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**May 2010**  
**Summary of Proposed Policy Changes for Health Service System Rules**

<b>Section</b>	<b>Rules Update</b>	<b>Rationale</b>
B.2.a.	Documentation required for domestic partner eligibility	Align rules with current law
C.4 and H.5	All members are required to maintain a correct address on file with HSS and must report primary address change within 30 days.	Aligns rules with current operational policy
I.1	Active employees who are eligible for Medicare have the option, but are not required, to enroll in Medicare Part A.	Correction to previously submitted draft
J.	Medicare Advantage enrollment – deleted language about active employees.	Active employees are not offered Medicare Advantage plans
O.2.d.	Employee member who has had benefits terminated while on leave due to premium payment delinquency must notify HSS within 30 days of returning to work	Align rules with current policy
R	COBRA	Factual errors corrected

Additional non-substantive changes were made to improve organization and clarity of language.

The section and page numbers in this document refer to the draft rules document “HSSRulesDraft050610.doc”



# Health Service System Rules

Not yet approved by the Health Service System Board, proposed effective date July 1, 2010.

# DRAFT

**Health Service System**

CITY & COUNTY OF SAN FRANCISCO

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## **A. HEALTH SERVICE SYSTEM MEMBER ELIGIBILITY**

In accordance with City Charter Section 12.202, and San Francisco Administrative Code Section 16.700, the following persons shall be members of the San Francisco Health Service System. A member will be the primary enrolled subscriber for benefits offered through the Health Service System. Members shall have a choice of benefit plans provided by the Health Service System.

### **1. 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 Health Service 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 Health Service 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 (1,040) hours 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.

### **2. Elected Officials.** All elected officials, including but not limited to:

- (1) the Mayor
- (2) the Board of Supervisors
- (3) the Assessor-Recorder
- (4) the Treasurer
- (5) the City Attorney
- (6) the Public Defender
- (7) the Sheriff

### **3. All Members of the Following Boards and Commissions During Their Time in Service with 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
- (30) Parking and Traffic Commission  
(until such time as Section 4.116 of the Charter is repealed)
- (31) Planning Commission
- (32) Police Commission
- (33) Port Commission
- (34) Public Utilities Commission
- (35) Recreation and Parks Commission
- (36) Residential Rent Stabilization and Arbitration Board
- (37) Retirement Board
- (38) Small Business Commission
- (39) Sunshine Ordinance Task Force
- (40) War Memorial and Performing Arts Center Board
- (41) Youth Commission

4. **All Officers and Employees as Determined Eligible by the Governing Board of Education of the San Francisco Unified School District.**
5. **All Officers and Employees as Determined Eligible by the Governing Board of Education of the San Francisco Community College District.**
6. **All Officers and Employees as Determined Eligible by the Governing Bodies of the:**
  - (1) San Francisco Transportation Authority
  - (2) San Francisco Parking Authority
  - (3) San Francisco Redevelopment Agency
  - (4) Treasure Island Development Authority
  - (5) San Francisco Superior Court
7. **Any Other Employees Not Listed in Sections A.1 –A.6, as Determined Eligible by Ordinance.**

#### **8. Retirees**

As used in these Rules, Retiree members are defined as:

- (1) A former employee member who leaves active employment after meeting his or her employer's requirements for retirement based on duration of service, disability or vesting. To be eligible for health benefits at the premium contribution rate established for retirees, a retiree must have been enrolled in a health benefit plan through the Health Service System for some period during his or her term of employment with the City and County of San Francisco, the San Francisco Unified School District or the San Francisco Community College District.
  - (2) An employee member who resigned and withdrew his or her funds from a retirement system within thirty (30) days immediately prior to the date on which, but for his or her resignation, he or she could have been retired for service as a member of a retirement system. Coverage of a resigned member must be continuous and, if lapsed, may not be reinstated without Board approval. (See San Francisco City Charter Section A8.425.)
9. **Former Elective Members of the Legislative Body.** 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.

**B. ELIGIBLE DEPENDENTS OF HEALTH SERVICE SYSTEM MEMBERS**

If enrolled by a Health Service System member, the following dependents of a member shall be eligible for coverage subject to the following conditions and limitations:

**1. A Member's Legal Spouse**

- a. A member's legal spouse shall be eligible as a dependent of the member provided that the member files a copy of their marriage certificate with the Health Service System.
- b. When a member is granted a final dissolution of marriage or is legally separated, the member's former spouse shall not be eligible as a dependent. A member must immediately notify the Health Service System in writing when the a final dissolution of marriage or legal separation has been granted. When a member has been granted a final dissolution of marriage, or is legally separated, coverage for his or her dependent children shall continue as long as they are otherwise eligible. However, coverage for step-children will not continue.
- c. For a marriage that is not recognized by the federal government, employer payments for the legal spouse's health coverage may not be eligible for pre-tax treatment under applicable federal and state income tax law. Thus, coverage of the dependent spouse could result in additional imputed income to the employee member, with possible withholding for payroll taxes, including income and Social Security taxes, on such amounts.

