco

- No appointment necessary

- Application drop-off

- Application review

- Consult with HSS Benefits Analysts

SFUSD

April 8, 2010

Thursday

8:30^{AM} to 4:00^{PM}

555 Franklin Street

San Francisco

- Application drop-off

- Consult with HSS representatives by appointment only:
call (415) 554-1750

The Last Day To Submit Open Enrollment Changes Is April 30, 2010

Open Enrollment is your annual opportunity to make health benefit election changes without any qualifying events. Completed Open Enrollment applications for Plan Year 2010-2011 and required documentation must be received at HSS by 5:30^{PM}, April 30, 2010. Open Enrollment applications can be delivered to HSS in person, sent through the mail or sent by fax to (415) 554-1721. See page 7 for a checklist of required eligibility documentation.

April 2010 Ineligible Dependent Amnesty

It is the responsibility of HSS members to notify the Health Service System when an enrolled dependent becomes ineligible due to divorce, dissolution of partnership, age or any other reason. (See pages 6-7.) Per HSS rules, if a member fails to notify HSS when an enrolled dependent becomes ineligible, the member will be held responsible for the costs of all health premiums and medical service provided, dating back to the date of the dependent's initial ineligibility. Avoid incurring penalties from the dependent audits that are being planned for later this year. Drop ineligible dependents during April 2010 Open Enrollment and HSS will give you amnesty from penalties.

Employee Contributions Will Increase For Medical Plans Effective July 1, 2010

Employee premium contributions for Blue Shield, Kaiser and City Plan will be increasing in Plan Year 2010-2011. The amount of the increase is dependent upon the medical plan you elect and the bargaining unit you are represented by. Check the rate charts on pages 30-31 before deciding what action to take during Open Enrollment.

Medical Plan Benefit Changes Effective July 1, 2010

Blue Shield HMO:	\$20 office visit co-pay \$15 co-pay for routine services (physical, well baby, pre/post natal care) \$100 emergency room co-pay
Kaiser HMO:	\$15 office visit co-pay \$100 emergency room co-pay
City Plan PPO:	No plan changes
VSP Vision:	\$5 VSP eye doctor visit co-pay for some acute eye conditions

Mental Health Parity Act

Effective July 1, 2010, all Health Service System administered plans are in compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA). Contact your plan if you have questions about mental health benefits.

Selecting a Primary Care Physician

After you are enrolled in either the Blue Shield HMO or the Kaiser HMO you should contact your plan to select your Primary Care Physician (PCP). (You can contact your plan to request a change of Primary Care Physician at any time throughout the year.) If you do not make a change to your PCP after one has been assigned, you will need to use the PCP assigned by your plan until you actively request a change.

Visit myhss.org To Download Open Enrollment Applications, Benefits Guides & More

PDF versions of Open Enrollment Applications and Benefits Guides are available online at the HSS website myhss.org. You will also find additional resources to support your decision making process, such as Evidence of Coverage (EOC) documents, Summaries of Benefits and other plan information.

Plan Year 2010-2011 changes take effect July 1, 2010. The alerts above include highlighted changes only and may not cover every Plan change for 2010-2011. Please read the Evidence of Coverage (EOC) document for details about your plan's benefits. EOCs are available on myhss.org.

Open Enrollment Rules & Guidelines

Open Enrollment offers you the opportunity to make changes to your healthcare elections without any qualifying event requirements.

Things You Can Do During Open Enrollment

During Open Enrollment you can:

- Elect a different medical plan.
- Add or drop eligible dependents from medical coverage.

To make changes you must submit a completed Open Enrollment application in person, by mail or by fax to HSS no later than 5:30PM, April 30, 2010.

If you are enrolling new dependents you must provide documentation to HSS proving that your dependents meet eligibility requirements for the upcoming year. A Social Security number for each enrolled individual is also required.

What To Expect If You Make a Change to Your Elections During Open Enrollment

Any changes you elect to make during the April 2010 Open Enrollment period will take effect July 1, 2010 and remain in effect through June 30, 2011.

Dependents who are deleted from coverage during the Open Enrollment period are not eligible for COBRA continuation coverage.

If you elect to change your medical plan, the plan will issue you a new medical ID card. You should receive your new ID card before July 1, 2010. If you do not receive your card, contact the plan.

If You Don't Make Any Changes During Open Enrollment

If you don't make any changes during April 2010 Open Enrollment and you are currently enrolled in Blue Shield, Kaiser or the City Plan, your current medical plan elections as well as the eligible dependents you have covered on your plan will remain the same.

Payroll Deduction Amounts

The amount deducted from your paycheck will change in accordance with any approved changes to the rates for Plan Year 2010-2011. (See pages 30-31 of this guide for 2010-2011 rates.) Check your paystub to be sure the correct deduction is being taken. You are responsible for making sure all required healthcare contributions are paid.

Benefit Election Changes Outside of Open Enrollment

Outside of Open Enrollment you must have a qualifying event in order to make changes to your healthcare elections. See pages 20-21 of this guide.

No Dual HSS Plan Coverage

HSS members and their dependents cannot be enrolled in two HSS administered medical plans at the same time. For those members who do submit dual enrollment elections, HSS will eliminate dual coverage as follows:

- For any member who is covered both as a member and as a dependent of another member, coverage as a dependent will be terminated.
- For dependents who are covered by two different members, the dependent(s) will be covered by the member who covered the dependent(s) first.

Open Enrollment

FREQUENTLY ASKED QUESTIONS

Medical Coverage	
What if I don't want to make any changes to my medical coverage?	If you do not want to choose a different medical plan and you are not adding or dropping dependents, effective July 1, 2010, you do not need to take any action during 2010 Open Enrollment.
How do I choose a different medical plan?	Review the plan options carefully, then submit a completed Open Enrollment application form and any required eligibility documentation to HSS no later than 5:30PM, April 30, 2010. For a list of required eligibility documentation see page 7.
How do I add a dependent to my medical plan?	You must submit a completed Open Enrollment application form and any required eligibility documentation to HSS no later than 5:30PM, April 30, 2010. For a list of required eligibility documentation see page 7.
How do I drop a dependent from my medical plan?	You must submit a completed Open Enrollment application form to HSS no later than 5:30PM, April 30, 2010. No additional documentation is required when you are dropping a dependent from coverage during Open Enrollment.
Your Open Enrollment Application	
May I fax my Open Enrollment application to HSS?	Yes, you may fax your Open Enrollment application and required eligibility documentation. The HSS fax number is (415) 554-1721. Please keep a copy of your fax confirmation. Do not fax the same application multiple times. HSS will email confirmations of fax receipt within two business days. Faxed applications must be received by HSS no later than 5:30PM, April 30, 2010.
What else is required in addition to my application form?	Your application must be accompanied by any required eligibility documentation. For a list of required eligibility documentation see page 7.
May I get Open Enrollment materials online?	Yes, you may download the Open Enrollment application form and 2010-2011 Benefits Guide from our website myhss.org .
Will I receive a confirmation after I submit my Open Enrollment application?	Yes, HSS will mail a letter to the home address that is on file with HSS, confirming your benefit elections. These letters will be sent in June 2010.

