



Health Service System Rules

Approved by the Health Service System Board on May 12, 2011,
to be effective July 1, 2011.

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 (HSS). Members are eligible to choose from the 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 Health Service 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) 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

- 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, a Retiree member is defined as: 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 (SFUSD) or the San Francisco Community College District (CCD). SFUSD and CCD may impose additional requirements for health coverage.

9. Resigned Members

As used in these Rules, a resigned member is defined as 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 is at the unsubsidized rate. Coverage must be continuous and, if lapsed, may not be reinstated without Board approval. (See San Francisco City Charter Section A8.425 and Administrative Code 16.701.d.)

10. 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 may be enrolled within 30 days of marriage, during the open enrollment period, or within 30 days of a qualifying event as defined in Section G. 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, the spouse's Social Security number, and Medicare card (if applicable) with the Health Service System. Coverage shall be effective as of the first day of the coverage period following the date in which HSS receives documentation.
- 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 as of the last day of the coverage period in which the divorce or final dissolution has been granted. A member must immediately notify the Health Service System in writing when the divorce or final dissolution of marriage 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 stepchildren will not continue.

2. A Member's Legal Domestic Partner

- a.** A domestic partner may be enrolled within 30 days of registration of domestic partnership, during open enrollment, or within 30 days of a qualifying event as defined in Section G. A domestic partner of a member shall be eligible as a dependent of a member if the member meets the following requirements:
- b.** The member must provide to HSS a certification of domestic partnership that has been processed per the requirements of the issuing city or county:
 - (1) For members residing in San Francisco, Domestic Partnership must be established by filing the Declaration of Domestic Partnership with the San Francisco County Clerk. (Domestic Partnership registration completed through a Notary Public in San Francisco is not accepted by HSS.)
 - (2) Members residing in California (including San Francisco) may alternatively provide a California Secretary of State Certificate of Registration of Domestic Partnership. (See www.sos.ca.gov).
 - (3) If the member resides in a city, county or state 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.

- (4) 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.
 - (5) The domestic partner's Social Security number and Medicare card (if applicable) must also be provided to HSS. Coverage will be effective on the first day of the coverage period following the date in which HSS receives all documentation.
- c.** 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 E.) Once a member's partner is no longer eligible, any children of the former partner are also no longer eligible.

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 (up to 26) of an enrolled member.
- A legally adopted child, or child placed for adoption with, an enrolled member, (up to age 26) .
- A stepchild (up to age 26) who is a natural child of, a legally adopted child of, or a child placed for adoption with, a member's enrolled spouse or domestic partner
- A child (up to age 19) under the legal guardianship of a member, a member's spouse or a member's domestic partner
- A member's child (up to age 19) as directed by Court order.

a. Eligibility Requirements for Natural Children, Adopted Children, Step Children

To be an eligible dependent child under these rules, a child must be under the age of 26 and be one of the following:

- (1) A natural child of an enrolled member.
- (2) A legally adopted child of, or a child placed for adoption with, an enrolled member.
- (3) A stepchild who is a natural child, legally adopted child, or child placed for adoption with, of a member's enrolled spouse or domestic partner.
- (4) A child may be enrolled within 30 days of birth, adoption, or adoption placement date, during open enrollment, or within 30 days of a qualifying Event as defined in Section G.
- (5) A member must provide eligibility documentation for the child including a birth certificate or adoption certificate or court documents and a Social Security number.
- (6) No child of a member may remain, or be enrolled, in the Health Service System past the maximum age of 26 except a disabled child as provided in Section 3c below.
- (7) Coverage will become effective on the first day of the coverage period following the receipt of all documentation by HSS by required deadlines.
- (8) Recertification of eligibility may be required as determined by HSS.

b. Eligibility Requirements for Children Under Legal Guardianship

To be eligible, a child under legal guardianship of a member, a member's enrolled spouse, or member's enrolled domestic partner, must meet all of the following criteria.

