

HEALTH SERVICE SYSTEM MEMBERSHIP RULES

[July 1, 2010]

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HEALTH SERVICE SYSTEM MEMBERSHIP RULES ~~AND~~ REGULATIONS

~~PART II—MEMBERSHIP AND COVERAGE~~

A. EMPLOYEES

1. Member

In accordance with City Charter Section 12.202, and Section 16.700, Participation of the San Francisco Administrative Code, Chapter 16 Officers and Employees Generally, Article XV Health Service System, Section 16.700, the following persons shall be eligible to participate in the San Francisco Health Service System:

a. City and County ~~e~~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 ~~e~~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)
- ~~(30)~~ Planning Commission
- ~~(31)~~ Police Commission
- ~~(32)~~ Port Commission
- ~~(33)~~ Public Utilities Commission
- ~~(34)~~ Recreation and Parks Commission
- ~~(35)~~ Residential Rent Stabilization and Arbitration Board
- ~~(36)~~ Retirement Board
- ~~(37)~~ Small Business Commission
- ~~(38)~~ Sunshine Ordinance Task Force
- ~~(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 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 Charter 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.1, Subsection 1-Dependents (Dependent 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)~~.

j. Eligibility Information Requirements. All members are required to provide the Health Service System their social security numbers and the social security numbers of their dependants, and any other eligibility information required under federal, state or local law, unless there is a valid basis for not doing so. The failure to provide social security numbers, or other required eligibility information, will result in the loss of health coverage.

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, i.e., members may not be enrolled in a plan both as a member and a dependent of another member. In addition, Hhe or she may not be enrolled in two different benefit plans.

3. Coverage Periods

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

(1) 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 31 st	1st of the following calendar month

(ii2) 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

(iii3) 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

(iv4) Eligible Employees of the San Francisco Unified School District.

a.(i) Monthly

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

b.(ii) 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:

(1) 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 31 st	Last day of the month Last day of the pay period following the Eligibility Event Date

(ii2) 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

(iii3) 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

(iv4) Eligible Employees of the San Francisco Unified School District.

a.(i) Monthly

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

b.(ii) Bi-Weekly

Coverage Termination Date
Last day of the pay period following the Eligibility Event Date

c. Continuation Coverage

—The Health Service System shall provide continuing coverage to applicable members and dependents ~~under-pursuant to~~ the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”) laws, rules and regulations. Eligible members and dependents may elect continuation coverage for themselves as individuals, or in combination with each other.

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 with the exception of dental coverage. Dental coverage may only be canceled during open enrollment.

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 ~~include~~ ~~mean~~ each of the following:

(1) 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 the following July 1. City College and School District employees must meet their employer's respective eligibility requirements.

(2) An individual who would qualify for coverage under Section A.5.a(1) above, 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 Section A.5.a(1), except that he or she shall pay a rate consisting of: ~~(4i)~~ the rate established for retired employees, plus ~~(2ii)~~ 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 underby Section A.5.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 ~~R~~retirement ~~S~~system within thirty (30) days immediately prior to the date on which, but for his resignation, ~~he~~ could have been retired for service as a member of a ~~R~~retirement ~~S~~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 ~~s~~ ~~older~~ 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 ~~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 Health Service 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 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.

b. 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. 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, if eligible, 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.

~~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.~~

~~dc.~~ 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. They must make the required health coverage payments directly to the Health Service System by the applicable due date.

~~_____ed.~~ All retired members and dependents with Medicare Part A and 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 plan, with the exception of members with Medicare Part A and Part B who live outside the Medicare Advantage service area of their health plan. Active employees, and/or their dependents, may voluntarily participate in the Medicare Advantage program of their health plan.

~~_____~~ Retirees who fail to enroll in a 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.

e. All members and dependents are required to provide the Health Service System their social security numbers, and any other information required under federal, state or local law, unless there is a valid basis for not doing so. The failure to provide member social security numbers, or other required eligibility information, will result in the loss of health coverage.

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 ~~or/~~ her pay. ~~After the time that~~ the City subsidy ends, ~~then~~ the employee is ~~then~~ responsible for paying the entire cost of the health coverage. This includes both health (including vision) and dental. The employee has the choice of continuing health (including vision) and dental, only health, only dental, or not at all. The employee must make the required health coverage payments directly to the Health Service System by the applicable due date.

a. Educational Leave and Personal Leave.

Membership in the Health Service System continues for the duration of the approved 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 directly to the Health Service System by the applicable due date.

b. Leave for Employment as an Employee Organization Officer or Representative.

