HEALTH SERVICE SYSTEM
A DIVISION OF THE DEPARTMENT OF HUMAN RESOURCES
CITY AND COUNTY OF SAN FRANCISCO

BENEFIT INFORMATION

-for-

MANAGEMENT CAFETERIA PLAN

Including

Comparisons of Dental Plans and Information on all Voluntary Benefits

(Health Plan Comparison provided separately)

PLAN YEAR
OCTOBER 1, 2001 – JUNE 30, 2002

NINE MONTH PLAN YEAR

ANNUAL OPEN ENROLLMENT PERIOD
JULY 30, 2001 – AUGUST 17, 2001

DSC Last printed 7/12/01 8:46 AM elg

OPEN ENROLLMENT INFORMATION SITES

Employee Benefit Specialists Enrollment Counselors will be available at each of these sites to assist you. You may use any of these sites; they are not limited to employees of the department in which they are located.

JULY 30 - AUGUST 10, 2001 CITY HALL, ROOM 34 8:00 A.M. –4:00 P.M BY APPOINTMENT ONLY		
August 13, 2001 9:00 a.m. – 4:00 p.m.	SF General Hospital	Main Hospital Bldg., 2nd Floor 1001 Potrero Ave., SF
August 14 &15, 2001 9:00 a.m. – 4:00 p.m.	Hall of Justice	850 Bryant Street, SF
August 16 &17, 2001 9:00 a.m. – 4:00 p.m.	Airport -- DHR	245 S. Spruce Ave, South San Francisco
To be Determined	Hetch Hetchy	Junction 120 49 Moccasin

SHADED DAYS ARE AVAILABLE BY APPOINTMENT ONLY

CONTACT INFORMATION

Health Service System Membership Division
1145 Market Street, Suite 200
San Francisco, CA 94103
(415) 554-1750; (800) 541-2266 (outside 415 area code)
Web Address: http://sfgov.org/hss

HEALTH PLANS

City Health Plan
1145 Market Street, Suite 200
San Francisco, CA 94103
(415) 554-1725
(800) 795-2351 outside 415 Area Code

Kaiser Foundation Health Plan, Inc.
2425 Geary Boulevard
San Francisco, CA 94115
(800) 464-4000
Group No. 888
Website: www.ca.kaiserpermanente.org
Member website: www.kponline.org

HealthNet
155 Grand Avenue
Oakland, CA 94612
(800) 522-0088
Group No. 61515
Website: www.healthnet.com

Blue Shield of California
50 Beale Street
San Francisco, CA 94105
(800) 424-6521
Group No. H11054
Website: www.blueshieldca.com

DENTAL PLANS

Delta Dental
P.O. Box 7736
San Francisco, CA 94120
(888) 335-8227
(800) 4-AREA-DR (referrals to Delta dentists)
Group No. 9502-0003 City Employees
Group No. 9502-0004 Perm. Muni Drivers
Website: www.deltadentalca.org

PMI Dental Health Plan
12898 Towne Center Drive
Cerritos, CA 90703
(800) 422-4234
Group No. 3461
Website: www.deltadentalca.org

Pacific Union Dental
1390 Willow Pass Road, Ste. 800
Concord, CA 94520
(800) 999-3367
(925) 363-6000
Group No. 94227

MENTAL HEALTH AND CHEMICAL DEPENDENCY TREAMENT (CITY HEALTH PLAN ONLY)

United Behavioral Health
P.O. Box 23250
Oakland, CA 94623-0250
(800) 888-2998

Website: www.ubnet.com

DEPENDENT CARE & MEDICAL REIMBURSEMENT ACCOUNTS

Employee Benefit Specialists, Inc.
P.O. Box 11657
Pleasanton, CA 94588
(800) 229-7683

Website: www.ebsbenefits.com

VISION CARE PLAN

Vision Service Plan
P.O. Box 254500
Sacramento, CA 95865-4500
(800) 877-7195
Website: www.vsp.com

ALL OTHER VOLUNTARY BENEFITS

Employee Benefit Specialists, Inc.
P.O. Box 11657
Pleasanton, CA 94588
(800) 229-7683

Website: www.ebsbenefits.com

Health Service System
A Division of the Department of Human Resources
1145 Market Street 2nd Floor
San Francisco, CA 94103

August, 2001

Dear Member or Prospective Member:

We are pleased to provide you with the 2001 – 2002 Benefits Information Booklet for the Management Cafeteria Plan. This plan is once again administered by our third-party administrator, Employee Benefits Specialist, Inc., (EBS). As in past years, EBS will conduct the open enrollment process and act throughout the year as a one stop resource for your benefit questions and needs. You can reach EBS at 800-229-7683.

Employees represented by MEA and certain unrepresented managers and elected officials are eligible for this plan. You will be receiving a flexible credit amount $278.96 per month, or $128.75 per pay period to allocate towards any of the benefits described herein.

Again this year, staff will be available for enrollment meetings at various locations throughout the City and County. The scheduled times and locations are listed on the inside front cover of this booklet. If you have any questions about the enrollment, the plan, or any of the benefits offered please call EBS at (800)-229-7683.

Finally, we welcome your feedback throughout the year on the quality of service you receive from EBS and the Health Service System. Please feel free to contact HSS to tell us of any ideas and concerns so that we may continue making progress toward our customer service goals. Be aware this plan year will be nine (9) months, ending June 30, 2002. **Beginning with the fiscal year 2002, all employees will be included in the same open enrollment period.**

Very truly yours,

HEALTH SERVICE BOARD

Claire Zvanski, President
Melissa Welch, Vice President
Karen Breslin, Commissioner
James M. Deignan, Commissioner
Scott Heldfond, Commissioner
Mark Leno, Commissioner
Aleeta Van Runkle, Commissioner

DEPARTMENT OF HUMAN RESOURCES

Andrea R. Gourdine, Director
Yvonne Hudson, Deputy Director, HSS

EMPLOYEE BENEFIT SPECIALISTS, NC.

Joan Rhodes, President

Table of Contents

IMPORTANT INFORMATION -- READ THIS FIRST!

This Booklet Provides Only An Overview -- Consult The Individual Health And Dental Plan Booklets For Details.

This booklet provides an *overview* of the benefit plans for your convenience. It does not provide a complete explanation of any particular benefit or insurance plan. Each benefit and or insurance plan has a booklet or policy, detailing the features, exclusions and restrictions of that plan. Please read the plan booklets and insurance policies carefully. **If the information in this booklet is different from the information in the benefit plan booklet, you should rely on the benefit plan booklet.** The information shown in your actual insurance policy supersedes any information in this summary booklet. You may obtain benefit plan booklets from the benefit plans directly or at any of the Open Enrollment information sites. Please contact EBS for additional information about obtaining a copy of your policy for the voluntary insurance plans.

This Booklet Is Valid Only For Employees that are eligible for the City's Management Cafeteria Plan.

The Management Cafeteria Plan is available to all employees represented by MEA, some other unrepresented managers, and elected officials. **Enrollment is mandatory to avoid forfeiture of your flex credits.**

Only Eligible Dependents May Be Enrolled In HSS.

You are welcome to enroll all dependents who meet the HSS eligibility requirements. However, please be aware that HSS enforces its eligibility requirements. Documentation of the relationship between you and your dependents will be required. If you have enrolled dependents who are not eligible, you must repay all expenses paid for them, and you may face additional penalties.

Enroll New Dependents Within 30 Days.

All newly acquired dependents (for example, a new spouse or a newborn child) must be enrolled in the Health Service System within 30 days of the day on which the person becomes your dependent. For example, you must enroll a new spouse within 30 days of your marriage, and you must enroll a new child within 30 days of the baby's birth or adoption.

No Plan Can Guarantee The Continued Participation Of Any Particular Provider.