Eligibility

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

Member Eligibility

The following SFUSD employees are eligible for healthcare coverage administered by the Health Service System:

- All full-time Permanent Civil Service and Permanent Exempt employees whose normal work week is not less than twenty (20) hours.
- All part-time Permanent Civil Service and Permanent Exempt employees who work less than 20 hours per week will be eligible upon completion of 1040 hours in a 12 month period.
- All Provisional employees will be eligible upon completion of 1040 hours in a 12 month period unless otherwise approved by the SFUSD Board.

SFUSD Temporary Exempt or “As Needed” employees are not eligible for healthcare coverage administered by the Health Service System.

HSS requires a valid Social Security number for all individuals enrolled in an HSS administered health plan. Members and dependents who do not have a Social Security number on file at HSS risk having their benefits terminated.

Dependent Eligibility

Spouse/Domestic Partner

A member’s legal spouse or domestic partner may be eligible for HSS healthcare coverage. Proof of marriage or registered domestic partnership is required. Enrollment must occur within 30 days of the date of marriage or partnership; in that case coverage begins on the first day of the month after the completed application is filed with HSS. Legal spouses and partners can also be added to coverage during annual Open Enrollment.

Natural Children, Step-Children, Adopted Children

To be eligible, a natural child, step-child or adopted child of a member, or a member’s spouse or domestic partner, must meet all of the following criteria:

1. Child must be under 25 years of age.
2. Child must be unmarried.
3. Child cannot be working full time.
4. Child must reside in the member’s home (except for full-time college students and children living with a divorced spouse).
5. Child must be declared as an exemption on the member’s federal income tax return. (Some exceptions are allowed in the event of a member’s divorce or dissolution if natural or adopted child is declared by a former spouse/partner.)

Legal Guardianships and Other Children Residing in a Member’s Home (IRS Exemption)

Children under legal guardianship and other children residing full time in a member’s home may be eligible if they meet all of the following criteria:

1. Child must be under 19 years of age.
2. Child must be unmarried.
3. Child cannot be working full time.
4. Child must reside in the member’s home and be economically dependent on the member.
5. Child must be declared as an exemption on the member’s federal income tax return. A copy of the member’s federal income tax return must be submitted to HSS annually.

Court Ordered Children

Children covered by a National Medical Support Notice (Court Order) can be covered to age 19.

Disabled Children

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

1. Child was continuously enrolled in an HSS administered medical plan from age 19-25.
2. Child was enrolled in an HSS administered medical plan on the child's 19th birthday and continuously for one year prior to age 19.
3. Child sustained a qualifying disability prior to reaching age 25.
4. Child is incapable of self-sustaining employment due to the qualifying disability.
5. Child is unmarried.
6. Child permanently resides with the member.
7. Child is economically dependent on the member for all of his or her economic support and is declared on member's IRS tax return.
8. Member submits required documentation of the disability at least 60 days prior to the child's attainment of age 25 and every year thereafter.

Social Security Numbers Required

Members and dependents who do not have a Social Security number on file at HSS risk having benefits terminated. Social Security numbers for newborns must be provided within 6 months of the date of birth. Visit www.ssa.gov/pubs/10023.html for more information. If your dependent does not qualify for a Social Security number, please contact HSS at (415) 554-1750.

Financial Penalties for Failing to Disenroll Ineligible Dependents

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

REQUIRED ELIGIBILITY DOCUMENTATION

	EVIDENCE OF HIRE	BENEFIT AUTH. FORM	MARRIAGE CERTIFICATE	DOMESTIC PARTNER REG.	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	COURT ORDER	INCOME TAX RETURN	MEDICAL EVIDENCE	SOCIAL SECURITY #
Employee: Permanent/Provisional	■									■
Employee: Temporary/Exempt		■								■
Spouse			■							■
Domestic Partner				■						■
Child: Natural					■					■
Child: Step-child			■	■	■			■		■
Child: Domestic Partner				■	■					■
Child: Adopted						■				■
Child: Legal Guardianship							■			■
Child: IRS Exemption					■			■		■
Child: Court Ordered							■			■
Child: Disabled								■	■	■

Eligibility

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

Temporary Certificated Employees

Temporary certificated employees with contracts that end June 30, 2010 are as follows:

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

If you are a Temporary Certificated employee your last day of coverage will be June 30, 2010. Effective July 1, 2010, you may elect to continue coverage under the COBRA provision. Please see pages 22-23 of this guide for more information.

Temporary School-Term Biweekly Employees

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

- Clerical Workers
- Paraprofessionals
- Security Aides

If you are a Temporary School-Term Biweekly employee your last day of coverage will be June 22, 2010. Effective June 23, 2010, you may elect to continue coverage under the COBRA provision. Please see pages 22-23 of this guide for more information about COBRA.

Reminder: Temporary Employees Do Not Submit Changes During Open Enrollment

Temporary employees are not eligible to submit changes during the Open Enrollment period because active employment coverage will not be in effect as of July 1, 2010; employment for temporary employees will have terminated by this date. COBRA simply continues plan coverage in place as of June 30, 2010 (monthlies) or as of June 23, 2010 (biweeklies).

However, temporary employees are able to make changes when re-enrolling in the future with an eligible SFUSD assignment.

Rehired in the Fall?

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

Benefits Administered By SFUSD

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

Dental Plan (Delta Premier)

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

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

Flexible Spending Accounts (FSAs)

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

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

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

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

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

Choosing a Medical Plan

1 PPO vs. HMO

Learn about the differences between a PPO plan and an HMO plan. (See the chart on page 12 of this guide.)

