

Management Cafeteria Plan

2009
2010



Health Service System

CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

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Pacificare Plan No Longer Being Offered

To help keep costs down for both you and your employer, the PacifiCare HMO plan is no longer being offered in Plan Year 2009-2010. Members enrolled in PacifiCare must elect a different medical plan by submitting an Open Enrollment Application to HSS no later than 5pm, April 30, 2009. PacifiCare participants who do not submit an application to elect a new medical plan during April 2009 Open Enrollment will be defaulted to the City Plan.

Blue Shield Office Visit Co-Pays Increase To \$15

The amount you will pay for an office visit increases to \$15 for the Blue Shield HMO as of July 1, 2009.

City Plan & Blue Shield Brand Name & Non-Formulary Prescription Co-Pays Increase

Blue Shield and City Plan enrollees will pay more for brand-name and non-formulary prescriptions. Changes will take effect on July 1, 2009. The cost of prescriptions for generic drugs will not change. See pages 18-21 for details.

Pharmacy Prescriptions - Brand Name	\$20 co-pay 30 day supply
Pharmacy Prescriptions - Non Formulary	\$35 co-pay 30 day supply
Mail Order Prescriptions - Brand Name	\$40 co-pay 90 day supply
Mail Order Prescriptions - Non Formulary	\$70 co-pay 90 day supply

No Changes To Kaiser Benefits

There are no changes to Kaiser medical benefits or co-pay costs in Plan Year 2009-2010.

Employee Contributions Will Increase For All Medical Plans

The twice monthly employee contributions for all medical plans will increase in 2009-2010. The amount of the increase is dependent upon the medical plan you elect. Be sure to check the Rates chart on page 23 so that you are aware what your contribution costs will be for 2009-2010 before deciding what action to take during Open Enrollment.

Twice Monthly Flexible Credit Allocations Increase

For Plan Year 2009-2010 eligible City and County of San Francisco enrollees will receive \$317.95 in flexible credits twice monthly. Eligible Superior Court enrollees will receive \$559.00 in credits twice monthly. See page 12 for details.

Plan Year 2009-2010 changes take effect July 1, 2009. These alerts include highlighted changes only and may not cover every Plan change for 2009-2010. Please read the Evidence of Coverage (EOC) document for details about your plan's benefits. EOCs are available on myhss.org.

EBS Appointments Required

All Management Cafeteria Plan participants must contact EBS at (800) 229-7683 and schedule an Open Enrollment appointment to allocate flexible credits for the 2009-2010 plan year. If you do not allocate your credits they will be automatically distributed. See page 13 for details.

The Last Day To Submit Open Enrollment Changes Is April 30, 2009

Completed Open Enrollment Applications for Plan Year 2009-2010 must be submitted to HSS by 5PM, April 30, 2009. Open Enrollment Applications can be delivered to HSS in person, sent through the mail or transmitted by fax. Applications must be delivered with required eligibility documentation or they cannot be processed. See page 9 for a checklist of required eligibility documentation.

HSS Address:

Health Service System
1145 Market Street, 2nd Floor
San Francisco, CA 94103

HSS Fax:

(415) 554-1752

Things You Can Do During Open Enrollment

During Open Enrollment you can:

- Elect a different medical or dental plan.
- Add or drop eligible dependents from medical or dental coverage.
- Enroll in a 2009-2010 Healthcare and/or Dependent Care Flexible Spending Account.

HSS Open Enrollment Open House April 1-30, 2009

Members are invited to visit HSS at 1145 Market Street, 2nd Floor from April 1-30 for in-person assistance with Open Enrollment. HSS medical and dental vendors will be on-site April 13-30.

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

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

Social Security Numbers Are Required For All Members & Dependents

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

Election Changes Outside Of Open Enrollment

Outside of the annual Open Enrollment period you must have a qualifying event in order to make any changes to your healthcare elections. See pages 10-11 for qualifying event guidelines.

Open Enrollment

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

Things You Can Do During Open Enrollment

During Open Enrollment you can:

- Elect a different medical or dental plan.
- Add or drop eligible dependents from medical or dental coverage.
- Enroll in a 2009-2010 Healthcare and/or Dependent Care Flexible Spending Account.

To make changes you must submit a completed Open Enrollment Application in person, by mail or by fax to HSS no later than 5 PM on April 30, 2009.

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

EBS Appointments Required

All Management Cafeteria Plan participants must contact EBS at (800) 229-7683 and schedule an appointment to allocate flexible credits for 2009-2010. Failure to take action will result in automatic distribution. See page 13 for details.

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

Any changes you elect to make during the April 2009 Open Enrollment period will take effect July 1, 2009 and remain in effect through June 30, 2010.

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

If you elect to change your medical plan, the plan will issue you a new medical ID card. You should receive your new ID card before July 1, 2009. If you do not receive your card, contact the plan.

If You Don't Make Any Changes During Open Enrollment

If you are currently enrolled in Blue Shield, Kaiser or City Plan and don't make changes during Open Enrollment, your current medical and dental plan elections and the eligible dependents you have covered will remain the same. PacifiCare members who do not elect an alternate medical plan will be automatically enrolled in the City Plan. Without re-enrollment all current Healthcare and Dependent Care FSAs will end June 30, 2009. And if you don't meet with EBS to allocate flexible credits, your credits will be automatically distributed.

Payroll Deduction Amounts

The amount deducted from your paycheck will change in accordance with any approved changes to the rates for Plan Year 2009-2010. (See page 23 of this guide for 2009-2010 rates.) Check your paystub to be sure the correct deduction is being taken. You are responsible for making sure all required healthcare contributions are paid.

No Dual HSS Plan Coverage

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

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

Open Enrollment

FREQUENTLY ASKED QUESTIONS

	Medical & Dental	Flexible Spending Accounts	Flexible Credits
What if I don't want to make any changes to my benefit elections in 2009-2010?	If you want to keep the same medical and dental plan and are not adding or dropping dependents you do not need to take any action. Note: All PacifiCare participants must enroll in an alternate medical plan by April 30, 2009.	FSAs require re-enrollment every year. You must meet with EBS to continue your FSA for the coming year. If you do not take action, your FSA contributions will cease the last pay period of June, 2009.	You must allocate your flexible credits every year. To continue your allocations in 2009-2010, meet with EBS during Open Enrollment. If you don't take action, credits are automatically distributed. (See page 13 for details.)
How do I make changes to my benefit elections in 2009-2010?	You must submit a completed Open Enrollment Application form and any required eligibility documentation to HSS no later than 5 PM, April 30, 2009.	Meet with EBS during Open Enrollment to make changes to your FSA contributions for the coming year. If you don't, you will not have an FSA in 2009-2010.	You must meet with EBS during Open Enrollment to make changes to your flexible credit allocations for the coming year. Otherwise, credits are automatically distributed. See page 13.
How do I add or drop a dependent from my medical and/or dental plan during Open Enrollment?	Submit a completed Open Enrollment Application and required eligibility documentation to HSS no later than 5 PM, April 30, 2009. No documentation is required when dropping dependents.		If you are adding or dropping dependents during Open Enrollment this may modify the allocation of your flexible credits. Be sure to discuss these changes with EBS.
May I fax my enrollment information?	Yes, you can fax your Open Enrollment Application and eligibility documentation to HSS at (415) 554-1752. Please keep a copy of your fax confirmation as proof of your submission.	No—if you would like a Flexible Spending Account in 2009-1010 you must meet with EBS. If you do not, your FSA contributions will end the last pay period of June, 2009.	No, flexible credit allocations must be done in person at an Open Enrollment meeting with an EBS representative. Contact EBS at (800) 229-7683 to schedule your appointment. Otherwise credits will be automatically distributed.
If I have questions about enrollment, or want to schedule my EBS appointment, whom do I contact?	If you have questions about medical and dental enrollment, contact HSS member services at (415) 554-1750.	To schedule the April 2009 appointment during which you can re-enroll in or open a Flexible Spending Account, contact EBS at (800) 229-7683.	Contact EBS by calling (800) 229-7683 to schedule your April 2009 appointment. Otherwise, your flexible credits will be automatically distributed.

New Hires, Promotions & Returning Employees

Management Cafeteria Plan

In addition to the medical, dental and vision plan benefits offered to eligible City employees, Management Cafeteria Plan participants are allocated flexible credits that they can apply to a variety of pre- and post-tax benefits. For an overview of the value of this year's credits and Cafeteria benefit options, see page 12 of this guide. To allocate your flexible credits you must meet in person with a representative from EBS at the HSS office within 30 days of your date of hire or promotion. Appointments are available on Wednesdays. Call HSS at (415) 554-1750 to schedule your EBS appointment.

New or Rehired Employees Must Enroll Within 30 Days

Eligible new and rehired employees must enroll in an HSS medical and/or dental plan within 30 calendar days of their initial appointment date or within 30 calendar days of meeting the eligibility requirements for coverage. If you do not enroll within this 30 day period, you must wait until the next Open Enrollment or when you have a qualifying change in family status. (See pages 10-11 for details about qualifying events.)

How To Enroll

To enroll in an HSS medical and/or dental plan, new or returning employees must submit a completed Enrollment Application and any required eligibility documentation to HSS. For a checklist of required eligibility documentation see page 9. Please submit copies of eligibility documentation – not your original documents. If you choose not to hand in an application during your orientation, applications and supporting documentation can be mailed, faxed or dropped off at the HSS office withing 30 calendar days of your official start date. See page 64 for HSS phone, fax and address details. You must also meet with EBS to allocate your flexible credits. If you do not meet with EBS, your flexible credits will be automatically distributed. (See page 13 for more information.)

When Coverage Begins

Coverage usually begins on the first available benefit period after your start date. There are two benefit periods each month. The first benefit period is from the first day of the month to the 15th. The second benefit period is from the 16th of the month to the last day of the month. Contact HSS Member Services if you have questions about when your coverage will begin.

Responsibility For Healthcare Contributions

Healthcare contributions are taken from active employee paychecks twice monthly. No healthcare contribution deductions are taken from any third paycheck in a month. You should carefully check your paycheck stub to verify that the correct healthcare contribution is being deducted. If the deduction is incorrect or does not appear on your paycheck stub, contact HSS Member Services. You are responsible for all required healthcare contributions, whether they are deducted from your paycheck or not.

Healthcare Contribution Calendar

Payroll Deductions Taken Twice Monthly

Healthcare contributions are deducted from paychecks twice monthly—a total of 24 payroll deductions per year. Your first paycheck each month will have a deduction that pays for healthcare coverage for the first half of that month. Your second paycheck each month will have a deduction that pays for healthcare coverage for the second half of the month. There will be no healthcare contribution deduction taken from your third paycheck in the months of September 2009 and March 2010.

2009 PAY DATE	COVERAGE PERIOD	2010 PAY DATE	COVERAGE PERIOD
July 7, 2009	July 1-15, 2009	January 5, 2010	January 1-15, 2010
July 21, 2009	July 16 -30, 2009	January 19, 2010	January 16-31, 2010
August 4, 2009	August 1-15, 2009	February 2, 2010	February 1-15, 2010
August 18, 2009	August 16-31, 2009	February 16, 2010	February 16-28, 2010
September 1, 2009	September 1-15, 2009	March 2, 2010	March 1-15, 2010
September 15, 2009	September 16-30, 2009	March 16, 2010	March 16-31, 2010
September 29, 2009	NO DEDUCTION	March 30, 2010	NO DEDUCTION
October 13, 2009	October 1-15, 2009	April 13, 2010	April 1-15, 2010
October 27, 2009	October 16-31, 2009	April 27, 2010	April 16-30, 2010
November 10, 2009	November 1-15, 2009	May 11, 2010	May 1-15, 2010
November 24, 2009	November 16-30, 2009	May 25, 2010	May 16-31, 2010
December 8, 2009	December 1-15, 2009	June 8, 2010	June 1-15, 2010
December 22, 2009	December 16-31, 2009	June 22, 2010	June 16-30, 2010

If you take an approved leave of absence you may need to pay HSS directly for the healthcare contributions that were being deducted from your paycheck. If you decide to continue healthcare coverage during a leave you can sign-up for easy, secure Auto-Pay. With Auto-Pay your monthly healthcare contribution can be charged automatically to your VISA or Mastercard while you are on leave. See page 32 for more information about HSS healthcare coverage and leaves of absence.

Eligibility

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

Member Eligibility

The following are eligible to participate in the Health Service System as defined in San Francisco Administrative Code Section 16.700:

- City and County Employees
 - All permanent employees of the City and County of San Francisco whose normal work week is not less than 20 hours;
 - All regularly scheduled provisional employees of the City and County of San Francisco whose normal work week is not less than 20 hours;
 - All other employees of the City and County of San Francisco, including temporary exempt “as needed” employees, who have worked more than 1040 hours in any consecutive 12 month period and whose normal work week is not less than 20 hours.
- Elected Officials
- All members of designated boards and commissions during their time in service to the City and County of San Francisco as defined in San Francisco Administrative Code Section 16.700(c).
- 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.

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

Spouse/Domestic Partner

- A member’s legal spouse or domestic partner may be eligible for healthcare coverage administered by the Health Service System. Proof of marriage or registered domestic partnership is required when enrolling a spouse or domestic partner.
- An individual who has been granted a final dissolution of marriage or is legally separated from an HSS member is not eligible. If a domestic partnership has been dissolved, the former partner of the HSS member is not eligible.

Natural Children, Step-Children, Adopted Children, Legal Guardianships

Children who may be covered under an HSS plan include a member’s natural child, a step-child (as long as the HSS member is married to the natural parent), a legally adopted child, a child under legal guardianship and a natural or legally adopted child of an eligible spouse or domestic partner. Legal documentation is required to enroll an adopted child or a child under guardianship. To qualify, a child must meet all of the following five criteria:

1. Child must be under 25 years of age or currently under legal guardianship.
2. Child must be unmarried.
3. Child cannot be working full time.
4. Child must reside in the member’s home (except for full-time college students and children living with a divorced spouse).
5. Child must be declared as an exemption on the member’s federal income tax return.

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

Children who are not a member’s natural child, step-child, legally adopted child, child under legal guardianship or the natural or legally adopted child of an eligible spouse or domestic partner may also be eligible for coverage under an HSS plan. To qualify, a child must meet all of the following five criteria:

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

Court Ordered Children

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

Disabled Children

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

1. Child must be unmarried.
2. Child is incapable of self-sustaining employment due to physical handicap or mental retardation that existed prior to the child’s attainment of age 25.
3. Child must permanently reside in the member’s home and be economically dependent on the member for all of his or her economic support.
4. Child must be declared as an exemption on the member’s federal income tax return. A copy of the member’s federal income tax return must be submitted to HSS annually if requested.
5. Child must have been enrolled in an HSS health plan on a continuous basis prior to the child’s 19th birthday.
6. Member submits acceptable medical documentation of the disability at least 60 days prior to child’s attainment of age 25. HSS may periodically request documentation of the disability.

REQUIRED ELIGIBILITY DOCUMENTATION

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

A Social Security number must also be provided for all enrolled individuals.

