

HEALTH SERVICE SYSTEM MEMBERSHIP RULES AND REGULATIONS

PART II – MEMBERSHIP AND COVERAGE

A. EMPLOYEES

1. Member

In accordance with Section 16.700, Participation of the San Francisco Administrative Code, Chapter 16 Officers and Employees Generally, Article XV Health Service System, the following shall be eligible to participate in the Health Service System:

- a. City and County employees
 - 1. All permanent employees of the City and County of San Francisco whose normal work week at the time of inclusion in the system is not less than twenty (20) hours;
 - 2. All regularly scheduled provisional employees of the City and County of San Francisco whose normal work week at the time of inclusion in the system is not less than twenty (20) hours;
 - 3. All other employees of the City and County of San Francisco, including “as needed” employees who have worked one thousand and forty hours (1,040) in any consecutive twelve (12) month period and whose normal work week at the time of inclusion in the system is not less than twenty (20) hours.

b. Elected officials. All elected officials of the City, including but not limited to members of the Board of Supervisors, the Mayor, the Assessor-Recorder, the City Attorney, District Attorney, Public Defender, Sheriff and Treasurer.

c. All members of the following boards and commissions during their time in service to the City and County of San Francisco:

- 1. Access Appeals Commission
- 2. Airport Commission
- 3. Art Commission
- 4. Asian Art Commission
- 5. Board of Education
- 6. Board of Appeals
- 7. Building Inspection Commission
- 8. Civil Service Commission
- 9. Commission on the Aging
- 10. Commission on the Environment
- 11. Commission on the Status of Women
- 12. Community College District Governing Board
- 13. Concourse Authority
- 14. [Elections Commission](#)

- 15. Ethics Commission
- 16. [Entertainment Commission](#)
- 17. Fine Arts Museums Board of Trustees
- 18. Fire Commission
- 19. Film and Video Arts Commission
- 20. [First Five Commission](#)
- 21. Health Commission
- 22. Health Service Board
- 23. [Historic Preservation Commission](#)
- 24. Human Rights Commission
- 25. Human Services Commission
- 26. Juvenile Probation Commission
- 27. [Law Library Board of Trustees](#)
- 28. Library Commission
- 29. Municipal Transportation Authority
Parking and Traffic Commission (until such time as Section 4.116
Of the Charter is repealed)
- ~~(25)~~30. Planning Commission
- ~~(26)~~31. Police Commission
- ~~(27)~~32. Port Commission
- ~~(28)~~33. Public Utilities Commission
- ~~(29)~~34. Recreation and Parks Commission
- ~~(30)~~35. Residential Rent Stabilization and Arbitration Board
- ~~(31)~~36. Retirement Board
- ~~(32)~~37. Small Business Commission
- ~~(33)~~38. [Sunshine Ordinance Task Force](#)
- ~~(34)~~39. War Memorial and Performing Arts Center Board
- 40. [Youth Commission](#)

d. All officers and employees as determined eligible by the Governing Board of [Education of](#) the San Francisco Unified School District.

e. All officers and employees as determined eligible by the Governing Board of the San Francisco Community College District.

f. All officers and employees as determined eligible by the governing bodies of the San Francisco [County](#) Transportation Authority, San Francisco Parking Authority, San Francisco Redevelopment Agency, [Treasure Island Development Authority](#) San Francisco Superior Court and any other employees as determined eligible by ordinance.

g. All retirees, surviving spouses, surviving domestic partners and resigned employees. For the purposes of this Chapter, resigned employees shall have the same meaning as used in Section A8.425 of the Charter.

h. All dependents of the foregoing categories as they are determined eligible by the appropriate governing body and as defined in Part II, Section B, Subsection 1-Dependents Eligibility.

i. Members shall also include former elective members of the legislative body who have served in office after January 1, 1981 and whose total service at the time of termination of service on such legislative body is not less than twelve (12) years when the respective legislative body provides for the continuation of health benefits as authorized by Government Code Section 53201. (moved from Section 5-c – Continuation of Coverage After Retirement).

2. Choice of Benefit Plans

a. Members shall have a free choice of benefit plans provided by the System. A member may participate in only one health, dental or disability plan as the subscriber.

b. Members who may also be eligible to participate as a dependent of another member may not be enrolled in any one benefit plan more than once. He or she may be enrolled in two different benefit plans.