2 Plan Service Areas

Find out which plans offer service to you based on the home address of the primary HSS member. See the chart on page 13 of this guide or contact the plan.

3 Medical Groups, Doctors and Hospitals

Identify which doctors, hospitals and other medical services that you and your family prefer. If you are enrolled in an HMO, the Primary Care Physician you select will have an impact on which doctors and hospitals you can access.

4 Vendor Report Cards & Quality Ratings

Visit online resources that can assist you in your decision making process.

HSS Vendor Report Cards
www.myhss.org

National Committee for Quality Assurance
www.ncqa.org

California Office of the Patient Advocate
www.opa.ca.gov

Agency for Healthcare Research & Quality
www.ahrq.gov/consumer/insuranceqa/

Integrated Healthcare Association
www.iha.org

CalHospitalCompare
www.CalHospitalCompare.org

5 Medical Needs & Services Covered

Make sure you understand how your plan works by reviewing the benefits summary and Evidence of Coverage (EOC) documents. Don't wait until you need emergency care to educate yourself about plan details. Here are some common questions to consider when deciding which plan can best meet your particular needs:

- Do you or a family member need to see medical specialists for a particular condition?
- Does someone in your family take regular prescription medication?
- Are the doctors or medical facilities in a plan in a convenient location for you?
- Will you need prior approval to ensure coverage for care if you are hospitalized or require surgery?
- Will you or any family members be seeking mental health care?
- How are benefits paid?

6 Plan Costs

Compare the costs of each available medical plan. See pages 30-31 of this guide for plan rate charts.

Medical Plan Options

These medical plan options are available to active HSS members and eligible dependents. Employee premium contributions are deducted from the member's paycheck.

Health Maintenance Organization (HMO)

An HMO is a medical plan that requires you receive all of your care from a network of participating physicians, hospitals, and other healthcare providers. Generally, to be covered for non-emergency benefits, you need to access medical care through your PCP (Primary Care Physician).

HSS offers the following HMO plans:

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

Preferred Provider Organization (PPO)

A PPO is a medical plan that gives you freedom of choice by allowing you to go to any in-network or out-of-network healthcare provider. When you go to in-network providers the plan pays higher benefits and you pay less out-of-pocket. A PPO doesn't assign you a Primary Care Physician, so you have more responsibility for coordinating your care.

HSS offers the following PPO plan:

- **City Health Plan**
(administered by UnitedHealthcare)

The healthcare plans administered by HSS do not guarantee the continued participation of any particular doctor, hospital or medical group during the Plan Year. After Open Enrollment, you won't be allowed to change your healthcare elections because your provider and/or medical group chooses not to participate in a particular plan. You'll be assigned or required to select another provider.

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

This benefits guide cannot cover every detail of your plan contract. The EOC (Evidence of Coverage) contains a complete list of benefits and exclusions in effect for each plan from July 1, 2010 through June 30, 2011. Review your EOC for plan details. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. You can download plan EOCs at myhss.org.

Employee vs. Employer Premium Contribution Costs

On average, an employee contributes 14% of the total cost of a health plan premium. Your employer pays 86% of the cost of employee and dependent health coverage.

PPO vs. HMO

QUICK COMPARISON CHART

	City Plan PPO	Blue Shield HMO	Kaiser HMO
Do I have to select a Primary Care Physician (PCP) to coordinate my care?	No	You can choose your Blue Shield PCP after you enroll, or Blue Shield will assign.	You can choose your Kaiser PCP after you enroll, or Kaiser will assign.
Do I have to use a contracted network provider?	You can use any licensed provider. Out-of-network providers will cost you more.	Yes. All services must be received from a contracted network provider.	Yes. All services must be received from a Kaiser facility.
Is my access to hospitals and specialists determined by my Primary Care Physician's medical group affiliation?	No	Yes. PCP referrals will in most cases be made within his or her medical group's network of doctors and hospitals.	Yes. All services must be received from a Kaiser facility.
Do I have to pay an annual deductible?	Yes	No	No
Is preventative care covered, such as a routine physical and well baby care?	Yes, after annual deductible is met.	Yes	Yes
Does the plan have a maximum lifetime limit for healthcare services?	Yes. The plan will pay a maximum lifetime benefit of \$2 million per covered person.	No	No
Do I have to file claim forms?	Only if you use an out-of-network provider.	No	No

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

Medical Plan Service Areas

To enroll in Blue Shield or Kaiser, you must reside within a zip code serviced by the plan. Refer to the chart below or contact the plan to determine whether or not you live in the plan's service area.


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

■ = Available in this County.

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

If you do not see your County listed above please contact the medical plan to see if service is available to you.

Medical Plan Benefits-at-a-Glance

	blue  of california	KAISER PERMANENTE®
DEDUCTIBLES		
Plan-year deductible	None	None
Lifetime maximum	None	None
PREVENTIVE & ROUTINE CARE		
Routine physical	\$15 co-pay	\$15 co-pay
Immunizations & inoculations	No charge	No charge
Gynecologic exam	\$15 co-pay	\$15 co-pay
Well baby care	\$15 co-pay	\$15 co-pay
PHYSICIAN CARE		
Office & home visits	\$20 co-pay	\$15 co-pay
Hospital visits	No charge	No charge
PRESCRIPTION DRUGS		
Pharmacy - generic drugs	\$5 co-pay 30 day supply	\$5 co-pay 30 day supply
Pharmacy - brand-name drugs	\$20 co-pay 30 day supply	\$15 co-pay 30 day supply
Pharmacy - non-formulary drugs	\$35 co-pay 30 day supply	Physician authorized only
Mail order - generic drugs	\$10 co-pay 90 day supply	\$10 co-pay 100 day supply
Mail order - brand-name drugs	\$40 co-pay 90 day supply	\$30 co-pay 100 day supply
Mail order - non-formulary drugs	\$70 co-pay 90 day supply	Physician authorized only
OUTPATIENT SERVICES		
Diagnostic x-ray & laboratory	No charge	No charge
EMERGENCY		
Hospital emergency room	\$100 co-pay waived if hospitalized	\$100 co-pay waived if hospitalized
Urgent care facility	\$20 co-pay within CA network	\$15 co-pay
HOSPITALIZATION		
Inpatient	\$100 co-pay per admittance	\$100 co-pay per admittance
Oupatient	\$50 co-pay	\$15 co-pay
SURGERY		
In hospital	\$100 co-pay per admittance	\$100 co-pay per admittance

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

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers

Out-of-Network Providers*

Out-of-Area Providers*

\$250 employee only
 \$500 employee + 1
 \$750 employee + 2 or more

\$250 employee only
 \$500 employee + 1
 \$750 employee + 2 or more

\$250 employee only
 \$500 employee + 1
 \$750 employee + 2 or more

\$2,000,000 per covered person for any combination of In-Network, Out-of-Network and Out-of-Area options utilized.