Qualifying Changes in Family Status

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

Marriage or Domestic Partnership

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

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

Birth or Adoption

To enroll your newborn/newly adopted child in your HSS healthcare coverage you must submit a

completed HSS Enrollment Application and a copy of the birth certificate or adoption documentation **within 30 days** from the date of birth or placement for adoption. Coverage for your newborn child will be effective on the child's date of birth provided you meet the deadline and documentation requirements stated above. Coverage for your newly adopted child will be effective on the date the child is placed with you provided you meet the deadline and documentation requirements stated above. If you do not complete the enrollment process **within 30 days** from the date of birth or placement for adoption of a new child, you must wait until the next annual Open Enrollment period to do so.

Divorce, Separation and Dissolution of Partnership

To terminate healthcare coverage for your ex-spouse/domestic partner due to divorce, legal separation or dissolution of domestic partnership, you must submit a completed HSS Enrollment Application and a copy of your divorce decree, legal separation documents or dissolution of domestic partnership documents **within 30 days** from the date of divorce, legal separation or dissolution of domestic partnership. Coverage for your ex-spouse/domestic partner will terminate on the last day of the coverage period in which the divorce, legal separation or dissolution of domestic partnership occurred, provided you meet the deadline and documentation requirements stated above. If you do not complete the coverage termination process **within 30 days** from the date of your divorce, legal separation or dissolution, coverage for your ex-spouse/domestic partner will terminate on the last day of the coverage period in which you submit a completed HSS Enrollment Application

and required documentation and you will be responsible for paying all required contributions up to the coverage termination date.

Loss of Other Healthcare Coverage

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

Obtaining Other Coverage

You may terminate healthcare coverage for yourself and/or your enrolled dependents if you or they become eligible for other healthcare coverage by submitting a completed HSS Enrollment Application and proof of other healthcare coverage enrollment **within 30 days** from the date of your enrollment in another healthcare plan. Your HSS healthcare coverage will terminate on the last day of the coverage period in which HSS receives a completed HSS Enrollment Application provided you meet the deadline and documentation requirements stated above. Please note that there may be an overlap of healthcare coverage between the date your other coverage begins and the date your HSS coverage terminates. You are responsible for paying all required contributions up to the termination date of your HSS healthcare coverage. If you do not complete the coverage termination process

within 30 days from the date of your enrollment in another healthcare plan, you must wait until the next annual Open Enrollment.

Death of a Dependent

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

Death of a Member

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

Whenever you update your coverage because of a qualifying change in family status, you should carefully check your paycheck to verify that the correct healthcare contribution is being deducted. If the deduction is incorrect or doesn't appear on your paycheck, contact HSS Member Services at (415) 554-1750 for assistance. You are responsible for all required healthcare contributions, whether they are deducted from your paycheck or not.

It is your responsibility to notify HSS when any dependent covered on your plan becomes ineligible.

30 Day Rule

If you have a qualifying change in your family status and do not submit a completed HSS Enrollment Application within 30 days you must wait until the next Open Enrollment to do so.

Management Cafeteria Plan Options

The following is a list of options available under the Management Cafeteria Plan and the funding options (flexible credit and/or payroll deduction) for each benefit option. Eligible **City and County of San Francisco enrollees** will receive \$317.95 in credits **twice monthly** to purchase from among the options listed below. Eligible **Superior Court enrollees** will receive \$559.00 in credits **twice monthly** to purchase from among the options listed below.

PRE-TAX FLEXIBLE CREDIT OPTIONS

	Tax Status	Flexible Credit	Payroll Deduction
Medical Insurance	Pre-Tax	Yes	Yes
Dependent Care Flexible Spending Account	Pre-Tax	Yes	Yes
Healthcare Flexible Spending Account	Pre-Tax	Yes	Yes
Cancer Insurance	Pre-Tax	Yes	Yes
Heart and Stroke Insurance	Pre-Tax	Yes	Yes
Accident Insurance	Pre-Tax	Yes	Yes
Long Term Disability	Pre-Tax	Yes	No

\$50,000 Term Life Insurance provided at not cost to all employees eligible for this plan.

POST-TAX FLEXIBLE CREDIT OPTIONS

	Tax Status	Flexible Credit	Payroll Deduction
Universal Life Insurance	Post-Tax	Yes	Yes
Short Term Disability	Post-Tax	Yes	Yes
Long Term Care	Post-Tax	Yes	Yes
Veterinary Pet Insurance	Post-Tax	Yes	Yes
Group Legal Plan	Post-Tax	Yes	Yes
Computer Purchase Program	Post-Tax	Yes	Yes
Supplemental Term Life Insurance	Post-Tax	Yes	No
Misc. Reimbursement Account	Post-Tax	Yes	No
Commuter Check	Post-Tax	Yes	No

Flexible credits applied to post-tax benefits will result in imputed income.

Flexible Credit Allocation Guidelines

Initial Enrollment

Eligible employees will be allowed to allocate available flexible credits to any combination of available pre- or post-tax benefit options based on the actual cost of each benefit.

Benefit options include medical plan premiums. If 100% of flexible credits are applied toward the medical plan and the cost of the plan exceeds the total credits available, the additional amount will be covered by a payroll deduction.

Denied Coverage

Members who elect to enroll in any voluntary benefit plan and are later denied coverage for which they have allocated flexible credits may elect one of the following:

- The member may reallocate 100% of the flexible credit amount that was allocated to the denied benefit option(s) to the Miscellaneous Reimbursement option. (Imputed income will be calculated.)

OR

- The member may elect to forfeit 100% of the flexible credit amount that was allocated to the denied benefit option(s) for the duration of the plan year.

Members who elect to reallocate flexible credits to the Miscellaneous Reimbursement option will not receive the retroactive value of the applicable flexible credits but will have the applicable amount applied to the Miscellaneous Reimbursement account on a prospective basis.

Family Status Changes

Members may only elect to reallocate flexible credits where the reallocation relates directly to a qualified change in family status.

Open Enrollment

Members must re-allocate flexible credits during Open Enrollment. This requires an in-person appointment with an EBS representative. Contact EBS at (800) 229-7683 to schedule your appointment.

Any member who does not take action to make a flexible credit allocation during Open Enrollment will be subject to the following:

- If the member currently has medical plan coverage through Kaiser, Blue Shield or City Plan, flexible credits for the 2009-2010 Plan Year will be automatically applied to the actual cost of the medical plan at the same level of coverage currently in place. Any additional amount required to cover the actual cost of the medical plan will be covered by payroll deductions. All remaining credits, if any, will be allocated to the Miscellaneous Reimbursement Account and subject to imputed income.
- If the member currently has medical plan coverage through PacifiCare, the member must enroll in an alternate medical plan during Open Enrollment. PacifiCare participants who do not submit an application to HSS electing a new medical plan during April 2009 Open Enrollment will be automatically enrolled in the City Plan PPO as of July 1, 2009 at the same level of coverage currently in place through PacifiCare. Any additional amounts required to cover the actual cost of the medical plan will be covered by payroll deductions. All remaining credits, if any, will be allocated to the Miscellaneous Reimbursement Account and subject to imputed income.
- If the member currently has no medical plan coverage, all credits will be allocated to the Miscellaneous Reimbursement Account and subject to imputed income.

Choosing a Medical Plan

1 PPO vs. HMO

Learn about the differences between a PPO plan and an HMO plan. (See the chart on page 15.)

2 Plan Service Areas

Find out which plans offer service to you based on the home zip code of the primary HSS member. See the chart on page 17 of this guide or contact the plan.

3 Doctors and Hospitals

Determine which doctors, hospitals and other medical services that you and your family prefer.

4 Vendor Report Cards & Quality Ratings

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

HSS
www.myhss.org

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

Integrated Healthcare Association
www.iha.org/p4ptopr.htm

National Committee for Quality Assurance
www.ncqa.org

AHRQ
www.ahrq.gov/consumer/insuranceqa/

5 Medical Needs & Services Covered

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

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

6 Plan Costs

Compare the costs of each available medical plan. See page 23 of this guide for cost comparison charts.

PPO vs. HMO

QUICK COMPARISON CHART

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

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

Medical Plan Options

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

Health Maintenance Organization (HMO)

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

HSS offers the following HMO plans:

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

Preferred Provider Organization (PPO)

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

HSS offers the following PPO plan:

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

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

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

This benefits guide cannot cover every detail of your plan contract. The EOC (Evidence of Coverage) contains a complete list of benefits and exclusions in effect for each plan from July 1, 2009 through June 30, 2010. Review your EOC for plan details. If any discrepancy exists between the information provided in this guide and the EOC, the EOC will prevail. You can download plan EOCs at myhss.org.

PacifiCare Discontinued

The PacifiCare plan is no longer being offered in 2009-2010. PacifiCare participants must elect an alternate medical plan by April 30, 2009.

Medical Plan Service Areas

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

COUNTY	CITY HEALTH PLAN	BLUE SHIELD	KAISER
Alameda	■	■	■
Alpine	■		
Calaveras	■		
Contra Costa	■	■	■
Madera	■	■	○
Marin	■	■	■
Mariposa	■		○
Merced	■	■	
Mono	■		
Napa	■		○
Sacramento	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Clara	■	■	○
Santa Cruz	■	■	
Solano	■	■	■
Sonoma	■	■	○
Stanislaus	■	■	■
Tuolumne	■		
Yolo	■	■	○
Outside of California	■	Urgent Care/ER Only	Urgent Care/ER Only

■ = Available in this County.

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

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

Medical Plan Benefits-at-a-Glance

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

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

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers

Out-of-Network Providers*

Out-of-Area Providers*

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

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

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

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

85% covered after deductible

Not covered

85% covered after deductible

100% covered no deductible

50% covered no deductible

100% covered no deductible

85% covered after deductible

50% covered after deductible

85% covered after deductible

85% covered after deductible

50% covered after deductible

85% covered after deductible

85% covered after deductible

50% covered after deductible

85% covered after deductible

85% covered after deductible

50% covered after deductible

85% covered after deductible

\$5 co-pay 30 day supply

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

\$5 co-pay 30 day supply

\$20 co-pay 30 day supply

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

\$20 co-pay 30 day supply

\$35 co-pay 30 day supply

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

\$35 co-pay 30 day supply

\$10 co-pay 90 day supply

Not covered

\$10 co-pay 90 day supply

\$40 co-pay 90 day supply

Not covered

\$40 co-pay 90 day supply

\$70 co-pay 90 day supply

Not covered

\$70 co-pay 90 day supply

85% covered after deductible;
 may require prior notification

50% covered after deductible;
 may require prior notification

85% covered after deductible;
 may require prior notification

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

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

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

85% covered after deductible;
 may require prior notification

50% covered after deductible;
 may require prior notification

85% covered after deductible;
 may require prior notification

85% covered after deductible

50% covered after deductible

85% covered after deductible

85% covered after deductible;
 may require prior notification

50% covered after deductible;
 may require prior notification

85% covered after deductible;
 may require prior notification

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

Medical Plan Benefits-at-a-Glance

	blue  of california	KAISER PERMANENTE®
REHABILITATIVE		
Physical/Occupational therapy	\$15 co-pay	\$10 co-pay authorization req.
Acupuncture	\$15 co-pay 30 visits / year max	Not covered authorization req.
Chiropractic	\$15 co-pay 30 visits / year max	\$10 co-pay 30 visits / year max
PREGNANCY & MATERNITY		
Pre/post-natal physician care For hospital stay, see Hospitalization.	No charge newborn must be enrolled within 30 days of birth	\$10 co-pay newborn must be enrolled within 30 days of birth
INFERTILITY		
IVF, GIFT, ZIFT & Artificial Insemination	50% covered of the allowable amount; limitations apply	50% covered limitations apply
TRANSGENDER		
Office visits & outpatient surgery	Co-pays apply authorization req. \$75,000 lifetime max.	Co-pays apply authorization req. \$75,000 lifetime max.
DURABLE MEDICAL EQUIPMENT		
Home medical equipment	No charge	No charge as authorized by PCP according to formulary
Prosthetics/orthotics	No charge when medically necessary	No charge when medically necessary
Hearing aids	No charge 1 per ear every 36 months; \$2,500 max.	No charge 1 per ear every 36 months; \$2,500 max.
MENTAL HEALTH		
Inpatient hospitalization	\$100 co-pay per admittance	\$100 co-pay per admittance; max 45 days per year
Outpatient treatment	\$25 co-pay non-severe; 60 visit max. \$15 co-pay severe; no limit	\$5 co-pay group \$10 co-pay individual; up to 20 visits per year
SUBSTANCE ABUSE		
Inpatient	\$100 co-pay per admittance for short-term detox; max 30 days per year	\$100 co-pay per admittance for up to 30 day detox
Outpatient	\$25 co-pay up to 60 visits combined w/ outpatient non-severe mental health visits	\$5 co-pay group \$10 co-pay individual
EXTENDED & END-OF-LIFE CARE		
Skilled nursing facility	No charge up to 100 days per year	No charge up to 100 days per year
Hospice	No charge authorization required	No charge when medically necessary

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

CITY HEALTH PLAN (administered by United Healthcare)

In-Network Providers

Out-of-Network Providers*

Out-of-Area Providers*

85% covered after deductible; 60 visits / year

50% covered after deductible; 60 visits / year

85% covered after deductible; 60 visits / year

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

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

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

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

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

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

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

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

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

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

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

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

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

85% covered after deductible; when medically necessary

50% covered after deductible; when medically necessary

85% covered after deductible; when medically necessary

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

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

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

85% covered after deductible; up to 30 hospital days per year max; auth. required

50% covered after deductible; up to 30 hospital days per year max; auth. required

85% covered after deductible; up to 30 hospital days per year max; auth. required

85% covered after deductible; up to 25 visits per year max; authorization required

50% covered after deductible; up to 25 visits per year max; authorization required

85% covered after deductible; up to 25 visits per year max; authorization required

85% covered after deductible; 30 day detox / 60 day rehab; authorization required

50% covered after deductible; 30 day detox / 60 day rehab; authorization required

85% covered after deductible; 30 day detox / 60 day rehab; authorization required

85% covered after deductible; up to 25 visits per year max; authorization required

50% covered after deductible; up to 25 visits per year max; authorization required

85% covered after deductible; up to 25 visits per year max; authorization required

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

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

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

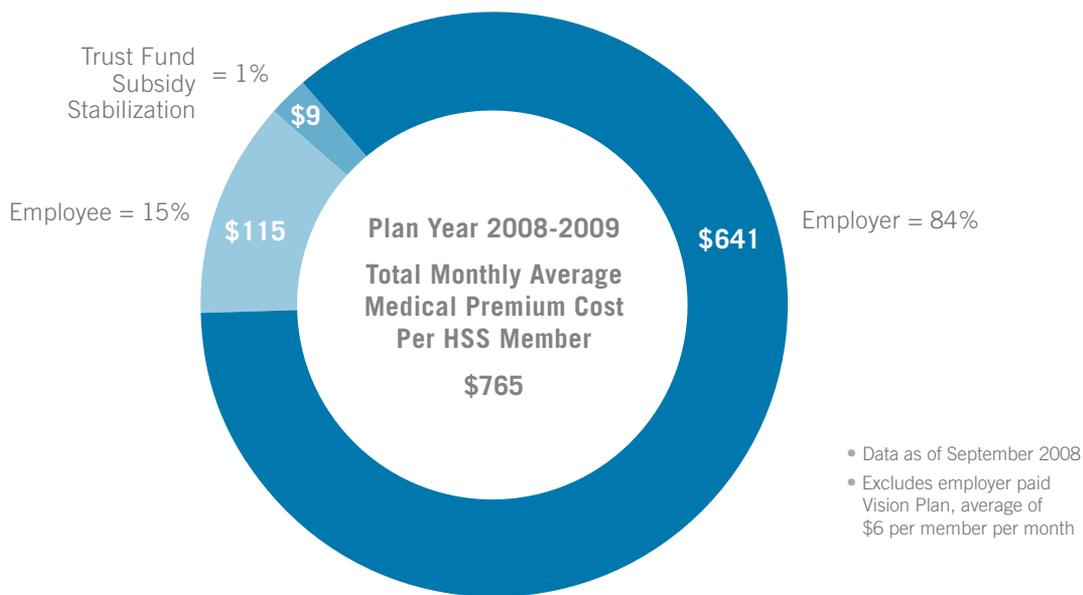
85% covered after deductible; \$10,000 max; prior notification required

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

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

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

Medical Plan Costs



The San Francisco Health Service System provides medical and other non-pension benefits to City and County employees, City College and San Francisco Unified School District employees, San Francisco Superior Court employees, and retirees and dependents. The Health Service System is responsible for designing healthcare benefits, selecting and managing plan providers and determining some aspects of benefit eligibility to supplement the eligibility rules contained in the City Charter and applicable ordinances. In addition, the Health Service System is responsible for administration of health benefits, including maintaining employee membership and financial accounting records. Additional financial information, including audited Health Service System Trust Fund Financial Statements, is available online at myhss.org.