Membership in the Health Service System continues for the duration of the approved 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 paying the entire premium amount directly to the Health Service System by the applicable due date.

_____ In certain cases, the union 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 this premium is paid. The Health Service System will not seek payment directly from the member's union.

c. 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 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 date.

d. 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 or/ her health coverage, 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 date.

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 the Health Service System. 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 member must immediately notify the Health Service System in writing if the member's spouse is granted a final dissolution of marriage or is legally separated. In the event 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.

Under applicable federal and state income tax law, for marriages that are not recognized by the Federal government, payments for the legal spouses health coverage may not be eligible for pre-tax treatment, and coverage of the non-employee spouse could result in additional imputed income to the employee, with possible withholding for payroll taxes, including income and social security taxes, on such amounts.

b. A member's domestic partner. 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 Health Service System 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 a city or county certificate or Declaration of Domestic Partnership (the "Declaration") is filed with the Health Service System and, ~~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 the Health Service System. The parties also must acknowledge that the responsibility may be greater to the Health Service System than that undertaken in the domestic partner registration.
- (3)- The parties agree to immediately notify the Health Service System 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's health coverage 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. If the member's spouse is granted a final dissolution of domestic partnership, or is legally separated,

the non-employee spouse shall not be eligible as a dependent. A member must immediately notify the Health Service System in writing if the member's spouse is granted a final dissolution of domestic partnership or is legally separated. In the event a member has been granted a final dissolution of domestic partnership, or is legally separated, coverage for his or her dependent children shall continue as long as they are otherwise eligible.

bc. Children.

(1) Definitions. Children shall include:

- (i) Natural child of the member
- (ii) A step-child so long as member is married to natural parent
- (iii) A legally adopted child
- (iv) Child under legal guardianship
- (v) 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 meeting the eligibility requirements of B.1.c(1)(iv) and B.1.c(2)(iii), the child's eligibility to be declared as a dependent on the domestic partner's federal income tax return shall be sufficient.

(2) Children under the age of nineteen (19). A child living with the member in a parent-child relationship, who is economically dependent upon the member, under the age of eighteen (18), and 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 the child from group coverage. Any medical services provided, or benefits paid, on behalf of the child after the termination date are subject to collection by the benefit plan involved. Notwithstanding the foregoing, a 1040 tax form and notarized statement of fact shall not be required for children of members whose spouse or domestic partner has retained custody after a divorce, final dissolution of domestic partnership, or legal separation.

(3) Children from birthage nineteen (19) to twenty-five (25); years of age who meet all of the following conditions: Children from age nineteen (19) to twenty-five (25) years of age who meet all of the following conditions are eligible for dependent coverage:

- (1i): Dependent is not married;
- (2ii): Dependent does not work full time;
- (3iii): 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; and

~~(4iv):~~ Dependent is eligible to be declared as a dependent child on member's or the member's enrolled domestic partner's income tax return.

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 Section B.1c(4) below.

~~e. — For the purpose of (b) above, children shall include:~~

- ~~Natural child of the member~~
- ~~A step-child so long as member is married to natural parent~~
- ~~A legally adopted child~~
- ~~Child under legal guardianship~~
- ~~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. (4) Eligibility for Disabled Children over the age of eighteen (18). A disabled child may be continued as a dependent in the Health Service system, as long as the child remains disabled, provided that he or she who is:~~

- ~~(i) is over the age of 19 or over;~~
- ~~(ii) is unmarried;~~
- ~~(iii) is incapable of self-sustaining employment due to physical handicap or mental disability/retardation;~~
- ~~(iv) sustained a qualifying the disability must have occurred prior to the child's attainment of age 25;~~
- ~~(v) permanently resides with the employee/retiree member;~~
- ~~(vi) is dependent on the member for substantially all of his economic support; and~~
- ~~(vii) who is a dependent in a health plan of the Health Service System health plan on a continuous basis; and~~
- ~~(viii) was enrolled in a Health Service System health plan on the child's nineteenth birthday and continuously for at least one year prior to the child's nineteenth/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 ~~nine~~nineteen (199) 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~~nineteen (199), shall not be subject to the continuous coverage provisions of this subsection. Nonetheless, after enrollment, all members shall be required to maintain coverage on a continuous basis for their disabled children over the age of nineteen (19).

~~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.~~

hd. Eligibility Requirements for Spouses, Domestic Partners and Children. 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 only during ~~the~~any annual open enrollment period with coverage effective July 1st with proof of eligibility. All members are required to provide the Health Service System their dependent social security numbers, and any other eligibility information required under federal, state or local law, unless there is a valid basis for not doing so. The failure to provide dependent social security numbers, or other required eligibility information, will result in the loss of health coverage.

ie. Member Responsibility to Notify Health Service System in Writing to Cancel Dependent Coverage. 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 to, or a refund of contributions made on account of, an ineligible dependent.