85% covered after deductible

Not covered

85% covered after deductible

100% covered no deductible

50% covered no deductible

100% covered no deductible

85% covered after deductible

50% covered after deductible

85% covered after deductible

85% covered after deductible

50% covered after deductible

85% covered after deductible

85% covered after deductible

50% covered after deductible

85% covered after deductible

85% covered after deductible

50% covered after deductible

85% covered after deductible

\$5 co-pay 30 day supply

50% covered after \$5 co-pay; 30 day supply

\$5 co-pay 30 day supply

\$20 co-pay 30 day supply

50% covered after \$20 co-pay; 30 day supply

\$20 co-pay 30 day supply

\$35 co-pay 30 day supply

50% covered after \$35 co-pay; 30 day supply

\$35 co-pay 30 day supply

\$10 co-pay 90 day supply

Not covered

\$10 co-pay 90 day supply

\$40 co-pay 90 day supply

Not covered

\$40 co-pay 90 day supply

\$70 co-pay 90 day supply

Not covered

\$70 co-pay 90 day supply

85% covered after deductible;
 may require prior notification

50% covered after deductible;
 may require prior notification

85% covered after deductible;
 may require 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;
 if non-emergency 50% after deductible

85% covered after deductible

50% covered after deductible

85% covered after deductible

85% covered after deductible;
 may require prior notification

50% covered after deductible;
 may require prior notification

85% covered after deductible;
 may require prior notification

85% covered after deductible

50% covered after deductible

85% covered after deductible

85% covered after deductible;
 may require prior notification

50% covered after deductible;
 may require prior notification

85% covered after deductible;
 may require prior notification

*City Plan Benefits are based on Reasonable & Customary charges. In some cases, billed amounts may exceed Reasonable & Customary fees, resulting in higher out-of-pocket costs for you.

Medical Plan Benefits-at-a-Glance

	blue  of california	KAISER PERMANENTE®
REHABILITATIVE		
Physical/Occupational therapy	\$20 co-pay	\$15 co-pay authorization required
Acupuncture	\$15 co-pay 30 visits/yr; ASH network only	Not covered
Chiropractic	\$15 co-pay 30 visits/yr; ASH network only	\$15 co-pay 30 visits/yr; ASH network only
PREGNANCY & MATERNITY		
Pre/post-natal physician care For hospital stay, see Hospitalization	\$15 co-pay newborn must be enrolled within 30 days of birth	\$15 co-pay newborn must be enrolled within 30 days of birth
INFERTILITY		
IVF, GIFT, ZIFT & Artificial Insemination	50% covered of the allowable amount; limitations apply	50% covered limitations apply
TRANSGENDER		
Office visits & outpatient surgery	Co-pays apply authorization req. \$75,000 lifetime max	Co-pays apply authorization req. \$75,000 lifetime max
DURABLE MEDICAL EQUIPMENT		
Home medical equipment	No charge	No charge as authorized by PCP according to formulary
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary
Hearing aids	No charge 1 per ear every 36 months; \$2,500 max	No charge 1 per ear every 36 months; \$2,500 max
MENTAL HEALTH		
Inpatient hospitalization	\$100 co-pay per admittance	\$100 co-pay per admittance
Outpatient treatment	\$20 co-pay non-severe and severe	\$7 co-pay group \$15 co-pay individual
SUBSTANCE ABUSE		
Inpatient	\$100 co-pay per admittance for acute short-term detox	\$100 co-pay per admittance
Outpatient	\$20 co-pay	\$5 co-pay group \$15 co-pay individual
EXTENDED & END-OF-LIFE CARE		
Skilled nursing facility	No charge up to 100 days per year	No charge up to 100 days per year
Hospice	No charge authorization required	No charge when medically necessary

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

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers

Out-of-Network Providers*

Out-of-Area Providers*

85% covered after deductible; 60 visits / year

50% covered after deductible; 60 visits / year

85% covered after deductible; 60 visits / year

50% covered after deductible; \$1,000 / year

50% covered after deductible; \$1,000 / year

50% covered after deductible; \$1,000 / year

50% covered after deductible; \$1,000 / year

50% covered after deductible; \$1,000 / year

50% covered after deductible; \$1,000 / year

85% covered after deductible; newborn must be enrolled within 30 days of birth

50% covered after deductible; newborn must be enrolled within 30 days of birth

85% covered after deductible; newborn must be enrolled within 30 days of birth

50% covered after deductible; limitations apply; prior notification required

50% covered after deductible; limitations apply; prior notification required

50% covered after deductible; limitations apply; prior notification required

85% covered after deductible; prior notification required; \$75,000 lifetime max

50% covered after deductible; prior notification required; \$75,000 lifetime max

85% covered after deductible; prior notification required; \$75,000 lifetime max

85% covered after deductible; rental not to exceed purchase price

50% covered after deductible; rental not to exceed purchase price

85% covered after deductible; rental not to exceed purchase price

85% covered after deductible; when medically necessary

50% covered after deductible; when medically necessary

85% covered after deductible; when medically necessary

100% covered after deductible; 1 per ear every 36 months; \$2,500 max

100% covered after deductible; 1 per ear every 36 months; \$2,500 max

100% covered after deductible; 1 per ear every 36 months; \$2,500 max

85% covered after deductible; authorization required

50% covered after deductible; authorization required

85% covered after deductible; authorization required

85% covered after deductible

50% covered after deductible

85% covered after deductible

85% covered after deductible; authorization required

50% covered after deductible; authorization required

85% covered after deductible; authorization required

85% covered after deductible

50% covered after deductible

85% covered after deductible

85% covered after deductible; 120 days per year; prior authorization required; custodial care not covered

50% covered after deductible; 120 days per year; prior authorization required; custodial care not covered

85% covered after deductible; 120 days per year; prior authorization required; custodial care not covered

85% covered after deductible; \$10,000 max; prior notification required

50% covered after deductible; \$10,000 max; prior notification required

85% covered after deductible; \$10,000 max; prior notification required

*City Plan Benefits are based on Reasonable & Customary charges. In some cases, billed amounts may exceed Reasonable & Customary fees, resulting in higher out-of-pocket costs for you.