3. Coverage Periods

a. **Coverage Effective Date.** Coverage shall be effective as set forth below:

(i) Eligible Permanent, Provisional and Temporary Exempt Employees of the City and County of San Francisco and Other Designated Employers.

Eligibility Event Date	Coverage Effective Date
1 st thru 31st 15 th	16th 1 st of the following month
16th thru 31st	1 st of the following month

(ii) Eligible Commissioners of the City and County of San Francisco

Eligibility Event Date	Coverage Effective Date
1 st thru 31 st	1 st of the following month

(iii) Eligible Employees of the San Francisco Community College District

Eligibility Event Date	Coverage Effective Date
1 st thru 15 th	16 th
16 th thru 31 st	1 st of the following month

(iv) Eligible Employees of the San Francisco Unified School District

a. Monthly

Eligibility Event Date	Coverage Effective Date
1 st thru 31 st	1 st of the following month

b. Bi-Weekly

Coverage Effective Date
First day of the pay period following the Eligibility Event Date

b. **Coverage Termination Date.** Coverage shall terminate as set forth below:

(i) Eligible Permanent, Provisional and Temporary Exempt Employees of the City and County of San Francisco and Other Designated Employers

Eligibility Event Date	Coverage Termination Date
1 st thru 31st 15 th	15th Last day of the month
16 th thru 31 st	Last day of the month

(ii) Eligible Commissioners of the City and County of San Francisco

Eligibility Event Date	Coverage Termination Date
1 st thru 31 st	Last day of the month

(iii) Eligible Employees of the San Francisco Community College District

Eligibility Event Date	Coverage Termination Date
1 st thru 15 th	15 th
16 th thru 31 st	Last day of the month

(iv) Eligible Employees of the San Francisco Unified School District

a. Monthly

Eligibility Event Date	Coverage Termination Date
1 st thru 31 st	Last day of the month

b. Bi-Weekly

Coverage Termination Date
Last day of the pay period that includes the Eligibility Event Date

c. Continuation Coverage

The Health Service System shall provide continuing coverage to applicable members and dependents pursuant to the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”) laws, rules and regulations.

4. Open Enrollment Period

a. The Health Service System shall conduct an annual open enrollment that shall be for a period of three to four weeks as approved by the Health Service Board.

b. A member may make all changes that are not otherwise provided in these Rules including changes in benefit plans, and the addition or cancellation of dependents during this open enrollment period. Retirees may cancel dependents at any time.

c. All changes made during the annual open enrollment period shall be effective on the following July 1st.

5. Continuation of Coverage after Retirement

a. Definition of “Retiree” As used in these Rules, the term “Retiree” shall mean each of the following:

A member who retires for service, disability or vesting may continue coverage by the Health Service System at the rate established for retired employees, provided he or she applies for continuation within thirty days after such retirement is approved by his or her Retirement System and provided he or she has been enrolled in a health plan through the Health Service System for some period during his or her term of employment with the City, School District or Community College District. Thereafter, application for enrollment may be made only during the annual open enrollment period each year with coverage to become effective July 1.

An individual who would qualify for coverage under a. but for the fact that he or she has never been enrolled in a health plan through the Health Service System for some period during his or her term of employment with the City, School District or Community College District may enroll in a health plan as described in a, except that he or she shall pay a rate consisting of (i) the rate established for retired employees, plus (ii) that which the City, School District, or Community College would have contributed to the Health Service System on account of his or her membership had he or she been covered by a.1. An individual so situated may also participate at his or her own cost (the resigned rate) in any other benefits of the Health Service System that are made available to retired employees.

b. A member who resigned and withdrew his or her funds from a Retirement System within thirty days immediately prior to the date on which, but for his resignation, he could have been retired for service as a member of a Retirement System, may continue coverage by the

Health Service System at the rate established for resigned employees under the provisions of Charter Section A8.425. A resigned member would also include older teachers who took all of their money out of the San Francisco Retirement System (SFRS) to join the State Teachers Retirement System (STRS). Such resigned members must apply for continuation of coverage within thirty days after such resignation.