None of the benefit plans can guarantee that any particular doctor, dentist, hospital, medical group or other provider will continue to participate in that benefit plan for the entire year. You cannot change plans merely because your provider chooses not to participate in a particular benefit plan.

If you choose Kaiser, HealthNet, Blue Shield, PMI Dental and/or Pacific Union Dental, this means that you may not be able to see a particular doctor or dentist if

that provider chooses to drop out of the plan.

If you choose the City Health Plan and/or Delta Dental, this means that you will be reimbursed at a lower rate if you see a provider who is not a preferred provider. It is your responsibility to determine whether the provider you are seeing is a preferred provider.

List Your Primary Care Physician/Dentist On The Enrollment Form.

If you enroll in the HealthNet or Blue Shield health plans, or the PMI or Pacific Union dental plans, you can avoid delays in obtaining services by listing your primary care physician or dentist on the enrollment form. To do this, **you should contact the benefit plan and confirm that the physician/dentist you want to use is one of their providers.** If you need assistance in selecting a physician/dentist, contact the plan directly or consult with a representative at one of the open enrollment sites listed on the first page of this booklet.

Verify Your Home Address With Your Payroll Department So That The Benefit Plans Can Contact You.

Please make sure that your payroll department has your correct home address so that the benefit plans and HSS can mail you important information.

YOUR FLEX CREDIT CONTRIBUTIONS TO THE HEALTH PLAN OF YOUR CHOICE MAY BE ALLOCATED AT THE FULL PREMIUM AMOUNT OR IN $25 INCREMENTS. NO OTHER AMOUNTS WILL BE ACCEPTED.

How Open Enrollment Works

Enrollment is mandatory to avoid forfeiture of your flex credits. If you fail to enroll, the Health Service System will apply your flex credits to your Health Premium only. Any unused credit will be lost for the plan year.

Changes You May Make During Open Enrollment

During the Open Enrollment period (July 30 – August 17) you may do any of the following:

- Enroll or cancel yourself or a dependent in a health plan.
- Enroll or cancel yourself or a dependent in a dental plan.
- Transfer from one health or dental plan to another health or dental plan.

(You must make the above changes by completing a HSS Enrollment Application)

- Enroll or re-enroll in the Flexible Spending Accounts (Health Care and Dependent Day Care). **You must re-enroll in this plan each year.**
- Enroll in, modify or cancel any of the voluntary benefits offered under the Management Cafeteria Plan.

Your new coverage begins October 1, 2001 and continues through June 30, 2002, provided you and your dependents remain eligible. The health and dental benefit plans you select (except Delta Dental) will send you and your dependents membership/identification cards directly to your home. Until you receive those cards, you should use the group identification numbers listed in the contact information on the first page of this booklet.

No Changes Allowed After Open Enrollment Closes On August 17

You must see an enrollment counselor to make changes to your elections

EBS enrollment counselors must submit all signed forms to HSS by August 24, 2001

No changes are effective without a signed enrollment form submitted to HSS

Changes to your health/ dental plans or dependent status must be made on a HSS Enrollment application.

You cannot make any changes to your benefits after August 17 unless the change is on account of and consistent with a qualifying change in family status (marriage, divorce, birth or death of a dependent, etc.).

For your convenience, appointments will be scheduled to meet with an enrollment counselor during the first two weeks of open enrollment (July 30 – August 10).

Please call EBS at (800) 229-7683.

The following is a list of options available under the Management Cafeteria Plan, and the funding options (flex credit and/or payroll deduction) for each benefit.

Benefit Section 125 Plan	Tax Status	Flexible Credit	Payroll Deduction
Medical Insurance	Pre-Tax	Yes	Yes
Medical Reimbursement Account	Pre-Tax	Yes	Yes
Adoption Assistance Reimbursement Account	Pre-Tax	Yes	Yes
Dependent Care Account	Pre-Tax	Yes	Yes
Long Term Disability	Pre-Tax	Yes	No
Short Term Disability	Pre-Tax	Yes	Yes
Cancer Insurance	Pre-Tax	Yes	Yes
Accident Insurance	Pre-Tax	Yes	Yes
Heart and Stroke Insurance	Pre-Tax	Yes	Yes
$50,000 Term Life Insurance provided at no cost to all employees eligible for this plan			
Benefit Non-Section 125 Plan Benefit Options	**Tax Status**	**Flexible Credit**	**Payroll Deduction**
Universal Life Insurance	Post-Tax	Yes	Yes
Supplemental Term Life Insurance	Post-Tax	Yes	No
Flexible Benefit Post Tax Reimbursement Account	Post-Tax	Yes	No
Commuter Check	Both*	Yes	Yes
Veterinary Pet Insurance	Post-Tax	Yes	Yes
Long Term Care	Post-Tax	Yes	Yes
Accidental Death and Dismemberment Insurance	Post-Tax	Yes	Yes
Group Legal Plan	Post-Tax	Yes	Yes
Computer Purchase Program	Post-Tax	Yes	Yes

*Commuter checks are pre-tax up to $65 per month. Anything over that is post tax

Benefit Plans Offered By HSS

Health Plans. The following health plans are available:

- City Health Plan
- Kaiser[1]
- HealthNet[1]
- Blue Shield[1]

Dental Plans. The following dental plans are available:

- Delta Dental
- PMI Dental[1]
- Pacific Union Dental[1]

Mental Health/Chemical Dependency Benefit. Mental Health/Chemical Dependency (alcohol, drugs, etc.) rehabilitation benefit is provided automatically to all employees and eligible dependents. Kaiser members receive this benefit through Kaiser and should contact Kaiser if they need assistance. Health Net members receive this benefit through MHN (Mental Health Network) and should contact Health Net if they need assistance or refer to the 800 # on the back of their ID card for MHN. Members of City Health Plan and Blue Shield health plan receive this benefit through United Behavioral Health.

Vision Care Plan. A vision care plan is provided automatically to all employees and eligible dependents. Kaiser members receive this benefit through Kaiser and should contact Kaiser if they need assistance. Members of other health plans receive this benefit through Vision Service Plan whose contact information is listed on the first page of this booklet. Exams are covered once a year, lenses and frames are covered every two years. Check with your medical plan about obtaining more frequent exams.

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[1] If you enroll in one of these plans, you must live in the plan's service area. Refer to the health and dental plan service area charts in this booklet.

BENEFIT PLANS OFFERED THROUGH THE MANAGEMENT CAFETERIA PLAN

Medical Reimbursement Account

Employees can set aside employer and employee dollars on a pre-tax basis to fund this account up to $5,000 per plan year. The money is reimbursed to the participants every pay period in which they have submitted a claim for qualifying expenses. Qualifying expenses are those described in IRC Section 213 for out of pocket (not reimbursed through insurance) medical, dental and vision expenses. Claims are submitted to and processed from EBS' Pleasanton office. Reimbursements are made via check sent to the employees' homes or direct deposited into a designated account.

Adoption Assistance Account

This program provides an exclusion from an employee's gross income for amounts paid or expenses incurred by an employee for qualified adoption expenses in connection with the adoption of an eligible child by an employee if such amounts are furnished pursuant to an adoption assistance. The maximum exclusion from gross is $5,000 ($6,000 in the case of an adoption of a child with special needs.) There are income limitations, which effect the maximum exclusion allowance. If your AGI is $75,000 the income limitation does not apply to you, if your AGI is above $115,000 you do not qualify for a deduction under this plan. If your income is between $75,000 and $115,000 then the maximum exclusion reduces down according to a formula. (Qualified Adoption Expenses minus [qualified adoption expenses x ((modified Adjusted Gross Income - $75,000) divided by $40,000)] Example of the formula if your Modified Adjusted Gross Income is $85,000 and your adoption expenses were $5,000, then the formula is as follows [$85,000 - $75,000 = $10,000 divided by $40,000 equals 25%] The maximum amount of the exclusion is therefore $3,750, because 25% of $5,000. The limit applies cumulatively over all taxable years rather than an annual limitation.