Vision Plan Benefits

All HSS members and eligible dependents who are enrolled in an HSS medical plan receive vision benefits, including an annual eye exam.

VSP Vision

All HSS members and eligible dependent(s) who enroll in the City Health Plan, Blue Shield HMO or Kaiser HMO can access vision benefits administered by Vision Service Plan (VSP). The vision plan provides you and your eligible dependents with one eye exam with a VSP network doctor every 12 months; helps you and your eligible dependents cover the cost of visual correction eyewear, such as glasses or contacts; and offers limited coverage for some acute eye conditions.

Choice of Providers

Under the vision plan, you have the choice of using a VSP network doctor or a non-VSP doctor. It is usually to your advantage financially to use a VSP network doctor because covered services are provided to you at a higher benefit and you will have lower out-of-pocket costs.

You can find a VSP network doctor in your area by visiting www.vsp.com or contacting VSP Member Services at (800) 877-7195.

Accessing Your Vision Benefits

There are no ID cards issued for the vision plan. When you wish to receive service from a VSP network doctor, contact the doctor, identify yourself as a VSP member, and make an appointment. VSP will provide benefit authorization to the doctor. Services must be received prior to the benefit authorization expiration date. If you receive services from a VSP network doctor without benefit authorization or obtain services from an out-of-network provider, you are responsible for payment in full to the provider. You can then submit an itemized bill directly to VSP for partial reimbursement. Download a claim form at www.vsp.com.

Plan Benefits, Limits and Exclusions

- The vision plan covers one set of contacts or eyeglass lenses every 24 months, based on your last date of service. If retractor examination reveals an Rx change of .50 diopter or more after 12 months, replacement lenses are covered.
- Eligible dependent children are covered in full for polycarbonate prescription lenses.
- Cosmetic extras such as progressive lenses, tinted lenses or oversize lenses will cost you extra. If you use a VSP network doctor, you'll pay the VSP discounted price for these cosmetic extras. If you're using an out-of-network provider, you'll pay the retail price.
- The vision plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, the plan will pay the basic cost of the allowed lenses and you'll be responsible for any additional cost for the options, unless the extra is defined in the VSP Schedule of Benefits.
 - Blended or UV protected lenses
 - Contact lenses (except as noted in the Schedule of Benefits)
 - Oversize lenses
 - Photochromic and tinted lenses
 - Progressive multi-focal lenses
 - Coatings of the lens or lenses, except scratch resistant coatings
 - Laminating of the lens or lenses
 - A frame that costs more than the Plan allowance
 - Certain limitations on low vision care
 - Cosmetic lenses
 - Optional cosmetic processes

VISION PLAN BENEFITS AT-A-GLANCE		
	VSP Network Benefit	Out-Of-Network Benefit
Vision Exam	Covered in full once every 12 months* after the \$10 co-pay	up to \$40 every 12 months* after the \$10 co-pay
Single Vision Lenses	Covered in full once every 24 months* after the \$25 co-pay	up to \$45 every 24 months* after the \$25 co-pay
Lined Bifocal Lenses	Covered in full once every 24 months* after the \$25 co-pay	up to \$65 once every 24 months* after the \$25 co-pay
Lined Trifocal Lenses	Covered in full once every 24 months* after the \$25 co-pay	up to \$85 once every 24 months* after the \$25 co-pay
Frames	Covered up to \$150 every 24 months* after the \$25 co-pay; there may be a network discount for amount exceeding allowance	up to \$55 once every 24 months* after the \$25 co-pay
Contact Lenses	Covered up to \$150 every 24 months* no co-pay; in lieu of frames/lenses; allowance applies toward contact lens fitting, evaluation exam and contacts	Covered up to \$105 every 24 months* no co-pay; in lieu of frames/lenses; allowance applies toward contact lens fitting, evaluation exam and contacts
Urgent Eye Care	\$5 co-pay limited coverage for urgent and acute eye conditions	Not covered

*Based on your last date of service.

Acute and Urgent Eye Care

With a \$5 co-pay, VSP now offers limited coverage for urgent and acute eye conditions, including treatment of pink eye, sudden onset of flashers and floaters and diagnosis of eye pain or sudden changes in vision. You can visit any VSP network doctor; no appointment is necessary. VSP acute eye care does not cover chronic conditions like diabetes-related eye disease or glaucoma. VSP doctors will refer you to your primary medical doctor for treatment of uncovered eye conditions.

Vision Expenses Not Covered

- Orthoptics or vision training and any associated supplemental testing, plano (non-prescription) lenses or two pairs of glasses in lieu of bifocals.
- Replacement of lenses or frames furnished under this plan that are lost or broken, except at the contracted intervals.

- Medical or surgical treatment of the eyes, except for limited acute eye care described above.
- Corrective vision treatments such as, but not limited to, LASIK and PRK laser surgery. (You may be eligible for discounts when services are provided by a VSP network doctor – call VSP.)

Coordinating Vision Benefits with Medical Plan Benefits

Some HMOs also offer optometry and eyecare services such as eye exams, glasses and lenses. HSS recommends that you compare the out-of-pocket cost you will incur using HMO vision services to out-of-pocket costs when using a VSP network doctor.

No Medical Plan, No Vision Benefits

If you don't enroll in an HSS medical plan, you and your dependents will not have the vision benefits available through VSP.

Changing Benefit Elections

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

Marriage or Domestic Partnership

To enroll a new spouse or domestic partner and his or her eligible child(ren) in your HSS healthcare coverage you must submit a completed HSS Enrollment application and a copy of your marriage license or certificate of domestic partnership and birth certificates for the child(ren) to the Health Service System **within 30 days** from the date of your marriage or certification of domestic partnership. (HSS also requires a Social Security number for all enrolled members.) Coverage for your spouse or domestic partner and his or her eligible children is effective on the first day of the month following the submission of the required application and documentation within the 30 day time frame. If you do not complete the enrollment process **within 30 days** from the date of your marriage or certification of domestic partnership, you must wait until the next annual Open Enrollment period to add your new family members.