Such resigned members must make arrangements to pay contributions monthly in advance to the Health Service System by direct payment.

c. Coverage of a resigned member must be continuous and if lapsed may not be reinstated without Board approval.

d. If sufficient funds are available, all contributions to the System must be paid through the retiree's pension check.

e. A retiree who returns to work for the City and County of San Francisco, the San Francisco Unified School District or the Community College District must continue retiree coverage and continue to pay to the Health Service System the rate of contribution established for retirees.

6. Medicare

a. All members and/or their dependents who attain age 65 and who qualify for eligibility in the Part A (HOSPITAL) portion of Medicare on a noncontributory basis (Premium Free) must enroll.

All retired members and/or their dependents must enroll in the Part B (MEDICAL) portion of Medicare, if eligible.

All active employees and/or their dependents over the age of 65 must enroll in the Part B (MEDICAL) portion of Medicare upon retirement if eligible.

b. All retired members and/or their dependents who qualify for early Social Security, and thereby become eligible for the Medicare Part A and B portions, must enroll. It is the responsibility of the member to notify the Health Service System of Medicare eligibility.

c. Failure of an eligible member or dependent to enroll in the Part A of Medicare, if eligible on a non-contributory basis, will result in the member and his/her dependents being transferred to the City Health Plan. Claims will be processed at a lower benefit level. Failure of an eligible member or dependent to enroll in the Part B of Medicare will result in the member and his/her dependents being transferred to the City Health Plan. Claims will be processed at a lower benefit level.

d. Members and dependents in Medicare, regardless of Health Plan, who anticipate being out of the United States for six (6) months or more, will be allowed to enroll in the City Health Plan.

Applications must be made thirty (30) days in advance of leaving the United States. Members who establish permanent residency outside the United States may retain this coverage indefinitely.

e. All retired members and dependents with Medicare Part A and B who are enrolled in health maintenance organizations which have a ~~Medicare Plus Choice~~ [Medicare Advantage](#) contract with the Health Service System must participate in the ~~Medicare Plus Choice~~ [Medicare Advantage](#) program of their selected health plan with the exception of members with Medicare Part A and Part B who live outside the ~~Medicare Plus Choice~~ [Medicare Advantage](#) service area of their health plan. Active employees and/or their dependents may voluntarily participate in the ~~Medicare Plus Choice~~ [Medicare Advantage](#) program of their health plan.

Retirees who fail to enroll in a ~~Medicare Plus Choice~~ [Medicare Advantage](#) program will no longer be allowed to remain in the health maintenance organization and will be required to enroll in the City Health Plan.

7. Employees on Authorized Leave Without Pay

Eligibility for membership in the Health Service System continues for the duration of all approved leaves. However, immediately upon going on unpaid status, the employee is responsible for making any payments that would otherwise have been deducted from his/her pay. At the time that the City subsidy ends, then the employee is responsible for paying the entire cost of the health coverage. This includes both health and dental. The employee has the choice of continuing health and dental, only health, only dental, or not at all.

Educational Leave and Personal Leave

Membership in the Health Service System continues for the duration of the leave that has been approved. For the first twelve (12) weeks, the City subsidy continues and the member is only responsible for premium amounts previously deducted from his/her pay check. If the approved leave continues beyond twelve (12) weeks, and City subsidy is discontinued, the member is responsible for the entire premium amount.

Leave for Employment as an Employee Organization Officer or Representative

Membership in the Health Service System continues for the duration of the leave that has been approved. For the first twelve (12) weeks, the City subsidy continues and the member is only responsible for premium amounts previously deducted from his/her pay check. If the approved leave continues beyond twelve (12) weeks, and City subsidy is discontinued, the member is responsible for the entire premium amount.

In certain cases, the union which the member is serving will pay the cost of the member's health and/or dental insurance. It is still the member's responsibility to make sure this premium is paid. The Health Service System will not seek payment from the member's union.

Family Care Leave

While a member is on Family Care Leave, the Health Service System coverage continues as long as the member continues to pay any premium portion that was deducted from his/her paycheck. The City subsidy continues for the duration of the Family Care Leave.

Personal Leave Following Family Care Leave

If a member has been on Family Care Leave and continues his/her leave by personal leave for the same reason and has maintained his/her health coverage, then the City subsidy continues for the duration of the leave.