Dependent Care Account

Employees can set aside employer and employee dollars on a pre-tax basis to fund this account up to $5,000 per 12 month period. Participants can send in annual claims for their childcare and be reimbursed automatically each pay period. Reimbursement checks are sent to the participants' homes or the funds can be direct deposited. This account is governed by IRC Section 129, and the expenses that qualify are care expenses for children under the age of 13, for the hours while the employee is at work. The care provider does not have to be a licensed facility, it can be provided by an individual even if that individual is related to the participant (the caregiver just cannot be a dependent of the participant) as long as a social security number is provided. Care for dependents over the age of 13 qualifies if the dependent lives in the participant's home for a majority of each day and requires care while the participant is at work and is claimed as a tax dependent of the employee (this includes older children with special care needs, parents, and spouses.)

FLEXIBLE BENEFIT POST TAX REIMBURSEMENT ACCOUNT

Qualifying Expenses for this Account include:

Note: Verification of the expense is required.

MEA Dues: This post tax reimbursement program can be used to reimburse your MEA dues. MEA members sign up for a payroll deduction to pay their Association dues, then elect to have those dues reimbursed to them with after tax employer dollars once a month. In addition you can use this account for other professional dues and auto club dues.

Health Club and Fitness - Members can use the post tax 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)

Executive Coaching - Through the Management Cafeteria Plan, you can use post-tax employer dollars for professional and personal coaching. You must provide receipts from a bona fide 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.

Prior Service Buy Back - If you are having a San Francisco retirement service withholding from your paycheck or you pay by personal to purchase "prior service" you may choose to be reimbursed from the flex plan.

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 are eligible for reimbursement. For example, the entry to or membership in the SF Zoo, Academy of Science, Opera, Asian Art Museum, deYoung Art Museum, SF Symphony, the SF Ballet etc. will qualify for reimbursement. You can be reimbursed for membership, season or individual tickets, or other contributions.

Long Term Care Reimbursement Account - To purchase long term care through the Management Cafeteria Plan. If you are purchasing long term care through PERS you may be reimbursed on a post tax basis for some or all of that premium cost. PERS holds enrollment for the Long Term Care in the spring of each year. Employees must enroll through PERS directly for this benefit. Any employee that has signed up for the PERS long term care program can set aside some employer dollars on an after-tax basis to reimburse themselves for some or all of the cost of this program.

Auto/Homeowner's Insurance Reimbursement

You may elect to be reimbursed for your auto and homeowners insurance premiums. In order to be reimbursed you must submit a receipt showing current payment of auto insurance premiums. This is a post tax benefit.

VOLUNTARY INSURANCE OPTIONS

Group Term Life Insurance/ Supplemental Term Life Insurance

All eligible employees under the Management Cafeteria Plan are provided with, at no cost, a $50,000 policy of group term life insurance coverage on themselves. Members can purchase additional amounts of term insurance in $10,000 increments from $10,000 to $300,000 on themselves through this program. Credits allocated toward the supplemental coverage are after tax amounts. The maximum amount of additional coverage is $250,000. There is a $50,000 guarantee issue for new hires for the supplemental insurance. Amounts above the additional $50,000 or any supplemental insurance purchased at a date later than when the employee is initially eligible will require evidence of insurability.

Long Term Disability

All eligible employees are able to purchase long term disability insurance through the Management Cafeteria Plan using pre-tax employer flex credits, or pre-tax payroll deductions. This plan is designed to provide insureds with a monthly disability income benefit to replace a portion of their earnings if they are unable to work due to bodily injury or sickness. This program has a 90 day elimination period, meaning that the benefits begin paying after the insured has been out of work due to disability 90 consecutive days; the benefits begin on the 91st day. The benefit maximum on this policy is 66 2/3 of the basic monthly earnings which you declare at the time of enrollment in this program to a maximum of $7,500 per month. (If you receive a pay raise you should contact HSS or EBS to have your policy upgraded to reflect your current salary). The benefits are payable for the period during which you continue to meet the definition of disability up to age 65.

Long Term Care Insurance

If you do not buy long term care through PERS you can purchase coverage through John Hancock. The premiums are deducted from paychecks on a post-tax basis. The premiums will be paid directly to the carrier for this plan. The enrollment counselors can assist you with the plan design that works best. The plan is flexible and allows you to cover yourself, your spouse, your parents, grandparents, and in-laws.

Universal Life Insurance

This plan is designed to provide permanent insurance protection coupled with cash accumulation. Members can purchase this life insurance protection in amounts from $5,000 to $500,000 for non-smokers and $250,000 for smokers, subject to current underwriting guidelines of the insurance carrier. The cash accumulation feature of the policy will earn current market interest on a tax-deferred basis, with a minimum of 4.5% interest compounded annually. In addition, the plan allows employees to cover their spouse and dependents, whether they cover themselves or not. Employees own the policy and can continue the coverage even if they leave CCSF. The majority of employees today have term insurance provided by their employer (as is case with MEA $50,000) which ceases when they terminate. Coverage can be purchased for spouses, domestic partners and children.

This is a post tax benefit.

Veterinary Pet Insurance

Veterinary Pet Insurance offers use of veterinarians worldwide with no pre-authorization required. The policy pays for prescriptions, lab fees, x-rays, surgery, hospitalization, and treatment for any covered medical problem. This is a post tax benefit.

Voluntary AD&D

ING Employee Benefits Accidental Death and Dismemberment Insurance can provide protection for employees 24-hours a day. The accidental death and dismemberment insurance plan offers employees an effective way to enhance their benefit program at little cost. Benefits are available under this plan for employees only or employees and their family members. Employees will be able to select coverage from $25,000 to $500,000 in increments of $25,000. Payments will be made if the loss by dismemberment is sustained within 180 days (except where state law provides otherwise) of the date of the accident, but in no case will payments exceed the full face amount of the insurance.

Cancer Intensive Care Insurance

This plan is designed to assist insureds with the out of pocket costs associated with cancer treatment. An American Cancer Society study found that up to 75% of the costs incurred by a family when a parent or spouse is diagnosed with and treated for cancer are not the type reimbursed or covered by major medical insurance. Over the past couple of decades the treatments for cancer have changed, and have become much more effective. While major medical covers most of the actual medical costs, there are other costs incurred that are not reimbursed, such as the cost of being out of work, hiring in house assistance for house cleaning and/or childcare etc. Over half of the households where a breadwinner is diagnosed with cancer end up filing bankruptcy even if they have medical insurance. The intensive care portion of this plan is an optional rider to pay daily benefits while the insured is in intensive care for any reason not just for cancer treatment. Employees can use pre-tax employer or employee dollars to fund the purchase of this benefit.

Short Term Disability

Participants can elect to have flex dollars or payroll deductions to pay for the ING Employee Benefits or Colonial short term disability policies on a pre-tax basis. You may elect coverage under either carrier based on your needs. The short-term disability policy is designed as an income replacement policy in the event that an insured is disabled due to an injury or sickness. The plans have various elimination and benefit periods to choose from. The elimination period is the amount of time that the insured has to be out of work due to a disability before the policy begins paying. The longer the elimination period the lower the cost. The benefit period is the amount of time that the insured will be paid benefits. There is a benefit period as short as three months available, to coordinate with the long term disability policy.