- (1) Child must be under 19 years of age;
- (2) Child may be enrolled within 30 days of the effective date of Legal Guardianship, during open enrollment, or within 30 days of a qualifying event as defined in Section G.
- (3) The member must provide eligibility documentation, including a copy of the legal judgement or decree assigning Legal Guardianship and a Social Security number.
- (4) Coverage will become effective on the first day of the coverage period following the receipt of all documentation by HSS by required deadlines.
- (5) Recertification may be required as determined by HSS.
- (6) Grandchildren, nieces and nephews, the spouse of a member's child and other relatives or children of no family relation residing with a

member are not eligible to be enrolled in an HSS administered health plan unless the child meets the qualifications for a child under Legal Guardianship.

c. Eligibility Requirements for Children Under Court Order

For the child to be eligible, a member must be required by judgement, decree or order issued by a court to provide health coverage for the child.

- (1) Child must be under 19 years of age;
- (2) The member must provide HSS with a copy of the Court Order and the child's Social Security number.
- (3) Recertification may be required as determined by HSS.

d. Age Exemption for Eligible Adult Disabled Children

To be an eligible dependent child under this rule, the child must be an adult disabled child who is incapable of self-support because of a mental or physical condition that existed prior to age 26 and continuously since age 26 and all of the following criteria must be met:

- (1) Adult child was enrolled in a Health Service System medical plan on the child's 19th birthday and continuously for at least one year prior to the child's 19th birthday;
- (2) Adult child was continuously enrolled in an HSS administered medical plan from age 19 to 26;
- (3) Adult child sustained a qualifying disability prior to the child's attainment of age 26;
- (4) Adult child is incapable of self-sustaining employment due to the physical or mental disability;
- (5) Adult child is unmarried;
- (6) Adult child permanently resides with the employee/retiree member;
- (7) Adult 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 at least sixty (60) days prior to child's attainment of age 26 and every year thereafter as requested:
 - a. certification that adult child is enrolled in Medicare (section J) due to a Social Security-qualifying disability
 - b. AND/OR HSS disabled dependent forms completed and signed by a physician.
- (9) All enrolled dependents who qualify for Medicare due to a disability are required to enroll in Medicare. (See section J.) Members must

notify the Health Service System of any dependent's eligibility for, and enrollment in, Medicare.

- (10) Once enrolled, the member must continuously enroll the disabled adult child with HSS and Medicare (if eligible) to maintain future eligibility.

A newly hired employee who adds an eligible dependent disabled child, who is age 26 or older, must meet all requirements listed, except c.1 and c.2 above.

4. Surviving Dependents

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 and must meet eligibility requirements in Sections B.1 and B.2.

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. An eligible surviving spouse or domestic partner not enrolled at the time of the member's death is eligible for coverage but must wait for the next open enrollment period or other qualifying event.

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 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 occur during the annual open enrollment period, with coverage effective the following July 1st upon submission to the Health Service System of a completed enrollment application and required eligibility documentation.

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. Exceptions can be made on a case-by-case basis for members and dependents who do not

qualify for Social Security numbers upon approval of the Health Service System Director.

4. Member Addresses Required

All members are required to keep a current address on file with the Health Service System. Members must report address changes to the Health Service System within thirty (30) days. Members are responsible for promptly responding to notices mailed by the Health Service System to the address on file with HSS.

D. TAXATION OF HEALTH BENEFITS OF A DOMESTIC PARTNER OR SAME SEX SPOUSE

1. Premium contributions for the domestic partner's health coverage may or may not be eligible for pre-tax treatment contingent on applicable federal and state income tax law. Thus, coverage of the domestic partner dependent could result in additional imputed income to the member, with possible withholding for payroll taxes, including income and Social Security taxes, on such amounts.
2. Members who file a *Declaration That Enrolled Dependent Meets IRS Standard For Pre-Tax Health Premium Deduction* form with HSS will pay member health premium contributions for the domestic partner and/or the partner's children on a pre-tax basis effective the first day of the coverage period following the date in which HSS receives the form. Imputed income will not accrue for the employer's portion of premium contributions for qualifying dependents. Changes in a dependents tax status cannot be made retroactively. An Annual declaration must be filed for each qualifying dependent.