Domestic Partner Tax Alert: In keeping with IRS requirements, when you elect healthcare coverage for your domestic partner (and any dependent of your domestic partner), you will be taxed by the federal government on the value of the City and County of San Francisco's contribution toward the cost of healthcare coverage for these dependents. This is referred to as imputed income and may increase your net pay. The State of California does not tax these benefits.

Birth or Adoption

Coverage for your newborn child is effective on the child's date of birth provided you meet the deadline and documentation requirements stated below. Coverage for your newly adopted child is effective on the date the child is placed with you

provided you meet the deadline and documentation requirements stated below. To enroll your newborn or newly adopted child you must submit a completed HSS Enrollment application and a copy of the birth certificate or adoption documentation **within 30 days** from the date of birth or placement for adoption. If you do not complete the enrollment process **within 30 days** from the date of birth or placement for adoption of a new child, you must wait until the next annual Open Enrollment period. A Social Security number must be provided within 6 months of the date of birth or adoption, or your child's coverage may be terminated. Visit ssa.gov/pubs/10023.html for more information.

Loss of Other Healthcare Coverage

Employees and eligible dependents who lose other coverage may be enrolled by submitting a completed HSS Enrollment application and proof of the loss of coverage (for yourself and/or your dependents) **within 30 days** from the date other coverage terminates. Coverage for your dependent will be effective on the first day of the coverage period following the date HSS receives a completed HSS Enrollment application, provided you meet the 30 day deadline and eligibility documentation requirements. There may be a break in healthcare coverage between the date that other coverage terminates and the date that HSS coverage begins. If you do not complete the enrollment process **within 30 days** from the date that other coverage terminates, you must wait until the next annual Open Enrollment period to add your dependent.

Divorce, Separation and Dissolution of Partnership

Termination of HSS health coverage for your ex-spouse/domestic partner due to divorce, legal

separation or dissolution of domestic partnership is required by law. You must submit a completed HSS Enrollment application and a copy of your divorce decree, legal separation documents or dissolution of domestic partnership documents **within 30 days** from the date of divorce, legal separation or dissolution of domestic partnership. Coverage for your ex-spouse/domestic partner will terminate on the last day of the coverage period in which the divorce, legal separation or dissolution of domestic partnership occurred, provided you meet the deadline and documentation requirements stated above. If you do not complete the coverage termination process **within 30 days** from the date of your divorce, legal separation or dissolution, coverage for your ex-spouse/domestic partner will terminate on the last day of the coverage period in which you submit a completed HSS Enrollment application and required documentation. You will be responsible for paying all required premium contributions up to the coverage termination date. Failure to notify HSS of a divorce or dissolution of partnership may result in financial penalties equal to the total cost of premiums and services provided for the ineligible ex-partner or ex-spouse covered on your plan.

Obtaining Other Coverage

You may terminate healthcare coverage for yourself and/or your enrolled dependents if you or they become eligible for other healthcare coverage. Submit a completed HSS Enrollment application and proof of other healthcare coverage enrollment (for yourself and/or your dependents) **within 30 days** from the date of your enrollment in another healthcare plan. Your HSS healthcare coverage will terminate on the last day of the coverage period in which HSS receives a completed HSS Enrollment application provided you meet the deadline and documentation requirements stated above. Please note that there may be an overlap of healthcare coverage between the date your other coverage begins and the date your HSS coverage terminates. You are responsible for paying all required contributions up to the termination date

of your HSS healthcare coverage. If you do not complete the coverage termination process **within 30 days** from the date of your enrollment in another healthcare plan, you must wait until the next annual Open Enrollment.

Death of a Dependent

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

Death of a Member

In the event of a member's death, surviving dependent(s) or another designee should contact HSS **within 30 days** from the date of the member's death to obtain information about eligibility for survivor healthcare benefits.

Whenever you update your coverage because of a qualifying change in family status, carefully check your paycheck to verify that the correct employee premium contribution is being deducted. If the deduction is incorrect or doesn't appear on your paycheck, contact HSS Member Services at (415) 554-1750. If an employee premium contribution is not made within 45 days from the date it is due, coverage will be terminated and you will not be permitted to re-enroll until Open Enrollment in spring 2011, with coverage to begin July 1, 2011.

Ineligible Dependent Penalty

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

COBRA

COBRA is a Federal Law that provides for continuation of healthcare coverage when coverage is lost due to specific qualifying events.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted in 1986 offers employees and their covered dependents the opportunity to elect a temporary extension of healthcare coverage in certain instances where coverage would otherwise end.

COBRA Qualifying Events

Employees have the right to elect continuation of coverage if healthcare coverage is lost due to any of the following qualifying events:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct.
- Reduction in number of hours of employment that makes the employee ineligible for healthcare coverage.

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

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

Covered dependent children have the right to elect continuation coverage if healthcare coverage is lost due to any of the following qualifying events:

- Loss of dependent child status under the plan rules.

- Voluntary or involuntary termination of the employee's employment for reasons other than gross misconduct.
- Reduction in number of hours of employment that makes the employee ineligible for healthcare coverage.
- Parent's divorce, legal separation or dissolution of domestic partnership from the covered employee.
- Death of the covered employee.

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

COBRA Notification & Time Limits for COBRA Elections

When a qualifying event occurs, the COBRA Administrator FBMC will notify you of the opportunity to elect COBRA coverage. You have 60 days from the date of this notification to complete enrollment for yourself and any dependents who were covered on your employer-provided plan at the time of your termination. The coverage will be retroactive to the date of the COBRA qualifying event so you will not have a break in your healthcare coverage. While covered under COBRA, you have 30 days from the date of the qualifying event to add any newly eligible dependent (spouse, domestic partner, newborn or adopted child) to your COBRA coverage.

Duration of COBRA Continuation Coverage

COBRA beneficiaries are generally eligible for group coverage for a maximum of 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to be covered for up to 36 months.

In the case of a dependent losing coverage (divorce or aging out of a plan) the employee or dependent must notify the COBRA Administrator within 30 days of the qualifying event.

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

Termination of COBRA Continuation Coverage

COBRA coverage will end if:

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

Paying for COBRA

Once COBRA continuation coverage is elected, it is the responsibility of the covered individual(s) to remit the required healthcare premium payments directly to the COBRA Administrator.