Accident Insurance

This benefit provides 24-hour accident coverage for both on and off the job accidents. There is no deductible or limit on the number of covered accidents in a year. Individual or family coverage is available. It is easy to apply for this coverage, there is no medical exam. This covers expenses which you might incur if you are injured in an "accident" (skiing, hiking, etc.) that are not reimbursed through other types of insurance. The plan pays benefits directly to the insured. The plan is guaranteed renewal to age 70, and you may keep the coverage until age 70 even if you change jobs, as long as you continue to pay the premiums. The plan has a schedule of benefit payments for covered accidents, there is a hospital confinement benefit, a disability benefit, and a medical expense benefit. Brochures will be available at the enrollment sites. You may allocate flexible credits or payroll deduct the cost of this benefit on a pre-tax basis.

Heart & Stroke Insurance

This plan is similar to the cancer plan but pays benefits for insureds being treated for heart attacks, heart disease and strokes. The plan has an optional intensive care rider that can be added to it to pay daily benefits while the insured is in intensive care for any reason. The members can allocate pre-tax employer or employee dollars to fund the purchase of this benefit.

OTHER BENEFITS OFFERED UNDER THE MANAGEMENT CAFETERIA PLAN INCLUDE:

Group Legal

Pre-Paid Legal Services, Inc. (PPLSI) is a pioneer in the North American legal plan industry. PPLSI provides access to high quality legal services at cost effective rates. The plan offers unlimited telephone consultations with affiliated attorneys. The consultations can be for either business or personal issues, there is no limit on the type of issue. The plan provides 2 letters or business phone calls per year, legal review of contracts or documents of up to 10 pages. There are different benefit levels that you can choose from. Plan information will be available at the enrollment sites for you to review and select the plan that suits you best. This option is offered on a post tax basis.

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 counseling session.

Commuter Check

Employees can allocate employer or employee money pre-tax (up to $65 per month) for mass transit expenses, any amounts above that are taxable. Employees that participate in this benefit elect the amount they need for transit expenses and they receive Commuter Checks to use for transit tickets. Commuter Checks come in different denominations and are accepted by all Bay Area transit operators. The employees receive their Commuter Checks at the end of each month in time to purchase the following month's transit tickets.

Computer Purchase Program

New benefit for 2001-2002 plan year! The Flexible benefit plan now offers you the opportunity to purchase desktop and or laptop computers with flexible benefit dollars. The systems are through a reputable computer manufacturer and offer favorable financing. More details about the program and the systems available will be available at the Health Fair and at all enrollment locations.

HEALTH PLANS

An Overview Of The Different Types Of Health Plans

Indemnity/Preferred Provider Plan -- City Health Plan.

HSS offers one indemnity plan -- the City Health Plan. In the City Health Plan, you may receive health care services from any licensed medical provider you choose, but you must pay the provider directly, and then submit a claim for reimbursement to the City Health Plan. The City Health Plan will pay a percentage of the bill. Before the City Health Plan will pay any benefits, however, you must pay an annual deductible. The City Health Plan also requires that you obtain preauthorization for some services from the City Health Plan prior to receiving those services.

A Staff Model HMO, such as Kaiser, has doctors who treat Kaiser members exclusively, and who provide services at facilities operated by the HMO. For example, if you join Kaiser, you will see a Kaiser doctor at a Kaiser facility. Your primary care doctor within the Kaiser Medical Group will coordinate any care or treatment you need.

A network model HMO, such as HealthNet and Blue Shield, contracts with independent multi-specialty medical groups and independent physician associations to provide services at fixed rates to HMO members. If you enroll in a network HMO, you must select a medical group and a primary care physician within the medical group. The primary care physician will coordinate any care or treatment you need.

To participate in an HMO you must live in one of the zip code areas served by that HMO. Please refer to the service area chart at the end of this section.

Changes To The Health Plans Since Last Year

Changes To The City Plan

- Hearing aides $1,000 maximum every 36 months
- Infertility treatment at 50% up to six natural artificial inseminations; three stimulated artificial inseminations; one course of GIFT, ZIFT, or IVF per lifetime; preauthorization required
- Immunization increased to 100% with preferred provider; not subject to deductible.
- Transgender benefits with a $50,000 maximum after a one-year plan waiting period.
- Pharmacy deductible of $50.00 eliminated.
- Viagra six tablets covered per 30 days.
- Eye examinations every twelve- (12) months.
- All mental health and substance abuse benefits administered by United Behavioral Health (UBH) at 1-800-888-2998. Chemical rehabilitation up to sixty (60) days: two lifetime courses.

Changes To Kaiser

- Enhanced Infertility benefit: 50% coverage for GIFT procedure. (IVF not covered)
- Hearing Aid Devices Covered
- Online Prescription Refills through www.kponline.org as well as advice nurses appointment scheduling and health information.
- New Medical Office Building in San Francisco.
- Health Advice Nurse available 7 days a week, 24 hours a day.

Changes To HealthNet

- Chiropractic and Acupuncture benefits with herbal supplements $10 copay unlimited visits through ASHP (American Specialty Health Plan)
- Prosthesis at 100%
- Infertility at 50% to include IVF, GIFT and ZIFT
- Hearing aid benefit, one per ear including digital every 36 months
- Chemical dependency covered up to 60 days outpatient through MHN (Mental Health Network)
- 35,800 doctors, over 400 hospitals and 4,300 pharmacies
- Dental Rx (prescriptions) covered
- Healthline 24-hours, 7 days a week nurse assistance

- Well Rewards, discounts on supplements, exercise equipment, massage therapy, gym membership, etc.
- Member appeals process: automatic third-party review
- Internet access: www.healthnet.com for:
    - Provider listing
    - Pharmacy
    - Benefits
    - Wellness
    - Email customer service with questions

Blue Shield New Plan offering

Blue Shield offers the following new programs:

- Chiropractic/ Management Cafeteria Plan benefit $10.00 copay, 30 visits per year through ASHP (American Specialty Health Plans)
- Prosthesis at 100%
- Internet access: www.blueshieldca.com
- Health Education/Alternative care discount- www.mylifepath.com
- Health improvement programs - "First Steps" Prenatal program
- Access+ Specialist- direct access to specialist for $30 copay.

Away from Home Care for dependent children at college or while traveling

Service Area By Health Plan ** RESTRICTED TO NEW ENROLLEES EXISTING MEMBERS CAN STAY

County	City Health Plan	Kaiser	HealthNet	Blue Shield
Alameda	■	■	■	■
Alpine	■			
Amador	■	■ some zip codes *	■ **	
Butte	■		■	■
Calaveras	■			
Colusa	■		■	
Contra Costa	■	■	■	■
Del Norte	■			
El Dorado	■	■ some zip codes *	■ some zip codes *	■
Fresno	■	■ some zip codes *	■ some zip codes *	■
Glenn	■		■	
Humboldt	■		■	
Imperial	■	■ some zip codes *	■ some zip codes *	■
Inyo	■			
Kern	■	■ some zip codes *	■ some zip codes *	■
Kings	■	■	■	■
Lake	■		■	
Lassen	■			
Los Angeles	■	■ some zip codes *	■	■
Madera	■	■ some zip codes *	■	■
Marin	■	■	■	■
Mariposa	■	■ some zip codes *	■	
Mendocino	■		■ some zip codes *	
Merced	■		■	■
Modoc	■			
Mono	■			
Monterey	■			
Napa	■	■ some zip codes *	■	■ some zip codes *
Nevada	■		■	■
Orange	■	■	■	■
Placer	■	■ some zip codes *	■ some zip codes *	■
Plumas	■		■ some zip codes *	
Riverside	■	■ some zip codes *	■ some zip codes *	■
Sacramento	■	■	■	■
San Benito	■			
San Bernardino	■	■ some zip codes *	■ some zip codes *	■
San Diego	■	■ some zip codes *	■	■
San Francisco	■	■	■	■
San Joaquin	■	■	■	■
San Luis Obispo	■		■	■
San Mateo	■	■	■	■
Santa Barbara	■		■	■
Santa Clara	■	■ some zip codes *	■	■
Santa Cruz	■		■	■
Shasta	■			■
Sierra	■		■	
Siskiyou	■			
Solano	■	■	■	■
Sonoma	■	■ some zip codes *	■	■
Stanislaus	■	■	■	■
Sutter	■	■ some zip codes *	■	
Tehama	■		■ some zip codes *	
Trinity	■			■ some zip codes *
Tulare	■	■ some zip codes *	■	■
Tuolumne	■			
Ventura	■	■ some zip codes *	■	■
Yolo	■	■ some zip codes *	■	■
Yuba	■	■ some zip codes *	■	
Out of State	■		ER ONLY	