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

It is the responsibility of the member to provide immediate written notification to the Health Service System when canceling 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 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 but not limited to any employer premium costs and costs for medical services provided, dating back to the date of the dependent's ineligibility.

F. OPEN ENROLLMENT PERIOD

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.

1. A member may change their benefit plan elections, and add or cancel dependents during this annual open enrollment period.
2. A member must submit all required enrollment applications and eligibility documentation by the open enrollment due date established by the Health Service System.
3. A retiree may waive medical coverage at any time. A retiree may only waive dental coverage for themselves and enrolled dependents during open enrollment, unless there is a qualifying event. (See Section G.)
4. Dependents who are deleted from coverage during open enrollment are not eligible for COBRA continuation coverage.
5. All changes made during the annual open enrollment period shall be effective on the following July 1st.

G. 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 eligible stepchildren, as defined in Section B.3., 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 eligible stepchildren, as defined in Section B.3., 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 and Placement for Adoption

If an enrolled member, or the member's spouse or domestic partner, adopts a child, or has a child placed for adoption, the member may add the child to his or her existing coverage outside of open enrollment.

5. Legal Guardianship

If an enrolled member, or the member's spouse or domestic partner, assumes legal guardianship of a child, the member may add the child to his or her existing coverage outside of open enrollment.

6. Court Order

If an enrolled member is ordered by a court to provide health coverage for a child, the member may add the child to his or her existing coverage outside of open enrollment.

7. Loss of Other Coverage

Members and eligible dependents who lose other coverage may be enrolled in Health Service System coverage. Members must provide proof of loss of coverage.

8. Divorce, Legal Separation or Dissolution of Partnership

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

9. An active member may drop coverage for self or dependents outside of open enrollment only with proof of other coverage.**10. A retiree may waive medical coverage for self or dependents at any time outside of open enrollment by submitting required forms to HSS.** If retiree waives coverage, he or she may not re-enroll until the next open enrollment or outside of open enrollment if there is a qualifying event as defined in Section G. (Retirees may not waive dental coverage outside of open enrollment.)**H. 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 1st, 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 coverage period after such application is received by 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 Establishing Permanent Residence Outside of the United States

- Retired members and dependents, regardless of health benefit plan, who reside outside of the United States are required to enroll in the City Health Plan or temporarily waive coverage.
- Medicare enrollment is not required for members residing outside the United States; however, services within the United States will **not** be covered if Medicare enrollment is waived or discontinued. Members will be required to complete an HSS form certifying that they are waiving Medicare enrollment and waiving health coverage within the United States.
- For retired members and dependents who reside outside the United States and continue their Medicare enrollment, services within the United States will be covered. Services outside the United States will be paid at the out-of-area reimbursement rate.
- 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 coverage indefinitely and must make the required premium 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.

I. 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 through the Health Service System at the rate established for retired employees, provided he or she applies for continuation of 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

Per City Charter Section A8.428, an individual who would qualify for coverage under Section I. 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 I.1., except that he or she shall pay the full unsubsidized rate. The full, unsubsidized rate is the total premium paid to the health plan consisting of both the retiree contribution and the employer contribution.

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 at the full unsubsidized rate for resigned employees as established by the Health Service Board under the provisions of Charter Section A8.425. A resigned member also includes teachers moved their funds from the San Francisco Employees Retirement System (SFERS) to 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, the Health Service System requires all premium payments to be deducted from the retiree member'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. Failure to make premium contributions by the applicable due date may result in termination of coverage.

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.

Change in primary residence may require a change in health plan. A retiree who becomes ineligible for coverage because he or she moves outside of the plan's service area may be required by the plan to pay for all services received while ineligible.

J. REQUIRED MEDICARE ENROLLMENT

Medicare is a federal health insurance program for people age 65 years or older, under age 65 with Social Security-qualified disabilities, and people of any age with End-Stage Renal Disease. The different parts of Medicare help cover specific services: Part A covers hospital insurance, Part B covers medical insurance, and Part D covers prescription drug insurance. (See www.medicare.gov.)