B. DEPENDENTS

Dependents of a member shall be eligible for coverage subject to the following conditions and limitations:

1. Eligibility

a. A member's legal spouse or domestic partner. A member's legal spouse shall be eligible as a dependent of the member provided that the member file a copy of their marriage certificate with HSS. If the member's spouse is granted a final dissolution of marriage or is legally separated, the non-employee spouse shall not be eligible as a dependent. A domestic partner of a member shall be eligible as a dependent of a member if the member and the non-employee domestic partner file an HSS Declaration of Domestic Partnership (the "HSS Declaration") declaring under penalty of perjury that the following conditions are true and correct to the best of the parties knowledge:

1. A true and correct copy of the parties Declaration of Domestic Partnership (the "Declaration") is filed with HSS, that it has been processed in accordance with Section 62.3 of the San Francisco Administrative Code and that it is in full force and effect.

2. The parties agree that they are both economically responsible to third parties for the common necessities of life, defined as food, shelter and medical care, and this shall remain the case for expenses incurred during the period the non-employee domestic partner is covered by HSS. The parties also must acknowledge that the responsibility may be greater to HSS than that undertaken in the domestic partner registration.

3. The parties agree to immediately notify HSS in writing if there is any change of circumstances attested to in the domestic partner registration.

4. The parties understand that under applicable federal and state income tax law, payments for health coverage of the domestic partner may not be eligible for pre-tax treatment under the City's Section 125 Plan and that coverage of the non-employee domestic partner could result in additional imputed income to the employee, with possible withholding for payroll taxes (including income and social security taxes) on such amounts.

Domestic partner status shall be established by completing the above referenced HSS Declaration executed by both the member and the non-employee domestic partner.

b. Children from birth to twenty-five (25) years of age who meet all of the following conditions:

1. Dependent is not married
2. Dependent does not work full time
3. Dependent continues to reside in the home, with the exception of a full-time student attending an accredited college or university, trade or secondary school
4. Dependent is eligible to be declared as a dependent child on member's or the member's enrolled domestic partner's income tax return.

c. For the purpose of (b) above, children shall include:

1. Natural child of the member
2. A step-child so long as member is married to natural parent
3. A legally adopted child
4. Child under legal guardianship
5. A natural or legally adopted child of an enrolled domestic partner of an employee or a child under legal guardianship of an enrolled domestic partner.

For purposes of the requirements of (b)(4) and (c)(3), the child's eligibility to be declared as a dependent on the domestic partner's federal income tax return shall be sufficient.

d. A child living with the member in a parent-child relationship and economically dependent upon the member, age 18 or under, who has never been married is also an eligible dependent provided the member declares the dependent as an exemption on his or her income tax. A notarized copy of the subscriber's 1040 Tax Form or a notarized statement of fact, indicating that the child is claimed as a dependent, must be submitted each year the child remains on the plan. Failure to do so will result in the termination of said child from group coverage under the Health Service System. Any medical services provided or benefits paid on behalf of said child after the termination date are subject to collection by the benefit plan involved.

e. A child who is over the age of 19; unmarried; incapable of self-sustaining employment due to physical handicap or mental retardation; the disability must have occurred prior to the child's attainment of age 25; permanently resides with the employee/retiree member; dependent on the member for substantially all of his economic support; and who is a dependent in a health plan of the Health Service System on a continuous basis and was enrolled prior to the child's nineteenth birthday may be continued as a dependent in this Health Service System, as long as the child remains so incapacitated. Eligibility may continue by the filing of acceptable medical evidence with the Health Service System at least sixty (60) days prior to the attainment of age twenty-five (25) and annually thereafter. The medical evidence submitted must contain the following information certified by a physician:

- the name of the child
- the nature of the disability

- the onset date of the disability
- the probable future course and duration of the disability
- a statement that the disability renders the child incapable of self support

Dependents in this status added after age nineteen (19) may continue coverage up to the age of twenty-five (25) years if they meet all other dependent eligibility conditions.