Health Plan Rates

Health Rate for Charter pick up only, no dependents subsides Plan Year 7/1/01 to 6/30/02

Bi-Weekly Rates

City Health Plan

Employee Only	$48.40
Employee + One Dependent	$151.72
Employee + Plus 2 or More Dependent	$258.22
Employee + One Dependent Medicare	$151.72
Employee + One Dependent Medicare + 1 or more dependent	$258.22

Kaiser

Employee Only	$0.00
Employee + One Dependent	$93.81
Employee + Plus 2 or More Dependent	$171.67
Employee + One Dependent Medicare	93.81
Employee + One Dependent Medicare + 1 or more dependent	$171.67

Health Net

Employee Only	$1.51
Employee + One Dependent	$101.31
Employee + Plus 2 or More Dependent	$184.46
Employee + One Dependent Medicare	$89.10
Employee + One Dependent Medicare + 1 or more dependent	$172.25

Blue Shield

Employee Only	$2.39
Employee + One Dependent	$103.06
Employee + Plus 2 or More Dependent	$186.58

DENTAL PLANS

You may enroll in any of the dental plans offered by HSS at no charge to you or your dependents

An Overview Of The Different Types Of Dental Plans

Indemnity Dental Plan -- Delta Dental.

Delta Preferred Option Plan is an indemnity dental plan. You may see the dentist of your choice. However, if you use a Delta Preferred Option dentist you will not pay a deductible for all services. Your dentist submits a claim for reimbursement to Delta, and you may have to pay a percentage of the bill (ranging from no cost for preventive and diagnostic services, to 20% for basic services such as fillings and extractions, to 50% for major services such as crowns, dentures or bridges.) There is an annual dollar limit on benefits ($2,500 per plan year).

If you use Delta participating dentists, you are guaranteed that your percentage of the bill will only be that percentage of a fee agreed upon by Delta and your dentist.

If you use a non-participating dentist who charges higher fees than are charged by the majority of Delta-participating dentists, you may have to pay the difference in fees.

Dental Managed Care Plans -- PMI and Pacific Union

HSS offers two dental managed care plans -- PMI Dental Health and Pacific Union Dental. If you enroll in one of these plans, **you must receive all care from dentists affiliated with PMI or Pacific Union Dental**. Dental services are provided by a primary care dentist who treats you or, when necessary, refers you to other dentists within the plan's network. Generally, you pay only a low co-pay for services. Preauthorization from the plan is required for major services.

To enroll in PMI or Pacific Union, you **must live in a zip code area served by the plan.** Check the service area listed in this booklet. You may not enroll in a plan if you live outside that plan's service area.

COMPARISON OF DENTAL PLANS

These dental plans are available to active City employees and their dependents. Nurses, San Francisco Community College District and San Francisco Unified School District employees are provided with dental coverage through their District's.

This is only a brief summary of the dental plans. The extent of the coverage is governed at all times by the terms of the individual dental plans. Consult the individual benefit plan booklets for details.

PLAN NAME	DELTA DENTAL	PMI	PACIFIC UNION DENTAL
Provider of Service	Any licensed dentist. Generally higher benefits if you use Delta dentists.	Service is provided by PMI dentists only. You must live in the service area and you must choose your dentist from dentists contracting with the plan.	Service is provided by Pacific Union dentists only. You must live in the service area and you must choose your dentist from dentists contracting with the plan.
Cleanings and Exams	No charge. Limit once every six months.	No charge. Limit once every six months.	No charge. Limit once every six months.
X-rays	100%	No charge.	No charge.
Extractions	80%	No charge.	No charge.
Fillings	80%	No charge.	No charge.
Crowns	80%	No charge.	No charge.
Dentures, Pontics and Bridges	50%. Dentures are covered at 50% of maximum fee allowance.	No charge. Full and partial dentures once every 5 years. Fixed bridgework; certain limitations apply.	No charge. Full dentures, upper or lower, once every 5 years. Fixed bridge work; certain limitations apply.
Root Canals	80%	No charge.	No charge.
Orthodontia	Covered for adults and children at 50%, up to a maximum of $2,500 lifetime.	$1,600 charge per case to age 19. $1,800 charge per case age 19 or older plus $350 start-up fee. Other limitations apply.	$1,660 charge per case through age 19. $1,880 charge per case age 20 or older. Other limitations apply.
Annual Maximum	$2,500 per person per benefit year, excluding orthodontic benefits.	None.	None.
Waiting Period	Six months for dentures, pontics, bridges and orthodontia for new enrollees.	None.	None.

SERVICE AREAS BY DENTAL PLAN

County	Delta Dental	PMI Dental	Pacific Union Dental
Alameda	■	■	■
Alpine	■		
Amador	■		
Butte	■	■	
Calaveras	■		
Colusa	■		
Contra Costa	■	■	■
Del Norte	■		
El Dorado	■	■	■
Fresno	■	■	■
Glenn	■		
Humboldt	■	■	
Imperial	■	■	
Inyo	■		
Kern	■	■	■
Kings	■	■	■
Lake	■	■	
Lassen	■		
Los Angeles	■	■	■
Madera	■	■	■
Marin	■	■	■
Mariposa	■		
Mendocino	■		
Merced	■		■
Modoc	■		
Mono	■		
Monterey	■	■	■
Napa	■	■	■
Nevada	■		■
Orange	■	■	■
Placer	■	■	■
Plumas	■		
Riverside	■	■	■
Sacramento	■	■	■
San Benito	■		■
San Bernardino	■	■	■
San Diego	■	■	■
San Francisco	■	■	■
San Joaquin	■	■	■
San Luis Obispo	■	■	■
San Mateo	■	■	■
Santa Barbara	■	■	■
Santa Clara	■	■	■
Santa Cruz	■	■	■
Shasta	■	■	
Sierra	■		
Siskiyou	■		
Solano	■	■	■
Sonoma	■	■	■
Stanislaus	■	■	■
Sutter	■	■	
Tehama	■	■	
Trinity	■		
Tulare	■	■	■
Tuolumne	■	■	
Ventura	■	■	■
Yolo	■	■	
Yuba	■	■	
Out of State	■		

FLEXIBLE SPENDING ACCOUNTS

How The Flexible Spending Accounts Work

Flexible Spending Accounts are a way to be reimbursed for certain health care and dependent day care expenses using tax-free dollars. You may open a Health Care Account or a Dependent Day Care Account, or both. You may use the Health Care Account to be reimbursed for medical, dental, and vision expenses incurred for you and your dependents if they are not covered by a health plan. You may use the Dependent Day Care Account to be reimbursed for child care or care for other dependent family members provided during the plan year so that you can work. **If you do not use the money in your accounts within the plan year, you lose what is left in the accounts at the end of the year.**

How Money Is Put Into Flexible Spending Accounts.

When you enroll, you decide how much money you want to contribute from flex credits or each paycheck to one or both accounts. The tax-free dollars you choose to set aside will be taken out of each biweekly paycheck before taxes and put into your accounts.

Note that if you are on leave without pay status, no contributions to your Flexible Spending Accounts will be made. In addition, contributions will cease and you will not be reimbursed for expenses incurred after you leave City service unless you continue participation through COBRA.