**2. A Member's Legal Domestic Partner**

- a. A domestic partner of a member shall be eligible as a dependent of a member if the member meets the following requirements.
  - (1) The member must provide to the Health Service System either a true and correct copy of a city or county Declaration (or Certification) of Domestic Partnership that has been processed per the requirements of the issuing city or county, or a California State Certificate of Registration of Domestic Partnership that has been processed per California Family Code Section 297.
  - (2) If the member resides in a city or county that does not issue certification of Domestic Partnership, then the member and his or her domestic partner must sign and submit a notarized Health Service System Declaration of Domestic Partnership form. The requirements for domestic partner eligibility in the Health Service System may be greater than what is required by a city or county for domestic partner registration.
  - (3) The member and his or her legal domestic partner must certify to the Health Service System that they are economically responsible to each other for the common necessities of life, defined as food, shelter and medical care, and that this shall remain the case for expenses incurred during the period the member's domestic partner is covered by the Health Service System.

- (4) The member and his or her legal domestic partner must immediately notify the Health Service System in writing in the case of legal separation, dissolution of the domestic partnership or any change of circumstances as attested to in the Declaration of Domestic Partnership.
- b.** When the member is granted dissolution of domestic partnership, is legally separated, or there is any change of circumstances as attested to in a Declaration of Domestic Partnership, the member's partner is no longer eligible as a dependent. A member must immediately notify the Health Service System in writing when the member's partner is not eligible. Failure to do so can result in termination of coverage and financial penalties. (See Section D.) Once a member's partner is no longer eligible, any stepchildren of the former partner are also no longer eligible.
- c.** Payments for the domestic partner's health coverage may not be eligible for pre-tax treatment under applicable federal and state income tax law. Thus, coverage of the domestic partner dependent could result in additional imputed income to the employee member, with possible withholding for payroll taxes, including income and Social Security taxes, on such amounts.

### **3. Children**

To be an eligible dependent child under these rules, a child must be one of the following and meet all other applicable criteria as stated in this Section B.3.

- A natural child of an enrolled member.
- A legally adopted child of an enrolled member.
- A child under legal guardianship of an enrolled member.
- A child residing in an enrolled member's home who is declared as an exemption on the member's federal income tax return.
- A step-child who is a natural or legally adopted child of a member's enrolled spouse or domestic partner.
- A child under the legal guardianship of a member's enrolled domestic partner.

#### **a. Eligibility Requirements for Natural Children, Step-Children and Adopted Children**

To be eligible, a natural child, step-child or adopted child of a member, or of 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 enrolled member's, spouse's or domestic partner's federal income tax return (except in the case of divorce or dissolution of partnership, where a member's natural or

adopted child is declared as an exemption on his or her former spouse's or partner's federal income tax return, and has not been adopted by a subsequent spouse or partner of the member's ex-spouse or partner);

- (6) The member must provide eligibility documentation for the child, including a Social Security number, as requested by the Health Service System. No child of a member may remain, or be enrolled, in the Health Service System past the maximum age of 25 except a disabled child as provided for in Section 3.c. below.

**b. Eligibility Requirements for Children Under Legal Guardianship and Other Children Residing in a Member's Home (IRS Exemption)**

To be eligible, a child under legal guardianship of a member, a member's spouse or domestic partner or a child living in the member's home who is not a natural, adopted or step-child, must meet all of the five 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 or be under legal guardianship.

The member must provide eligibility documentation for a child who is either under Legal Guardianship or is an IRS exemption living in the member's home, including a Social Security number, as requested by the Health Service System.

**c. Age Exemption for Eligible Disabled Children**

A disabled child may be covered as a dependent in the Health Service System beyond age 25 if all of the following criteria are met:

- (1) Child was enrolled in a Health Service System medical plan on the child's nineteenth birthday and continuously for at least one year prior to the child's nineteenth birthday;
- (2) Child was continuously enrolled in an HSS administered medical plan from age 19 to 25;
- (3) Child sustained a qualifying disability prior to the child's attainment of age 25;
- (4) Child is incapable of self-sustaining employment due to the physical or mental disability;
- (5) Child is unmarried;
- (6) Child permanently resides with the employee/retiree member;

- (7) Child is dependent on the member for substantially all of his economic support and is declared as an exemption on the member's federal income tax;
- (8) Member submits acceptable medical documentation to the Health Service System of the disability at least sixty (60) days prior to child's attainment of age 25 and every year thereafter as requested.

The medical evidence submitted to continue coverage for a disabled child must be certified by a physician and contain all of the following information:

- 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

All enrolled dependents who qualify for Medicare due to a disability are required to enroll in Medicare. Members must notify the Health Service System of any dependent's eligibility for, and enrollment in, Medicare.

A newly hired employee who adds an eligible dependent disabled child, who is over the age of 19, must meet all requirements listed, except c.(2) above. Once enrolled, however, the member must continuously enroll the disabled eligible child to maintain future eligibility.

#### **d. Surviving Dependents**

Because they are dependents themselves, surviving dependents do not have the member privilege of enrolling any individuals as additional dependents on their coverage. Dependents enrolled at the time of the member's death may continue to be enrolled as long as they remain eligible. Surviving dependents include:

- (1) **The surviving spouse or surviving domestic partner of an eligible member employee or retiree.** The surviving spouse or surviving domestic partner of an employee or retiree member must have been married, or registered as the member's domestic partner, for a period of at least one year prior to the death of the member.
- (2) **Surviving dependent children of an eligible member employee or retiree.** Surviving children must meet eligibility requirements for dependent children as defined in Section B.