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. Dependents of Active Employee Members

All legal spouses, natural children, adopted children or children under legal guardianship of an active member who are eligible due to either age or disability, have the option, but are not required, to enroll in Medicare Part A as soon as they are eligible.

All domestic partner and same sex spouse dependents of active employee members who are eligible due to reaching age 65 or older must enroll in both non-contributory Medicare Part A and contributory Medicare Part B. If the domestic partner dependent or same sex spouse is eligible but fails to enroll in either non-contributory Part A or contributory Part B of Medicare that dependent's coverage will be terminated.

3. Retired Members

Retired members who are eligible due to either age or disability must enroll in both non-contributory Medicare Part A and in contributory 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. A retired member who is eligible but fails to enroll in both non-contributory Part A and in contributory Part B of Medicare, will be automatically transferred to the City Health Plan 20 until proof of Medicare enrollment is provided. City Plan 20 provides coverage at a higher out-of-pocket cost to the retiree member.

4. Dependents of Retired Members

All dependents of retired members who are eligible due to either age or disability must enroll in both non-contributory Medicare Part A and contributory Medicare Part B. If a dependent is eligible but fails to enroll in either non-contributory Part A or contributory Part B of Medicare that dependent's coverage will be terminated. (Some dependents will only be eligible for Part B.)

K. MEDICARE ADVANTAGE ENROLLMENT

Medicare Advantage program participation is required for all retired members and dependents enrolled in Medicare, who are enrolled in a Health Maintenance Organization (HMO) with the exception of members with who live outside the Medicare Advantage health benefit plan service area. (Retirees who fail to maintain their enrollment in Medicare Part A, Part B will be automatically transferred to the City Health Plan 20. City Plan 20 provides coverage at a higher out-of-pocket cost to the retiree member. See Section J.)

L. 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 or plans 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 enrollment.

M. MEMBER HEALTH BENEFITS COVERAGE PERIODS

1. Coverage Effective Date. Coverage shall be effective as set forth below. See Appendix A for coverage period schedules for July 1, 2011 through June 30, 2012.

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 st thru 31 st	1 st day of the following coverage period

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

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
1 st thru 31 st	1 st day of the following coverage period

c. Eligible Employees of the San Francisco Unified School District

(i) Monthly

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
1 st thru 31 st	1 st day of the following coverage period

(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 st thru 15 th	16 th of that month
16 th thru 31 st	1 st day of the following coverage period

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 st thru 31 st	Last day of the coverage period 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 st thru 31 st	Last day of the coverage period 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 st thru 31 st	Last day of the coverage period 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 st thru 15 th	15 th of that month
16 th thru 31 st	Last day of the coverage period for which the employee premium contributions have been made in full

- e. Termination date for deceased eligible members**

COVERAGE TERMINATION DATE
Coverage terminated as of the day after death

N. 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. See Appendix A for coverage period schedules for July 1, 2011 through June 30, 2012.

a. Eligible Dependents

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
At the time of member's original enrollment	1 st day of the coverage period after a completed application is filed with the Health Service System.

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 st day of the coverage period 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 1st day of the coverage period 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 and Children Placed for Adoption

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of the commencement of legal custody or placement.	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.

An adopted child of a member (or member’s spouse or domestic partner) 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 N.1.c. and N.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 N.1.c. and N.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 Health Service System receives 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 coverage period.

- (4) 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 (or Member’s Spouse or Domestic Partner) Has Assumed Legal Guardianship

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of commencement of legal guardianship	1 st day of the coverage period after a completed application is filed with the Health Service System

An eligible dependent child whom the member (or member’s spouse or domestic partner) 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 coverage period 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 st day of the coverage period 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 coverage period 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.	1 st day of the coverage period after a completed application is filed with the Health Service System

Eligible dependents who lose group health insurance coverage through job displacement may apply for coverage through the Health Service System within thirty (30) days 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 other than listed above is subject to the discretion of the Health Service System.

i. Open Enrollment Coverage Effective Date

Dependents not enrolled by the member at the time of the member’s 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.