How You Get Money Back From Your Flexible Spending Accounts.

You will be reimbursed from your accounts when you submit eligible expenses to Employee Benefit Specialists, Inc. (EBS), the company that handles these accounts for the Management Cafeteria Plan. Claim forms for reimbursement are available from HSS and/or EBS. Although your expenses must be for services incurred from October 1 through June 30, you may file plan year claims until September 31. Any claims postmarked after September 31 **will not** be processed.

> **REMEMBER:** There will always be a waiting period from the time the money is deducted from your paycheck until you receive your reimbursement check. Plan on a minimum turnaround time of two to three weeks.

Important Rules About Flexible Spending Accounts -- Read This Before Enrolling!

- ⇒ **You must re-enroll in your Flexible Spending Accounts *every* Open Enrollment.**
- ⇒ **You will forfeit any money left in your accounts after the end of the claim filing period,** so you should carefully figure out how much you want to set aside for each account. There are no exceptions to this rule.
- ⇒ **You cannot transfer money between the Health Care and Dependent Care accounts.**
- ⇒ **You cannot change the amounts you contribute into your Flexible Spending Accounts during the year unless the changes is on account of and consistent with a qualifying change in family status.**
- ⇒ **Expenses for services before or after the period for which you enroll are not eligible.** For example, a medical expense incurred in September is not eligible for reimbursement from a Health Care Account because your account is not open until October 1.
- ⇒ **Your expenses must meet the Internal Revenue Service (IRS) criteria.**

Health Care Flexible Spending Account

You may contribute from $130 to $5,000 a year ($5.00 to $192.30 per biweekly paycheck) into the Health Care Account. You may use your Health Care Account to be reimbursed for eligible expenses for you and your family. Eligible family members include any person you claim as a dependent for income tax purposes.

Eligible expenses are defined by the IRS. They include, but are not limited to, medical, dental, and vision care expenses that are not covered by any medical, dental, or vision plan, or that you pay out of your own pocket. You cannot be reimbursed for premiums you pay towards any insurance coverage, cosmetic surgery, the cost of weight loss supplements, over-the-counter drugs or medical supplies, smoking cessation products, prescriptions for cosmetic purpose (e.g., Rogaine), health club membership, and many other services. Other health care expenses that the IRS says are eligible are listed on the following chart.

- Abdominal supports
- Acupuncture
- Air conditioning, where necessary for relief from an allergy or relieving difficulty in breathing; when prescribed by your doctor
- Diathermy
- Services of a Christian Science practitioner
- Excess cost of Braille books and magazines over cost of regular editions
- Eyeglasses/contact lenses
- Contact lens solutions
- Hydrotherapy
- In vitro fertilization
- LASIK surgery for eyes
- Organ donor's or possible organ donor's expenses
- Orthopedic shoes
- Portion of life-care fee paid to retirement home for medical care
- Prescribed birth control pills
- Psychiatric treatment and psychoanalysis, including cost of supporting a mentally ill dependent at a special equipped center
- Radial keratotomy
- Remedial reading for child
- Sacroiliac belt and trusAbdoms
- Sanitarium or similar institution
- Wages of guide for blind person
- "Seeing eye" dog and its maintenance
- Services of an osteopath
- Special equipment installed in your home or car for medical reasons
- Special school costs for physically and mentally handicapped children, including special tutoring fees
- Special telephone equipment for the deaf
- Sterilization; vasectomy
- Telephone-teletype costs and television adapter for closed caption service for deaf person

For more information about eligible Health Care Account expenses, contact Employee Benefit Specialists, Inc. using the contact information on the first page of this booklet.

Health Care Account Worksheet

Use the following worksheet to figure out how much money to contribute each pay period to your account if you are enrolling during Open Enrollment. Since you will lose any money you don't use during the year, you should be very conservative in your estimate of expenses you will incur.

1	**Total estimated eligible health care expenses for October 1, 2000 through September 30, 2001, assuming you are enrolling in the account during Open Enrollment.**	$_____
2	**Enter either $5,000 or the amount on line 1, whichever is lower.**	$_____
3	**Divide the number on line 2 by 26. This is the amount you should have deducted from flex credits or each paycheck for your health care account.**	$_____

Dependent Day Care Flexible Spending Account.

You may open a Dependent Day Care Account if you pay for day care so you can work. If you are married and wish to open this account, your spouse must also work, unless your spouse is a full-time student, or is physically or mentally disabled.

You may deposit $130 to $5,000 a year ($5.00 to $192.30 per biweekly paycheck) to your Dependent Day Care Account. If you are married, you may not be able to set aside the full $5,000 because of the following IRS rules:

- ◊ The amount you set aside cannot be more than your income or your spouse's income, whichever is less.
- ◊ If you and your spouse file separate tax returns, the most either of you may set aside is $2,500 a year.
- ◊ If your spouse goes to school full-time, you may set aside up to $2,400 a year if you have one eligible dependent and up to $4,800 a year if you have two or more eligible dependents.
- ◊ If your spouse also participates in a day care account at his or her workplace (or if your spouse is a City, School District or Community College District employee), the total amount you set aside to both Dependent Day Care Accounts cannot be more than $5,000.

You may use your Dependent Day Care Account to get reimbursed for day care expenses for your eligible dependents. For purposes of a Dependent Day Care Account only, your eligible dependents are:

- ◊ Your children under age 13, and
- ◊ Any person who is dependent upon you, who is physically or mentally incapable of self-care, who spends at least eight hours a day in your home, and who receives care from an outside provider.

Eligible expenses are defined by the IRS. They include, but are not limited to, the following:

- ◊ Day care providers or companies who are paid for providing day care while you work. Social Security and unemployment taxes you pay for the provider are also eligible expenses. A day care provider cannot be your child under age 19 or anyone you claim as a dependent. **Note that you must give the name, address, and taxpayer identification number of the organization or person providing the day care.** If you do not give this information, the IRS may tax your Dependent Day Care Account.
- ◊ Nursery school expenses.
- ◊ That portion of the cost of private school or another institution that is for the cost of care beyond educational requirements (e.g. after school care).
- ◊ That portion of the cost of overnight camp that is for "day care" ("night care" expenses are not eligible).

You cannot be reimbursed for day care expenses until after services have been rendered, even though you may have paid for them in advance.

For more information about eligible Health Care Account expenses, contact Employee Benefit Specialists, Inc. using the contact information on the inside front cover.

Dependent Day Care Tax Credit. Another way to save federal and state taxes on your day care expenses is by using the dependent day care tax credit on your tax returns. In most cases, however, the savings on federal and state taxes is greater with the Dependent Day Care Spending Account. Also, the Dependent Day Care Spending Account lets you save Social Security taxes on money set aside to that account. You do not save Social Security taxes when you use the dependent day care tax credit. You may use a combination of the Dependent Day Care Spending Account and the dependent day care tax credit. However, any amount you claim for the dependent day care tax credit is reduced by one dollar for every dollar you set aside for the Dependent Day Care Spending Account. You should consult with your tax or financial advisor about which method is better for you.

Dependent Day Care Account Worksheet

Use the following worksheet to figure out how much money to contribute each pay period to your account if you are enrolling during Open Enrollment. Since you will lose any money you don't use during the year, you should be very conservative in your estimate of expenses you will incur.