**C. ELIGIBILITY DOCUMENTATION REQUIRED****1. Members**

All members are required to provide eligibility documentation as requested by the Health Service System and as required under federal, state or local law. Failure to provide eligibility documentation as required shall result in termination of coverage.

**2. Dependents, Including Eligible Spouses, Domestic Partners and Children**

The Health Service System, and any health benefit plan vendor, may require proof of dependent eligibility at any time. Failure to furnish such proof within thirty (30) days after a request by the Health Service System shall result in termination of coverage.

Re-enrollment may thereafter occur upon submission to the Health Service System of a completed enrollment application and required eligibility documentation, during the annual open enrollment period, with coverage effective July 1<sup>st</sup>.

**3. Social Security Numbers Required**

All members are required to provide the Health Service System with Social Security numbers for themselves and all enrolled dependents. The failure to provide Social Security numbers will result in the termination of health coverage administered by the Health Service System. Upon the Health Service System Director's approval, exceptions can be made on a case-by-case basis for members and dependents who do not qualify for Social Security numbers.

**4. Member Addresses Required**

All members are required to keep a current address on file with the Health Service System. Members must notify the System within thirty (30) days of any address change. Members are responsible for promptly responding to notices mailed to the address on file with the Health Service System.

**D. MEMBER RESPONSIBILITY TO NOTIFY HEALTH SERVICE SYSTEM WHEN A DEPENDENT BECOMES INELIGIBLE**

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 for eligibility. There shall be no obligation on the part of the Health Service System to provide health coverage to, or refund of contributions made on account of, an ineligible dependent. If a member fails to notify the Health Service System when an enrolled dependent becomes ineligible the member may be held responsible for payment of all health premium costs, including any employer premium costs and costs for medical services provided, dating back to the date of the dependent's ineligibility.

**E. OPEN ENROLLMENT PERIOD**

1. The Health Service System shall conduct an annual open enrollment for a period of three to four weeks as approved by the Health Service Board.
2. A member may make changes, including changes in their benefit plan elections, and the addition or cancellation of dependents, during this open enrollment period.
3. Member must submit all required enrollment applications and eligibility documentation by required due dates established by the Health Service System.
4. Retirees may only terminate dental coverage for themselves and enrolled dependents during open enrollment, unless there is a qualifying event. (See Section F.)
5. Dependents who are deleted from coverage during open enrollment are not eligible for COBRA continuation coverage.
6. All changes made during the annual open enrollment period shall be effective on the following July 1<sup>st</sup>.

**F. QUALIFYING EVENTS FOR CHANGING BENEFIT ELECTIONS OUTSIDE OF THE OPEN ENROLLMENT PERIOD**

For enrollments due to a qualifying event, the member must notify the Health Service System and complete the enrollment process, including the submission of all required eligibility documentation, no later than thirty (30) calendar days after the qualifying event. The following qualifying events allow a member to make benefit election changes outside of open enrollment.

**1. Marriage**

A member's marriage allows the member to add his or her new spouse and accompanying eligible step-children, as defined in section 3.a., to his or her existing coverage.

**2. Domestic Partnership**

A member's domestic partnership allows the member to add his or her new partner and accompanying eligible step-children, as defined in section 3.a., to his or her existing coverage.

**3. Birth**

The birth of a child allows the member to add the child to his or her existing coverage.

**4. Adoption**

The adoption of a child allows the member to add the child to his or her existing coverage.

**5. Legal Guardianship**

A member who assumes legal guardianship of a child may add the child to his or her existing coverage.

**6. Child IRS Exemption**

A member who takes a child into his or her home, declares the child on federal income tax, and meets all other criteria listed in section 3.b. may add the child to his or her existing coverage.

**7. Loss of Other Coverage**

Members and eligible dependents who lose other coverage may be enrolled in Health Service System coverage.

**8. Divorce, Legal Separation or Dissolution of Partnership**

In the event of divorce, legal separation or dissolution of domestic partnership a member must terminate health coverage for the ex-spouse or domestic partner and any accompanying covered step-children.

**G. TRANSFER OF HEALTH BENEFIT PLANS**

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

**1. Members Residing Outside a Health Benefit Plan Service Area For Six or More Months**

A member who is leaving the area of service of a health benefit plan for a period in excess of six (6) months may apply for a transfer to a health 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 health benefit plan shall become effective on the first day of the month after such application is filed with the Health Service System. A member may return to the original health benefit plan, if written application to the Health Service System is made within thirty (30) days of return to the area of service.

**2. Retirees Residing Outside of the United States For a Minimum of Six Months**

Retired members and dependents enrolled in Medicare, regardless of health benefit 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. They must make the required health coverage payments directly to the Health Service System by the applicable due dates.