A newly hired employee who adds an eligible dependent child in this status who is over the age of nineteen (19) shall not be subject to the continuous coverage provisions of this subsection.

f. No child of a member may remain or be enrolled in the Health Service System past the maximum age of twenty-five (25) except a child provided for in subsection e above. Coverage past the age of twenty-five must be continuous.

g. In the event the member has been granted a final dissolution of marriage, or is legally separated, coverage for his dependent children shall continue as long as they are otherwise eligible.

h. The Health Service System and any health plan may require proof of dependent eligibility at any time. Failure to furnish such proof within thirty (30) days after request by the Health Service System shall result in termination of membership and re-enrollment may thereafter occur during any annual open enrollment period with coverage effective July 1st with proof of eligibility.

i. It is the responsibility of the member to notify the Health Service System in writing to cancel coverage for any dependent who no longer meets the conditions of eligibility. There shall be no obligation on the part of the Health Service System to provide health coverage or a refund of contributions made on account of an ineligible dependent.

2. Enrollment

a. Coverage Effective Date. Coverage shall be effective as set forth below:

(i) Eligible Dependents at the time of member’s initial enrollment.

<u>Eligibility Event Date</u>	<u>Coverage Effective Date</u>
<u>At the time of member’s original enrollment</u>	<u>Same day as member.</u>

Coverage for a dependent who is hospital confined shall be added effective on the date he is no longer hospital confined.

(ii.) Eligible spouses or domestic partners and such other eligible dependents acquired by such marriage or domestic partnerships.

<u>Eligibility Event Date</u>	<u>Coverage Effective Date</u>
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<u>Within 30 days after the date of marriage or domestic partnership</u>	<u>1st of the following month</u>
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Coverage for eligible dependents who are hospital confined shall be added effective the date they are no longer hospital confined. Documentation will be required.

(iii). Eligible newborns and adopted children.

<u>Eligibility Event Date</u>	<u>Coverage Effective Date</u>
<u>Within 30 days after birth or commencement of legal custody.</u>	<u>As of the date of birth or commencement of legal custody.</u>

Documentation of birth or adoption will be required. Enrollment shall be made by application to the Health Service System.

Notwithstanding the foregoing, after the expiration of the application period of thirty (30) days set forth above in this subsection (c), the ~~Deputy~~ Director of Human Resources Department of the Health Service System may permit the enrollment of a newborn child or a newly adopted child into a medical benefit plan offered by the Health Service System as follows:

(i) Upon satisfaction of each of the following conditions: (A) the Director has found that the member has acted in good faith and not in willful violation of the rules contained in this subsection (c); (B) the child’s membership will be effective on the date of birth or the date of commencement of legal custody, as the case may be; (C) the Director has found that under the terms of the contract between the Health Service System and the medical benefit plan in question (each, a “Medical Benefit Contract”), the child may be added as of such effective date without any adverse financial or other impact to the Health Service System; (D) the Health Service System has received full payment of all premiums (both employer-paid and member-paid portions) required in order to enroll the child for the period from such effective date through the end of the current calendar month. Newborns must be enrolled within six (6) months of the date of birth in order to comply with agreements established with the health plans.

(iv). Eligible dependent children whom the member has assumed legal custody of:

<u>Eligibility Event Date</u>	<u>Coverage Effective Date</u>
<u>Within 30 days of commencement of legal custody</u>	<u>1st day of the month following Health Service System’s receipt of completed application</u>

Documentation will be required.

(v). Other eligible dependents who have entered the United States or have moved into the service area of the member's benefit plan:

<u>Eligibility Event Date</u>	<u>Coverage Effective Date</u>
<u>Within 30 days of the occurrence</u>	<u>1st day of the month following Health Service System's receipt of completed application.</u>

Documentation will be required. Without documentation, the effective date is the 1st day of the month after 30 days from the date a completed application is filed with the Health Service System.

(vi). Eligible dependents who lose group health insurance coverage through job displacement, may apply for coverage through Health Service System. Approval or rejection are subject to the discretion of the Health Service System.

<u>Eligibility Event Date</u>	<u>Coverage Effective Date</u>
<u>Within 30 days of the last date of group coverage under another employer.</u>	<u>1st day of the month following Health Service System's receipt of completed application.</u>

Eligible dependents must provide a letter from the former employer or health carrier stating the reason for lost coverage and the last date of coverage. The approval or rejection of the application and the effective date of any coverage are subject to the discretion of the Health Service System and the Benefit Plan for which application is made.