2. Enrollment

a. Coverage Effective Date.

Eligibility qualification requires written notification to the Health Service System within thirty (30) days of a qualifying event. Coverage shall be effective as set forth below:

(i) 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 for the member, provided, however, that Coverage for a dependent who is hospital confined shall be added effective on the date he is no longer hospital confined.

(2) 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	<u>As of the date of marriage or domestic partnership, 1st day of the month a completed application is filed with Health Service System.</u>

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. 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 1st day of the month after a completed application is filed with Health Service System, provided that dependents who are hospital confined shall be added effective the date they are no longer hospital confined. Documentation will be required. Coverage for eligible dependents who are hospital confined shall be added effective the date they are no longer hospital confined.

(iii) Eligible newborns and adopted children.

Eligibility Event Date	Coverage Effective Date
Within 30 days after birth or commencement of legal custody.	<u>As of the date of birth or 1st day of the month after a completed application is filed with Health Service System demonstrating the commencement of legal custody.</u>

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

~~(1) 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.~~

~~(2) Notwithstanding the foregoing, after the expiration of the applicable period of thirty (30) days set forth in Subsection c 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:~~

- ~~(i) the Director has found that the member has acted in good faith and not in willful violation of the rules contained in Subsection b above;~~
- ~~(ii) 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;~~
- ~~(iii) 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; and~~
- ~~(iv) 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.~~

~~To comply with agreements established with the health plans, newborns must be enrolled within six (6) months of the date of birth in order.~~

~~Notwithstanding the foregoing, after the expiration of the application period of thirty (30) days set forth above in this subsection (c), the Director 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.4) Eligible dependent children whom the member has assumed legal custody of:

Eligibility Event Date	Coverage Effective Date
Within 30 days of commencement of legal custody	1 st day of the month after 30 days from the date a completed application is filed with 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 will be required.

~~_____~~ **(v.5), Other eligible dependents who have entered the United States or have moved into the service area of the member’s benefit plan:**

Eligibility Event Date	Coverage Effective Date
Within 30 days of the occurrence	1 st day of the month after the completed application is filed filed with Health Service System.

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. Coverage will be effective on the first day of the month after a completed application is filed with the Health Service System. 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.

~~(vi6.)~~ 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.~~

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 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. 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. Such application for coverage requires 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.~~

~~(7vii.)~~ Eligible children who gain eligibility by becoming a full-time students at times other than during the Open Enrollment, and who fulfills all other dependent eligibility criteria.

Eligibility Event Date	Coverage Effective Date
Within 30 days of attaining full time student status.	1 st day of the month following written notification to the Health Service System of the student's status.

~~A child who gains eligibility by becoming a full time student other than during 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. Coverage will be effective on the first day of the month following written notification to the Health Service System of the student's status. Documentation of student status will be required.~~

~~(8viii.)~~ 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 B.2 (Dependent 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.

~~(ix.9)~~ 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 as a dependent in only one health plan of one member.

~~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. Provided there is a change in family status, Aa member may cancel coverage for any or all of his or her dependents at any time by filing a cancellation request on forms prescribed by the Health Service System ~~and provided there is a change in family status~~. Cancellation of dependents' coverage shall become effective on the last day of the 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 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 month in which discovery of ineligibility occurs. The fact that the date of ineligibility ~~can not~~cannot 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~~ 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 for the following reasons- shall be entitled to elect continued coverage under the Health Service System~~because:~~

- (1) ~~an~~The employee terminates employment (voluntarily or involuntarily) except for employees terminated for the employee's gross misconduct;
- (2) ~~The~~an employee's hours of work are reduced resulting in loss of coverage;
- (3) ~~of a~~Divorce or legal separation from an employee; or
- (4) ~~a~~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 continued coverage under the Health Service System for up to eighteen (18) 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.

b. ~~For the purpose of Group C continuation C coverage, D domestic P partners and the dependent children of D domestic P partners shall be eligible.~~

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

d. Dependents may elect continuation coverage for themselves as individuals, or in combination with each other and/or the eligible member.