**3. Members Enrolled in a Discontinued Health Benefit Plan**

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

**4. School Term Employees**

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

**H. CONTINUATION OF HEALTH BENEFITS COVERAGE AFTER RETIREMENT****1. Service, Disability or Vesting Retirement for Members Who Have Been Enrolled in Health Service System Health Benefit Plans While Actively Employed**

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 coverage within thirty (30) days after such retirement is approved by his or her retirement system. Thereafter, application for enrollment may be made only during the annual open enrollment period each year with coverage to become effective the following July 1. In addition to Health Service System requirements, City College and School District employees must meet their employer's respective eligibility requirements. To be eligible for health benefits at the premium contribution rate established for retirees, a member must have been enrolled in a health benefit plan through the Health Service System for some period during his or her term of employment with the City and County of San Francisco, the San Francisco Unified School District or the San Francisco Community College District.

**2. Service, Disability or Vesting Retirement for Members Who Have Not Been Enrolled in Health Service System Health Benefit Plans While Actively Employed**

An individual who would qualify for coverage under Section H. 1. above, but for the fact that he or she has never been enrolled in a health benefit 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 benefit plan as described in Section H.1., except that he or she shall pay a rate consisting of:

- a. The rate established for retired employees, plus
- b. That which the City and Count of San Francisco, the San Francisco Unified School District or the San Francisco Community College District would have

contributed to the Health Service System on account of his or her membership had he or she been covered under Section H.1. An individual so situated may also participate at his or her own cost in any other benefits of the Health Service System that are made available to retired employees.

### **3. Resigned Retiree Members**

A member who resigned, and withdrew his or her funds from a retirement system within thirty (30) days immediately prior to the date on which, but for his or her resignation, he or she 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 also includes teachers who took all of their money out of the San Francisco Employees Retirement System (SFERS) to join the State Teachers Retirement System (STRS). Such resigned members must apply for continuation of coverage within thirty (30) days after resignation. Such resigned members (including Surviving Spouse dependents) must make arrangements to pay contributions monthly in advance to the Health Service System by the applicable due dates. Coverage of a resigned member must be continuous and, if lapsed, may not be reinstated without Board approval.

### **4. Retiree Premium Contribution Payments Required**

If sufficient funds are available, all contributions to the Health Service System must be paid through the retiree's pension check. If sufficient funds are not available, the retiree must make required premium contributions directly to the Health Service System by applicable due dates.

### **5. Retiree Must Notify the Health Service System of Current Primary Address**

A retiree member who is enrolled in a Health Service System administered health benefit plan is obligated to maintain his or her correct primary residential address on file with the Health Service System and notify the Health Service System within thirty (30) days of any primary address change.

## **I. REQUIRED MEDICARE ENROLLMENT**

### **1. Active Employee Members Age 65 and Over**

All active employees over the age of 65 have the option, but are not required, to enroll in Medicare Part A as soon as they are eligible.

### **2. Retired Members**

Retired members who are eligible due to either age or disability must enroll in both non-contributory Medicare Part A and in Medicare Part B. (Some retired members will only qualify for Medicare Part B.) It is the responsibility of the member to notify the Health Service System of Medicare eligibility and enrollment. Failure of an enrolled retired member, who is eligible to enroll in both non-contributory Part A and in Part B of Medicare, will result in the member being transferred to the

City Health Plan 20, which provides coverage at a higher out-of-pocket cost to the retiree member.

**3. Member Dependents**

All member dependents who are eligible due to either age or disability must enroll in both non-contributory Medicare Part A and Medicare Part B. If an enrolled member dependent who is eligible to enroll in either non-contributory Part A or Part B of Medicare, and fails to do so, that dependent’s coverage will be terminated. (Some dependents will only be eligible for Part B.)

**J. MEDICARE ADVANTAGE ENROLLMENT**

All retired members and dependents enrolled in Medicare Part A and Part B, who are enrolled in health maintenance organizations which have a Medicare Advantage contract with the Health Service System, must participate in the Medicare Advantage program of their selected health benefit plan, with the exception of members with Medicare Part A and Part B who live outside the Medicare Advantage health benefit plan service area. Retirees who fail to enroll in a Medicare Advantage health benefit plan when it is offered by the Health Service System will be required to enroll in the City Health Plan.

**K. NO DUAL HEALTH PLAN COVERAGE**

Health Service System members and their dependents cannot be enrolled in two Health Service System administered medical or dental plans at the same time. In other words, members may not be enrolled in a plan both as a member and as a dependent of another member. If dual enrollment elections are submitted, HSS will automatically eliminate dual coverage as follows:

1. For any member who is covered both as a member and as a dependent of another member, coverage as a dependent will be terminated.
2. For dependents who are covered by two different members, the dependent(s) will be covered by the member who covered the dependent(s) first based on the date of the completed enrollment.