(vii.) Dependents not enrolled by the member at the time of his or her enrollment or within the applicable periods of eligibility as described in this Section B2 (Enrollment) may thereafter be enrolled only during the annual open enrollment period each year with coverage to be effective July 1. Documentation of eligibility will be required.

(viii.) Eligible dependents must be enrolled in the same benefit plan as the member. Effective July 1, 2006, a child who may be eligible as a dependent of more than one member may be enrolled in only one health plan.

~~a. — A member may enroll his eligible dependents at the time of original enrollment. Coverage for eligible dependents becomes effective on the same day as for the member, provided, however, that a dependent who is hospital confined shall be eligible on the date he is no longer hospital confined.~~

~~b. — An employee or retired member who marries or enters into a domestic partnership after becoming a member may enroll his or her spouse or domestic partner and such other eligible dependents acquired by such marriage or domestic partnership. Documentation will be required. Enrollment is to be made within thirty (30) days after the date of marriage or domestic partnership and coverage for eligible dependents so enrolled shall become effective as of the date~~

~~of such marriage or domestic partnership, provided such dependents who are hospital confined shall be added effective the date they are no longer hospital confined.~~

~~c. — A member's newborn child must be enrolled in the System in order for said child to have coverage, provided such enrollment is made within thirty (30) days after birth. Such enrollment shall be made by application to the Health Service System and shall be effective from the date of birth. Documentation of birth will be required.~~

~~— A member's adopted child may be enrolled in the Health Service System, provided such enrollment is made within thirty (30) days of commencement of legal custody. Such enrollment shall be made by application to the Health Service System and shall be effective from the date on which such legal custody commenced. Documentation of adoption will be required.~~

~~— Notwithstanding the foregoing, after the expiration of the applicable period of thirty (30) days set forth above in this subsection (c), the Deputy Director of Human Resources for the Health Service System may permit the enrollment of a newborn child or a newly adopted child into a medical benefit plan offered by the Health Service System as follows:~~

~~(i) — Upon satisfaction of each of the following conditions: (A) the Deputy Directory has found that the member has acted in good faith and not in willful violation of the rules contained in this subsection (c); (B) the child's membership will be effective on the date of birth or the date of commencement of legal custody, as the case may be; (C) the Deputy Director has found that under the terms of the contract between the Health Service System and the medical benefit plan in question (each, a "Medical Benefit Contract"), the child may be added as of such effective date without any adverse financial or other impact to the Health Service System; (D) the Health Service System has received full payment of all premiums (both employer paid and member-paid portions) required in order to enroll the child for the period from such effective date through the end of the current calendar month. Newborns must be enrolled within six (6) months of the date of birth in order to comply with agreements established with the health plans.~~

~~d. — An eligible dependent child whom the member has assumed legal custody of may be enrolled in the Health Service System provided such enrollment is made within thirty (30) days of commencement of legal custody. Such enrollment shall be made by application to the Health Service System and shall be effective the first day of the pay period after thirty (30) days from the date a completed application is filed with the Health Service System.~~

~~e. — Other eligible dependents who have either entered the United States or have moved into the service area of the member's benefit plan may be enrolled in the Health Service System provided such enrollment is made within thirty (30) days of occurrence. Documentation will be required. If documentation is provided, coverage will be effective on the first day of the pay period following the application date; otherwise coverage will be effective on the first day of the pay period after thirty (30) days from the date a completed application is filed with the Health Service System.~~

~~f. — Eligible dependents who lose group health insurance coverage through job displacement may apply for coverage through the Health Service System within thirty (30) days or earlier of the last date of group coverage under another employer. Such application for coverage requires: 1) a letter from the former employer or health carrier stating the reason for lost coverage and the last date of coverage. The approval or rejection of the application and the effective date of any coverage are subject to the discretion of the Health Service System and the Benefit Plan for which application is made.~~

~~g. — A child who gains eligibility by becoming a full time student at other than the Open Enrollment and who fulfills all other dependent eligibility criteria may be enrolled if application is made within thirty (30) days of attaining full time student status. Documentation of student status will be required.~~

~~h. — Dependents not enrolled by the member at the time of his or her enrollment or within the applicable periods of eligibility as described in this Section B2 (Enrollment) may thereafter be enrolled only during the annual open enrollment period each year with coverage to be effective July 1. Documentation of eligibility will be required.~~