O. WAIVING HEALTH BENEFITS COVERAGE (VOLUNTARY)

A member may waive coverage by submitting a completed HSS application form and requesting that coverage be waived. 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 1st.
- c.** Based on the rules governing qualifying events as set forth in Section G, 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 member may waive medical coverage for himself or herself or a dependent at any time. (Dental coverage can only be waived during open enrollment, unless there is a qualifying event. See Section G.)
- e.** A member may elect to waive enrollment in a health benefit plan for himself or herself, and any enrolled dependents for the duration of an unpaid leave if appropriate notice and documentation is given to the Health Service System in advance or immediately upon the commencement of the unpaid leave. (See Section R.)

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 N.1.h.

- c. A member may waive coverage if other medical or dental coverage has been obtained. An application form and required documentation must be submitted to HSS within 30 days of the date other coverage begins. The waiver will be effective the first day of the coverage period following receipt of application. Exceptions to this rule are at the discretion of the Director.

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 health 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."

P. 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.
- c. Premium contributions are due prior to the effective coverage period. See Appendix A.

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 member a notice of delinquency. Such notice shall be addressed to the current address on file with HSS, and shall be sent by U.S. Mail. Such delinquency notice shall indicate that, unless all premium contributions are paid by the due date specified, coverage shall be terminated on the last day of the coverage period in which full payment was made.
- b. If the member fails to pay all delinquent premium contributions by the due date specified in the notice, coverage the member's coverage shall be terminated as of the last day of the coverage period in which full payment was made. HSS shall provide each affected member a notice of termination of coverage. If payment is made within 14 calendar days of notice of termination, HSS will reinstate coverage with a \$50 reinstatement charge.

- c. Members will be allowed one period of delinquent payment per benefit year. Repeated payment delinquency periods will result in termination of coverage.
- d. Partial payment of delinquent premium contributions shall not be sufficient to avoid or delay termination. Any such partial payment received by the Health Service System shall be applied to the most delinquent full coverage period. Premium contributions insufficient for a full coverage period will be returned or refunded.
- e. 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 coverage period following his or her return to active employee status, provided the employee notifies the Health Service System in writing within thirty (30) days of the date he or she returns to work.
- f. 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.

Q. TERMINATION OF HEALTH BENEFITS COVERAGE (INVOLUNTARY)

1. Unless noted in the subsections below, termination date of coverage will vary depending on the member's premium contribution dates and corresponding coverage periods.
2. 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. (See Section P.2.)
3. 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 any enrolled dependents, benefits coverage will be terminated. (See Section C, Eligibility Documentation Required.)
4. Benefits of a member or dependent who becomes ineligible for any reason shall terminate on the last day of the coverage period for 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 coverage period in which discovery of ineligibility occurs. (See Section E for member penalties that will be incurred when a member fails to notify the Health Service System when a member's dependent becomes ineligible.)

5. Failure to comply with the conditions and requirements set forth in these Rules may result in retroactive termination of coverage.
6. Upon termination of a member's coverage, dependent coverage shall also be terminated.
7. 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 1st.

R. 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. Employees must notify HSS in advance or immediately upon their leave to either waive coverage or arrange for payment of employee contributions while on leave.

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 immediately notify the Health Service System – no later than thirty (30) days of returning to work.

2. Waiving Coverage While on Authorized Unpaid Leave

At any time during an 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 immediately notify the Health Service System – no later than thirty (30) days of returning to work in order to resume coverage and return premium contributions to active status. Coverage will resume the first day of the next coverage period following HSS notification of return to work.

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.