**L. MEMBER HEALTH BENEFITS COVERAGE PERIODS**

1. **Coverage Effective Date.** Coverage shall be effective as set forth below:
  - a. **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 <sup>st</sup> thru 31 <sup>st</sup>	1st of the following calendar month

**b. Eligible Commissioners of the City and County of San Francisco**

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
1 <sup>st</sup> thru 31 <sup>st</sup>	1 <sup>st</sup> of the following month

**c. Eligible Employees of the San Francisco Unified School District**

(i) Monthly

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
1 <sup>st</sup> thru 31 <sup>st</sup>	1 <sup>st</sup> of the following month

(ii) Bi-Weekly

COVERAGE EFFECTIVE DATE
First day of the pay period following the Eligibility Event Date

**d. Eligible Employees of the San Francisco Community College District**

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
1 <sup>st</sup> thru 15 <sup>th</sup>	16 <sup>th</sup> of that month
16 <sup>th</sup> thru 31 <sup>st</sup>	1 <sup>st</sup> of the following month

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

**a. 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 <sup>st</sup> thru 31 <sup>st</sup>	Last day of the month for which the employee premium contributions have been made in full

**b. Eligible Commissioners of the City and County of San Francisco**

ELIGIBILITY EVENT DATE	COVERAGE TERMINATION DATE
1 <sup>st</sup> thru 31 <sup>st</sup>	Last day of the month for which the employee premium contributions have been made in full

**c. Eligible Employees of the San Francisco Unified School District**

(i) Monthly

ELIGIBILITY EVENT DATE	COVERAGE TERMINATION DATE
1 <sup>st</sup> thru 31 <sup>st</sup>	Last day of the month for which the employee premium contributions have been made in full

(ii) Bi-Weekly

COVERAGE TERMINATION DATE
Last day of the pay period following the Eligibility Event Date

**d. Eligible Employees of the San Francisco Community College District**

ELIGIBILITY EVENT DATE	COVERAGE TERMINATION DATE
1 <sup>st</sup> thru 15 <sup>th</sup>	15 <sup>th</sup> of that month
16 <sup>th</sup> thru 31 <sup>st</sup>	Last day of the month for which the employee premium contributions have been made in full

**M. DEPENDENT HEALTH BENEFITS COVERAGE PERIODS**

**1. Coverage Effective Dates**

Eligibility qualification requires submission of completed application form and other required documentation to the Health Service System within thirty (30) days of a qualifying event. Coverage shall be effective as set forth below:

**a. Eligible Dependents**

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
At the time of member’s original enrollment	Same day as member

A member may enroll his eligible dependents at the time of original enrollment. Coverage for eligible dependents becomes effective on the same day as the member. However, a dependent who is hospital confined at the time of the member’s original eligibility shall be added effective on the date he or she is no longer hospital confined. Eligibility documentation is required.

**b. Eligible Spouses, Or Domestic Partners, And Such Other Eligible Dependents Acquired By Such Marriage Or Domestic Partnerships**

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days after the date of marriage or domestic partnership	1 <sup>st</sup> day of the month after a completed application is filed with the Health Service System.

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 marriage or domestic partnership. 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 1<sup>st</sup> day of the month after a completed application is filed with Health Service System. However, hospital confined dependents shall be added effective the date they are no longer hospital confined. Documentation of marriage and domestic partnership is required.

**c. Eligible Newborns**

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days after birth or commencement of legal custody.	The date of birth as long as a completed application is filed with the Health Service System within thirty (30) days of the date of birth.

A member’s newborn child must be enrolled in the Health Service System 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 is required.

**d. Eligible Adopted Children**

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of the commencement of legal custody.	The commencement of legal custody as long as a completed application is filed with the Health Service System within thirty (30) days of the date of adoption.

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 is required.

**e. Limited Exceptions for Newborn and Adopted Child Enrollments**

Notwithstanding the foregoing, after the expiration of the applicable period of thirty (30) days set forth in Sections M.1.c. and M.1.d. above, the Health Service System Director may permit the enrollment of a newborn child or a newly adopted child into a medical benefit plan offered by the Health Service System upon satisfaction of each of the following conditions:

- (1) The Director has found that the member has acted in good faith and not in willful violation of the rules contained in Sections M.1.c. and M.1.d. above;
- (2) 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;
- (3) The Director has found that under the terms of the contract between the Health Service System and the benefit plan vendor 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; and
- (4) The Health Service System has received full payment of all premiums (both employer-paid and member-paid portions) required to enroll the child for the period from such effective date through the end of the current calendar month.
- (5) To comply with agreements established with the health benefit plan vendors, newborns must be enrolled within six (6) months of the date of birth to be eligible for coverage.

**f. Eligible Dependent Children for Whom the Member Has Assumed Legal Guardianship**

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of commencement of legal guardianship	1 <sup>st</sup> day of the month after a completed application is filed with the Health Service System

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 month after a completed application is filed with the Health Service System. Documentation of eligibility is required.

**g. Other Eligible Dependents Who Have Entered The United States or Have Moved Into The Service Area of the Member’s Health Benefit Plan**

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of the date the dependent changes his or her primary residence	1 <sup>st</sup> day of the month after a completed application is filed with the Health Service System.

Other eligible dependents who have either entered the United States or have moved into the service area of the member’s health benefit plan may be enrolled in the Health Service System provided such enrollment is made within thirty (30) days of the date the dependent changes his or her primary residence. Coverage will be effective on the first day of the month after a completed application is filed with the Health Service System. Documentation is required.

**h. Eligible Dependents Who Lose Group Health Insurance Coverage Through Job Displacement**

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of the last date of group coverage under another employer.	Subject to the discretion of the Health Service System and the health benefit plan for which application is made

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 a letter from the former employer or former health benefit plan vendor stating the reason for lost coverage and the last date of coverage. The approval or rejection of the application and effective date of any coverage are subject to the discretion of the Health Service System and the member’s health benefit plan vendor.