~~i. — Eligible dependents must be enrolled in the same benefit plan as the member.~~

3. Termination

a. Upon termination of a member's coverage, dependent coverage shall cease.

b. A member may cancel coverage for any or all of his or her dependents at any time by filing on forms prescribed by the Health Service System and provided there is a change in family status. ~~Members enrolled in the Section 125 Plan must cancel dependents pursuant to a Section 125 qualifying change in family status.~~ Cancellation of dependents' coverage shall become effective on the last day of the pay period month of receipt of such form in the Health Service System's office.

c. When a member is delinquent in the payment of Health Service contributions, coverage for dependents will be terminated concurrently with termination of coverage for the member.

d. Coverage of a dependent who becomes ineligible shall terminate on the last day of the pay period month in which ineligible status occurs. In the event that the date of ineligibility cannot be determined, termination shall be effective on the last day of the payroll period month in which discovery of ineligibility occurs. The fact that the date of ineligibility can not be determined does not preclude the denial of benefits or coverage by the benefit plan so affected.

e. Failure to comply with the conditions and requirements set forth in these Rules and Regulations with respect to dependent coverage may result in cancellation of coverage for such dependents.

4. Continuation of Coverage

a. Pursuant to the federally mandated Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) dependents who have lost coverage because: 1) an employee terminates employment (voluntarily or involuntarily) except for employees terminated for the employee's gross misconduct; 2) an employee's hours of work are reduced resulting in loss of coverage; 3) of divorce or legal separation from an employee; or 4) a child ceases to be a dependent child as defined by the Health Service System shall be entitled to elect continued coverage under the Health Service System. Dependents are entitled to coverage under the Health Service System for up to eighteen months in the case of dependents who lose coverage because of employee termination or reduction in hours and up to thirty-six months in the event of divorce, legal separation or cessation of dependent child eligibility. The deadlines for notices and payment shall be the same with respect to dependents as the deadlines applicable hereunder to employee members with respect to COBRA coverage.

For the purpose of Group Continuation Coverage, Domestic Partners and the dependent children of Domestic Partners shall be eligible.

A dependent who elects to continue will have a rate of contribution which shall not exceed 102 percent of the applicable contract rate.

5. Surviving Dependents

Modifications to this section will be presented later. Currently working with the Deputy City Attorney to confirm eligibility information related to Surviving Dependents.

C. EXEMPTIONS (Non-Coverage)

1. Basis of Exemption

a. Upon application made on forms prescribed by the Health Service System, an active or retired employee member will be exempted from coverage.

A member may apply for exemption from the Health Service System at the time of original enrollment; thereafter he or she may apply for exemption only during the annual open enrollment period each year, such exemption to be effective on the following July 1 unless otherwise provided by these rules.

b. Members enrolled in a ~~Medicare Plus Choice~~ [Medicare Advantage](#) Program may be transferred to an exempt status by completing the appropriate disenrollment applications and filing such applications with the System. Transfer to exempt status shall be effective the first of the month after completion and filing of the disenrollment applications with the System.

2. Duration of Exemption

a. Exemption shall remain in effect until lifted by the member, which shall only take place during the annual open enrollment period each year.

b. It shall be the sole responsibility of the member to apply for exemption in accordance with these Rules and Regulations.

c. A member who is in an exempt status and who loses group coverage through job displacement of a spouse may apply for coverage through the health Service System within thirty (30) days of the last date of group coverage under the same provisions as provided for dependents in Section B, subsection 2f.

d. A member who is married to or is the domestic partner of another member may apply for exemption or coverage for recognizable economic reasons at any time provided both members are enrolled in the same benefit plan of the Health Service System.

e. A member may apply for exemption (non-coverage) at any time upon submission of documentation that other medical or dental coverage has been obtained within thirty (30) days of application. Coverage Exemption will be effective the first day of the pay period month following application. ~~A member participating in the Section 125 Cafeteria Plan must satisfy the change in family status requirements adopted under rules and regulations of the Department of the Treasury.~~

f. An active employee who at the time of initial enrollment in the Health Service System applies for exemption must participate in a plan of the Health Service System during employment as an active employee in order to qualify for participation in the Health Service System at the rate established for retired employees after service, disability or vesting retirement.