S. 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"> • Employee’s termination • Employee’s reduction in working hours 	<ul style="list-style-type: none"> • Employee • Spouse • Dependent child 	18 months from date active employee coverage ends
<ul style="list-style-type: none"> • Covered employee’s death • Covered employee’s divorce or legal separation 	<ul style="list-style-type: none"> • Spouse • Dependent child 	36 months from date active employee coverage ends
<ul style="list-style-type: none"> • Loss of dependent child status 	<ul style="list-style-type: none"> • Child 	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.

T. 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 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. 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.

3. 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 1st 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.

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.

U. MEMBER APPEALS AND GRIEVANCES

1. Members who have a grievance with a specific benefit plan must first try and resolve their grievance through the plan's member assistance process. Grievances will not be considered by the Health Service System until this action is taken and documentation is submitted to HSS.
2. Members are advised that grievances relating to medical service received (or not received) from a 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).
3. 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

4. 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 U.1. above.
5. 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
6. 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
7. 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.
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 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.

V. GOVERNANCE OUTSIDE OF STATED RULES

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

APPENDIX A: BENEFITS COVERAGE PERIODS

Benefits coverage periods for members on a bi-weekly premium payment schedule of 26 premium payments per year:

July 1, 2011 – July 8, 2011
July 9, 2011 – July 22, 2011
July 23, 2011 – August 5, 2011
August 6, 2011 – August 19, 2011
August 20, 2011 – September 2, 2011
September 3, 2011 – September 16, 2011
September 17, 2011 – September 30, 2011
October 1, 2011 – October 14, 2011
October 15, 2011 – October 28, 2011
October 29, 2011 – November 11, 2011
November 12, 2011 – November 25, 2011
November 26, 2011 – December 9, 2011
December 10, 2011 – December 23, 2011
December 24, 2011 – January 6, 2012
January 7, 2012 – January 20, 2012
January 21, 2012 – February 3, 2012
February 4, 2012 – February 17, 2012
February 18, 2012 – March 2, 2012
March 3, 2012 – March 16, 2012
March 17, 2012 – March 30, 2012
March 31, 2012 – April 13, 2012
April 14, 2012 – April 27, 2012
April 28, 2012 – May 11, 2012
May 12, 2012 – May 25, 2012
May 26, 2012 – June 8, 2012
June 9, 2012 – June 30, 2012

APPENDIX A: BENEFITS COVERAGE PERIODS *(continued)*

Benefits coverage periods for members on a twice-monthly premium payment schedule of 24 premium payments per year:

July 1, 2011 – July 15, 2011

July 16, 2011 – July 31, 2011

August 1, 2011 – August 15, 2011

August 16, 2011 – August 31, 2011

September 1, 2011 – September 15, 2011

September 16, 2011 – September 30, 2011

October 1, 2011 – October 15, 2011

October 16, 2011 – October 31, 2011

November 1, 2011 – November 15, 2011

November 16, 2011 – November 30, 2011

December 1, 2011 – December 15, 2011

December 16, 2011 – December 31, 2011

January 1, 2012 – January 15, 2012

January 16, 2012 – January 31, 2012

February 1, 2012 – February 15, 2012

February 16, 2012 – February 29, 2012

March 1, 2012 – March 15, 2012

March 16, 2012 – March 31, 2012

April 1, 2012 – April 15, 2012

April 16, 2012 – April 30, 2012

May 1, 2012 – May 15, 2012

May 16, 2012 – May 31, 2012

June 16, 2015 – June 30, 2012

APPENDIX A: BENEFITS COVERAGE PERIODS *(continued)*

Benefits coverage periods for members on a monthly premium payment schedule of 12 premium payments per year:

- July 1, 2011 – July 31, 2011
- August 1, 2011 – August 31, 2011
- September 1, 2011 – September 30, 2011
- October 1, 2011 – October 31, 2011
- November 1, 2011 – November 30, 2011
- December 1, 2011 – December 31, 2011
- January 1, 2012 – January 31, 2012
- February 1, 2012 – February 29, 2012
- March 1, 2012 – March 31, 2012
- April 1, 2012 – April 30, 2012
- May 1, 2012 – May 15, 2012
- June 1, 2012 – June 30, 2012