Twice Monthly Medical Plan Rates

EMPLOYEE CONTRIBUTION RATES FOR PLAN YEAR JULY 1, 2009 - JUNE 30, 2010

CITY HEALTH PLAN

	CCSF	Superior Court
Employee Only	179.46	404.14
Employee + 1 Dependent	562.63	787.31
Employee + 2 or More Dependents	880.65	1,105.33

BLUE SHIELD

	CCSF	Superior Court
Employee Only	41.76	266.44
Employee + 1 Dependent	307.70	532.38
Employee + 2 or More Dependents	528.42	753.10

KAISER

	CCSF	Superior Court
Employee Only	7.50	232.18
Employee + 1 Dependent	239.16	463.84
Employee + 2 or More Dependents	431.44	656.12

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

Dental Plan Options

Dental benefits are an important part of your healthcare coverage and are key to your overall health. HSS offers a choice of plans, providers and coverage options at no premium cost to most HSS members.

HMO-Style Dental Plans

Much like medical HMO's, Dental Maintenance Organization (DMO) dental plans require that you receive all of your dental care from within a network of participating dental offices. These networks are generally much smaller than a dental PPO network.

Please note that you will be required to select a dental office which becomes your primary care office and you must go to this office for all of your dental care. Make sure that the dentist you wish to see is in a DMO plan before selecting it.

HSS offers the following DMO plans:

- DeltaCare USA
- Pacific Union Dental

PPO-Style Dental Plans

A PPO-style dental plan gives you the freedom to visit any in-network or out-of-network dentist of your choice. The plan pays higher benefits (and you pay less) when you visit an in-network dentist.

HSS offers you the following PPO-style dental plan:

- **Delta Dental**

The Delta Dental PPO has two different networks of participating dentists and dental care providers:

- The Delta Preferred Option network offers the highest benefit. Most preventive services are covered at 100%; many other services are covered at 90%.
- The Delta Premier network pays benefits based on a pre-arranged fee agreed to by the network's dentists. Most preventive services are covered at 100%; many other services are covered at 80%.

You may go to any dentist from either network, or you may also go to a dentist that is in neither network. When you go to any licensed dentist not in one of the networks described above, the plan pays the same percentage of cost that it pays a Delta Participating Dentist. However, the payment is based on what is considered reasonable and customary (R&C) for the geographical area. This means that your share of the expenses will be higher if your out-of-network dentist charges more than R&C. Don't be shy about asking a dentist financial questions upfront before receiving services. Delta customer service can also help you understand what your costs will be – call Delta with any questions.

Dental Plan Only?

Yes, you can elect to enroll in an HSS dental plan even if you elect not to enroll in an HSS medical plan.

Dental Plan Service Areas

To enroll in either DeltaCare USA or Pacific Union Dental, you must reside within a zip code serviced by the plan. Ask your dentist which plan(s) he or she contracts with before making your selection.

COUNTY	DELTA DENTAL	DELTACARE USA DMO	PACIFIC UNION DMO
Alameda	■	■	■
Alpine	■		
Calaveras	■		
Contra Costa	■	■	■
El Dorado	■	■	
Madera	■	■	■
Marin	■	■	■
Mariposa	■		
Merced	■	■	■
Mono	■		
Monterey	■	■	
Napa	■	■	■
Sacramento	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Clara	■	■	■
Santa Cruz	■	■	■
Solano	■	■	■
Sonoma	■	■	■
Stanislaus	■	■	■
Tuolumne	■		
Yolo	■	■	
Outside of California	■		

■ = Available in this County

Refer to the chart above to determine whether or not you live in the plan's service area. If you do not see your County listed above please contact the dental plan to confirm that service is available to you.

Dental Plan Benefits-at-a-Glance

	DELTA DENTAL		DELTACARE	PACIFIC UNION DENTAL
	In-Network Providers	Out-of-Network Providers		
Types of Service				
Cleanings & Exams	100% covered Limit 2x per plan year	100% covered Limit 2x per plan year	100% covered Limit 1 every 6 months	100% covered Limit 1 every 6 months
X-rays	100% covered	100% covered	100% covered	100% covered
Extractions	90% covered	80% covered	100% covered	100% covered
Fillings	90% covered	80% covered	100% covered Limitations apply to resin materials.	100% covered
Crowns	90% covered	80% covered	100% covered Limitations apply to resin materials.	100% covered
Dentures, Pontics & Bridges	50% covered	50% covered	100% covered Full and partial dentures 1x every 5 yrs; fixed bridgework; certain limitations apply.	100% covered Full and partial dentures 1x every 5 yrs; fixed bridgework; certain limitations apply.
Root Canals	90% covered	80% covered	100% covered Excluding the final restoration.	100% covered
Orthodontia	50% covered Adults and children; up to \$2,500 lifetime max.	50% covered Adults and children; up to \$2,500 lifetime max.	Employee pays: \$1,600/child \$1,800/adult Adult limitations apply.	Employee pays: \$1,600/child \$1,800/adult \$350 startup fee. Limitations apply.
Annual Maximum				
Total Dental Benefits	\$2,500 per year Excluding orthodontia benefits.	\$2,500 per year Excluding orthodontia benefits.	None	None
Annual Deductible				
Before Accessing Benefits	None	None	None	None

This guide offers general information only. Do not rely solely on this guide when making your health insurance decisions. Before enrolling in a plan, read the Evidence of Coverage to get specific details about benefits, costs and way the plan works. Plan EOCs are available on myhss.org.

Dental Plan Comparison

DENTAL PLAN QUICK COMPARISON

	Delta Dental PPO	Pacific Union Dental DMO	Deltacare USA DMO
Can I choose to receive services from any dentist?	Yes. You can use any licensed dental provider.	No. All services must be received from a contracted network provider. These networks are generally quite small.	No. All services must be received from a contracted network provider. These networks are generally quite small.
Must my primary care dentist refer me to a specialist for certain kinds of dental work?	No	Yes	Yes
Is there a waiting period before I can access treatment?	No waiting period, except for dentures, pontics, bridges and orthodontia which require a 6 month wait.	No waiting period.	No waiting period.
Will I pay a flat rate for most services?	No. Your out-of-pocket costs are based on a percentage of applicable charges.	Yes	Yes
Must I live in a certain service area to enroll in the plan?	No	Yes. You must live in this DMO's service area to enroll.	Yes. You must live in this DMO's service area to enroll.

Vision Plan Benefits

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

VSP Vision

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

Choice of Providers

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

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

Accessing Your Vision Benefits

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

Plan Benefits, Limits and Exclusions

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

VISION PLAN BENEFITS AT-A-GLANCE		
	VSP Network Benefit	Out-Of-Network Benefit
Vision Exam	Covered in full once every 12 months* after the \$10 co-pay	up to \$40 every 12 months* after the \$10 co-pay
Single Vision Lenses	Covered in full once every 24 months* after the \$25 co-pay	up to \$45 every 24 months* after the \$25 co-pay
Lined Bifocal Lenses	Covered in full once every 24 months* after the \$25 co-pay	up to \$65 once every 24 months* after the \$25 co-pay
Lined Trifocal Lenses	Covered in full once every 24 months* after the \$25 co-pay	up to \$85 once every 24 months* after the \$25 co-pay
Frames	Covered up to \$150 every 24 months* after the \$25 co-pay; there may be a network discount for amount exceeding allowance	up to \$55 once every 24 months* after the \$25 co-pay
Contact Lenses	Covered up to \$150 every 24 months* no co-pay; in lieu of frames/lenses; allowance applies toward contact lens fitting, evaluation exam and contacts	Covered up to \$105 every 24 months* no co-pay; in lieu of frames/lenses; allowance applies toward contact lens fitting, evaluation exam and contacts

*Based on your last date of service.

Vision Expenses Not Covered

- Orthoptics or vision training and any associated supplemental testing, plano (non-prescription) lenses or two pairs of glasses in lieu of bifocals.
- Replacement of lenses or frames furnished under this plan that are lost or broken, except at the contracted intervals.
- Medical or surgical treatment of the eyes.
- Corrective vision treatments such as, but not limited to, LASIK and PRK laser surgery. (You may be eligible for discounts when services are provided by a VSP network doctor. To inquire about discounts, call VSP.)

Coordinating Vision Benefits with Medical Plan Benefits

The VSP vision plan is designed to cover visual correction needs, such as eyeglasses and contact lenses. Some HMOs also offer optometry services where you can get eye exams and purchase glasses and lenses. HSS recommends that you compare the out-of-pocket cost you will incur using your HMO's vision services to your out-of-pocket costs when using a VSP network doctor. Also note that your medical plan may offer coverage for medical conditions and diseases relating to the eyes.

No Medical Plan, No Vision Benefits

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

Flexible Spending Accounts

An FSA is an IRS-approved tax favored account you can use to pay for eligible medical and dependent care expenses not covered by insurance. Funds are set aside from your salary pre-tax.

How an FSA Works

Flexible Spending Accounts (FSAs) let you set aside money pre-tax to pay for eligible healthcare and/or dependent care expenses. You can enroll in either a Healthcare FSA, a Dependent Care FSA or both.

It is possible to realize tax savings with an FSA—but keep in mind that any unused FSA dollars at the end of the year will be forfeited according to IRS rules. So you need to plan ahead to make the most of an FSA. To calculate potential FSA tax savings, visit myfbmc.com/ccsf and click on the tax calculator. You should also consult your tax adviser or the IRS for information about your specific situation.

The following information provides an overview of your FSA benefits. To get details about this benefit contact FBMC, the FSA administrator, or visit myfbmc.com/ccsf. You can also request an FSA resource guide from HSS Member Services.

Healthcare FSA

- Set aside from \$120 up to \$5,000 pre-tax in a Plan Year. Depending on the annual amount that you elect, deductions of between \$5.00 and \$208.33 will be taken twice monthly from your paycheck in Plan Year 2009-2010. No deduction is taken from the 3rd paycheck in any month.
- Submit reimbursement forms to FBMC for eligible out-of-pocket expenses, including healthcare deductibles, prescriptions, over-the-counter medical items and more for you and eligible dependents.
- When you sign-up for a Healthcare FSA the total annual amount you designate becomes available for eligible healthcare expenses at the start of the Plan Year. You do not have to wait for your contributions to accumulate in your account.

Dependent Care FSA

- Set aside from \$120 up to \$5,000 pre-tax in a Plan Year. Deductions will be taken twice monthly from your paycheck throughout Plan Year 2009-2010. Depending on the annual amount that you specify, deductions of between \$5.00 and \$208.33 will be taken twice monthly from your paycheck in 2009-2010. No deduction is taken from the 3rd paycheck in any month.
- Submit reimbursement forms to FBMC for eligible out-of-pocket expenses, such as certified day care, pre-school and elder care for your qualifying dependents.
- The funds for a Dependent Care FSA are available after they have been deducted from your paycheck and received by FBMC. Unlike a Healthcare FSA, the entire annual amount for a Dependent Care FSA is not available at the start of the Plan Year.

Estimating FSA Expenses

Before enrolling in an FSA make sure to work out a detailed estimate of the eligible expenses you are likely to incur for the year ahead. Budget conservatively because based on federal law any unreimbursed funds are forfeited at the end of the Plan Year and cannot be returned to you. You can find FSA calculation tools on myfbmc.com. For a list of eligible expenses, the definition of qualifying family members and how to submit reimbursements, visit myfbmc.com/ccsf.

FSA Administrator FBMC

The Flexible Spending Account benefit is administered by FBMC. Visit myfbmc.com/ccsf or call (800) 865-3262 on Monday-Friday, 4 AM-7 PM Pacific Time to get detailed information about your FSA.

- Learn more about FSAs.
- View a list of eligible expenses.
- Review the status of your reimbursement requests.
- Review your account balance and available funds.
- Download reimbursement forms.

Direct Deposit Reimbursement

To apply, complete the Direct Deposit Enrollment Form on myfbmc.com/ccsf or contact FBMC Customer Service at 1-800-342-8017. Processing your Direct Deposit enrollment may take four to six weeks.

- After your reimbursement claim is reviewed and approved, reimbursement funds are deposited into your checking or savings account.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement. (However, you will receive notification that the claim has been processed.)

Annual Re-enrollment Required

You must re-enroll in your Flexible Spending Accounts every Open Enrollment period.

No Transferring Between Accounts

You cannot transfer money between Healthcare and Dependent Care Flexible Spending Accounts.

Changing Contribution Amounts

You can't change the amounts you contribute to your Flexible Spending Account(s) during the Plan Year unless the change is consistent with a qualifying change in family status.

Termination or Retirement

If your employment ends during the Plan Year, you can only file claims for FSA eligible expenses that were incurred while you were actively employed.

Leaves of Absence

During an unpaid leave of absence, no contributions will be made toward these accounts. Accounts that remain unpaid for three consecutive pay periods will be terminated retroactively to the first missed pay period. You may only reinstate your Flexible Spending Account upon your return to work by contacting HSS and requesting a reinstatement.

Eligibility Time Period

Expenses for services incurred before July 1, 2009 or after June 30, 2010 are not eligible for reimbursement. For example, a medical expense incurred in June 2009 isn't eligible for reimbursement from a Healthcare Flexible Spending Account because your account is not open until July 1, 2009.

IRS Eligibility Criteria

Your expenses must meet the Internal Revenue Service (IRS) eligibility criteria. Please refer to IRS Publications 502 and 503 for details.