1 **Total estimated eligible dependent day care expenses from October 1, 2000 through September 30, 2001, assuming you are enrolling in the account during Open Enrollment.** $_____

2 **Enter the appropriate amount from the chart below, or the amount on line 1, whichever is lower.** $_____

3 **Divide the number on line 2 by 26. This is the amount you should have deducted from each paycheck to cover your dependent day care expenses.** $_____

If you are:	Enter on line 2:
Single	$5,000
Married, file a joint tax return	The lowest of $5,000, your income, or your spouse's income.
Married, file separate tax returns	The lowest of $2,500, your income, or your spouse's income
Married, spouse is disabled or a full-time student	$2,400 for 1 dependent $4,800 for 2 or more dependents

IMPORTANT NOTE:

If you are moving from the Fringe Benefits Management Company plan please make sure to note this on your enrollment form. You can not contribute more than $5,000 to a dependent care account in any calendar tax year. (This applies to all plans you have participated in during the year whether with this employer or other prior employers.) Make sure to account for all contributions made by you and or your spouse to a dependent care account during the current tax year to determine your contributions to this plan.

Adoption Assistance

An adoption assistance plan allows you to set aside pre-tax payroll deduction contributions for adoption expenses that are paid in connection with an employee's adoption of a child.

Maximum Deduction: The aggregate amounts paid or expenses incurred that may be taken into account in determining the deduction amount from your gross pay for all taxable years with respect to the adoption of a child may not exceed $5,000 or $6,000 in the case of a child with special needs. The deduction limit applies to all taxable years rather than applying as an annual limit.

The dollar limit applies to both married and unmarried individuals. Thus, an unmarried couple that adopts an eligible child must apply the $5,000 or $6,000 limitation to the couple's combined qualified adoption expenses.

There is also an income limitation on the amount of the deduction. If the total AGI (adjusted gross income) for both parents (married or not) is no more than $75,000 the income limitation does not apply.

Qualified Adoption Expenses

Qualified adoption expenses means reasonable and necessary adoption fees, court costs, attorney fees, traveling expenses (including costs of meals and lodging) while away from home, and other expenses that are directly related to, and the principal purpose of which is for, the legal adoption of an eligible child by the taxpayer. Qualified adoption expenses do not include any expense for (1) which a deduction or credit is allowed under any other provision of the Code, (2) to the extent that funds for the expense are received under any federal, state, or local program, (3) that is incurred in violation of federal or state law, (4) that is incurred in carrying out any surrogate parenting arrangement, (5) that is incurred in connection with the adoption of a child of the taxpayer's spouse, or (6) for which reimbursement is made under an employer program or otherwise. In addition, an expense paid (by a cash basis taxpayer) or incurred (by an accrual basis taxpayer) in a taxable year beginning before the plan was implemented.

Except with respect to foreign adoptions, it is not necessary that the adoption be finalized for expenses to be treated as qualified and thus eligible for exclusion. For domestic adoptions an individual may include in the $5,000 or $6,000 limitation on excludable benefits any qualified expenses incurred in connection with an unsuccessful adoption, even if the individual later successfully adopts another child.

Child with Special Needs

In general an eligible child is any individual who, at the time a qualified adoption expense is paid or incurred, is under the age of 18, or is, physically or mentally incapable of caring for himself or herself.

A "child with special needs" is any child if a state has determined that the child cannot or should not be returned to the home of his or her parents;

the state has determined that there exists with respect to the child a specific factor or condition (such as his or her ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical conditions or physical, mental, or emotional handicaps) because of which it is reasonable to conclude that the child cannot be placed with adoptive parents without providing adoption assistance; and

The child is a citizen or resident of the United States, as defined in IRS Code Section 217(h)(3).

Note: The restriction of special needs status to children who are U.S. citizens or residents effectively limits the exclusion for adoption expenses of foreign children with special needs to $5,000.

Adoption Tax Credit

There is an adoption tax credit available also. The rules for the credit and the maximum credit is the same as for this plan. An employee may claim both a credit and an exclusion in connection with the adoption of an eligible child. However, the employee may not claim both a credit and an exclusion for the same expense.

Note: For the purposes of an election of adoption assistance through a cafeteria plan , the commencement or termination of an adoption proceeding also is a status change that can warrant a mid-year election or re-election.

Important Note:

Unless the Code is modified, the tax credit and the deduction allowance under this plan for adoption assistance (except for those in connection with special needs children) expires December 31, 2001. Expenses paid or incurred after December 31, 2001 will not be qualified under either the credit or this deduction plan, unless the expenses are incurred in connection with the adoption of a child with special needs. If the law is updated and the credit and deduction is extended you will be notified by EBS.

CONTINUATION COVERAGE FOR SEPARATED EMPLOYEES AND DEPENDENTS (COBRA)

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), employees and their dependents who are enrolled in a health, dental or vision insurance plan are entitled to an extension of health coverage, called "continuation coverage," in certain circumstances (for example, termination of employment, divorce, etc. This is called a "qualifying event").

The same plans you participated in as an active employee can be continued (subject to change if the group coverage changes). The coverage period for an employee is 18 months. The coverage period for dependents is 36 months. In the case of a dependent losing coverage (divorce or aging out of the plan), the employee or dependent must inform the Health Service System within 30 days of this qualifying event.

Employees who separate from City service at age 60 or older, and who have worked for the City for at least five years, are entitled to extended COBRA coverage. Extended coverage will end when the employee reaches age 65, or a qualifying event occurs.

Members 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 on the 19th month of coverage.

When a qualifying event occurs, the Health Service System's third party administrator will notify you of your right to COBRA coverage. You will have 60 days from the date of the notice to elect COBRA coverage. The coverage must be continuous from the date of the qualifying event (i.e. you cannot have a break in your coverage).

Any newly eligible dependent (spouse, domestic partner or child) or any newborn or adopted child) is eligible to be added to COBRA coverage within 30 days from the date of the event (birth, marriage, etc.).

COBRA coverage will end at the earliest of: 1) coverage under another group plan if no pre-existing condition limitation under the new plan applies to the individual.; 2) failure to pay the contribution required under the plan within thirty (30) days; or 3) the end of the applicable COBRA period.

As an alternative to COBRA coverage, you might want to purchase individual coverage from your benefit plan. All of the benefit plans except City Health Plan allow persons who are currently covered under their plan to convert to individual coverage, with no health evidence or physical examination required. Contact the benefit plans for details and rates.

All employees and dependents who were covered under a HSS-sponsored 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.

Health Plan COBRA Rates (Table D)

MONTHLY RATES	CITY HEALTH PLAN	KAISER	HEALTHNET	BLUESHIELD
Employee	$325.17	$208.34	$221.54	$223.48
Employee + 1 Dependent	$553.50	$415.65	$442.11	$445.95
Employee + 2 or More Dependents	$788.87	$587.72	$625.86	$630.53

Dental Plan COBRA Rates (TABLE E)

MONTHLY RATES	DELTA	PMI	PACIFIC UNION DENTAL
Employee	$56.37	$22.61	$26.22
Employee + 1 Dependent	$92.62	$37.31	$43.29
Employee + 2 or More Dependents	$139.24	$55.17	$64.02

FREQUENTLY ASKED QUESTIONS

The questions and answers in this section are general in nature. Contact the HSS Membership Division at (415) 554-1750 if you need help with your particular situation.

What benefits are available to me?

The Management Cafeteria Plan currently offers health, dental, health care and dependent day care flexible spending accounts, and short-term disability insurance, long term disability insurance, cancer insurance, heart & stroke insurance, accident insurance, universal life insurance, supplemental term life insurance, flexible benefit miscellaneous post tax reimbursement account, commuter check, veterinary pet insurance, long term care insurance, accidental death and dismemberment insurance, and group legal. HSS provides $50,000 of term insurance at no cost to all employees eligible for this plan.

What is an Open Enrollment period?

An Open Enrollment is a period of time during which employees may change benefit plans and/or add or delete eligible dependents. The Open Enrollment period for 2001 is July 30 to August 17. The effective date of all Open Enrollment changes is October 1st. Note that this plan year is short, starting October 1st until June 30th. The following year the plan year will begin on July 1st and end June 30th.