**i. Open Enrollment Coverage Effective Date**

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 M. may thereafter be enrolled only during the annual open enrollment period with coverage to be effective July 1. Documentation of eligibility is required.

## **N. WAIVING HEALTH BENEFITS COVERAGE (VOLUNTARY)**

Upon application made on forms prescribed by the Health Service System, a member may waive coverage. It shall be the sole responsibility of the member to apply for a coverage waiver in accordance with these Rules. Unless otherwise noted in the subsections below, if an enrolled member waives coverage for himself, herself or any enrolled dependents, the termination date of coverage will vary depending on the member's premium contribution dates and corresponding coverage periods

### **1. Voluntary Waiver of Health Benefits Coverage**

- a.** A member may elect to waive coverage when he or she first qualifies for Health Service System eligibility per Section A.
- b.** A member may elect to waive coverage during the annual open enrollment period by submitting all required forms and documentation to the Health Service System no later than the required deadlines. Disenrollment from benefit plans takes effect the following July 1<sup>st</sup>.
- c.** Based on the rules governing qualifying changes in family status as set forth in Section F, a member may waive coverage outside of open enrollment by submitting required forms and documentation by the deadlines prescribed by the Health Service System.
- d.** A retiree may waive medical coverage for a dependent at any time. (Dental coverage can only be waived during open enrollment, unless there is a Qualifying Event - see Section F.)
- e.** A member may elect to waive enrollment in a health benefit plan for himself or herself and enrolled dependents for the duration of an unpaid leave if appropriate notice and documentation is given to the Health Service System prior to the start of the unpaid leave. (See Section Q.)

### **2. Duration of Voluntary Waived Health Benefits Coverage**

- a.** Waiver of coverage will remain in effect until lifted by the member, which shall only take place during the annual open enrollment period each year or if there is a qualifying event. To enroll in coverage a member must complete the required enrollment application and submit required documentation to the Health Service System by applicable due dates.
- b.** A member who has waived coverage 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 M.1.h.
- c.** A member may waive coverage at any time upon submission, within thirty (30) days, of documentation of the date that other medical or dental coverage has been obtained. The waiver will be effective the first day of the month following application.

### **3. Potential Impact of Waiving Employee Health Benefits On Eligibility For Retiree Health Benefits**

Under City Charter section A8.428, an active employee must participate in a Health Service System plan while an active employee to qualify for participation in the Health Service System as a "Retired Person" at the rate established for retired employees after service, disability or vesting retirement. Charter sections A8.428(a)(1) and (a)(4) require that "Retired Person(s)" be a "former member(s) of the health service system."

## **O. MEMBER PREMIUM CONTRIBUTIONS AND DELINQUENCIES**

### **1. Members Not Subject to Payroll or Pension Deductions**

- a.** It is the responsibility of the member to make payments directly to the Health Service System for employee and retiree premium contributions which are not, or cannot be, made by payroll or pension deductions.
- b.** Members not subject to payroll, or retirement pension, deductions must pay the Health Service System directly by applicable due dates.

### **2. Delinquent Payments**

- a.** Any member premium contributions not paid when due shall constitute delinquent payments. After any payment becomes delinquent, the Health Service System shall provide to each affected insured member 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 employee premium contributions are paid within fourteen (14) calendar days of the date of such notice, coverage for such insured shall be terminated on the last day of the month in which full payment was made.
- b.** If the affected insured member fails to pay all delinquent employee or retiree premium contributions within the fourteen (14) day period specified in subsection 2.a above, coverage for such insured shall be terminated as of the last day of the month in which full payment was made. Partial payment of delinquent premium contributions prior to the end of the fourteen (14) day period shall not be sufficient to avoid or delay termination. Any such partial payment received by the Health Service System shall be returned or refunded.
- c.** No monies shall be deducted from the member's payroll, or retirement pension, other than delinquent employee premium contributions due the Health Service System.
- d.** An employee member who does not make required premium contributions while on authorized leave will have his or her health plan benefits terminated. The health plan benefits in which he or she was enrolled prior to going on leave will

resume on the first of the month following his or her return to active employee status, provided the employee notifies the Health Service System within thirty (30) days of the date he or she returns to work.

- e. 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 employee premium contributions 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 employee premium contributions are paid to the Health Service System by such employer when due.

## **P. TERMINATION OF HEALTH BENEFITS COVERAGE (INVOLUNTARY)**

Unless noted in the subsections below, termination date of coverage will vary depending on the member's premium contribution dates and corresponding coverage periods.