Avoid Forfeiting FSA Contributions

All FSA claims for Plan Year 09-10 must be postmarked by September 30, 2010.

You will forfeit any money left in your FSA(s) after the end of this claim filing period. There are no exceptions.

Leaves of Absence and Your Benefits

Type of Leave	Eligibility	Your Responsibilities
<p>Family and Medical Leave (FMLA)</p> <p>Worker's Compensation Leave</p> <p>Family Care Leave</p>	<p>You may be eligible to continue your healthcare coverage for the duration of your approved leave of absence.</p> <p>You may have additional rights under an approved FMLA leave.</p> <p>Contact your departmental personnel representative for details.</p>	<ol style="list-style-type: none"> 1. Notify your department's personnel office. They will provide HSS with important information about your leave. 2. Contact HSS to arrange for the payment of any required contributions while you are on leave. Failure to do so can result in termination of benefits.
<p>Personal Leave Following Family Care Leave</p>	<p>If you have been on an approved Family Care Leave and elect to extend your leave period as a Personal Leave, you may be eligible to continue your healthcare coverage for the duration of your approved Personal Leave, if:</p> <ul style="list-style-type: none"> - The reason for the Personal Leave is the same as the reason for the prior Family Care Leave. - Your required healthcare contribution payments, if any, are current. 	<ol style="list-style-type: none"> 1. Notify your department's personnel office. They will provide HSS with important information about your leave. 2. Contact HSS to arrange for the payment of any required contributions while you are on leave. Failure to do so can result in termination of benefits.
<p>Educational Leave</p> <p>Personal Leave</p> <p>Leave for Employment as an Employee Organization Officer or Representative</p>	<p>You may be eligible to continue your healthcare coverage for the duration of your approved leave of absence.</p>	<ol style="list-style-type: none"> 1. Notify your department's personnel office. They will provide HSS with important information about your leave. 2. Contact HSS to arrange for the payment of any required contributions while you are on leave. Failure to do so can result in termination of benefits. 3. If your leave lasts beyond 12 weeks, you must pay the total cost of medical and dental coverage for yourself and any covered dependents. This includes any contribution amount that was being deducted from your paycheck plus the City and County of San Francisco's contribution. Contact HSS for details.

If your department or employer approves a leave of absence you can continue your healthcare coverage. You must make healthcare contribution payments directly to HSS during your leave. While on leave sign-up for easy, secure Auto-Pay. With Auto-Pay your monthly healthcare contribution is charged automatically to your VISA or Mastercard. Contact HSS or download the authorization form for Auto-Pay from myhss.org. Always contact HSS 30 days before returning to work after a leave in order to return your contributions to active status.

Approaching Retirement

Contact HSS three months before your retirement date for important information about continuing healthcare coverage after you leave active employment.

Transitioning to Retirement

If you choose to retire, the transition of your health benefits from active employment to retiree status does not happen automatically. You must elect to continue healthcare coverage in retirement by completing and submitting the required retiree enrollment forms and supporting documents to the Health Service System.

HSS recommends that you contact HSS Member Services and speak to a Benefits Analyst three months before your retirement date so that we can advise you about the actions you must take in order to maintain continuous healthcare coverage.

SFERS Pre-Retirement Seminars

If you are member of SFERS (San Francisco Employee Retirement System) you may be eligible to attend a pre-retirement planning seminar with speakers from SFERS, HSS and Social Security. You must pay a fee and register in advance. Contact SFERS at (415) 487-7000.

Eligibility

The San Francisco City Charter requires that to be eligible for retiree healthcare coverage the retiree must have been a member of the Health Service System at some time during their active employment. Other restrictions may apply.

Health Benefit Contributions For Retirees

If you choose to continue your medical and/or dental coverage through the Health Service System after you retire your required health benefit contribution may increase. This cost will depend on your plan choice, the number of dependents you cover on your plan

and your Medicare status. As a retired member you will also be required to pay for dental coverage. Contributions are deducted from your pension check. If required monthly contributions are greater than the total amount of your pension check you must contact HSS to make payment arrangements. HSS plan contribution rates are updated every Plan Year—make sure to evaluate contribution costs when you begin your retirement transition process. HSS Member Services can assist you with questions about contribution costs and eligibility.

Flexible Credits

You no longer have access to flexible credits when you retire.

Medicare & Your HSS Benefits

All retired members and their dependent family members who have reached the age of 65 are required to apply for Medicare Parts A and B. Failure to enroll in Medicare as required if you are age 65 or older and retired can result in penalties and limitations in your healthcare coverage.

Active Employees Over Age 65

If you are over age 65 and an active employee of the City & County of San Francisco, neither you nor your enrolled dependents over age 65 are required to enroll in Medicare. However, when you do retire, you will need to apply for Medicare immediately.

This information offers an overview of important topics related to benefits in retirement. It does not include all the information you may need to know. If you are planning to retire, please contact HSS Member Services at (415) 554-1750.

Separation From Employment and COBRA

If you are separated from City service but placed on an eligible holdover roster you may be eligible to continue your enrollment in HSS medical, dental and vision coverage.

Employees with Holdover Rights

Employees who are separated from City service and placed on an eligible holdover roster may be eligible to continue medical, dental and vision benefits for themselves and their covered dependents for up to five years, as long as they meet all of the following three requirements:

1. Employees must certify that they are unable to obtain healthcare coverage from another source;
2. Employees must complete and submit a Certificate of Eligibility Form to the Health Service System on an annual basis; and
3. Employees must pay the same amount that was deducted from his/her paycheck prior to lay off (rates subject to increase each Plan Year).

Employees with No Holdover Rights

Employees who are separated from all City service with no holdover rights may be eligible to continue medical, dental and vision coverage under COBRA. The healthcare coverage you had as an active employee will end on the last day of the coverage period in which your employment terminates.

Dependents of HSS Members

Covered dependents who no longer meet HSS eligibility requirements may be able to continue healthcare coverage through COBRA.

COBRA Continuation Coverage

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

COBRA Qualifying Events

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

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

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

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

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

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

COBRA Notification

When a qualifying event occurs, the COBRA Administrator FBMC will notify you of your right to elect COBRA coverage.

Time Limits for COBRA Elections

You will have 60 days from the date of this notification to elect COBRA coverage. The coverage will be continuous from the date of the qualifying event so you will not have a break in your healthcare coverage. While you are covered under COBRA, you have 30 days to add any newly eligible dependent (spouse, domestic partner, newborn or adopted child) to your COBRA coverage from the date of the event (birth, marriage, etc.).

Duration of COBRA Continuation Coverage

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

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

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

Termination of COBRA Continuation Coverage

COBRA coverage will end at the earliest of the date:

- You obtain coverage under another group plan if no pre-existing condition limitation under the new plan applies to the covered individual.

- You fail to pay the premium required under the plan within the grace period.
- The applicable COBRA period ends.

Paying for COBRA

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

COBRA Continuation Coverage Alternatives

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

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

This information does not reflect any changes to COBRA resulting from the federal American Recovery and Reinvestment Act (Stimulus Act), signed into law on February 17, 2009. For more information about how this legislation might impact your COBRA benefits contact FBMC.

COBRA Questions?

For questions about COBRA continuation coverage contact the COBRA Administrator FBMC at (800) 342-8017.

Life Insurance

Life Insurance

Life insurance is an essential part of financial planning; most people own life insurance to replace income that would be lost with the death of a wage earner.

When considering how much life insurance protection you need, consider the following:

- Who relies on your income for financial security?
- Do you have children who will need financial protection?
- Would your parents need to find another source to replace financial or other support that you currently give them?

There are three types of life insurance offered to eligible members under the Management Cafeteria Plan. One type of plan provides a group term life insurance benefit in the amount of \$50,000 that is fully paid for by your employer. A supplemental life insurance benefit is also available that allows eligible employees to purchase additional term life insurance for themselves to supplement the group term life insurance plan. And finally, members can select a universal life insurance benefit, which allows members to purchase coverage for themselves, their spouse/domestic partner and/or dependent children. The coverage for family members is available under the universal life insurance benefit even if the member does not elect this option to cover themselves.

Pre-Tax/After-Tax Premiums

The Internal Revenue Service (IRS) limits to \$50,000 the total amount of tax-free life insurance you may receive from your employer and purchase for yourself under a group term plan. Any coverage you purchase over this amount, or purchase on an individual basis, or that is not part of a group term plan, must be paid for with after tax dollars.

Beneficiary Designation

If you designate a beneficiary (such as a spouse or domestic partner) and your personal circumstances change (i.e. divorce) your beneficiary will remain the same as you originally stated unless you request a change. Unless you have a current life insurance beneficiary designation on file, your beneficiaries will follow current law: surviving spouse, then surviving children, then surviving parents. If none of these family members survive you, benefits will then be paid to your estate. To update your current beneficiary information contact EBS at (800) 229-7683 to request a form.

Basic Term Life Insurance Coverage

All employees who are eligible to participate in the Management Cafeteria Plan are provided a \$50,000 group term life insurance policy for themselves, at no cost.

Supplemental Life Insurance Coverage

Eligible members may elect to purchase additional amounts of term life insurance coverage for amounts ranging from \$10,000 to \$300,000 in increments of \$10,000. Flexible credits allocated toward supplemental life insurance coverage are after-tax amounts. There is a maximum \$50,000 guarantee issue for new employees. All amounts over \$50,000 or coverage elected after 31 days of initial eligibility require evidence of insurability.

Life Insurance

Sample Twice Monthly Premium Calculation

You can determine the twice monthly premium you will pay on an after tax basis by following the steps shown in the example below:

Sally is 45 years old and earns \$80,000 per year. She chooses to purchase two times her annual salary. (Remember Sally has \$50,000 of coverage provided to her by her employer at no cost.)

Step 1: $\$80,000 \times 2 = \$160,000$

Step 2: $\$160,000 \div \$10,000 = 16$

Step 3: $16 \times \$1.11 = \17.76 twice monthly cost

RELIASTAR SUPPLEMENTAL GROUP TERM LIFE INSURANCE RATES	
Age	Twice Monthly Pay Period Cost per \$10,000
< 30	\$.34
30-34	\$.38
35-39	\$.48
40-44	\$.67
45-49	\$1.05
50-54	\$1.71
55-59	\$2.85
60-64	\$4.47
65-69	\$7.70
70-74	\$13.68
75+	\$22.99

Universal Life Insurance

administered by ING

Universal Life Insurance

This program allows you to apply for an individual universal life insurance policy to assist you in meeting your personal and family insurance needs. You can also apply for individual life insurance policies for your spouse and dependent children, even if you choose not to apply for your own policy.

Premier Universal Life Insurance provides flexible life insurance protection. You can select the premium amount or the size of the death benefit that meets your needs. You can change your selections in the future during the annual open enrollment as your needs change.

This information is a brief description of coverage and is not a contract. Read your policy and riders carefully for exact terms and conditions. For more information call ING at (800) 537-5024.

Why Universal Life Insurance?

Premier Universal Life insurance is designed to provide life insurance coverage for your lifetime as long as sufficient premiums are paid. This policy offers you life insurance protection, tax-deferred cash value accumulation (based on current tax laws), cash value loans, and partial withdrawal privileges – all in one policy.

The premium you pay is based on the death benefit you select, the optional riders you choose, as well as your age and tobacco use. The insurance and premium amounts are flexible and may be re-evaluated as your needs change. Other benefits of this universal life insurance policy include the following:

Financial Protection

Because you care for your family and you want to leave your beneficiaries some financial security, the death benefit of your life insurance policy can provide money to help them meet financial obligations. These tax-free proceeds (based on current tax laws) can, at the discretion of your beneficiaries, help pay for child care, reduce bills, or help with educational expenses.

Payroll Deduction

You can elect to pay required premiums using a payroll deduction,

Affordable

Because this policy is owned by you, you choose the premium amount that fits your budget as well as your needs.

Portable

Should you retire or separate from employment, you can take the policy with you. ING, the insurance carrier, will bill you directly.

Flexible

You can choose the amount of life insurance you want to apply for and you can modify your policy by increasing or decreasing the amount of your life insurance. An increase in the amount of insurance may require evidence of insurability and will be rated at the age you are when you increase the death benefit.

Cash Value Accumulation

Premier Universal Life Insurance can build cash value that accumulates at the current non-guaranteed interest rate, less policy charges. Changes in the current non-guaranteed interest rate, current cost of insurance rates, and current expense charges are declared by the insurance company's board of directors and will affect the cash value. The current non-guaranteed interest rate will never be less than the guaranteed interest rate that is shown in your policy booklet.

Cash Value Loans

Once cash value accumulates, you can borrow against it at the rate shown in your policy. Interest is payable in advance. The death benefit will be reduced by the amount of any outstanding loan and unpaid accrued interest.

Annual Reports

To keep you informed, a report showing policy activity is sent annually. This report lists all the transactions, such as premium payments, loans, and withdrawals as well as interest, policy expenses, and policy values.

Optional Benefits

Spouse/Domestic Partner Coverage

Your spouse/domestic partner is eligible to apply for insurance by meeting certain eligibility requirements, even if you choose not to apply for insurance for yourself.

Universal Life Insurance

Child Coverage

Your unmarried, dependent children and dependent grandchildren ages 15 days through 24 years, are eligible to apply for a \$25,000 individual universal life insurance policy by meeting certain eligibility requirements. (Children age 18 – 24 must be present to sign the application.) Age restrictions and coverage limits may vary in some states. A child's term life insurance rider, available in coverage amounts of \$2,000 through \$10,000, can be attached to either your policy or your spouse's/domestic partner's policy. This rider covers all of your dependent children age 15 days through 24 years. On the policy anniversary date after a child reaches his or her 25th birthday, universal life insurance coverage can be converted to an individual policy for up to five times the term coverage and without evidence of insurability. The new policy can be converted to a life insurance policy offered by the Company at the time of conversion and must be for at least the minimum amount issued for the policy selected.

Qualified Issue Plan

Newly hired employees may apply for up to three times their annual salary, up to \$100,000 (defined benefit), or purchase a benefit amount determined by pricing premiums up to \$14 per week (money purchase). The benefit amount cannot exceed three times annual salary. No physical will be required for new hires only, if applying within these parameters.

Application Questions For New Hires

- During the past 12 months, have you missed 5 or more consecutive work days because of sickness or injury?
- Has the Proposed Insured been hospitalized in any medical facility or nursing home, as either an in or out patient, within the past 90 days?
- Has the Proposed Insured in the last years been diagnosed and/or treated by a member of the medical profession for positive HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immunodeficiency Syndrome)?
- Is the Insurance now applied for intended to replace, in whole or in part, any insurance or annuities on the life of the Proposed Insured?

Qualified Issue eligibility requirements include full-time employees who are actively at work and are between 15 and 70 years of age. Satisfactory responses to required application questions regarding health status are required.