Whom should I contact if I need an identification card or a benefit booklet, or if I have a question about a specific plan?

You should contact the benefit plan directly. Contact information is listed on the first page of this booklet. During Open Enrollment, benefit plan representatives will be available at all Open Enrollment sites to answer your questions and provide you with materials.

When may I transfer from one health plan to another or from one dental plan to another? Can I transfer if my doctor drops out of my plan?

Generally, you may transfer, cancel or enroll in a benefit plan only during one of the annual Open Enrollment periods. You cannot transfer to a different plan during a plan year solely because a doctor or dentist you wish to see is not in the plan.

What will happen if I do not enroll during the Open Enrollment period?

If you do not enroll during the Open Enrollment period HSS will apply your flex credits toward your health insurance premium only. Any credits not used will be lost for the duration of the plan year – October 1, 2001 through June 30, 2002.

Must I change plans if I move outside the service area of a plan in which I am enrolled?

If you move out the service area of a plan, you must transfer to the City Plan or elect to have no coverage through HSS. Contact HSS for assistance in making the transfer as soon as you decide to move.

What should I do if the payroll deduction for my benefits plan is incorrect or not being taken?

When you enroll in or change your benefits plan, you should carefully check your Statement of Earnings and Deductions (pay stub) to verify that the proper deduction has been made. If the deduction is incorrect or not being made, you should immediately contact the HSS Membership Division at (415) 554-1750 or (800) 541-2266 outside the 415 area code. You will be responsible for the entire amount of your contribution, whether it is taken out of your paycheck or not.

May I continue my coverage if I am on an authorized leave without pay?

Yes. You may maintain coverage by contacting HSS and making arrangements to pay any premium contributions due directly to HSS. Contact Colonial Insurance Co., to continue your short-term disability coverage with them. For information regarding continuation of the other voluntary benefits contact EBS at (800) 229-7683.

What if I do not pay premium contributions due while on unpaid leave?

If you do not pay your premium contributions while on leave, your coverage and your dependents' coverage will be cancelled. Once coverage is lost for non-payment of premium contributions, you and your dependents will not be reinstated into the benefit plan(s) you had until you return to work.

May I enroll eligible dependents? Who is an eligible dependent?

Yes. The following dependents are eligible to enroll in the System:

Your legal spouse or domestic partner. A spouse from whom you have been granted a final dissolution of marriage, or from whom you are legally separated, shall not be eligible.

Unmarried children from birth to twenty-five (25) years of age who meet all of the following conditions:

1) Dependent is not married; 2) does not work full time; 3) continue to reside in the home, except for full-time students and children living with a divorced spouse; and 4) is eligible to be declared as a dependent child on your income tax return.

Children shall include your natural child, step-child so long as your are married to the natural parent, a legally adopted child, a child under legal guardianship, and a natural or legally adopted child of an enrolled domestic partner.

A child living with you in a parent-child relationship and economically dependent upon you, 18 or under, is also an eligible dependent provided you declare the child as an exemption on your income tax. Documentation of dependency may be required.

A child who is incapable of self-support because of a physical or mental incapacity that existed prior to the child's nineteenth (19th) birthday may be continued as a dependent as long as the child remains so incapacitated, by the filing of acceptable medical evidence with the System at least sixty (60) days prior to the attainment of age twenty-three (23). The child must have been a dependent in the System on a continuous basis prior to the child's nineteenth birthday.

When may I enroll an eligible dependent?

You may enroll eligible dependents at the time you originally enroll, within 30 days of a qualifying change in family status, or during any Open Enrollment period.

You may enroll a spouse or domestic partner and such other eligible dependents acquired by such marriage or domestic partnership within thirty (30) days of the event. Coverage for these eligible dependents will be effective as of the date of marriage or domestic partnership.

A newborn child or adopted child may be enrolled within thirty (30) days after the birth or commencement of physical custody of such child. Coverage shall be effective from the date of birth for the newborn. An adopted child's coverage will be effective with the commencement of physical custody, i.e., the child is placed in the employee's home.

What is imputed income?

Imputed income is the taxable value of an employer provided non-tax deductible fringe benefit. Employees who are covering a domestic partner will be taxed on the value of the employer's contribution toward the cost of a domestic partner's health and/or dental insurance pursuant to Internal Revenue Service guidelines. If your domestic Partner is eligible to be claimed as a dependent for tax purposes, you will not be subject to imputed income.

What is a qualifying change in family status?

A qualifying change in family status is a change in your family situation that the IRS has decided allows you to change your benefits. Some qualifying changes in family status are:

- ◊ marriage or establishment of a domestic partnership
- ◊ divorce or termination of a domestic partnership
- ◊ birth, adoption of a child, or other acquisition of a child through marriage (e.g. step-children) or other legal process (e.g. a legal guardianship)
- ◊ changing from full to part-time work or losing employment by yourself or your spouse/domestic partner

The change you want to make to your benefits must be on account of and consistent with the change in your family status. For example, you may not add your spouse to your coverage when you have a baby, but you may add your baby. Contact HSS Membership for assistance if you have a change in your family situation that makes you need to change your benefits.

When may I cancel coverage for a dependent?

You may cancel coverage for a dependent during an Open Enrollment period or if you have a qualifying change in family status. Coverage will end at the end of the pay period in which the application is filed.

May dependents who are no longer eligible continue coverage in HSS?

Yes. Dependents who are no longer eligible may continue group coverage for up to thirty-six (36) months in the event of a divorce, legal separation, or loss of eligibility under HSS's eligibility guidelines.

A dependent usually may also convert to an individual policy with the benefit plan in which the dependent is enrolled by contacting the benefit plan within 30 days of loss of group coverage. The City Plan does not offer an individual policy.

Whose responsibility is it to notify HSS of a change in family status involving the addition or cancellation of a dependent?

It is your responsibility to make additions, cancellations or changes in your enrollment. You are, in most cases, the only person who is aware of any changes that occur in your family status requiring or permitting such additions, cancellation or changes.

HSS has no obligation to provide coverage for an ineligible dependent or to make a refund of contributions made on account of an ineligible dependent.

In the event of my death, what happens to the coverage of my dependents?

Generally, surviving dependents of an employee may continue coverage in HSS after the death of an active or retired employee. If you die, your dependents should contact HSS immediately.

When do I lose coverage if I leave employment with the City?

When you leave City employment, except for retirement, your coverage and your dependents' coverage will cease on the last day of the pay period in which your termination occurs, unless you elect to continue coverage under HSS pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

COBRA provides that employees who have terminated employment and their dependents are entitled to continue group coverage for a certain period by paying for the coverage at set rates. COBRA coverage will end at the earliest occurrence of:

1) coverage under another group plan; 2) failure to pay the contribution required under the benefit plan within thirty (30) days; or 3) the end of the applicable COBRA period. Coverage must be continuous.

What happens to my coverage when I retire?

If you retire on a service, disability or vesting retirement, you may continue coverage in HSS at the rate established for retired employees, provided you apply for continuation within thirty days after your retirement is approved by your Retirement System. You must have been enrolled in a health plan through HSS for some period during your employment with the City, School District or Community College District.

If you do not apply to enroll within thirty days of your retirement, you may only apply for enrollment during an Open Enrollment period, with coverage to become effective the following July 1.

What should I do if I have a problem with my health, dental or other benefit plan?

If you have a problem with a particular benefit plan, you should contact the benefit plan directly (including City Health Plan) and request information on pursuing a grievance. Every benefit plan has a grievance procedure. You may also let HSS know about your problem with the benefit plan by sending a letter with the details of your problem to HSS, Attention: Plan Complaints. HSS generally cannot resolve your problem with the benefit plan, but HSS and the Health Service Board will take your information into account when deciding whether to continue to contract with that particular benefit plan.