D. CONTRIBUTIONS AND DELINQUENCIES

1. Members Not Subject to Payroll Deductions

a. It is the responsibility of the member to initiate payment directly to the Health Service System of contributions which cannot or are not made by payroll or retirement roll reduction.

b. Members and beneficiaries not subject to payroll or retirement roll deductions must pay the Health Service System on the applicable due date.

2. Delinquent Payments

a. Any contributions or premiums not paid when due shall constitute delinquent payments. Promptly after any payment becomes delinquent, the Health Service System shall provide to each affected insured a notice of termination of coverage. Such notice shall be

addressed to the current address on file with the Human Resource Department and shall be deposited in the U.S. Mail. Such notice shall indicate that unless all delinquent contributions or premiums are paid within 30 days of the date of such notice, coverage for such insured shall be terminated as of ~~first due~~last day of the month ~~date on~~in which payment was delinquent.

b. If the affected insured fails to pay all delinquent contributions or premiums within the 30-day period specified in the immediately preceding paragraph, coverage for such insured shall be terminated as of the ~~first~~last day due date of the month ~~on~~in which payment was delinquent. No partial payment of delinquent contributions or premiums prior to the end of the 30-day period shall be sufficient to avoid or delay termination. Any such partial payment received by the Health Service System shall be returned or refunded.

No monies shall be deducted from the member's payroll or retirement pension other than delinquent contributions due the Health Service System.

An active member who is on authorized leave will be reinstated the first of the ~~pay~~period~~month~~ following his or her return to work with the health and/or dental coverage in which enrolled at the time of transfer to non-covered status because of delinquent contributions.

Notwithstanding anything to the contrary contained herein, if any applicable memorandum of understanding should require that the Health Service System continue coverage for any insured whose contribution or premium payments are delinquent hereunder, then the Health Service System shall not terminate such insured so long as the insured's employer has provided written notice to the Health Service System of the memorandum of understanding and all contributions or premiums are paid to the Health Service System by such employer as and when due.

E. TRANSFER OF BENEFIT PLANS

1. The application to change from one benefit plan to another may be made only during the annual open enrollment period each year unless otherwise provided for by these Rules and Regulations with coverage to become effective the following July 1st.

2. A member who is leaving the area of service of a benefit plan for a period in excess of six (6) months may apply for a transfer to a benefit plan servicing the area of residence. Application must be submitted to the Health Service System in writing at least thirty (30) days prior to the member's leaving the service area of the current plan. Transfer into the new benefit plan shall become effective on the first day of the ~~pay~~period~~month~~ after such application is filed with the Health Service System. A member may remain in the new benefit plan, or may return to the original plan if transfer of plan application is made within thirty (30) days of return to the area of service.

3. Members of a benefit plan discontinued during the benefit year will be provided a special enrollment period in order to select an alternative benefit plan. A member who does not enroll in an alternate benefit plan during the special enrollment period will automatically be enrolled in the City Health Plan I.

4. School term employees of the San Francisco Unified School District or Community College District may not transfer plans or add dependents to their existing plan during the open enrollment period unless they continue group coverage for the summer months.

EG. MEMBERSHIP APPEALS AND GRIEVANCES

Members having grievances which cannot be resolved to the satisfaction of the member may submit the facts in writing to the Health Service System, Attention: Appeals. Such grievance must be submitted within 60 days of the event giving rise to the grievance.

Members who have a grievance with a specific benefit plan must first try and resolve their grievance through the member assistance process of the plan. Grievances will not be considered until this action is taken.

The Health Service System shall consider each appeal or grievance and shall notify the member of its decision.

Any member dissatisfied with the Health Service System's decision shall retain the right to appeal in writing to the Health Service Board. Such appeal must be made within ten (10) business days of notification. An extension of time may be granted upon the showing of good cause.

The appeal to the Health Service Board shall be a written appeal specifically stating the member's basis for disagreement with the decision of the Health Service System.

The Health Service Board shall act to grant or deny all appeals so submitted.

All actions taken by the Health Service Board shall be final.

All appeals to the Health Service Board shall be heard in closed session unless the member requests that it be held in open session. The Health Service Board minutes shall not reflect any member-identifiable information relating to appeals.