Application Questions For New Applicants Who Are Not Newly Hired

- During the past 12 months, have you missed 5 or more consecutive work days because of sickness or injury?
- Has the Proposed Insured been hospitalized in any medical facility or nursing home, as either an in or out patient, within the past 90 days?
- Has the Proposed Insured in the last years been diagnosed and/or treated by a member of the medical profession for positive HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immunodeficiency Syndrome)?
- Is the Insurance now applied for intended to replace, in whole or in part, any insurance or annuities on the life of the Proposed Insured?
- Height and Weight
- In the last 5 years, has the Proposed Insured been treated or diagnosed for any heart trouble, stroke, or cancer?
- Has the Proposed Insured had or been treated for: disease or disorder of the heart, lungs, nervous system, liver, kidneys, colon or genitor-urinary system; stroke; high blood pressure; cancer or tumors; arthritis; diabetes; alcohol or drug use?
- Has the Proposed Insured consulted any physicians or surgeons in the last 5 years for any reason, including physical examinations?

If you answered "Yes" to any of the above questions, be prepared to give your enrollment representative details, such as your doctor's name; address and phone number, as well as your medical history, including medications you have taken in the past and are currently taking.

Universal Life Insurance

Policy Design Highlights

- Voluntary Life Insurance
- Individual, employee-owned policy
- High target premium for cash accumulation
- Interest on accumulation value credited daily
- Payable to age 100
- Unisex rates
- Tobacco and No Tobacco rates (for ages 18 years through 70); Standard rates (for ages 15 days through 17 years).

Available Benefit Riders

Accelerated Benefit Rider (ABR)

Pays the policy owner up to 50% of the available death benefit if an insured is diagnosed as having fewer than 12 months to live. Advance payments are treated as policy liens with interest charged. The advanced payment cannot be less than \$10,000.

This rider is automatically included on all policies, including dependent children unless prohibited by state regulations.

Accidental Death Benefit Rider (ADB)

Provides an additional benefit if the insured dies as the result of an accident, as defined in the policy. [This rider is available to employees and spouses/ domestic partners only. This rider pays a benefit equal to twice the policy face amount if the accident occurs in a common carrier.

Children's Term Insurance Rider (CTR)

This benefit provides term insurance on dependent children age 15 days through 24 years for amounts ranging from \$2,000 to \$10,000 (\$1,000 increments). This rider can be included on either an employee's policy or spouse's policy provided the employee or spouse is under the age of 61.

Waiver of Monthly Deduction Rider (WMD)

Designed to offer continued insurance protection if the insured becomes disabled, according to the policy terms for four months. WMD is available to employees under age 55 only.

Premier Universal Life Insurance Rates

Important: The rates shown below are for illustrative purposes only. Your actual rate will be determined at the time of your enrollment. The sample scenarios listed below represent the value of an employee only, no tobacco policy with the WMD Rider.

Issue Age	Insurance Amount	Cash Value
		at age 65 Non-Guar. 5.1%*
25	\$138,676	\$29,627
30	\$112,519	\$19,776
35	\$86,660	\$13,305
40	\$68,244	\$10,635
45	\$50,473	\$ 8,757
50	\$35,073	\$ 5,703
55	\$25,154	\$ 3,329
60	\$21,148	\$ 3,235
65	\$14,362	\$ 3,656
70	\$10,162	\$ 3,545

Important: The sample scenarios listed below represent the cost for an employee only, no tobacco, \$50,000 face value policy with waiver of monthly deduction.

Issue Age	Twice Monthly Premium	Cash Value
		at age 65 Non-Guar. 5.1%*
25	\$11.90	\$ 9,205
30	\$14.30	\$ 7,813
35	\$18.25	\$ 7,203
40	\$22.62	\$ 7,553
45	\$30.05	\$ 8,661
50	\$42.62	\$ 8,297
55	\$58.80	\$ 6,824
60	\$69.66	\$ 7,940
65	\$101.88	\$13,285
70	\$143.35	\$18,383

*The cash value shown is the non-guaranteed amount, and for ages 55 and older the tenth year value is shown.

Universal Life Insurance

Premier Universal Life Insurance for Dependent Children and Grandchildren*

Both tobacco and no tobacco rates are available for issue ages 18 through 24. No tobacco premiums are available for ages 18 through 24 years if the proposed insured has not used tobacco in any form in the last 24 months (two years).

Important: All rates shown are for illustration purposes and are not guaranteed at the time of purchase.

Issue Age	Twice Monthly Premium		Cash Value at Age 65 (Non-Guar. 5.1%*)	
	\$25,000 Standard Rates			
0		\$5.05		\$17,905
1		\$5.10		\$17,306
2		\$5.14		\$16,560
3		\$5.18		\$15,825
4		\$5.25		\$15,268
5		\$5.31		\$14,695
6		\$5.38		\$14,110
7		\$5.42		\$13,358
8		\$5.51		\$12,946
9		\$5.59		\$12,518
10		\$5.66		\$11,936
11		\$5.75		\$11,529
12		\$5.83		\$11,086
13		\$5.92		\$10,649
14		\$6.00		\$10,245
15		\$6.11		\$ 9,935
16		\$6.20		\$ 9,950
17		\$6.35		\$ 9,074
	\$25,000 No Tobacco	\$25,000 Tobacco	\$25,000 CV No Tobacco	\$25,000 CV Tobacco
18	\$5.68	\$6.72	\$5,647	\$ 5,039
19	\$5.68	\$7.54	\$5,073	\$ 7,679
20	\$5.75	\$8.43	\$4,802	\$10,666
21	\$5.88	\$8.76	\$4,784	\$10,568
22	\$6.03	\$9.08	\$4,811	\$10,419
23	\$6.18	\$9.28	\$4,806	\$10,055
24	\$6.35	\$9.62	\$4,853	\$ 9,898

Premier Universal Life Insurance for Available Dependent Rider

Children's Term Insurance Rider

Insurance Amt	Twice-Monthly Premium
\$ 5,000.....	\$1.52
\$ 7,000.....	\$2.12
\$ 9,000.....	\$2.73
\$10,000.....	\$3.03

All non-guaranteed cash value potential policy values shown assume that the currently illustrated non-guaranteed elements will continue unchanged for all years shown. This is not likely to occur, and actual results may be more or less favorable than those shown

*Grandchildren who are under age 14 and are residents of the state of New York are not eligible.

Short Term Disability Insurance

administered by ING

A very real concern among people who work for a living is a need to protect their income during periods of disability. Short term disability insurance helps to safeguard your income in the event you experience a prolonged sickness or injury. This insurance coverage is available to employees only; dependents are not eligible.

During your initial enrollment period (newly hired employees only), this coverage is available to you on a guaranteed issue basis, within income replacement guidelines, as long as you are currently active at work on a full-time or part-time basis. If you are signing up at a later date or adding an additional benefit amount, medical underwriting will be required.

Portable

Coverage is portable to age 70 and can be taken with you should you terminate employment with your current employer provided you have been covered under this plan for at least six consecutive months and are not: disabled; on leave of absence; retired from this employer; or covered under any other group disability income plan.

If when you leave your employer you do not start work with another employer, your coverage will end 12 months from the date of portability. If you become employed by the end of the 12-month period, you can continue this disability income insurance. Should your existing employer drop this group disability income coverage, you would no longer be eligible to continue this coverage.

Benefit Payments

Coverage provides benefit payments from \$300 to \$5,000 based on income replacement guidelines for covered disabilities. Disabilities lasting less than one month will be paid on a pro-rata basis of one thirtieth of the monthly benefit for each day you are disabled. The benefit amount you select cannot exceed 60 percent of your regular monthly earnings or 40% if you participate in California SDI.

Benefit Duration

Benefits are paid directly to the employee covered under this certificate while the employee is disabled (as defined in the certificate), up to a maximum benefit duration. The maximum benefit duration for this plan is 3 months.

Elimination Period

The elimination period is the number of days of total disability that the employee must wait before he or she can receive benefits. Your elimination period for this benefit is zero days if you are disabled due to injury and 14 days if you are disabled due to sickness.

Pre-existing Conditions

Pre-existing conditions are defined as any injury or illness that you have been treated for within 12 months prior to the effective date of your coverage. Benefits will be paid for a pre-existing condition within the first 12 months after the policy became effective for the participant. However, the benefit payable will be 50% of the regular benefit amount and will be limited to six weeks. Any disability occurring after the first 12 months will be eligible for standard benefit payment amounts. Consult the certificate for a complete definition of pre-existing conditions.

Partial Disability

Employees experiencing partial disability (as defined in the policy): are eligible to receive a benefit equal to 50% of their regular benefit amount for up to three months.

Waiver of Premium

All premiums are waived while an individual is receiving disability benefits payable under this policy, with the exception of the first premium.

Disability income benefits are contingent on proof of loss. In most cases this requires medical information from your healthcare provider.

Short Term Disability Insurance

ING Short Term Disability Insurance Rates

Rates listed are per \$100 of Benefit.

BENEFIT DURATION	ISSUE AGE	TWICE MONTHLY RATE/\$100
3 months.....	18-49.....	\$0.88
3 months.....	50-69.....	\$1.19
3 months.....	60-64.....	\$1.23

Rate Calculation Examples

Stan is 45 years old and earns \$65,000 per year. He participates in SDI so is only eligible for a 40% benefit maximum.

Step 1: $\$65,000 \div 12 \text{ months} = \$5,400$ monthly income

Step 2: $\$5,400 \times 40\% = \$2,200$ maximum monthly benefit eligible to receive

Step 3: $\$2,200 \text{ benefit elected} \div \$100 = 22$

Step 4: $22 \times \$0.88 = \19.36 twice monthly premium

Cheryl is 50 years old and earns \$70,000 per year. She participates in SDI so is only eligible for a 40% benefit maximum.

Step 1: $\$70,000 \div 12 \text{ months} = \$5,800$ maximum monthly income

Step 2: $\$5,800 \times 40\% = \$2,300$ maximum monthly benefit eligible to receive

Step 3: $\$2,300 \text{ benefit elected} \div 100 = 23$

Step 4: $23 \times \$1.19 = \27.37 twice monthly premium

To Estimate Your Cost

1. Determine your monthly income

\$ _____ Line 1

2. Determine your Monthly Benefit.

Do you participate in SDI? Yes/NO

If **yes** multiply your monthly income by 40%; the result is the maximum monthly benefit you are eligible to purchase.

If **no** multiply your monthly income by 60%; the result is the maximum monthly benefit you are eligible to purchase.

Select your benefit amount (you can purchase from \$300 up to your eligible maximum based on your salary or \$5,000 which ever is less.

\$ _____ Line 2

3. Divide the Benefit Amount you have selected in Line 2 by 100

\$ _____ Line 3

4. Multiply Line 3 by the appropriate rate and you will have your twice monthly premium.

\$ _____ Line 4

Important: Read Your Policy

These are plan highlights—not a contract. If these highlights and the policy differ, the policy will govern. Questions? Call ING at (800) 537-5024.

Long Term Disability Insurance

administered by UNUM

Note: employees who receive payment under this LTD plan are not eligible to receive payment under the City's Catastrophic Illness Program.

Eligibility

All members and/or persons represented by any of the following collective bargaining units who may qualify for membership in the Health Service System and are in active employment:

- Municipal Exec. Assoc. (MEA) Units M, EM Code 351
- Management Unrepresented, Ordinance 158-98 Union Code 002

Minimum Hours Requirement

Employees must be actively working at least 20 hours per week.

Rehire

If your employment ends and you are rehired within 12 months, your previous employment while in an eligible group will apply toward the waiting period. All other policy provisions apply.

Prior Service Credit

Unum will apply any prior period of work with your Employer toward the waiting period to determine your eligibility date.

Effective Date

Employees will be eligible on the first day of the benefit period following their first day of work.

Elimination Period

The Elimination Period is the length of time of continuous disability which must be satisfied before you are eligible to receive benefits.

Definition of LTD Disability

You would be considered disabled and eligible for benefits if due to injury or sickness:

- You are limited from performing the material and substantial duties of your regular occupation, due to your sickness or injury; and have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness.
- After benefits have been paid for 24 months, you are disabled when UNUM determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training and experience.
- During the elimination period you are unable to perform any of the material and substantial duties of your regular occupation.
- The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Partial Disability

If you have met the definition of disability as stated above and have satisfied the elimination period, you can return to work on a part-time basis and still receive partial benefits, provided your earnings are at least 20% less per month than your pre-disability earnings due to that same injury or illness.

Gainful Occupation

Gainful Occupation means an occupation that is or can be expected to provide you with an income at least equal to your gross disability payment.

Monthly LTD Benefit

66.667% of your monthly base earnings to a maximum of \$7,500 per month.

Disability payments will be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

Long Term Disability Insurance

Maximum Benefit Period

AGE AT DISABILITY	MAX PERIOD OF PAYMENT
Less than age 60	To age 60, but not less than 5 years
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

No premium payments are required for your coverage while you are receiving payments under this plan.

Disabilities That Are Not Covered

This plan does not cover disabilities caused by, contributed to by, or resulting from:

- Intentionally self inflicted injuries
- Active participation in a riot
- War, declared or undeclared, or any act of war
- Conviction of a crime under state or federal law
- Loss of professional license, occupational license or certification.
- UNUM will not pay a benefit for any period of disability during which you are incarcerated

Mental and Nervous

Disabilities due to a sickness or injury which are primarily based on a self reported symptoms and disabilities due to mental illness have a limited payment period of 24 months per lifetime. Mental and nervous benefits would continue beyond 24 months only if you are institutionalized or hospitalized as a result of the disability.

How Much Will the Plan Pay If You Are Disabled?

- Multiply your base monthly earnings by 66.667%

- The maximum monthly benefit is \$7,500
- Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your gross disability payment.
- Subtract from your gross disability payment any deductible sources of income.

The amount calculated above is your monthly payment.

How to Calculate Premiums

To calculate your premium for this coverage complete the calculation below. Note: If your monthly salary exceeds \$11,250 use \$11,250 as your Current Monthly Salary in the calculation.

Your Monthly Salary : \$ _____ x .0054 =
\$ _____ Estimated Monthly Cost

Example A:

Employee annual salary \$30,000 (\$2,500/month)

Your Monthly Salary \$2500 x .0054 = \$13.50
Estimated Monthly Cost

Example B:

Employee annual salary \$150,000 (\$12,500/month)

Your Monthly Salary \$11,250 x .0054 = \$60.75
Estimated Monthly Cost

The effective date of your coverage will be delayed if you are not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would become effective.

Important: Read Your Policy

These are plan highlights—not a contract. If these highlights and the policy differ, the policy will govern. Questions? Call UNUM at (800) 367-6166.

Accident Insurance

administered by Allstate Workforce Division

Why Accident Insurance?

Similar to life insurance, accident insurance pays cash benefits directly to the insured. This can help offset the loss of income that might result if you suffer from a covered accidental injury. This type of coverage does not pay medical providers, so it is not a substitute for primary or secondary medical coverage.

Policy Features

- Guaranteed renewable until age 70, subject to change in premiums by class
- Choose from individual or family coverage
- Benefits are paid directly to the insured, unless otherwise assigned
- Benefits are in addition to any other insurance the insured may have

The plan pays benefits for covered on or off the job accidental injuries, which result within 90 days (180 days for loss of life or limb) of the covered accident. Losses must be diagnosed by a physician. There are three levels of coverage available. Your policy will pay benefits based on the level of coverage you purchase.