1. When a member is delinquent in the payment of employee or retiree premium contributions, benefits coverage for the member and any enrolled dependents will be terminated.
2. If a member does not supply the Health Service System with all required eligibility documentation by required deadlines, including a Social Security number for himself or herself and/or enrolled dependents, benefits coverage will be terminated. (See Section C.)
3. Benefits of a member or dependent who becomes ineligible for any reason shall terminate on the last day of the month in which full premium payments have been received. In the event that the date of ineligibility cannot be determined, termination shall be effective on the last day of the month in which discovery of ineligibility occurs. The fact that the date of ineligibility cannot be determined does not preclude the denial of benefits or coverage by the benefit plan vendor so affected. (See Section D for member penalties that will be incurred if a member fails to notify the Health Service System when a member's dependent becomes ineligible.)
4. Failure to comply with the conditions and requirements set forth in these Rules may result in retroactive termination of coverage.
5. Upon termination of a member's coverage, dependent coverage shall cease.
6. An eligible member who has had benefits terminated may re-enroll himself or herself and his or her eligible dependents during annual open enrollment with benefits coverage to commence the following July 1<sup>st</sup>.

## **Q. EMPLOYEES ON AUTHORIZED UNPAID LEAVE**

Eligibility for membership in the Health Service System continues for the duration of all approved unpaid leaves. If an employee does not notify the Health Service System regarding his or her preference for either continuing or waiving coverage prior to going on authorized unpaid leave, existing health coverage will continue and the employee will be responsible for making all required health premium payments to the Health Service System by applicable due dates.

### **1. Continuing Coverage While on Authorized Unpaid Leave**

While on authorized leave, an employee can continue existing coverage for himself or herself and enrolled dependents. Employees may not make changes to medical or dental coverage after unpaid leave has begun. If an employee chooses to continue coverage while on authorized unpaid leave, he or she must make all required health premium payments directly to the Health Service System by applicable due dates. To return premium contributions to active status, employees must notify the Health Service System within thirty (30) days of returning to work.

### **2. Waiving Coverage While on Authorized Unpaid Leave**

Prior to the start of authorized leave an employee may waive his or her existing coverage. To waive coverage, an employee must notify the Health Service System and submit all required forms and documentation prior to the start of leave. Employee must notify the Health Service System within thirty (30) days of returning to work in order to resume coverage and return premium contributions to active status.

### **3. Educational Leave and Personal Leave**

Membership in the Health Service System continues for the duration of the approved leave. For the first twelve (12) weeks, the City subsidy continues and the member is only responsible for employee premium contribution amounts. If the approved leave continues beyond twelve (12) weeks, and the City subsidy ends, the member is responsible for paying the entire premium amount, which is the combined total of the employee's and employer's premium contributions. Payments must be made directly to the Health Service System by the applicable due dates.

### **4. Leave for Employment as an Employee Organization Officer or Representative**

Membership in the Health Service System continues for the duration of the approved leave. For the first twelve (12) weeks, the City subsidy continues and the member is only responsible for employee premium contribution amounts. If the approved leave continues beyond twelve (12) weeks, and the City subsidy is discontinued, the member is responsible for paying entire premium contribution amount directly to the Health Service System by the applicable due dates. In certain cases, the union in which the member is serving will pay the cost of the member's health and/or dental insurance. In these cases, it is still the member's responsibility to make sure the premiums are paid. The Health Service System will not seek payment directly from the member's union.

### **5. Family Care Leave**

While a member is on Family Care Leave, Health Service System coverage continues as long as the member continues to pay any premium portion that was deducted from his or her paycheck. The City subsidy continues for the duration of the Family Care Leave. The member is responsible for ensuring that the required health coverage payments are paid directly to the Health Service System by the applicable due dates.

### **6. Personal Leave Following Family Care Leave**

If a member has been on Family Care Leave, has maintained his or her health coverage, and continues his/her leave by personal leave for the same reason, then the City subsidy continues for the duration of the leave. The member is responsible for ensuring that the required health coverage payments are paid directly to the Health Service System by the applicable due dates.

## **R. COBRA CONTINUATION OF HEALTH BENEFITS COVERAGE**

- 1.** Pursuant to the federally mandated Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), and any subsequent federal legislation regarding COBRA, members and dependents who have lost coverage for the following reasons shall be entitled to elect COBRA continuation coverage under the Health Service System.

#### **a. COBRA Qualifying Events For Employees**

- The employee's employment is terminated (voluntarily or involuntarily) for reasons other than gross misconduct.
- The employee's regular work hours are reduced, resulting in loss of coverage.

#### **b. COBRA Qualifying Events For An Employee's Spouse or Legal Domestic Partner Who Is Covered on the Employee's Health Benefit Plan**

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee
- Covered employee's becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

#### **c. COBRA Qualifying Events for Dependent Children Covered on an Employee's Health Benefit Plan**

- Loss of dependent child status under either Health Service System or health benefit plan vendor rules
- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee

- Covered employee's becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

**2. Duration of COBRA Coverage**

The duration of COBRA coverage listed below may be extended (or shortened) in accordance with provisions in the original federal Act as well as subsequent federal legislation relating to COBRA..