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.~~

a. **Children.** Surviving children shall be allowed to enroll in Health Service System coverage, consistent with sections B.1.b – B.1.e, provided they pay the full cost of coverage without any employer subsidy directly to the Health Service System by the applicable due date.

b. **Spouse or Domestic Partner.** As set forth in City Charter Section A8.428, a surviving spouse or surviving domestic partner of an active or retired employee shall be eligible for benefits, provided that the surviving spouse or surviving domestic partner of an active or retired employee have been married, or registered as domestic partners, for a period of at least one year prior to the death of the active or retired employee. To establish eligibility, proof of marriage and/or domestic partnership must be provided to the Health Service System.

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 1st unless otherwise provided by these rules.

b. Members enrolled in a Medicare Advantage Program may be transferred to an exempt status by completing the appropriate disenrollment applications and filing ~~such the~~ applications with the Health Service System. Transfer to exempt status shall be effective the first of the month after the completion and filing of the disenrollment applications with the Health Service 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 ~~h~~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 2.a(6)f.~~

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 benefit plan.

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~~. The Exemption will be effective the first day of the month following application.

3. — Retiree Health Coverage. ~~f. Under City Charter section A8.428, A~~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 as a "Retired Person" at the rate established for retired employees after service, disability or vesting retirement, ~~i.e., Charter sections A8.428(a)(1) and (a)(4) require that "Retired Person(s)" be a "former member(s) of the health service system"~~

D. EMPLOYEE PREMIUM CONTRIBUTIONS AND DELINQUENCIES

1. Members Not Subject to Payroll Deductions

a. It is the responsibility of the member to initiate payments directly to the Health Service System of employee premium contributions which ~~cannot or~~ are not, or cannot be, made by payroll or retirement roll reductions.

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

2. Delinquent Payments

a. Any employee premium 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 employee premium contributions ~~or premiums~~ are paid within 1430 days of the date of such notice, coverage for such insured shall be terminated as of last day of the month in which payment was delinquent.

b. If the affected insured fails to pay all delinquent employee premium contributions ~~or premiums~~ within the 3014-day period specified in ~~the immediately preceding paragraph~~ subsection 2.a above, coverage for such insured shall be terminated as of the last day of the month in which payment was delinquent. ~~No p~~Partial payment of delinquent employee

premium contributions ~~or premiums~~ prior to the end of the ~~3014~~-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 active member who was on authorized leave will be reinstated on the first of the month following his or her return to work with the health and/or dental coverage in which he or she was enrolled at the time of transfer to non-covered status because of delinquent employee premium contributions.

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 ~~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 employee premium 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 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 plans, during the open enrollment period unless they continue group coverage for the summer months.

F.D. OTHER PUBLIC AGENCIES ELIGIBLE TO PARTICIPATE IN THE HEALTH SERVICE SYSTEM

~~1. Public Agencies Eligible to Participate in the Health Service System~~

~~1. a. 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 1st, then the participating agency and its employees, retirees, and dependents shall be eligible to enroll the following July 1st. These time requirements may be modified only with the approval of the Health Service Board.

~~2. b. Terminating Participation.~~ A participating agency may end its participation in the Health Service System only 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 1st in order to be effective the following July 1st. Coverage of all agency employees, retirees and dependents will terminate on June 30th, 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. e. 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. d. 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.

G. MEMBERSHIP APPEALS AND GRIEVANCES

1. City Charter Section 12.200(5) requires the Health Service Board to receive, consider and, within 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 plan. Grievances will not be considered by the Health Service System until this action is taken.

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

San Francisco Health Service System,
Attention: Member Appeals-
1145 Market Street, Suite 200
San Francisco, CA 94102

Such grievance must be submitted within sixty (60) days of the event giving rise to the grievance, or the denial of the grievance by the members specific benefit plan under Section G.2. above.

~~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.~~

4. _____ 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.

5. _____ 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~~ (1015) business days after the date the Health Service System mails its decision to the member at the Members last known address on file with the Health Service System. ~~of notification.~~ An extension of time may be granted upon the showing of good cause.

6. _____ The appeal to the Health Service Board shall ~~be a in writt~~ writtingen appeal and shall specifically identify the basis of ~~stating~~ the member's ~~basis for~~ disagreement with the ~~decision of the Health Service System~~ decision.

7. _____ Prior to the Health Service Board hearing, the Health Service System shall serve a written response to the member's grievance upon the member and the Board.

8. _____ The Health Service Board shall act to grant or deny all written appeals so submitted consistent with City Charter Section 12.200(5).

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

10. _____ 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.

11. _____ Members shall be allowed to bring a personal representative of their choosing, along with any other witnesses the member believes have direct knowledge of the facts underlying the member's claim, to the Health Service Board hearing. 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 Board may exclude any witness upon a finding that his or her testimony would be duplicative, without foundation and/or not relevant to the issues raised in the member's claim.