Accident Policy Benefits

Accidental Death and Dismemberment

Up to \$60,000 maximum for primary insured; up to \$30,000 maximum for spouse if covered; and up to \$5,000 maximum per child if covered. If accident occurs while covered person is a fare paying passenger on a common carrier, policy pays up to 3 times the maximum amount.

Dislocation or Fracture

Up to \$2,000 maximum for primary insured; up to \$1,000 maximum for spouse if covered; and up to \$500 maximum for each child if covered. Amount paid depends on dislocation or fracture as shown in the policy schedule. Only dislocations or fractures listed in the policy schedule are covered.

Hospital Confinement

Choice of \$100/\$200/\$300 per day. AWD pays the amount elected for each day a covered person is admitted to and confined as an inpatient in a hospital up to a maximum of 90 days for each period of continuous hospital confinement. Hospital must be located in the United States or its territories.

Ambulance

(if needed as a result of accidental injury)

\$100/\$200/\$300 AWD pays the amount elected for transfer to or from a hospital by regular ambulance. \$200/\$400/\$600 AWD pays the amount elected for transfer to or from a hospital by air ambulance.

Disability

Choice of \$600/\$1200/\$1800 per month, payable to the primary insured only, beginning the first day if totally disabled as a result of an injury for 3 full days. Payable for only one disability at a time. Maximum benefit period 6 months. For any period of disability less than one full month, 1/30th of the monthly disability is paid for each day of total disability.

Important: Read Your Policy

These are plan highlights—not a contract. If these highlights and the policy differ, the policy will govern. Questions? Call Allstate at (800) 229-7683.

Accident Insurance

Medical Expenses

Medical expenses up to \$250/\$500/\$750. Includes physician fees, X-rays, emergency services and repair to sound natural teeth if diagnosed by a dentist to have resulted from the accident. Emergency room services are included in the maximum amount and are limited to a maximum of \$50. Treatment must be received in the United States or its territories.

Sickness Disability Income Rider

Benefits are provided if the insured is totally disabled as a result of sickness not resulting from injury. After the 7 day elimination period (which is not retroactive) AWD pays the amount elected each month up to a maximum of 6 months when the insured employee is totally disabled as described below.

Total disability resulting from pregnancy or childbirth is covered the same as any covered sickness if the rider has been in effect for the 10 consecutive months preceding the commencement of such total disability. Total disability resulting from complications of pregnancy or childbirth are treated the same as any other sickness.

The insured employee is totally disabled when, due solely to sickness, he or she is unable to perform with reasonable continuity the substantial and material acts necessary to pursue his or her usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he or she could reasonably be expected to perform satisfactorily in light of his or her age, education, training, experience, station in life, physical and mental capacity.

Outpatient Physician's Treatment Benefit Rider

AWD pays a benefit when a covered person is treated by a physician outside of a hospital. This benefit is limited to 2 visits per calendar year, per covered person, and a maximum of 4 visits per calendar year if the policy is in force as family coverage. Treatment can be for sickness, annual wellness exams, or other visits to a physician outside of a hospital.

ACCIDENT INSURANCE PREMIUMS TWICE MONTHLY		
BASIC COVERAGE	Accident Only	Accident/Sickness
Individual	\$10.79	\$14.65
Family	\$18.70	\$22.53
ENHANCED COVERAGE	Accident Only	Accident/Sickness
Individual	\$20.52	\$28.23
Family	\$36.31	\$44.03
PREMIER COVERAGE	Accident Only	Accident/Sickness
Individual	\$30.25	\$41.80
Family	\$53.95	\$65.50

Accident Insurance

Accident Insurance Policy Termination and Grace Period

The policy terminates at the earliest of the end of the grace period, the end of the policy year in which the insured becomes age 70, or the insured's death. The spouse, if covered under the policy, becomes the new insured upon the insured's death. A grace period of 31 days is granted for payment of a premium falling due after the first premium is paid. The policy remains in force during the grace period. If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce. If your child is a covered person, the child's coverage ends on the policy anniversary next following the date the child is no longer eligible, which is either when the child marries or reaches age 21 (25 if a full-time student at a regular educational institution of higher learning beyond high school). Benefits shown are provided by 1 unit of Accidental Death and Dismemberment Policy AP2 or state variations thereof. This is an Accident Only policy which does not pay for any loss from sickness. Coverage is for on or off the job accidents. Provides supplemental medical expense coverage. A Sickness disability Income rider and/ or Sickness Hospital Confinement Rider can be added to this policy. (Contact your agent for more details.) This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy itself sets forth, in detail, the rights and obligations of both the insured and the insurance company.

Pre-Existing Condition Limitation

The sickness disability Income and Sickness Hospital Confinement riders have pre-existing condition limitations. A pre-existing condition is a condition which manifested itself within 2 years prior to the effective date of coverage; or for which medical advice or treatment was recommended by or received from a physician in the 2 year period prior to the effective date of coverage. If the insured has a pre-existing condition as defined, we will not pay benefits for such condition as defined, we will not pay benefits for such condition during the 2 year period beginning on the rider date, unless the condition was disclosed without material misrepresentation in answer to questions in the application for the rider, and is not excluded by name or specific description.

Exclusions and Other Limitations

The Sickness Hospital Confinement and sickness disability Income riders do not pay benefits due to sickness caused by or resulting from: any act of war, whether or not declared, participation in a riot, insurrection or rebellion; or attempted suicide, while sane or insane; or being under the influence of alcohol, narcotics or any other controlled substance or drug unless administered upon the advice of a physician; or alcoholism, drug addiction or dependence upon any controlled substance; or voluntary inhalation of gas or fumes; or mental illness without demonstrable organic disease. In addition, the Sickness Hospital Confinement Rider will not pay benefits for conditions caused by or resulting from: dental or plastic surgery for cosmetic purposes, unless the surgery is required to correct a disorder of normal body functions; a newborn child's routine nursing or routine well baby care; or childbirth unless this rider has been in effect for the 10 consecutive months preceding the hospital confinement (complications of pregnancy or childbirth are covered to the same extent as a sickness).

Policy AP2 or state variations thereof, does not cover any loss incurred as a result of injury incurred prior to the effective date of coverage, subject to the Incontestability Provision; or any act of war whether or not declared, participation in riot, insurrection or rebellion; or suicide or any attempt at suicide, whether sane or insane; or intoxicants or controlled substances; we are not liable for loss sustained or contracted in consequence of any person being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician; or any bacterial infection (except pyogenic infections which shall occur with and through an accidental cut or wound); or participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or the taking of poison or asphyxiation from or voluntary inhaling of gas or fumes; or committing or attempting to commit an assault or felony; or driving in any organized race or speed test or while testing an automobile or any vehicle on any racetrack or speedway; or mental diseases or deficiencies without demonstrable organic disease; or injuries sustained by a dependent child while practicing for or participating in an organized competitive football game; or hernia, including complications due to hernia. Any injury sustained while a covered person is an active member of the Military, Naval or Air Forces of any country or combination of countries is not covered. Upon notice and proof of service in such forces, we will return the prorated portion of the premium paid for any period of such service*. Disability benefits due as a result of sprained, strained or lame back or any intervertebral disc conditions are limited to 3 months for any one injury.

Cancer Insurance

administered by Allstate Workforce Division

Cancer and specified disease insurance can help you manage the high expenses of treatment; preserve savings; protect your family from financial hardship; concentrate on getting well. Similar to life insurance, this insurance pays cash benefits directly to the insured, helping to offset the loss of income that can result if you suffer from a covered illness. This type of coverage does not pay medical providers, so it is not a substitute for primary or secondary medical coverage.

- The policy is guaranteed renewable for life, subject to change in premiums by class.
- Benefits are paid directly to you unless assigned.
- Benefits paid in addition to any other coverage.
- Individual or family coverage available.

This insurance also pays benefits for Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Typhoid Fever, Bubonic Plague, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Epidemic Cerebrospinal Meningitis, Undulant Fever, Sickle Cell Anemia, Rocky Mountain Spotted Fever, Smallpox, Addison's Disease, Hansen's Disease and Tularemia.

If these highlights and the policy differ, the policy will govern. Questions? Call Allstate at (800) 229-7683.

Wellness Benefit Rider

Pays \$75 or \$100 each year for each covered person for specified cancer screening tests: Bone Marrow Testing; CA15-3 (test for breast cancer; CA125 (test for ovarian cancer); CEA (blood test for colon cancer); chest X-ray; colonoscopy; flexible sigmoidoscopy; hemocult stool analysis; PSA (test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); or biopsy for skin cancer. This benefit is payable annually for each covered person regardless of the outcome.

Cancer Initial Diagnosis Level Benefit Rider

Pays \$2,000, \$4,000, or \$5,000, (depending on what you choose.) a one-time benefit of the amount shown, when a person is diagnosed, (other than skin cancer).

Benefits

Hospital Confinement

The Policy has benefit options of \$200/\$300/\$400 day of continuous hospital confinement up to 70 days.

After the 70th day, we pay \$30 for each day thereafter of continuous hospital confinement.

At Home Nursing

Pays charges up to \$100 each day for private nursing care and attendance by a nurse at home. Must be required and authorized by the attending physician. Limited to the number of days of the previous continuous hospital confinement.

Government Hospital

AWD pays \$100 each day in lieu of all other benefits in the policy when confined to a hospital operated by or for the U.S. Government, (including the Veteran's Administration). In the event the hospital does not impose a charge for treatment, benefits will be as provided in any other hospital.

Surgery (Per Schedule in Policy)

Actual charges up to \$3,000 maximum depending on surgery. Outpatient surgery is paid at 150% of the surgical benefits, up to \$4,500.

Second Surgical Opinion

Actual charges up to \$200 must be incurred after diagnosis and before surgery.

Anesthesia

Actual charges of an anesthetist up to the greater of 25% of the amount paid for surgery or \$100.

Ambulatory Surgical Center

AWD pays charges up to the amount shown each day when surgery is performed at an Ambulatory Surgical Center.

Radiation Therapy, Radio-Active Isotopes Therapy, Chemotherapy and Immunotherapy

Actual charges up to \$10,000/\$15,000/\$20,000 each 12 month period beginning with the first day of benefit under this provision for covered treatment techniques used for the modification or destruction of cancerous tissue. CER1 Increases the benefit by \$5000 per unit each 12 month period beginning with the first day of benefit under the policy provision. CER1 Pays only after the \$10,000 each 12 month limit in CP10B is reached. The 12 month period in CER1 Runs concurrently with the 12 month period in CP10B and CER1 combined pay up to the maximum shown each 12 month period.

Cancer Insurance

New or Experimental Treatment

Actual charges up to \$10,000 every 12-month period.

Inpatient Drugs and Medicine

Actual charges up to \$250 maximum.

Blood, Plasma and Platelets

Actual charges up to \$10,000/\$15,000/\$20,000 each 12 month period beginning with the first day of benefit under this provision for blood, plasma, platelets and transfusions (including administration charges); processing and procurement costs; and cross matching. CER1 pays only after the \$10,000 each 12 month limit in CP10B is reached. The 12 month period in CER1 runs concurrently with the 12 month period in CP10B, CP10B, & CER1 combined pay up to the maximum shown each 12 month period. Donor replaced blood is not covered.

Physician's Attendance

Actual charges up to the \$30 per day for up to 70 days for a visit by a physician during a covered hospital confinement. Limited to one visit a day by one physician.

Private Duty Nursing Services

Actual charges up to the amount elected each day for up to 70 days while hospital confined when required and authorized by the attending physician.

Skin Cancer

Actual charges for removal of skin cancer up to \$120 for 1st removal, when a physician who is not a pathologist diagnoses it. If more than one skin cancer is removed at the same time, the policy pays \$60 for each additional skin cancer removed. Skin cancers diagnosed by a pathologist are eligible for other policy benefits.

Prosthesis

Actual charges up to \$2,000 for each prosthetic device prescribed as a direct result of surgery for cancer or specified disease treatment and which requires surgical implantation. Limited to \$2,000 for each covered person, for each amputation.

Ambulance

Actual charges up to \$200 on continuous hospital confinement for transportation by a licensed ambulance service, for transporting a covered person.

Non-Local Transportation

AWD pays the cost of round trip coach fare by common carrier or \$0.40 for each mile up to 700 miles for round trip personal vehicle transportation for treatment at a hospital (inpatient or outpatient).

Outpatient Lodging

Actual charges up to \$100 per day; maximum \$4,000 for a 12 month period.

Family Member Lodging and Transportation

- Lodging: Actual charges up to \$100 per day for hotel accommodations (60 days for each continuous confinement).
- Transportation: 1) Actual cost of round trip coach fare on common carrier; or 2) \$0.40 per mile up to 700 miles round trip (70 mile minimum round trip).

We do not pay the Family member Transportation benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation benefit, when the family member lives in the same city or town as the covered person.

Physical or Speech Therapy

Actual charges up to \$25 per day

Extended Care Facility

Actual charges up to \$100 per day (limited to the number of days of previous hospital confinement and must begin within 14 days after hospital confinement).

Mammography Benefit

Greater of \$50 or whatever the charges are, up to \$200) for baseline mammography for women ages 35-39; inclusive; mammography every 2 years, or more frequently upon a physician's recommendation for women 40 - 49; and annual mammography for women ages 50 and over.

Cervical Cancer Screening Test

Greater of \$50 or charges up to \$200 for annual cervical cancer screening test.

Waiver of Premium

Pays premiums after insured is disabled for 90 days. Disability must be a direct result of cancer diagnosed after the first 30-days of coverage.

Cancer Insurance

Cancer Initial Diagnosis Level Benefit Rider

Pays a one-time benefit for each covered person, when a covered person is diagnosed for the first time ever as having cancer (other than skin cancer). The first diagnosis must occur after the waiting period and is payable only once for each covered person.

Optional Benefits

Hospital Intensive Care Rider

This rider is not disease specific and pays a benefit for covered confinement for any covered illness or accident from the very first day of confinement, in intensive care. Coverage begins with the first day of admission and pays up to 45 days. For time periods less than a day (24 hours), a pro-rata share of the daily benefit is paid. Daily benefit amount is \$600 per day.

Eligibility/Termination

Family Plan coverage may include you, your spouse and dependent children as defined in the policy. Coverage for dependent children terminates on the policy anniversary next following the date the child is no longer eligible, which is either when the child marries or reaches age 21 (25 if a full-time student at an educational institution of higher learning beyond high school). Coverage for the insured's spouse ends upon valid decree of divorce.

Renewability

The policy is guaranteed renewable for life, subject to change in premiums by class. All premiums may change on a class basis. A notice is mailed in advance of any change.