COBRA Continuation Coverage Alternatives

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

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

Recent Federal Legislation & COBRA

This information does not reflect all the changes to COBRA resulting from the 2009 federal American Recovery and Reinvestment Act and subsequent federal legislation that temporarily expands and/or subsidizes COBRA coverage for some participants. For more information about how federal legislation may impact your COBRA benefits contact FBMC.

Continuing Dental Coverage

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

Frequently Asked Questions

What should I do if my healthcare contribution is incorrect or isn't being deducted from my paycheck?

When you select your initial healthcare coverage or change your coverage during the annual Open Enrollment period or because of a qualifying change in family status, you should carefully check your paycheck stub to verify that the correct healthcare contribution is being deducted.

If the deduction is incorrect or doesn't appear on your paycheck stub, you should contact the San Francisco Unified School District Benefits Office at (415) 241-6101 for assistance. You are responsible for all required healthcare contributions, whether they are deducted from your paycheck or not.

Who should I contact if I need an insurance ID card or if I have a question about my coverage?

Contact the plan directly. Refer to Key Contact Information on page 32 of this guide for benefit plan telephone numbers and website addresses. You may also obtain a copy of your plan's Evidence of Coverage from the HSS website: www.myhss.org.

What happens if I move outside the service area covered by my medical plan?

If you move out of the service area covered by your plan, you must elect healthcare coverage under an option that provides coverage in your area. Failure to change your healthcare elections will result in the non-payment of claims for services received. Contact HSS Member Services at (415) 554-1750.

Is healthcare coverage available for dependents that no longer meet the eligibility requirements for coverage under my plan?

Dependents who no longer meet the eligibility requirements for participation may be eligible to continue healthcare coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). See the COBRA section of this Benefit Guide (pages 22-23) for more information.

In the event of my death, what happens to the coverage of my dependents?

Generally, surviving dependents of an employee may continue healthcare coverage after the death of the employee. Upon your death, covered dependents should contact HSS Member Services for information on available healthcare coverage options.

What happens to my coverage when I retire?

Employees who retire from SFUSD may be eligible to continue healthcare coverage at the rates then in effect for retired employees. Contact the SFUSD Benefits Office at (415) 241-6101 to verify your eligibility for retiree healthcare benefits.

What if my healthcare provider chooses not to participate in my plan's network?

The healthcare plans administered by HSS do not guarantee the continued network participation of any particular doctor, hospital, medical group or other provider during the Plan Year.

After the annual Open Enrollment deadline, you will not be allowed to change your healthcare elections because your provider and/or your medical group chooses not to participate in a particular medical plan. You'll be assigned or will be required to select another provider.

When do I lose coverage if I leave employment with the District?

Contact HSS Member Services at (415) 554-1750 to confirm the date coverage will end. In general, when you leave SFUSD employment, your coverage and your dependents' coverage will continue through the end of the pay period (if you are paid on a bi-weekly basis) or end of the month (if you are paid on a monthly basis) in which your termination date occurs. You may be eligible to continue your healthcare coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). See pages 22-23 of this guide for more information about COBRA.

Can I continue (or discontinue) HSS healthcare coverage if I go on an approved Leave of Absence?

To ensure continued healthcare coverage, you must contact HSS about your individual situation before starting your leave. Stay informed—failure to abide by HSS requirements could result in the loss of healthcare coverage for you and your dependents while you are on an approved leave.

If you are continuing health coverage while on leave, you must make contribution payments directly to HSS during your leave. To make this easy, sign-up for the secure HSS Auto-Pay program. With Auto-Pay your monthly healthcare contribution is charged automatically to your VISA or Mastercard while you are on leave, ensuring that your benefits will not be at risk of termination due to non-payment. You can download the authorization form for HSS Auto-Pay at myhss.org. Or call HSS Member Services at (415) 554-1750 for more information.

If you wish to waive your healthcare coverage during an approved leave of absence, you must notify HSS in writing prior to the start of your leave. You must also notify HSS within 30 days before returning to active employment to request that your healthcare contributions be returned to active status.

What if I don't pay the required healthcare contributions while I'm on an unpaid leave?

If you don't pay the required healthcare contributions directly to HSS while you are on an unpaid leave of absence, your healthcare coverage, including enrolled dependents, will be terminated. Once coverage is terminated for non-payment of required healthcare contributions, you will not be eligible to reinstate your coverage until:

- You return to work and request a reinstatement of healthcare coverage from the SFUSD Benefits Office within 30 days of your return to work.

OR

- You submit a completed HSS Enrollment application during the next available Open Enrollment period for coverage to be effective the following plan year.

More Questions?

The information in this FAQ is general in nature and is not intended to be a complete source of information for HSS members. Please contact HSS or SFUSD Benefits for assistance with your particular situation.

Glossary of Healthcare Terms

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.

Co-Insurance

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

Co-payment

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

Deductible

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

Dependent

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

Dental Maintenance Organization (DMO)

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

Effective Date

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

Employee Premium Contribution

The amount you must pay toward the cost of your health plan premiums.

Employer Premium Contribution

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

Explanation of Benefits (EOB)

Written, formal statement sent to PPO enrollees that lists the services provided and costs billed by their health plan.

Evidence of Coverage (EOC)

The Evidence of Coverage gives details about the benefits and exclusions of your health plan and explains how to get the care you need. The EOC is an important legal document and is your contract with your Plan provider. It explains your rights, benefits and responsibilities as a member of your Plan. It also explains the Plan Providers responsibilities to you. The EOC should be reviewed in conjunction with this benefits guide because the guide does not list every service, limitation or exclusion of your plan. EOCs are available on myhss.org.

Exclusions

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

Formulary

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

Flexible Spending Account (FSA)

An account that you contribute to pre-tax and reimburses you for qualified healthcare and dependent care expenses.

Generic Drug

FDA approved prescription drugs that are a therapeutic equivalent to the Brand Name Drug, contain the same active ingredient as the Brand Name Drug, and cost less than the Brand Name Drug equivalent.

Health Maintenance Organization (HMO)

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

Imputed Income

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

In-Network

These providers or facilities are contracted with a health plan to provide services at pre-negotiated fees. Enrollees usually pay less when using an in-network provider, because these networks provide services at lower cost to the insurance companies with which they have contracts.

Medical Group

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

Lifetime Maximum Benefit

The maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime.

Non-Formulary Drug

A drug that is not on the insurer's list of approved medications. Non-formulary drugs can usually only be prescribed if a doctor's special request is submitted and approved.

Open Enrollment

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

Out-of-Network

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

Out-of-Pocket Costs

The actual costs you pay—including premiums, co-payments and deductibles—for your healthcare.

Out-Of-Pocket Maximum

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

Out-of-Area

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

Preferred Provider Organization (PPO)

An entity that contracts to provide healthcare services to subscribers at negotiated, often discounted, rates.

Premium

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

Primary Care Physician (PCP)

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

Qualifying Event

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

Reasonable and Customary Charges

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

Privacy Policy

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

Use and Disclosure of Health Information

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

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

To Make or Obtain Payment

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

To Conduct Healthcare Operations

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

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

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

For Treatment Alternatives

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

For Distribution of Health-Related Benefits and Services

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

For Disclosure to the Plan Actuaries

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

When Legally Required

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

To Conduct Health Oversight Activities

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

In Connection With Judicial and Administrative Proceedings

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

For Law Enforcement Purposes

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

In the Event of a Serious Threat to Health or Safety

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

Open Enrollment

For Specified Government Functions

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

For Worker's Compensation

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

Authorization To Use Or Disclose Health Information

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

Your Rights With Respect to Your Health Information

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

Right to Request Restrictions

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

Right to Receive Confidential Communications

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

Right to Inspect and Copy Your Health Information

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

Right to Amend Your Health Information

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

Right to an Accounting

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

Right to a Paper Copy of this Notice

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

Duties of the Health Plan

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

Written Authorizations & Requests

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

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

Effective Date

Original Effective Date: April 14, 2003
Revised January 1, 2010

Medical Plan Rates

EMPLOYEE ONLY

	BLUE SHIELD HMO		KAISER HMO		CITY PLAN PPO	
	SFUSD Pays	Employee Pays	SFUSD Pays	Employee Pays	SFUSD Pays	Employee Pays
BIWEEKLY						
Craft Unions Local 4, 6, 22, 38, 39, 40, 66, 104, 261, 377, 718, 853, 1414	218.24	55.79	218.24	4.08	218.24	209.45
Board Designated Confidential or Unrepresented and SEIU Local 1021	218.24	55.79	218.24	4.08	248.33	179.36
Board Designated Managerial	218.24	55.79	218.24	4.08	218.24	209.45
IFPTE Local 21	218.24	55.79	218.24	4.08	218.24	209.45
UESF Paraprofessionals	218.24	55.79	218.24	4.08	218.24	209.45
MONTHLY						
UASF, Cabinet, BOE	472.85	120.88	472.85	8.84	472.85	453.81
UESF Certified	472.85	120.88	472.85	8.84	472.85	453.81

EMPLOYEE PLUS 1 DEPENDENT

	BLUE SHIELD HMO		KAISER HMO		CITY PLAN PPO	
	SFUSD Pays	Employee Pays	SFUSD Pays	Employee Pays	SFUSD Pays	Employee Pays
BIWEEKLY						
Craft Unions Local 4, 6, 22, 38, 39, 40, 66, 104, 261, 377, 718, 853, 1414	491.81	55.79	440.08	4.08	522.72	313.59
Board Designated Confidential or Unrepresented and SEIU Local 1021	491.81	55.79	440.08	4.08	509.88	326.43
Board Designated Managerial	322.08	225.52	322.08	122.08	322.08	514.23
IFPTE Local 21	322.08	225.52	322.08	122.08	322.08	514.23
UESF Paraprofessionals	315.16	232.44	315.16	129.00	315.16	521.15
MONTHLY						
UASF, Cabinet, BOE	682.85	503.61	682.85	279.49	682.85	1,129.15
UESF Certified	682.85	503.61	682.85	279.49	682.85	1,129.15

Medical Plan Rates

EMPLOYEE PLUS 2 OR MORE DEPENDENTS

	BLUE SHIELD HMO		KAISER HMO		CITY PLAN PPO	
	SFUSD Pays	Employee Pays	SFUSD Pays	Employee Pays	SFUSD Pays	Employee Pays
BIWEEKLY						
Craft Unions Local 4, 6, 22, 38, 39, 40, 66, 104, 261, 377, 718, 853, 1414	522.72	251.93	522.72	105.57	522.72	650.86
Board Designated Confidential or Unrepresented and SEIU Local 1021	509.88	264.77	509.88	118.41	509.88	663.70
Board Designated Managerial	333.62	441.03	333.62	294.67	333.62	839.96
IFPTE Local 21	333.62	441.03	333.62	294.67	333.62	839.96
UESF Paraprofessionals	338.24	436.41	338.24	290.05	338.24	835.34
MONTHLY						
UASF, Cabinet, BOE	732.85	945.55	732.85	628.44	732.85	1,809.91
UESF Certified	732.85	945.55	732.85	628.44	732.85	1,809.91

All medical plan rates published in this Benefits Guide are subject to the final approval of the San Francisco Board of Supervisors.

Key Contact Information

SAN FRANCISCO UNIFIED SCHOOL DISTRICT

Benefits Office

555 Franklin Street, 2nd Floor
San Francisco, CA 94102
Tel: (415) 241-6101 x 3243, x3208, x3250
Fax: (415) 241-6375
www.sfusd.edu

DENTAL PLAN

Delta Dental Premier Plan

PO Box 7736
San Francisco, CA 94120
Tel: (888) 335-8227
Group No. 652-0001 (monthly employees)
Group No. 652-0002 (biweekly employees)
Email: cms@delta.org
www.deltadentalins.com

GROUP LIFE AND LONG-TERM DISABILITY INSURANCE

The Standard Insurance

PO Box 2800
Portland, OR 97208-2800

Group Life/AD&D

Tel: (800) 628-8600

Long Term Disability

Tel: (800) 368-1135

FLEXIBLE SPENDING ACCOUNTS

American Family Life Assurance Company

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

Eligible SFUSD employees receive dental, group life and long-term disability benefits through SFUSD. Flexible spending accounts and short-term disability insurance enrollments are processed by SFUSD. For assistance with these benefit programs please contact the SFUSD Benefits Office.

HEALTH SERVICE SYSTEM

Member Services

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

MEDICAL PLANS

City Health Plan (UnitedHealthcare)

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

Blue Shield of California

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

Kaiser Permanente

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

VISION PLAN

Vision Service Plan (VSP)

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

COBRA

Fringe Benefits Management Company (FBMC)

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