COBRA QUALIFYING EVENT	INDIVIDUALS ELIGIBLE	DURATION OF COBRA COVERAGE
<ul style="list-style-type: none"> <li>• Employee’s termination</li> <li>• Employee’s reduction in working hours</li> </ul>	<ul style="list-style-type: none"> <li>• Employee</li> <li>• Spouse</li> <li>• Dependent child</li> </ul>	18 months from date active employee coverage ends
<ul style="list-style-type: none"> <li>• Covered employee’s death</li> <li>• Covered employee’s divorce or legal separation</li> </ul>	<ul style="list-style-type: none"> <li>• Spouse</li> <li>• Dependent child</li> </ul>	36 months from date active employee coverage ends
<ul style="list-style-type: none"> <li>• Loss of dependent child status</li> </ul>	<ul style="list-style-type: none"> <li>• Child</li> </ul>	36 months from date active employee coverage ends

3. A COBRA eligible individual who elects COBRA coverage will have a contribution rate which shall not exceed 102 percent of the applicable contract rate.
4. The deadlines for notices and payments shall be the same with respect to dependents as the deadlines applicable to employee members with COBRA coverage.
5. Dependents may elect continuation coverage for themselves as individuals, or in combination with each other and/or the eligible member, consistent with COBRA.

**S. OTHER PUBLIC AGENCIES ELIGIBLE TO PARTICIPATE IN THE HEALTH SERVICE SYSTEM**

**1. Election to Participate**

San Francisco Administrative Code Section 16.700 authorizes specified public agencies other than the City and County of San Francisco to participate in the Health Service System, and to determine, by resolution of the appropriate governing body, the officers and employees who are eligible to enroll in the System. If a resolution electing to participate in the Health Service System is filed with the System on or before October 1<sup>st</sup>, then the participating agency and its employees, retirees, and dependents shall be eligible to enroll the following July 1<sup>st</sup>. These time requirements may be modified only with the approval of the Health Service Board.

**2. Terminating Participation**

A participating agency may end its participation in the Health Service System by filing a resolution of its governing body with the Health Service Board. The resolution must be filed with the Health Service Board no later than October 1<sup>st</sup> to be effective the following July 1<sup>st</sup>. Coverage of all agency employees, retirees and dependents will terminate on June 30<sup>th</sup>, the end of the plan year. The resolution electing to end participation in the Health Service System is irrevocable after it is filed with the Health Service Board. An agency may not file a resolution electing to resume participation in the System for five (5) years after the effective date of its exit from the System.

**3. Reports and Payments**

A participating agency shall perform the functions necessary to enroll its employees and to submit timely and accurate reports and payments as may be required by the Director of the Health Service System; provided, however, that the Director may not impose any reporting or payment requirements that differ from those applicable to the City and County of San Francisco, without approval of the Health Service Board.

**4. Exclusive Plans**

A participating agency may not maintain for its employees any medical plan or program offering hospital and medical care, other than the plans offered by the Health Service System, except as expressly agreed to by the Health Service Board.

**T. MEMBER APPEALS AND GRIEVANCES**

1. City Charter Section 12.200(5) requires the Health Service Board receive, consider and, within sixty (60) days after receipt, act upon any matter pertaining to the policies of, or appeals from, the Health Service System submitted to it in writing by any member or any person who has contracted to render medical care to the members.
2. Members who have a grievance with a specific benefit plan must first try and resolve their grievance through the member assistance process of the benefit plan vendor. Grievances will not be considered by the Health Service System until this action is taken.
3. Members are advised that grievances relating to medical service received (or not received) from an Health Maintenance Organization (HMO) plan may be filed with the California Department of Managed Healthcare (DMHC). Grievances relating to Preferred Provider Organization (PPO) medical services may be filed with the California Department of Insurance (DOI).

4. Members having grievances which cannot be resolved to the satisfaction of the member may submit the facts in writing to:

San Francisco Health Service System  
Attention: Member Appeals  
1145 Market Street, Suite 200  
San Francisco, CA 94102
5. Member grievances must be submitted within sixty (60) days of the event giving rise to the grievance, or the denial of the grievance by the member's specific benefit plan under Section G.2. above.
6. The Health Service System shall consider each appeal or grievance and shall notify the member of its decision within sixty (60) days of receiving a member grievance.
7. Any member dissatisfied with the Health Service System's decision shall retain the right to appeal the decision in writing to the Health Service Board. Such appeal must be made within fifteen (15) business days after the date the Health Service System mails its decision to the member at the member's last known address on file with the Health Service System. An extension of time may be granted upon the showing of good cause.
8. The appeal to the Health Service System Board shall specifically identify the basis of the member's disagreement with the Health Service System decision in writing.
9. Prior to the Health Service System Board hearing, the Health Service System shall serve a written response to the member's grievance upon the member and the Board.
10. The Health Service System Board shall grant, deny or otherwise respond to all written appeals submitted consistent with City Charter Section 12.200(5).
11. All actions taken by the Health Service System Board shall be final.
12. All appeals to the Health Service System 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.
13. Members shall be allowed to bring a personal representative of their choosing to the Health Service Board hearing, along with any other witnesses the member believes have direct knowledge of the facts underlying the member's claim. The Health Service System shall also be allowed to bring any witnesses it believes will help the Board in its decision making process. The Health Service System Board may exclude any witness upon a finding that their testimony would be duplicative, without foundation and/or not relevant to the issues raised in the member's claim.

**U. GOVERNANCE OUTSIDE OF STATED RULES**

Any activity or transaction between members, dependents and the Health Service System not explicitly determined in these Rules remains under the discretion of the Health Service System and/or the Health Service System Board.