PREMIUMS FOR ALLSTATE CANCER INSURANCE		
BASIC COVERAGE	Base Plan	Base Plan + ICR2
Individual	\$11.05	\$14.06
Family	\$18.57	\$24.57
ENHANCED COVERAGE	Base Plan	Base Plan + ICR2
Individual	\$14.08	\$17.07
Family	\$24.05	\$30.05
PREMIER COVERAGE	Base Plan	Base Plan + ICR2
Individual	\$18.22	\$21.23
Family	\$31.63	\$37.61

Issue Ages: 18-64/Rates are Twice Monthly

Waiting Period, Exceptions & Limitations

The policy and riders contain a 30-day waiting period that begins on the effective date. No benefits are payable for any covered person who has cancer or a specified disease diagnosed before coverage has been in force 30 days from the effective date, except should a covered person have cancer or a specified disease first diagnosed after signing the application and before the end of the waiting period, benefits for treatment of that cancer or specified disease will apply only to loss commencing after 2 years from the effective date of the policy; or at your option, you may elect to void the policy from the beginning and receive a full refund of premium, in accordance with the Notice of 30 Day right to Examine Policy Provision. The policy does not pay for any loss except for losses due directly from cancer specified disease. Diagnosis must be submitted to support each claim. The policy does not pay for any disease or incapacity that has been caused, complicated, worsened or affected by cancer or a specified disease or as a result of cancer or specified disease treatment. Treatment must be received in the United States or its territories.

This booklet highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy itself sets forth, in detail, the rights and obligations of both the insured and the insurance company. This is a Limited Benefit Cancer and specified Disease Policy with Optional Riders. The policy and riders are not a Medicare Supplement Policy. Allstate Financial Workplace Division is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a wholly owned subsidiary of the Allstate Corporation. ©2002 American Heritage Life Insurance Company allstate.com.

Heart & Stroke Insurance

administered by Allstate Workforce Division

Why Heart & Stroke Insurance?

Help protect yourself and your family against the financial hardship that can result from heart disease. Similar to life insurance, this insurance pays cash benefits directly to the insured, helping to offset the loss of income that can result if you suffer from a covered illness. This type of coverage does not pay medical providers, so it is not a substitute for primary or secondary medical coverage.

Policy Features

This benefit pays cash directly to the insured (unless otherwise assigned) for the service and treatment administered to or received by a covered person for a heart attack, heart disease or stroke. Such treatment or service must be a) incurred by a covered person while coverage under the policy is in force on that person; b) necessary for the care and treatment of a heart attack, heart disease or stroke. The Heart & Stroke Insurance plan provides benefits for the following types of services:

- Hospital Confinement
- Physiotherapy
- Oxygen
- Blood, Plasma and Platelets
- Coronary Angioplasty
- Coronary Artery Bypass Graft Operation
- Heart Transplant
- Surgery and Anesthesia
- Non-Local Transportation
- Inpatient Drugs and Medicine
- Physician's Attendance
- Private Duty Nursing
- Cerebral or Carotid Angiogram
- Cardiac Catheterization
- Pacemaker Insertion
- Thromboendarterectomy
- Second Surgical Opinion
- Cardiograms
- Ambulance
- Family Member Lodging and Transportation

Hospital Intensive Care Rider

This optional rider pays a benefit for covered confinement in a hospital intensive care unit for any covered illness or accident from the very first day of confinement. Benefits are paid in addition to other insurance coverage.

Exclusions & Limitations

Exclusions and limitations to the policy also apply to the rider. This highlights some features of the policy, but is not the insurance contract. Only the actual policy provisions control the benefits. The policy itself sets forth, in detail, the rights and obligations of both the insured and the insurance company. Please read the actual policy before deciding if this option is right for you and your family.

Renewability

Coverage is guaranteed renewable for life, subject to a change in premiums by class. This policy will remain in effect when renewal premiums are paid as they are due or during the grace period.

Coverage is also portable, which allows you to retain the policy if you change jobs or retire as long as you continue to make the required premium payments.

Termination of Insurance

If your spouse is a covered person, your spouse's coverage will end upon valid decree of divorce. If your child is a covered person, the child's coverage ends on the earlier of the policy anniversary date following a) the date the child marries or b) reaches age 21 (25 if a full time student at an educational institution of higher learning beyond high school).

Heart & Stroke Insurance

Exclusions and Limitations

This policy provides benefits only for Heart Attack, Heart Disease or Stroke. This policy does not cover any other disease or sickness or incapacity other than Heart Attack, Heart Disease or Stroke even though such disease, sickness or incapability may be caused, complicated or otherwise affected by Heart Attack, Heart Disease or Stroke. If a covered confinement is due to more than one covered condition, benefits will be payable as though the confinement were due to one condition. If a confinement due to a covered disease is also due to a condition that is not covered, benefits will be payable only for the part of confinement attributable to the covered condition.

Pre-Existing Condition Limitation

A pre-existing condition is not revealed in the application for which: symptoms existed within a 6 month period before the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis care or treatment; or medical advice or treatment was recommended by or received from

a physician within the 6 month period before the effective date of coverage. If a covered person has a pre-existing condition, the plan does not pay benefits for such conditions under this policy or any riders attached to this policy during the 6 month period beginning on the date that person became a covered person. If the loss is not due to a pre-existing condition, then the pre-existing condition limitation does not apply.

Important: Exclusions and limitations to the policy also apply to the rider. This highlights some features of the policy, but is not the insurance contract. Only the actual policy provisions control. The policy itself sets forth, in detail, the rights and obligations of both the insured and the insurance company.

If these highlights and the policy differ, the policy will govern. Questions? Call Allstate at (800) 229-7683.

PREMIUMS FOR HEART & STROKE INSURANCE

Base Plan		
	1/2 Unit of Coverage	1 Unit of Coverage
	Twice Monthly	Twice Monthly
Individual	\$4.51	\$8.99
Family	\$8.67	\$17.33
Base Plan / Adding ICR90 / \$300 a Day		
	1/2 Unit of Coverage	1 Unit of Coverage
	Twice Monthly	Twice Monthly
Individual	\$6.15	\$10.64
Family	\$11.96	\$20.63
Base Plan / Adding ICR90 / \$600 a Day		
	1/2 Unit of Coverage	1 Unit of Coverage
	Twice Monthly	Twice Monthly
Individual	\$7.80	\$12.29
Family	\$15.28	\$23.92

Issue Age: 18-64

Long Term Care Insurance

administered by MetLife

Long term care is the type of care you or someone in your family may need if you no longer can take care of yourself. For example, if you needed help getting dressed, eating, or bathing.

Plan Features

Coverage may be continued even if the member is no longer affiliated with the employer and the member retains the 10% Premium Discount.

Employees who are actively at work, as well as spouses, parents, parents-in-law, stepparents, step-parents-in-law, children and stepchildren (ages 18-84) are eligible for coverage.

Why Long Term Care?

On average, Americans now have more parents than children. In fact, they will spend more years caring for their parents than they will raising their children. As a result, learning to care for our older family members without over burdening ourselves has become one of today's major concerns.

- Consider that: 48.6% of people age 65 and older may spend time in a nursing home.
- 71.8% of people over the age of 65 may use some form of home healthcare.
- The national average nursing home cost is \$40,000 – in some parts of the country, costs run as high as \$100,000 (source New York State Partnership for Long Term Care 1997).

Nursing homes are the first place people associate with long term care. But one of the major benefits of planning for long term care is that you can decide where you would like to receive your care. Aside from nursing home care, there are assisted care living facilities, adult day care centers, and home healthcare providers.

Major medical insurance and Medicare, as well as Medicare supplements, are designed to pay for hospital, physician, surgical, rehabilitation, outpatient, and treatment expenses. These types of coverage were never designed to pay for long term care. They cover long term care when it is at the skilled level (acute care requiring nurses). Medicaid does pay for long-term

care at the custodial level. However, to qualify for Medicaid you must have \$2,000 or less in assets, not including your home and personal items (this amount could vary by state).

Long term care insurance can help secure not only your financial future, but also that of your family. A long-term care insurance policy can help protect your assets from the rising cost of care, allowing you to remain financially and socially independent.

Long Term Care Facts

- 10-15 million Americans will need some form of long term care by the year 2000 (source American Academy of Actuaries)
- 22.4 million families have some responsibility for providing care to a person over age 50 (source American Association of Retired Persons 1997)
- 40% of people receiving long term care are between the ages of 18 and 64 (source US Department of Health and Human Services 1997)
- By the year 2015, baby boomers (those born between 1945 and 1964) will begin to enter their 70's (source Health Insurance Association of America 1997)

Your long term care policy describes the types of coverage provided as well as any exclusions, limitations, reductions in benefits, what you must do to keep your policy in force and what would cause your policy to be discontinued. Your enrollment representative will be able to assist you with your questions and provide you with a quote specific to your situation.

Special Features

The following features are included in your policies and are designed to make your coverage more valuable:

Spousal and Marital Discounts

A 30% discount will be applied when both you and your Spouse or Domestic Partner are accepted for coverage.

A 15% "Marital discount" is applied if you apply for coverage, as a couple, and only one is accepted for coverage.

Long Term Care Insurance

Possible Tax Benefits

Generally, benefits from employee-paid plans are not taxable.

Premium Waiver

Once you begin receiving benefit payments, you don't have to pay premiums. Premium payments will resume when you no longer receive covered services.

Guaranteed Renewability

The policy cannot be cancelled as long as premiums are paid on time. Premiums can only be raised as the result of a rate increase made on a class-wide basis in California and approved by the Department of Insurance.

Note: Rates do not increase as you move into the next age bands. (The rates listed above are subject to change and should be used as samples only. They illustrate a 10% discount for a Multi-Life group rate. Many factors determine the rates. Smoking, health, whether Spouse or Domestic Partner is applying, what riders you choose, etc. Your EBS counselor will use a calculator to finish. The rates may change further, after it goes through underwriting process. Note: If a spouse/domestic partner enrolls with EE, a discount of 30% will be applied to the final rates. This illustration is a general description of coverage and is not a contract. For a rate quote you must speak with your EBS enrollment counselor. Any differences in premiums between this illustration and those quoted will be determined in favor of the quoted rates. Please review your policy for all terms and conditions.

MetLife Ideal Partnership Long Term Care

Nursing Home Daily Benefit.....	100%
Residential Care Facility Benefit.....	100%
100%Home Healthcare Benefit.....	100%
Elimination Period	90 days
Benefit Period	3 years
Daily Benefit	\$150.00
Payment Type.....	Life-Pay
Underwriting Class.....	Standard

Sample: Partnership Long Term Care Insurance Rates

Age	Twice Monthly Cost
18-30	\$51.46
35.....	\$58.19
40.....	\$63.56
45.....	\$69.41
50.....	\$74.96
55.....	\$80.94
60.....	\$100.80
65.....	\$135.92
69.....	\$187.14
70.....	\$204.67
69.....	\$329.28

Important: Read Your Policy

These are plan highlights—not a contract. If these highlights and your policy differ, the policy will govern. Questions? Call MetLife at (888) 565-3716.

Pet Care Insurance

administered by PetCare

QuickCare Gold

The most comprehensive coverage. Accident and illness coverage that protects your cat or dog in virtually any situation. Choose between 70% or 90% coverage.

- Accident – Cat \$2,500/Dog \$3,000 – Coverage amount is for each separate accident.
- Illness – Cat \$2,500/Dog \$3,000 – Total lifetime coverage per illness category; cardiovascular & respiratory system; Digestive system; Urogenital system-Musculoskeletal system; Nervous system. Eyes-ears-skin-endocrine system; Blood & lymphoid system-infectious diseases-cancer.
- Accidental Death - \$500 (No deductible) – If your pet should die from injuries as a result of an accident, its original purchase price will be reimbursed, up to policy limits.
- Boarding Kennel Fees - \$250 (No Deductible) Boarding or home care for your pet to a maximum of \$25/day should you become hospitalized for more than 48 hours and are unable to provide pet care.
- Recovery Costs - \$150 (No deductible) – To pay for advertising or to offer a reward should your pet become lost or missing.

Deductible \$100 for Accident or Illness

QuickCare Gold Advantages

- Unlimited number of accidents covered
- No maximum annual illness benefit restrictions
- Eligible enrollment age 8 weeks–10 years (cat), 8 years (dog), 6 years (select breed dog).
- Lifetime coverage once enrolled in the program
- Lifetime maximum illness coverage \$30,000 (cat), \$36,000 (dog), split equally into 12 illness categories

QuickCare Gold Twice Monthly Premiums

Plan	Cat	Dog
70% Coverage.....	\$ 9.98	\$14.03
90% Coverage.....	\$12.68.....	\$21.23

For QuickCare Gold, medical records will be requested at the time of enrollment.

Some breeds are more susceptible to certain illnesses; therefore premiums are slightly higher for the following “select” breeds: Basenji, Basset Hounds, Boxers, Bulldogs, Bull Terriers, Dalmations, Deerhounds, Doberman Pinschers, Dogue de Bordeaux, German Shepherds, all Greyhounds, Great Danes, Irish Wolfhounds, Leonbergers, all Mastiff breeds, all Mountain Dogs, Newfoundlands, Old English Sheepdogs, Rottweilers, St Bernards and Wheaten Terriers. All Shar-Pei’s and Shar-Pei crossbreeds are excluded from illness coverage and eligible for accident coverage only.

QuickCare

Selected Accident Only coverage for cats and dogs.

Coverage Amounts and Description

100% of payable claims are paid after any applicable deductible up to policy limits.

- Foreign Body Ingestion: \$2000 / An ingested foreign body needs to be surgically removed.
- Motor Vehicle Accident: \$2000 / Medical treatment for injuries resulting from any form of motor vehicle accident.
- Bone Fractures: \$2000 / Fractures not caused by a motor vehicle accident.
- Poison Ingestion: \$1500
- Lacerations: \$500 / Medical treatment for an accidental laceration such as cut pads or dog/cat bites and abscesses.
- Burns: \$500
- Allergic Reaction to Insect Bites/Stings: \$500
- Accidental Death: \$500 (No deductible) / If your pet should die from injuries as a result of an accident, its original purchase price will be reimbursed, up to policy limits.

Deductible \$50 (unless otherwise noted)

QuickCare Twice Monthly Premiums

Cat.....	\$5.98
Dog.....	\$5.93

Pet Care Insurance

Quickcare Optimum

Illness Coverage: First time Illness diagnosis.

Accident Coverage: Foreign Body; Motor Vehicle Accident; Poison Ingestion; Bone Fracture; Lacerations; Burns; Allergic Reaction to Insect Bites.

Wellness Plan: up to \$150 annually for vaccinations, annual physical exam, spay/neuter, heartworm, teeth cleaning.

Additional Benefits: Recovery Costs of advertising a reward should your pet be lost or stolen. Euthanasia and Cremation, to cover the cost for euthanasia, burial, and cremation.

Deductible \$100 for Accident or Illness

QuickCare Optimum Twice Monthly Premiums

Cat.....	\$13.56
Dog.....	\$15.60

Quickcare for Indoor Cats

Selected accident and illness coverage for kittens and cats that live primarily indoors.

- Feline Lower Urinary Tract Disease (FLUTD): \$2,500 (\$200 deductible)
- Cancer: \$2,500 (\$200 deductible) / Should your cat be diagnosed with any malignant tumor, diagnosed by histopathology
- Infectious Disease: \$2,500 (\$200 deductible)
- Feline Asthma: \$2,500 (\$200 deductible)
- Diabetes Mellitus: \$2,500 (\$200 deductible)
- Foreign Body Ingestion: \$2,000 / An ingested foreign body needs to be surgically removed
- Bone Fractures: \$2,000
- Poison Ingestion: \$1,000
- Feline High-Rise Syndrome: \$1,500 / Medical treatment for injuries resulting from accidentally falling from an elevated dwelling
- Bite Wounds and Bite Wound Abscesses: \$500
- Burns: \$500

Deductible \$50 (unless otherwise noted)

QuickCare for Indoor Cats Advantages

- Unlimited number of (listed) accidents covered
- No 30 day waiting period
- No age limitations for enrollment
- Enrollment as early as 8 weeks of age

QuickCare Twice Monthly Premiums for Indoor Cats

Cat.....	\$6.38
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Quickcare Senior

Selected accident and illness coverage with no age limitations specially tailored for senior cats and dogs.

Coverage Description

Includes, but is not limited to: prescribed medication, X-rays, surgeries, hospitalization, ultrasounds, MRI/CAT scans, homeopathic treatments including acupuncture and chiropractic, chemotherapy and referrals.

Deductible \$50 (unless otherwise noted)

QuickCare Senior Advantages

- Pick Your Veterinarian. You can use any licensed veterinarian of your choice.
- Hereditary and Chronic Defects Coverage. Provides coverage for hereditary and chronic defects, including hip dysplasia.
- No Itemized Restrictive Schedule of Benefits
- Benefit from PetCare's Maximum Discount

QuickCare Senior Twice Monthly Premiums

Cat.....	\$10.38
Dog.....	\$15.83

Enrolling Your Pet

You will need to bring the following information with you to enroll your pet: veterinarian provider's name, address and phone number, as well as the date of the pet's most recent physical exam and vaccination history. Your pet's medical records will be requested on the application. Enrolled pets must have an annual physical exam each year, to keep the policy in force. Policy renews annually. Questions about your policy? Contact PetCare at (866) 275-7387.

Miscellaneous Reimbursement Account

Members may opt to allocate flexible credits towards the post-tax Miscellaneous Reimbursement Account. In order to be reimbursed from this account, members are required to submit a claim directly to EBS for reimbursement, and for most qualifying expenses proof of the expense (a receipt) will be required.

Qualifying Expenses

MEA Dues

MEA members must sign up for a payroll deduction to pay their Association dues in order to have those dues reimbursed to them monthly. You can also use this account for other professional dues and auto club dues.

Health Club and Fitness

Members can use this account for dues and initiation fees for health clubs, the purchase of fitness equipment, and related items such as vitamins, weight loss programs and non-prescription smoking cessation programs. (Prescription smoking cessation programs are eligible for pre-tax reimbursement through the medical reimbursement plan).

Auto and Homeowners Insurance

You may elect to be reimbursed for your auto and/or homeowners or renters insurance expenses. In order to be reimbursed you must submit a receipt showing current payment of either of these insurance premiums.

Executive Coaching

Champion athletes use coaches to make their game legendary. Executive coaching gives that same exceptional one-on-one support and motivation for your personal and professional life. Everybody is different and coaching helps you focus on your goals in life. The best athletes in the world have coaches. This doesn't mean that something has to be fixed; it means, "I want to be extraordinary." You must be able to present receipts from an eligible coaching professional.

State Disability Insurance

If you are in a position that requires a contribution through payroll deduction to the California State Disability plan, you can sign up to be reimbursed some or all of that cost. You may submit a copy of your paycheck stub for this expense and be reimbursed automatically.

Prior Service Buy Back

If you are having a deduction from paycheck to purchase "prior service" you may choose to be reimbursed for this deduction. If you make cash payments to the Retirement System and you select this option, you may submit a receipt for reimbursement.

Tuition Reimbursement

If you are participating in any training program and you have exceeded your \$1000 allocation from the MEA training fund, you may be reimbursed the excess through this plan. Only classes that are qualified under the training program through the MEA training account are eligible. You will be reimbursed the excess over the \$1000 for classes that qualify.

San Francisco Cultural and Entertainment Event Reimbursement

Events or entertainment that are partially or fully sponsored by the Hotel Tax Fund or operated directly by the City and County of San Francisco, for example, the entry to or membership in the San Francisco Zoo, Academy of Science, Opera, Asian Art Museum, deYoung Art Museum, San Francisco Symphony, the San Francisco Ballet etc. will qualify for reimbursement. You can be reimbursed for membership, season tickets, individual tickets, or other contributions.

Long Term Care Reimbursement Account

There are two ways to purchase long term care through the flexible benefits program. You may elect to use available flex credits or a post-tax payroll deduction. If you are purchasing long term care through PERS you may be reimbursed for some or all of that premium cost. PERS holds enrollment for Long Term Care in the spring of each year. Employees must enroll through PERS directly for the benefit to be reimbursed.

Pre-Tax Retirement Deductions

If you are having a pre-tax retirement deduction taken from your paycheck, you can be reimbursed through this account. You must submit a copy of your paycheck stub showing the deductions to receive a reimbursement. However, per IRS regulations, deferred compensation deductions are not eligible for Miscellaneous Reimbursement.

Pre-Paid Legal

More and more Americans are realizing that legal problems are a fact of life and that legal protection is a necessity. As a Pre-Paid Legal member, legal assistance is just a phone call away. Eligible employees, spouses and dependent children up to age 21 are covered under this plan. (Dependents who are full time students are covered to age 23. Proof is required; see your membership packet for details.)

You'll have your Provider Attorney's toll-free consultation number on the back of your membership card. When you call your Provider Attorney's office and give the nature of your legal question or problem, you will be asked for a time when it would be convenient for an attorney to call you.

Preventative Legal Services

Unlimited Phone Consultations

You have unlimited toll-free access to your Provider Attorney for personal or business related legal matters immediately after you enroll. You can call your Provider Attorney's toll-free number during regular business hours.

Phone Calls and Letters

A phone call or letter from your Provider Attorney can get you the results you want fast. Your Provider Attorney will recommend a letter or phone call when that is the best legal step for you. One call or letter per personal subject related matter is free with membership. Plus you're entitled to two business letters each year at no additional cost. Additional assistance on the same subject is provided at a 25% discount.

Contract and Document Review

You can have an unlimited number of personal legal documents of up to 10 pages each reviewed by your Provider Attorney. Included each year is one business document review at no additional cost. Your Provider Attorney will analyze the documents and suggest any beneficial changes before you sign.

Wills for You and Your Family

Included in this program is a will for you at no additional charge. Not just a "simple" will, but one that meets most American's needs with free yearly reviews and updates. Wills for covered family members are just \$20 each; changes and updates are \$20. Trust preparation is available at 25% discount.

Motor Vehicle Legal Services

Minor Legal Expenses

Your Provider Attorney will represent you or your eligible covered family members against moving traffic violations at no additional cost to you. Now you can have help with traffic tickets and not have to worry about the cost of representation.

Major Legal Expenses

Your Provider Attorney will defend you or your covered family members when you are charged with Manslaughter, Involuntary Manslaughter, Negligent Homicide, or Vehicular Homicide at no added cost to you.

Important: Read Your Contract

These are plan highlights—not a contract. If these highlights and your contract differ, the contract will govern. Questions? Call Pre-Paid Legal at (800) 654-7757.

Pre-Paid Legal

Trial Defense Services

During your first year of membership, you have up to 60 hours of your Provider Attorney's time at no additional cost when you or your spouse is named defendant or respondent in a covered civil or criminal action filed in court. The criminal action must arise out of the performance of the covered person's employment responsibilities. Your Provider Attorney can advise you on the documents required to determine coverage under this benefit.

Of these 60 hours, up to 2.5 hours may be used for all legal services rendered in defense of a covered suit prior to actual trial. Up to 57.5 of the remaining hours are available for actual trial time, including covered preliminary hearings.

Your available hours of service increase when you renew your membership as follows:

- 2nd year renewal - 3 hours of pre-trial time plus 117 hours of trial time at no added cost
- 3rd year renewal - 3.5 hours of pre-trial time plus 176.5 hours of trial time at no added cost
- 4th years renewal - 4 hours of pre-trial time plus 236 hours of trial time at no added cost
- 5th year renewal - 4.5 hours of pre-trial time plan 295.5 hours of trial time at no added cost.

IRS Audit Legal Services

Your Pre-Paid Legal membership will help you defray the costs of an IRS audit and give you the legal support you need.

You have up to 50 hours of your Provide Attorney's time available at no additional cost when you or a covered family member receives a written notice of an IRS audit or is requested to appear at IRS offices regarding your tax return. Your 50 hours are available as follows:

- Up to one hour for consultation, advice, and assistance when you receive written notice from the IRS of an audit or appearance.

- If there is no settlement within 30 days, you have up to 2.5 hours for audit representation, negotiations, phone conversations, and settlement conferences prior to litigation.
- If there is no settlement without litigation, up to 46.5 hours are available for actual trial appearance if the IRS sues you or if you pay the disputed tax and sue the IRS.

Should you need legal services not covered by this plan, your Provider Attorney will render assistance at a 25% reductions to his or her standard hourly rate for you or any covered dependent. (Hourly rates for referral attorneys and court appearances may vary.) Please note that a retainer may be required for services to be rendered under this benefit. Your Provider Attorney must have five days notice prior to court representation. Telephone advice is available immediately.

Pre-Paid Legal Twice Monthly Premiums

Family Plan.....	\$11.22
Family Plan w/Legal Shield Benefit Option	\$21.13

This benefit is portable without rate increase. The plan covers member, member's spouse or domestic partner, never married dependent children up to the age of 21 living at home, never married dependent children who are full time students up to the age of 23.

Corporate and Business Tax Returns Not Covered Under This Plan

This program does not cover corporate or business tax returns. Coverage for this service begins with the tax return due April 15 of the year you enrolled.

Additional Benefits

Wells Fargo Benefit

If you are an active MEA member you are eligible for a program through Wells Fargo offering reduced mortgage costs, free checking, low interest credit cards and other benefits. There is no cost to participate in this program. You will receive a flyer in the mail directly from MEA describing the features and how to access them. You do not have to enroll in this program during your enrollment appointment.

Commuter Check

The City and County of San Francisco offers a pre-tax commuter benefit for all employees. This pre-tax program allows you to have up to \$120 per month deducted from your paycheck for qualified commuting expenses.

In addition to the City's pre-tax program, eligible members may also sign up for a post-tax commuter benefit using their available flexible credits. There is no limit on the amount of flexible credits you can allocate toward this plan and you can contribute these post-tax credits in addition to any pre-tax payroll deductions you may have elected under the City's plan.

Once a month Commuter Checks are sent to participants to use to buy transit tickets. Participants will receive their Commuter Checks at the end of each month in time to purchase the following month's transit tickets.

Gateway Computer Purchase Program

The City and County of San Francisco and Gateway are proud to bring you a special offering on technology solutions. Gateway is pleased to offer, through EBS, select employees of the City and County of San Francisco a 10% discount off of the base price of any new Gateway® consumer PC .

Gateway also offers training, Internet access, home installation, and networking, whatever you need to turn your new PC into a complete technology solution. And it's all available through your local Gateway store, your source for service, advice, free seminars, and more!

You can work directly with the friendly, knowledgeable Gateway sales representatives to help assess your needs and help you choose the PC, software and peripherals that fit the way you live. Please contact us to build the technology solution that is right for you!

- Visit your local Gateway® store and identify yourself as an MEA member and provide your program code, which is BEPU20236.
- Call (877) 485-1462 to order by phone. Please make sure you identify yourself as an MEA member and provide the program code above
- Visit the MEA Employee Purchase website at <http://esource.gateway.com/SanFranEPP>.

The 10% discount does not apply to the Solo @1400, any system upgrades, downgrades, Gateway Business Products, or peripheral items. Such discount does not include or otherwise apply to warranty upgrades, add-ons, accessories, applicable taxes or charges for packing, hauling, storage or shipping. This discount available to the employees through this program may not be combined with other local and/or national discounts and special programs. Discount is available only at the time of purchase. Gateway Terms & Conditions of Sale apply. Gateway.com and Gateway Country Stores, LLC are separate legal entities. Gateway, the Gateway Stylized Logo and the Black-and-White Spot Design are trademarks or registered trademarks of Gateway, Inc. in the U.S. and other countries.

Privacy Policy

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

Use and Disclosure of Health Information

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

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

To Make or Obtain Payment

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

To Conduct Healthcare Operations

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

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

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

For Treatment Alternatives

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

For Distribution of Health-Related Benefits and Services

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

For Disclosure to the Plan Actuaries

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

When Legally Required

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

To Conduct Health Oversight Activities

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

In Connection With Judicial and Administrative Proceedings

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

For Law Enforcement Purposes

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

In the Event of a Serious Threat to Health or Safety

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

Privacy Policy

For Specified Government Functions

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

For Worker's Compensation

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

Authorization To Use Or Disclose Health Information

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

Your Rights With Respect to Your Health Information

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

Right to Request Restrictions

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

Right to Receive Confidential Communications

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

Right to Inspect and Copy Your Health Information

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

Right to Amend Your Health Information

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

Right to an Accounting

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

Right to a Paper Copy of this Notice

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

Duties of the Health Plan

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

Written Authorizations & Requests

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

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

Effective Date

Original Effective Date: April 14, 2003
Revised January 1, 2009

Key Contact Information

HEALTH SERVICE SYSTEM

Member Services

1145 Market Street, Suite 200
San Francisco, CA 94103
(Civic Center Station between 7th & 8th)
Tel: (415) 554-1750
(800) 541-2266 (outside 415)
Fax: (415) 554-1752
www.myhss.org

MEDICAL PLANS

City Health Plan (UnitedHealthcare)

Tel: (866) 282-0125
Group No. 705287
www.myuhc.com

Blue Shield of California

Tel: (800) 642-6155
Group No. H11054
www.blueshieldca.com/sfhss

Kaiser Foundation Health Plan, Inc.

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

VISION PLAN

Vision Service Plan (VSP)

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

FLEXIBLE SPENDING ACCOUNTS

Fringe Benefits Management Company (FBMC)

Tel: (800) 342-8017
Customer Service M-F 4AM-7PM
(800) 865-3262
Automated Interactive Benefits 24 hrs
www.myfbmc.com/ccsf

DENTAL PLANS

Delta Dental

Tel: (800) 765-6003
Group No. 9502-0003
www.wekeepyoumiling.org/group_sites/ccsf/

DeltaCare USA Dental

Tel: (800) 422-4234
Group No. 01797-0001
www.wekeepyoumiling.org/group_sites/ccsf/

Pacific Union Dental

Tel: (800) 999-3367
(925) 363-6000
Group No. 705287-0046
www.myuhcdental.com

MANAGEMENT CAFETERIA PLAN FLEXIBLE CREDIT BENEFITS

Employee Benefit Specialists (EBS)

Tel: (925) 460-3910
www.ebsbenefits.com

COBRA

Fringe Benefits Management Company (FBMC)

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

CITY AGENCIES

Department of Human Resources

Tel: (415) 557-4800
www.sfgov.org/dhr

San Francisco Employees' Retirement System (SFERS)

Tel: (415) 487-7000
www.sfgov.org/site/sfers

This guide was printed in the USA on ancient forest friendly, recycled paper comprised of 40% post-consumer waste. When it has outlived its usefulness to you, please recycle.

Health Service System

CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG