contents

2007-08

City & County of San Francisco

MANAGEMENT CAFETERIA PLAN

Don't Forfeit Your Flex Credits!

Make an appointment to allocate your flex credits.

New Hires:
Contact HSS by calling 415/554-1715

Open Enrollment:
Contact EBS at 800/229-7683

Do you need to to submit an Open Enrollment Application to the Health Service System by the April 27 deadline?

YES **if any ONE of the following applies to you:**

- You are currently enrolled in the Health Net HMO.
- You want to delete a dependent from your healthcare coverage.
- You want to add a dependent to your healthcare coverage.
- You want to elect a different medical/dental plan.

NO **if the following applies to you.**

You are not a Health Net member and you don't want to make any changes to your current benefits elections.

KEY CONTACT INFORMATION

Key Contact Information

Health Service System

Health Service System Member Services
1145 Market Street, Suite 200
San Francisco, CA 94103
(Between 7th and 8th Streets — Civic Center Muni/BART Station)
(415) 554-1750; (800) 541-2266 (outside 415 area code)
Fax: (415) 554-1752 www.myhss.org

Medical Plans

City Health Plan *(administered by UnitedHealthcare)*
Tel: (866) 282-0125 Group No: 705287
www.myuhc.com

Blue Shield of California
Tel: (800) 424-6521 Group No. H11054
www.mylifepath.com

Kaiser Foundation Health Plan, Inc.
Tel: (800) 464-4000 Group No. 888
www.members.kp.org

PacifiCare
Tel: (800) 624-8822 Group No. 240803
www.pacificare.com

Dental Plans

Delta Dental
Tel: (888) 335-8227
(800) 4-AREA-DR (referrals to Delta dentists)
Group No. 9502-0003
www.deltadentalca.org

DeltaCare USA Dental *(Formerly PMI)*
Tel: (800) 422-4234 Group No. 01797-0001
www.deltadentalca.org

Pacific Union Dental
Tel: (800) 999-3367 Group No. 94227
(925) 363-6000
www.pacificuniondental.com

Vision Plan

Vision Service Plan (VSP)
Tel: (800) 877-7195 Group No.12145878
www.vsp.com

Healthcare and Dependent Care Flexible Spending Accounts

Fringe Benefits Management Company (FBMC)
Tel: (800) 342-8017 Customer Service M-F 7am – 7pm
(800) 865-3262 Automated Interactive Benefits 24 hrs
www.myfbmc.com

Management Cafeteria Plan Administrator

Employee Benefit Specialists
Tel: (800) 229-7683
www.ebsbenefits.com

WELCOME

Dear Member:

Welcome to open enrollment for the 2007-2008 plan year. This year, our theme at Health Service System has been "new," because your Health Service Board and staff of the Health Service System have been hard at work on a series of improvements to make your health coverage choices better and more affordable.

Karen Breslin
President
Health Service Board

New Member Guides

We hope you like your new member guide, which has been completely redesigned for this year. We wanted to make the guides easier to use (and more appealing to look at). Please take the time to read over your guide, as important notices will appear throughout to help you make better informed, more confident decisions about your medical, dental and other benefit choices.

New Mix of Medical Plans

This year, the Health Service Board conducted a rigorous RFP (or request for proposal) process to make sure members were offered medical plans delivering the best coverage for the lowest cost. As a result, PacifiCare and Blue Shield were able to offer a better value, and Health Net was discontinued. The good news is that Health Net members (and all members) now have the option of choosing a plan that will likely offer them access to the same providers for a lower cost.

Improved Information and Communications

As mentioned earlier, one of our goals for this year's open enrollment was to help you better prepare to make confident benefit choices. Some of the ways were have done this include:

- Posters in your work area and flyers in your pay check (or payroll advice)
- A special open enrollment section on our web site, myhss.org.
- E-mail updates for members who visit myhss.org and sign up for "E-Updates"

And, for the second week (April 9-13) of on-site open enrollment in the HSS Market Street office, representatives from our medical, dental, and vision plans will be present to answer your questions.

As always, our objective at open enrollment is to help you make the best decisions for you and your dependents—ones that you'll be satisfied with for the duration of the plan year. We hope the improvements your Health Service Board and staff of the Health Service System have worked on so hard this year help everyone achieve that goal.

Best Regards,
Karen Breslin

Health Service Board

Karen Breslin, President
James Deignan, Vice President
Scott Heldfond, Commissioner
Sharon Johnson, Commissioner
Mitch Katz, M.D., Commissioner
Claire Zvanski, Commissioner
Sean Elsbernd, Supervisor

Health Service System

Bart Duncan, Director
Jeffrey Hildebrant, Assistant Director
Tess Navarro, Chief Financial Officer

NOTICE OF THE CITY AND COUNTY OF SAN FRANCISCO HEALTH SERVICE SYSTEM PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW 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 AND PURPOSE FOR WHICH YOUR HEALTH 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 payment of benefits.

TO CONDUCT HEALTH CARE 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 such activities as:

- 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 to 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 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.

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.

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.

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 laws related to worker's compensation 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 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. If you wish to make a request for restrictions, please send your written request to:

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

Right to Receive Confidential Communications. You have the right to request 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. If you wish to receive confidential communications, please send your written request to:

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

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:

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

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 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. A request for an amendment of records must be made in writing to:

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

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 a list of disclosures of your health information made by the Health Service System for any reason other than for treatment, payment or health operations. The request must be made in writing to:

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

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 the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Health Service System will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request 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. To obtain a paper copy, please send your written request to:

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

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 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 to:

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

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.

EFFECTIVE DATE

Original effective date: April 14, 2003

Revised: January 1, 2007

Eligibility

Member Eligibility

The following employees are eligible for health care coverage administered by the Health Service System:

- All permanent employees of the City and County of San Francisco whose normal work week is not less than twenty (20) hours;
- All regularly scheduled provisional employees of the City and County of San Francisco whose normal work week is not less than twenty (20) hours;
- All other employees of the City and County of San Francisco including temporary exempt "as needed" employees, who have worked more than one thousand and forty hours (1040) in any consecutive twelve (12) month period and whose normal work week is not less than twenty (20) hours.

Dependent Eligibility

The following dependents of an enrolled member may be eligible for health care coverage administered by the Health Service System:

- Your legal spouse or domestic partner. Please note that a spouse from whom you have been granted a final dissolution of marriage or from whom you are legally separated, or a domestic partner from whom you dissolve your domestic partnership, are not eligible.

  You'll be required to provide proof of marriage or domestic partnership when enrolling a spouse or domestic partner.

- Unmarried children from birth to age twenty-five (25) who 1) aren't married ; 2) don't work full time; 3) continue to reside in the home, except for full-time students and children living with a divorced spouse; and 4) are declared as an exemption on your federal income tax return.

Children include your natural child, step-child (as long as you're married to the natural parent), a legally adopted child, a child under legal guardianship and a natural or legally adopted child of an eligible domestic partner. Legal documentation is required for adoptions and guardianships.

- A child 1) living with you in a parent-child relationship who is economically dependent upon you for support; 2) is 18 years of age or younger; 3) isn't married; and 4) is declared as an exemption on your federal income tax return. A copy of your federal income tax return may be required each year.

- A child who is covered by National Medical Support Notice (Court Order) will be covered to age 19.

- A child who 1) is over the age of 19; 2) is unmarried; 3) is incapable of self-sustaining employment due to physical handicap or mental retardation that existed prior to the child's attainment of age 25; 4) permanently resides with the employee/retired member; dependent on the member for substantially all of his/her economic support; 5) has been a dependent in a medical plan administered by the Health Service System on a continuous basis; and 6) was enrolled prior to child's nineteenth (19) birthday.

Eligibility may continue by the filing of acceptable medical evidence with the Health Service System at least sixty (60) days prior to the attainment of age twenty-five (25) and annually thereafter.

Enrollment

ANNUAL OPEN ENROLLMENT

During the annual Open Enrollment period, all eligible employees will receive important information regarding their rights and responsibilities for electing health care coverage or making changes to current coverage elections. You must submit a completed enrollment application and all required documentation prior to the Open Enrollment deadline. Enrollment/change requests received after the Open Enrollment deadline will not be processed.

During the annual Open Enrollment you may:

- Continue your current benefit elections for the next Plan Year
- Choose a different medical and/or dental plan
- Add or drop eligible dependents to/from coverage
- Enroll or re-enroll in the Health Care and/or Dependent Care Flexible Spending Accounts.

Important: You must re-enroll in the Health Care and/or Dependent Care Flexible Spending Account(s) each year if you wish to contribute pre-tax dollars to one or both of these accounts after July 1st.

The coverage you elect during the annual Open Enrollment period will be in effect on July 1st of each year and continue through June 30th of the following year, provided you and your dependents remain eligible. Until you receive your medical plan identification card, you should use the group identification numbers listed in the Key Contact Information section of this guide.

IMPORTANT NOTICE

HSS members and their dependents may not 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 follow:

- For any member who is covered both as a member and as the 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.

NEW EMPLOYEES

New employees must enroll in an available medical and/or dental plan within thirty (30) days of their initial appointment or within thirty (30) days of meeting the eligibility requirements for coverage. Coverage will be effective on the first day of the pay period following the eligibility date provided the Health Service System receives your completed enrollment application and any required documentation.

If you don't enroll within your initial 30-day enrollment period, you must wait until 1) the next annual Open Enrollment period; or 2) you have a qualifying change in family status.*

**See Qualifying Change in Family Status information later in this section for details.*

DEPENDENTS

Eligible dependents, as defined in the Eligibility section of this guide must be enrolled 1) during your initial enrollment period as described above; 2) during the annual Open Enrollment period; or 3) within thirty (30) days of a qualifying change in family status.

Coverage for eligible dependents added during initial enrollment will become effective the same day as the employee unless the dependent is confined in a hospital in which case coverage will be in effect on the date the dependent is released from the hospital.

ENROLLMENT

Important: Coverage for enrolled dependents may be terminated within thirty (30) days of a qualifying change in family status or during the annual Open Enrollment period for a coverage termination date of the following July 1.

QUALIFYING CHANGE IN FAMILY STATUS

A qualifying change in family status is a change in your family situation, as defined by IRS guidelines, which allows you to make certain changes to your benefit elections. A qualifying change in family status may include, but is not limited to:

- **Marriage.** You may enroll your spouse, and his/her eligible child(ren), by submitting a completed enrollment application form and a copy of your marriage license/birth certificate to the Health Service System within thirty (30) days of your marriage. Coverage for your spouse and any eligible child(ren) will be effective on the date of marriage, provided you meet the enrollment deadline and documentation requirements stated above.

- **Domestic Partnership.** You may enroll your domestic partner, and your domestic partner's child(ren), within thirty (30) days of the declaration of domestic partnership, by submitting a 1) completed enrollment application; 2) Certificate of Domestic Partnership showing that a domestic partnership has been processed and that the declaration was either filed with the San Francisco County Clerk's Office or notarized by a notary public or other satisfactory legal evidence of domestic partnership that is valid and binding in another jurisdiction; and 3) copy of the birth certificate for any enrolled child. Coverage for your domestic partner and your domestic partner's child(ren) will be effective on the date of declaration of the domestic partnership, provided you meet the enrollment deadline and documentation requirements stated above.

Important: When you elect coverage for your domestic partner (and any dependent(s) of your domestic partner), you will be taxed on the value of the City and County of San Francisco's contribution toward the cost of a healthcare coverage for these dependents, pursuant to Internal Revenue Service guidelines. This is referred to as imputed income.

- **Birth or Adoption of a Child.** You may enroll your newborn child within thirty (30) days of the date of birth by submitting a completed enrollment application and certificate of birth to the Health Service System. Coverage will be in effect on the child's date of birth provided you meet the submission deadline and documentation requirements listed. An adopted child may be enrolled within thirty (30) days of commencement of physical custody of the child. An adopted child's coverage will be in effect on the date of commencement of physical custody, provided you meet the deadline and documentation requirements listed.

- **Loss of Other Coverage.** You may enroll a qualified dependent that loses health care coverage elsewhere by submitting a completed enrollment application and proof of the loss of coverage within thirty (30) days of the date of loss. The effective date of coverage will be the first day of the pay period following the date HSS receives a completed enrollment application and any required documentation.

- **Obtaining Other Coverage.** If you or a covered dependent obtain health care coverage elsewhere, you may cancel your coverage or that of your dependent by submitting a completed enrollment application and proof of the other coverage within thirty (30) days of the effective date of the other coverage. Coverage(s) will cease on the last day of the pay period in which HSS receives a completed change application and required documentation.

- **Divorce, Legal Separation, Dissolution of Domestic Partnership or Death.** You may cancel coverage(s) for your spouse/domestic partner and his/her child(ren) within thirty (30) days of your divorce, legal separation or dissolution of domestic partnership by submitting an enrollment application form and a copy of your final divorce decree, legal separation papers which have been filed with the County Clerk, the dissolution document issued by the County Clerk or death certificate.

  Except for death, coverage will cease on the last day of the pay period in which the applicable event occurred provided you meet the notification and documentation requirements stated above.

- **Ineligibility.** Dependent(s) should be cancelled from your coverage once they become ineligible. Please refer to Dependent Eligibility on page 7. If a dependent doesn't meet any one of the criteria for eligibility, you must cancel his/her coverage immediately.

Important: All change requests must be on account of and consistent with the change in your family status. Contact HSS Member Services for more information.

PLAN OPTIONS

Management Cafeteria Plan Options

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 option. Eligible **City and County of San Francisco enrollees** will receive $259.10 in credits per pay period to purchase from among the options listed below. Eligible **Superior Court enrollees** will receive $404.46 in credits per pay period to purchase from among the options listed below.

Pre-Tax Benefit Options	Tax Status	Flexible Credit	Payroll Deduction
Medical Insurance	Pre-Tax	Yes	Yes
Dependent Care Account	Pre-Tax	Yes	Yes
Medical Reimbursement Account	Pre-Tax	Yes	Yes
Adoption Assistance Reimbursement	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 no cost to all employees eligible for this plan			

Post-Tax Benefit 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

Flex credits applied to post-tax benefits options 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 percent 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

Member's 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 percent 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 percent 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

Any member who doesn't make an active flexible credit allocation election during Open Enrollment will be subject to the following:

- If the member has allocated flexible credits to a medical plan option in the current Plan Year, all available flexible credits will be automatically applied to the actual cost of the same medical plan at the same level of coverage for the following Plan Year. Any additional amount required to cover the actual cost of the medical plan option, will be covered by payroll deduction.
- If the member has not allocated flexible credits to a medical plan option in the current Plan Year, but the member is enrolled in a medical plan, all available flexible credits will be automatically applied to the actual cost of the same medical plan option at the same level of coverage for the following Plan Year. Any additional amount required to cover the actual cost of the medical plan option, will be covered by payroll deduction. All credits remaining, if any, will be assigned to the Miscellaneous Reimbursement Account and will be subject to imputed income.

Medical Plan Options

The medical plan options described below are available to active City and County of San Francisco employees and their eligible dependents. Required medical plan premiums, if any, will be deducted from your bi-weekly paycheck on a pre-tax basis, where applicable.

City Health Plan PPO

City Health Plan is a Preferred Provider Organization (PPO). A PPO is a medical plan that gives you freedom of choice between PPO providers who offer their services at discounted rates, and non-PPO providers.

When you obtain care from a PPO provider, the plan pays higher benefits, up to 85% after the required deductible, and your out-of-pocket expenses are less. When you use a PPO provider, he/she will submit claims on your behalf.

If you obtain care from a non-PPO provider, the plan pays lower benefits and you may be required to pay for services directly to the provider and submit your own claims to the plan.

You must pay the applicable deductible each Plan Year for most services before this plan will pay benefits. After your deductible requirement has been met, you'll pay a percentage of the cost of services provided.

Refer to the Plan Document for a detailed list of covered expenses, exclusions and limitations under this plan.

Blue Shield of California HMO

Blue Shield of California is a Health Maintenance Organization (HMO). An HMO is a medical plan that requires you to receive all of your care from contracted health care providers. Services are provided by a primary care physician who treats you or, when necessary, refers you to other doctors within the HMO network. Most services are covered at 100% after you pay the applicable copayment.

Refer to the applicable Blue Shield Evidence of Coverage for a detailed list of covered services, exclusions and limitations.

Kaiser Permanente HMO

Under the Kaiser Permanente HMO plan, you're required to receive all of your care through an integrated system of participating physicians, hospitals and other health care providers. You have access to full-service medical care. You must use plan providers at Kaiser Permanente facilities to be covered. Most services are covered at 100% after you pay the applicable copayment.

Refer to the applicable Kaiser Permanente Evidence of Coverage for a detailed list of covered services, exclusions and limitations

PacifiCare HMO

PacifiCare is a Health Maintenance Organization (HMO). You're required to select a primary care physician who is contracted with PacifiCare and who is primarily responsible for the coordination of your healthcare services. Your primary care physician will seek authorization for any referrals to a PacifiCare contracted specialist, as well as initiate any necessary hospital services. Most services are covered at 100% after you pay the applicable copayment..

Refer to the applicable PacifiCare Evidence of Coverage for a detailed list of covered services, exclusions and limitations.

Important: To participate in an available HMO plan, you must live in a one of the zip code service areas served by that HMO. Please refer to the Medical Plan Service Areas chart on page 15 of this guide for details.

MEDICAL PLANS

Bi-Weekly Medical Plan Rates

for Plan Year July 1, 2007- June 30, 2008

	CCSF	Superior Court
CITY HEALTH PLAN		
Employee Only	$ 43.74	$ 229.80
Employee + One Dependent	$ 242.98	$ 429.04
Employee + 2 or Dependents	$ 432.18	$ 618.24
BLUE SHIELD		
Employee Only	$ 4.69	$ 190.75
Employee + One Dependent	$ 194.96	$ 381.02
Employee + 2 or Dependents	$ 342.80	$ 528.86
KAISER		
Employee Only	$ 3.20	$ 189.26
Employee + One Dependent	$ 191.98	$ 378.04
Employee + 2 or Dependents	$ 338.67	$ 524.73
PACIFICARE		
Employee Only	$ 15.76	$ 201.82
Employee + One Dependent	$ 217.10	$ 403.16
Employee + 2 or Dependents	$ 373.55	$ 559.61

Medical Plan Service Areas

■ = Available in this county

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

County	City Health Plan	Blue Shield	Kaiser	PacifiCare
Alameda	■	■	■	■
Alpine	■			
Amador	■		❍	
Butte	■	■		
Calaveras	■			
Colusa	■			
Contra Costa	■	■	■	■
El Dorado	■	❍	❍	❍
Fresno	■	■	❍	■
Glenn	■			
Lake	■			
Lassen	■			
Madera	■	■	❍	❍
Marin	■	■	■	❍
Mariposa	■		❍	
Mendocino	■			
Merced	■	■		■
Mono	■			
Monterey	■			
Napa	■		❍	

Medical Plan Services Areas Continued

■ = Available in this county

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

County	City Health Plan	Blue Shield	Kaiser	PacifiCare
Nevada	■	❍		❍
Placer	■	❍	❍	❍
Plumas	■			
Sacramento	■	■	■	■
San Benito	■			
San Francisco	■	■	■	■
San Joaquin	■	■	■	■
San Mateo	■	■	■	■
Santa Barbara	■	■		■
Santa Clara	■	■	❍	■
Santa Cruz	■	■		■
Sierra	■			
Solano	■	■	■	■
Sonoma	■	■	❍	■
Stanislaus	■	■	■	■
Sutter	■		❍	
Tuolumne	■			
Yolo	■	■	❍	■
Yuba	■		❍	
Outside of Area	■	Emergency/ Urgent Care Only	Emergency/ Urgent Care Only	Emergency/ Urgent Care Only

Dental Plan Options

The dental plan options described below are available to eligible employees and their eligible dependents. See the Dental Plan Comparison chart on the next page for details of each of the dental plan options.

DELTA DENTAL PLAN

Delta Dental Plan provides three options for selecting a dental provider. Each option provides coverage for the same types of services, but at different benefit levels.

- **Delta Dental PPO Plan**. For the lowest out-of-pocket expense, you can visit a PPO network provider. PPO level benefits are available from more than 13,000 PPO offices in California. Significant cost savings are available when visiting a dentist in the PPO network through negotiated lower fees on services.

- **DeltaPremier.** Considerable savings are also available when using a DeltaPremier provider. Your out-of-pocket expense may be greater than when using a PPO provider.

- **Non-Delta Dental Providers.** You may elect to receive services from any licensed dental provider. Providers who don't participate in the Delta Dental network generally charge fees that are higher than those charged by providers who participate in the network, resulting in higher out-of-pocket costs to you.

DELTACARE USA DENTAL PLAN (Formerly PMI Dental Plan)

DeltaCare USA Dental Plan is a managed dental care plan. If you enroll in this plan, you must receive all services from dentists affiliated with DeltaCare USA . 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 copayment for services. Preauthorization from the plan is required for major services.

PACIFIC UNION DENTAL PLAN

Pacific Union Dental Plan is a managed dental care plan. If you enroll in this plan, you must receive all care from dentists affiliated with 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 copayment for services. Preauthorization from the plan is required for major services.

Important: To elect coverage in the DeltaCare USA or Pacific Union Dental Plan, you must live in a service area served by the dental plan. Please refer to the Dental Plan Service Areas chart on page 19 for details.

Dental Plan Comparison

The chart below is a brief summary of available dental plan options. If any discrepancy exists between the information in this chart and the official Plan Documents, the official Plan Documents will govern.

TYPE OF SERVICE	DELTA DENTAL		DELTACARE USA	PACIFIC UNION
	Delta PPO Option	**DeltaPremier & Non-Delta Providers***		
Cleanings and Exam	100% Limit 2x per Plan Year	100% Limit 2x per Plan Year	100% Limit once every 6 months	100% Limit once every 6 months
X-rays	100%	100%	100%	100%
Extractions	90%	80%	100%	100%
Fillings	90%	80%	100%	100%
Crowns	90%	80%	100%	100%
Dentures, Pontics and Bridges	50%	50%	No charge Full and partial dentures once every 5 years; Fixed bridgework; certain limitations apply	No charge Full and partial dentures once every 5 years; Fixed bridgework; certain limitations apply
Root Canals	90%	80%	100%	100%
Orthodontia	Covered for adults and children at 50% up to a maximum of $2,500 lifetime	Covered for adults and children at 50% up to a maximum of $2,500 lifetime	$1660 per case to age 19; $1880 charge per case age 19 or older; $350 start-up fee Other limitations apply	$1600 per case to age 19; $1800 charge per case age 19 or older; $350 start-up fee Other limitations apply
Annual Maximum	$2,500 per person per Plan Year excluding ortho benefits	$2,500 per person per Plan Year excluding ortho benefits	None	None
Waiting Period	6 months for dentures, pontics, bridges, and orthodontia for new enrollees	6 months for dentures, pontics, bridges, and orthodontia for new enrollees	None	None

* Benefits are based on Reasonable and Customary charges for non-Delta Providers

Dental Plan Service Areas

■ = Available in this county

County	Delta Dental	DeltaCare USA	Pacific Union
Alameda	■	■	■
Alpine	■		
Amador	■		
Butte	■	■	■
Calaveras	■		
Colusa	■	■	■
Contra Costa	■	■	■
El Dorado	■	■	■
Glenn	■		
Lake	■	■	
Madera	■	■	■
Marin	■	■	■
Mariposa	■		
Mendocino	■	■	■
Merced	■	■	■
Mono	■		
Monterey	■	■	■
Napa	■	■	■
Nevada	■		

If you don't see your County listed, contact the dental plan for enrollment eligibility information

Dental Plan Services Areas Continued

■ = Available in this county

County	Delta Dental	DeltaCare USA	Pacific Union
Placer	■	■	■
Plumas	■		
Sacramento	■	■	■
San Benito	■		■
San Francisco	■	■	■
San Joaquin	■	■	■
San Mateo	■	■	■
Santa Clara	■	■	■
Santa Cruz	■	■	■
Sierra	■		
Siskiyou	■	■	■
Solano	■	■	■
Sonoma	■	■	■
Stanislaus	■	■	■
Sutter	■	■	
Tuolumne	■		
Yolo	■	■	
Yuba	■	■	
Outside of Area	■		

If you don't see your County listed, contact the dental plan for enrollment eligibility information

VISION PLAN

Vision Plan

The City & County of San Francisco offers all members and their eligible dependent(s) that enroll in the City Health Plan, Blue Shield HMO, Kaiser HMO or PacifiCare HMO a vision plan that is administered by Vision Service Plan (VSP).

If you don't enroll in an available medical plan option, you won't have vision plan coverage.

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 eyewear, such as glasses or contacts.

Under the vision plan, you have the choice of using a VSP network doctor or a non-VSP provider. It is to your advantage 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. When 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. There are no ID cards issued for the vision plan.

TYPE OF SERVICE	VSP NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
Vision Exam	Covered in full every 12 months[1] after the $10 co-pay	Up to $40 every 12 months[1] after the $10 co-pay
Single Vision Lenses	Covered in full once every 24 months[1] after the $25 co-pay	Up to $45 every 24 months[1] after the $25 co-pay
Lined Bifocal Lenses	Covered in full once every 24 months[1] after the $25 co-pay	Up to $65 once every 24 months[1] after the $25 co-pay
Lined Trifocal Lenses	Covered in full once every 24 months[1] after the $25 co-pay	Up to $85 once every 24 months[1] after the $25 co-pay
Frames ***Note:*** *Single co-pay of $25 applies to both frames and lenses*	Covered up to $130 once every 24 months[1] after the $25 co-pay	Up to $55 once every 24 months[1] after the $25 co-pay
Contact Lenses	Covered up to $150[2] once every 24 months[1] in lieu of frames/lenses; no co-pay	Covered up to $105[2] once every 24 months[1] in lieu of frames/lenses; no co-pay

[1]Based on your last date of service
[2]The allowance will apply toward the contact lens fitting and evaluation exam, and contacts.

VISION PLAN

Benefit Authorization

When you make an appointment with a VSP network doctor, the doctor will obtain benefit authorization directly from VSP. Services must be received prior to the benefit authorization expiration date. You pay only the applicable copayment(s), if any, to a VSP network doctor for services covered by the Plan. VSP will pay the doctor directly for the remainder of eligible charges. 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 and then submitting an itemized bill directly to VSP for partial reimbursement. A claim form can be obtained by accessing the VSP Web site at www.vsp.com.

Plan Limits and Exclusions

- The visionplan covers one set of contacts or eyeglass lenses every 24 months.
- If you choose contact lenses, you'll be eligible for a frame 24 months after the last date of obtaining the contacts lenses. This rule also applies to your eligible dependents.
- 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 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 Schedule of Benefits.
  - Blended lenses
  - Contact lenses (except as noted in the Schedule of Benefits)
  - Oversize lenses
  - Photochromic and tinted lenses
  - Progressive multi-focal lenses
  - The coating of the lens or lenses, except scratch resistant coatings
  - The 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
  - UV (ultraviolet) protected lenses

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 normal intervals
- Medical or surgical treatment of the eyes
- Costs for securing materials such as lenses and a frame under the vision plan
- Corrective vision treatment such as, but not limited to, RK 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).

Flexible Spending Accounts (FSAs)

What is a Flexible Spending Account?

Fringe Benefits Management Company (FBMC) administers IRS-approved tax-favored Flexible Spending Accounts (FSAs) for eligible City and County of San Francisco employees to help stretch your medical expense and dependent care expense dollars.

Flexible Spending Accounts Feature

- IRS-approved reimbursement of eligible expenses tax free
- per-pay-period deposits from your pre-tax salary
- savings on income and Social Security taxes
- security of paying anticipated expenses with your FSA

Is an FSA right for me?

If you spend money on recurring eligible expenses during the Plan Year, you may save money by paying for them with an FSA. A portion of your salary is deposited into your FSA each pay period.

- You decide the amount you want deposited each pay period, within specified limits.
- You're reimbursed for eligible expenses before income and Social Security taxes are deducted.
- You save income and Social Security taxes each time you receive wages.
- Determine your potential savings with a Tax Savings Analysis. Click on the "Tax Calculator" link at www.myfbmc.com.

What types of FSAs are available?

Eligible employees may enroll in a Health Care FSA as well as a Dependent Care FSA. If you incur both types of expenses during a Plan Year, you can establish both types of FSAs.

Health Care FSAs

Medical expenses not covered by your insurance plan may be eligible for reimbursement using your Health Care FSA, including but not limited to:

- birth control pills
- eyeglasses
- orthodontia and
- Over-the-counter (OTC) items.

Dependent Care FSAs

Dependent care expenses, whether for a child or an elder, include any expense that allows you to work, including but not limited to:

- day care services
- in-home care
- nursery and preschool and
- summer day camps.

Refer to the Health Care FSA and Dependent Care FSA sections of this enrollment guide for specifics on each type of FSA.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Minimum Contribution is $5.00 per pay period.
Maximum Contribution is $192.30 per pay period.

A Health Care FSA is an IRS-approved tax favored account you can use to pay for your eligible medical expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free.

Whose expenses are eligible?

You may use your Health Care FSA to receive reimbursement for eligible expenses incurred by:

- yourself
- your spouse
- your qualifying child or
- your qualifying relative.

A individual is a qualifying child if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are 18 years old or younger (23 years, if a full-time student) at the end of the taxable year and
- haven't provided more than one-half of their own support during the taxable year (and receive more than one-half of their support from you during the taxable year if a full-time student age 19 through 23 at the end of the taxable year)

An individual is a qualifying relative, if they:

- have a specified family-type relationship to you, are not someone else's qualifying child and receive over one-half of their support from you during the taxable year or
- if no specified family-type relationship to you exists, are a member of and live in your household (without violating local law) for the entire taxable year and receive more than one-half of their support from you during the taxable year

Important: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Health Care FSA.

Partial list of medically necessary eligible expenses*

Acupuncture • Hearing aids and exams • Ambulance service • In vitro fertilization • Birth control pills and devices • Injections and vaccinations • Chiropractic care • Nursing services • Contact lenses (corrective • Optometrist fees • Dental fees • Orthodontic treatment • Diagnostic tests/health screening • Over-the-Counter items • Doctor fees • Smoking cessation programs/treatments • Drug addiction/alcoholism treatment • Surgery • Drugs • Transportation for medical care • Experimental medical treatment • Weight-loss programs/meetings • Eyeglasses • Wheelchairs • Guide dogs • X-rays

***Subject to change per IRS regulations**

Important: Budget conservatively. No reimbursement or refund of Health Care FSA funds is available for services that do not occur within the Plan Year.

When are my funds available?

Once you sign up for a Health Care FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of your deductions.

Are prescriptions eligible for reimbursement?

Yes, most filled prescriptions are eligible for Health Care FSA reimbursement, as long as you properly substantiate the expense. Proper submission of the

reimbursement request is needed to ensure that the drug is eligible for reimbursement. The IRS requires the complete name of all medicines and drugs be obtained and documented on pharmacy receipts (including prescription number, date(s) of service and total dollar amount). This information must be included when submitting your request to FBMC for reimbursement.

Over-the-Counter Expenses

Your Over-the-Counter (OTC) items, medicines and drugs may now be reimbursable through your Health Care FSA! Save valuable tax dollars on certain categories of OTC items, medicines and drugs, such as allergy remedies, antacids, cold remedies and pain relief remedies. You may be reimbursed for OTCs through your Health Care FSA if:

- the item, medicine or drug was used for a specific medical condition for you, your spouse and/or your dependent(s)
- the submitted receipt clearly states the purchase date and name of the item, medicine or drug
- the reimbursement request is for an expense allowed by the Health Care FSA plan and IRS regulations and
- you submit your reimbursement request in a timely and complete manner.

Important: OTC items, medicines and drugs, including bulk purchases, must be used in the same plan year in which you claim reimbursement for their cost. A list of eligible OTC categories will be updated on a quarterly basis by FBMC. It is your responsibility to remain informed of updates to this list, which can be found at www.myfbmc.com.

Newly eligible OTC items, medicines and drugs are not considered a valid change in status event that would allow you to change your annual Health Care FSA election or salary reduction amount. Be sure to maintain sufficient documentation to submit receipts for reimbursement. You may resubmit a copy of your receipt from your records if a rejected OTC expense becomes eligible for reimbursement later in the same plan year.

Is orthodontic treatment reimbursable?

Orthodontic treatment designed to treat a specific medical condition may be reimbursable if the proper documentation is attached to the initial FSA Reimbursement Request Form:

- a written statement from the treating dentist/orthodontist showing the type and date the service was incurred, the name of the eligible individual receiving the service and the cost for the service
- a Letter of Medical Need from the treating dentist/orthodontist and
- a copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment.

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For available reimbursement options please contact FBMC Customer Service at 1-800-342-8017.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Health Care FSA include:

- insurance premiums
- vision warranties and service contracts and
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

How do I request reimbursement?

Requesting reimbursement from your Health Care FSA is easy. Simply mail or fax a completed FSA Reimbursement Request Form along with receipts showing the following:

- a receipt, invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided and

- an Explanation of Benefits (EOB) from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost or
- a written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the receipt, invoice or bill for the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Health Care FSA. This information is required with each request for reimbursement.

Mail to:
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 850-425-4608

Direct Deposit

Enroll in Direct Deposit to expedite the time of your reimbursement.

- FSA reimbursement funds are automatically 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).

To apply, complete the Direct Deposit Enrollment Form available at www.myfbmc.com or contact FBMC Customer Service by at 1-800-342-8017. Please note that processing your Direct Deposit enrollment may take between four and six weeks.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Minimum Contribution is $5.00 per pay period. Maximum Contribution depends on your tax filing status.

A Dependent Care FSA is an IRS tax-favored account you can use to pay for your eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free.

Whose expenses are eligible?

You may use your Dependent Care FSA to receive reimbursement for eligible dependent care expenses for qualifying individuals.

A qualifying individual includes a qualifying child, if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specific family-type relationship to you
- live in your household for more than half of the taxable year
- are 12 years old or younger and
- haven't provided more than one-half of their own support during the taxable year.

A qualifying individual includes your spouse, if they:

- are physically and/or mentally incapable of self-care
- live in your household for more than half of the taxable year and
- spend at least eight hours per day in your home.

A qualifying individual includes your qualifying relative, if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- are physically and/or mentally incapable of self-care
- are not someone else's qualifying child
- live in your household for more than half of the taxable year and
- spend at least eight hours per day in your home and
- receive over one-half of their support from you during the taxable year.

Important: If you're the tax dependent of another person, you can't claim qualifying individuals for yourself. You can't claim a qualifying individual if they file a joint tax return with their spouse. Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care FSA.

Maximum annual contribution

- If you're married and filing separately, your maximum annual deposit is $2,500.
- If you're single and head of household, your maximum annual deposit is $5,000.
- If you're married and filing jointly, your maximum annual deposit is $5,000.
- If either you or your spouse earns less than $5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is $3,000 a year for one dependent and $5,000 a year for two or more dependents.

When are my funds available?

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Health Care FSA, the entire maximum annual amount isn't available during the Plan Year, but rather after your payroll deductions are received and processed each pay period.

Should I claim tax credits or exclusions?

Since money set aside in your Dependent Care FSA is always tax-free, you guarantee savings by paying for your eligible expenses through your IRS tax-favored account. Depending on the amount of income taxes you're required to pay, participation in a Dependent Care FSA may produce a greater tax benefit than claiming tax credits or exclusions alone. Remember, you can't use the dependent care tax credit if you are married and filing separately. Further, any dependent care expenses reimbursed through your Dependent Care FSA can't be filed for the dependent care tax credit, and vice versa. To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information.

Ineligible Expenses

Expenses not eligible for reimbursement through your Dependent Care FSA include, but are not limited to:

- books and supplies
- child support payments or child care if you are a non-custodial parent
- health care or educational tuition costs and
- services provided by your dependent, your spouse's dependent or your child who is under age nineteen (19).

How do I request reimbursement?

Requesting reimbursement from your Dependent Care FSA is easy. Simply mail or fax a completed FSA Reimbursement Request Form along with receipts showing the following:

- the name, age and grade of the dependent receiving the service
- the cost of the service
- the name and address of the provider and
- the beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

Mail to: Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 850-425-4608

Direct Deposit

Enroll in Direct Deposit to expedite the time of your reimbursement.

- FSA reimbursement funds are automatically 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).

To apply, complete the Direct Deposit Enrollment Form available at www.myfbmc.com or contact FBMC Customer Service at 1-800-342-8017. Please note that processing your Direct Deposit enrollment may take between four to six weeks.

FBMC Web Site and Interactive Voice Response (IVR)

Visit www.myFBMC.com or call 1-800-865-3262 to get detailed information about your FSA. To access your account online or via IVR, all you need is your Social Security number and a Personal Identification Number (PIN). The last four digits of your Social Security Number will be your first PIN. After your initial login/call, you may elect to change your PIN. You can use the FBMC Web site or IVR to:

- review the status of your reimbursement requests
- review your account balance and available funds
- download forms and
- review frequently asked questions about FSAs.

Important reminders for Flexible Spending Account participants

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

- **All claims must be postmarked no later than September 30, 2008. YOU WILL FORFEIT ANY MONEY LEFT IN YOUR FSA 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.**

- During an unpaid leave of absence, no contributions are being made toward these accounts, unless otherwise provided by law. Accounts that remain unpaid for three consecutive pay periods will be terminated, and you may only reinstate your Flexible Spending Account upon your return to work by contacting HSS and requesting a reinstatement.

- You can't transfer money between the Health Care and Dependent Care Flexible Spending Accounts.

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

- Expenses for services incurred before or after the period for which you enroll aren't eligible for reimbursement. For example, a medical expense incurred in June isn't eligible for reimbursement from a Health Care Flexible Spending Account because your account is not open until July 1.

- If you plan to retire and have money in these accounts, you should file claims for reimbursement prior to your retirement date. Retirees are not eligible to participate in an FSA.

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

FAQS

Frequently Asked Questions

The information in this section is general in nature and is not intended to be a complete source of information for HSS members. Please contact HSS Member Services for assistance with your particular situation.

What should I do if the payroll deduction for my health care coverage is incorrect or isn't being deducted from my paycheck?

When you select your initial health care coverage or change your coverage during the annual Open Enrollment or because of a qualifying change in family status, you should carefully check your Statement of Earnings and Deductions (pay stub) to verify that the correct premium deduction is being taken.

If the premium deduction is incorrect or doesn't appear on your pay stub, you should contact HSS Member Services for assistance. You'll be responsible for all required premium payments, whether they are taken out of your paycheck or not.

Who should I contact if I need a health care identification card or a benefit booklet, or if I have a question about my coverage?

Contact the plan directly. Refer to the Key Contact Information section of this guide for benefit plan telephone numbers and Web site addresses.

What happens if I move outside the service area covered by my medical/dental plan?

If you move out of the service area covered by your plan, you must elect health care coverage under an option that provides coverage in your area. Failure to change your health care elections may result in non-payment for services received. Contact HSS Member Services for assistance.

Is health care coverage available for dependents that no longer meet the eligibility requirements for coverage under my plan?

Yes. Pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), dependents who are no longer eligible may continue group coverage for up to thirty-six (36) months in the event of loss of eligibility under Health Service System's eligibility guidelines.

See the Continuation Coverage for Separated Employees and Dependents (COBRA) section of this guide for details.

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

Generally, surviving dependents of an employee may continue health care coverage after the death of the employee. Upon your death, covered dependents should contact HSS Member Services for information on available health care coverage continuation options.

What happens to my coverage when I retire?

If you retire on a service, disability or vesting retirement, you may continue your health care coverage at the rates then in effect for retired employees, provided you apply for coverage within thirty (30) days

from your retirement effective date. Other conditions may apply. Contact HSS Member Services for details.

What if my health care provider chooses not to participate in my plan's network?

The medical, dental and vision plans do not guarantee the continued network participation of any particular doctor, dentist, hospital, medical group or other provider during the Plan Year.

After the annual Open Enrollment deadline, you won't be allowed to change your medical and/or dental plan elections because your provider and/or your medical group choose not to participate in a particular benefit plan. You'll be assigned or will be required to select another provider.

Leaves of Absence and Your Benefits

The following information provides important details regarding your rights and responsibilities for maintaining benefits coverage during an approved leave of absence. Failure to follow the requirements detailed below may result in the loss of health care coverage for you and your covered dependents. ***Read this information carefully.***

You are responsible for notifying your department of all leaves of absence. The type and length of leave may affect the amount you're required to pay to maintain your benefit coverage elections. If you have questions about costs, payment options or eligibility to continue your coverage while on a leave of absence, contact HSS Member Services for assistance prior to the start of your leave.

Family and Medical Leave

You may be eligible to continue your current benefit coverage elections for the duration of an approved Family and Medical Leave (under the Family and Medical Leave Act).

- During your approved leave, you're required to pay all premium amounts, if any, that were previously deducted from your bi-weekly paycheck. You must pay all amounts due directly to the Health Service System.
- If you wish to waive benefits coverage during your approved leave, you must notify the Health Service System in writing prior to the start of your leave.

Family Care Leave

You may be eligible to continue your current benefit coverage elections for the duration of an approved Family Care Leave, subject to the following:

- During your approved leave, you're required to pay all premium amounts, if any, that were previously deducted from your bi-weekly paycheck. You must pay all amounts due directly to the Health Service System.
- If you wish to waive benefits coverage during your approved leave, you must notify the Health Service System in writing prior to the start of your leave.

Personal Leave Following Family Care Leave

If you've 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 current benefit coverage elections for the duration of an approved Personal Leave, subject to the following:

- The reason for the Personal Leave must be the same as the reason for the prior Family Care Leave.
- Your required health care premium payments, if any, must be current.
- During your approved leave, you are required to pay all premium amounts, if any, that were previously deducted from your bi-weekly paycheck. You must pay all amounts due directly to the Health Service System.
- If you wish to waive benefits coverage during your approved leave, you must notify the Health Service System in writing prior to the start of your leave.

Educational and Personal Leave

You may be eligible to continue your current benefit coverage elections for the duration of an approved Educational or Personal Leave, subject to the following:

- During the first 12 weeks of your approved leave, you're required to pay all premium amounts, if any, that were previously deducted from your bi-weekly paycheck. You must pay all amounts due directly to the Health Service System.
- If your leave lasts beyond 12 weeks, you're responsible for paying the total cost of medical and dental coverage for yourself and any covered dependents. The total cost of coverage includes any premium amount that was previously deducted from your bi-weekly paycheck and all amounts that the City and County of San Francisco had been contributing for coverage on behalf of yourself and any covered dependents.

If you wish to waive benefits coverage during your approved leave, you must notify the Health Service System in writing prior to the start of your leave.

Leave for Employment as an Employee Organization Officer or Representative

You may be eligible to continue your current benefit coverage elections for the duration of the leave subject to the following:

- During the first 12 weeks of your leave, you're required to pay all premium amounts, if any, that were previously deducted from your bi-weekly paycheck. You must pay all amounts due directly to the Health Service System.
- If your leave lasts beyond 12 weeks, you're responsible for paying the total cost of medical and dental coverage for yourself and any covered dependents. The total cost of coverage includes any premium amount that was previously deducted from your bi-weekly paycheck and all amounts that the City and County of San Francisco had been contributing for coverage on behalf of yourself and any covered dependents.
- The organization for which you are serving as a representative may pay the cost of the health care coverage during the leave. However, it is your responsibility to ensure that all required payments are made to the Health Service System in a timely manner. The Health Service System will not attempt to collect required premium payments from the organization.
- If you wish to waive benefits coverage during your leave, you must notify the Health Service System in writing prior to the start of your leave.

Other Leaves

Please contact HSS Member Services for information about eligibility to continue your health care coverage elections for other types of leaves.

Important: If you do not pay the required health care premium payments in a timely manner while on a leave of absence, your health care coverage and that of any covered dependent(s) will be terminated. If your health care coverage is terminated for non-payment of premiums, you will only be allowed to re-elect health care coverage 1) within thirty (30) days from your return to work from a leave of absence. You must notify the Health Service System to reinstate your coverage; or 2) during the next annual Open Enrollment period for coverage to be effective July 1.

Layoff/Separation from Employment and Your Benefits

Employees with Holdover Rights

Employees, who are separated from City service and are placed on a holdover roster, may be eligible to continue medical, dental and vision benefits for themselves and their covered dependents for up to five (5) years, as long as they meet the following requirements:

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

Important: If you don't pay the required health care premium payments in a timely manner while on a holdover status or you fail to submit the required Certificate of Eligibility Form when requested, your health care coverage and that of any covered dependent(s) will be terminated.

Employees with No Holdover Rights

Employees, who are separated from all City service and have no holdover rights, may be eligible to continue medical, dental and vision coverage under COBRA. Your coverage as an active employee will terminate on the last day of the pay period in which you separate from City service. See the Continuation Coverage for Separated Employees and Dependents (COBRA) section of this guide for details.

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 medical, dental or vision insurance plan may be entitled to an extension of health care coverage, called "continuation coverage," in certain circumstances (for example, termination of employment, divorce, etc. This is called a "qualifying event").

The same plans you were enrolled in as an active employee can be continued (subject to change if the group coverage changes). The coverage period for an employee is in most instances eighteen (18) months. The coverage period for dependents may be up to 36 months under certain circumstances. In the case of a dependent losing coverage (divorce or aging out of the plan), the employee or dependent must inform the COBRA Administrator within thirty (30) days of this qualifying event.

Employees, who are disabled on the date of their qualifying event, or at any time during the first sixty (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 COBRA Administrator will notify you of your right to elect COBRA coverage. You will have sixty (60) days from the date of the notice to elect COBRA coverage. The coverage will be continuous from the date of the qualifying event (i.e. you will not have a break in your health care coverage). Any newly eligible dependent (spouse, domestic partner, newborn or adopted child) is eligible to be added to your COBRA coverage within thirty (30) days from the date of the event (birth, marriage, etc.).

COBRA coverage will end at the earliest of the date: 1) you obtain coverage under another group plan if no pre-existing condition limitation under the new plan applies to the individual; 2) you fail to pay the premium required under the plan within the grace period; or 3) the applicable COBRA period ends.

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

All employees and dependents that 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.

Adoption Assistance

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 adoption assistance.

The maximum exclusion from gross income is $5,000 ($6,000 in the case of an adoption of a child with special needs.) There are income limitations, which affect the maximum exclusion allowance. If your adjusted gross income (AGI) is less than $75,000, the income limitation does not apply to you. If your AGI is more than $115,000 you do not qualify for a deduction under this plan. If your AGI is between $75,000 and $115,000 then the maximum exclusion reduces down according to the following formula:

(Qualified Adoption Expenses minus [qualified adoption expenses x (modified Adjusted Gross Income - $75,000) divided by $40,000)]

Example: 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.

Group Term Life Insurance

Life insurance is an essential part of financial planning; one reason most people own life insurance is 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 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.

GROUP TERM LIFE INSURANCE

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 HSS or EBS 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 $250,000 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.

RELIASTAR SUPPLEMENTAL GROUP TERM LIFE INSURANCE RATES

Age	Bi-weekly pay period cost per $10,000
< 30	.32
30-34	.37
35-39	.46
40-44	.65
45-49	1.02
50-54	1.66
55-59	2.77
60-64	4.34
65-69	7.48
70-74	13.29
75+	22.34

SAMPLE CALCULATION

You can determine the bi-weekly 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:** $80,00 x 2 = $160,000
- **STEP 2:** $160,000 ÷ $10,000 = 16
- **STEP 3:** 16 x $1.02= $16.32 per pay period

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.

Horizon 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 as your needs change during the annual open enrollment.

WHY UNIVERSAL LIFE INSURANCE?

Horizon 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

Providing protection for your family has never been easier. If you elect to pay required premiums using a payroll deduction, you eliminate the need to write checks and pay postage.

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. We 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.

Cash Value Accumulation

Horizon 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 credited, 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.

Child Coverage

Your unmarried, dependent children and 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. 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.

This information is a brief description of coverage and is not a contract. Read your policy and riders carefully for exact terms and conditions.

Qualified Issue Plan

Eligible employees may apply for an amount of coverage up to $100,000 for $14 per week (money purchase) or up to 3 times their current salary, not to exceed $100,000 (defined benefit).

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

- Has the Proposed Insured used tobacco in any form in the last 24 months (2 years)?
- 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?
- Is the Proposed Insured presently taking any medication or under a doctor's care for any condition?
- 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, along with your Doctor's name; address; and phone number.

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 percent 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)

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.

Horizon 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 at a cost of $20 bi-weekly.

Issue Age	Insurance Amount	Cash value at age 65 Non-Guar. 5.4%*
25	$91,319	$30,006
30	$71,596	$17,238
35	$53,957	$16,363
40	$41,868	$12,643
45	$31,695	$ 9,051
50	$24,163	$4,939
55	$17,422	$2,154
60	$15,096	$1,736
65	$10,000	$2,305
70	$10,000	$2,511

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

Issue Age	Bi-Weekly Premium	Cash value at age 65 Non-Guar. 5.4%*
25	$11.56	$16,202
30	$14.38	$11,944
35	$18.64	$15,157
40	$23.60	$15,102
45	$30.74	$14,321
50	$39.90	$10,283
55	$54.80	$6,245
60	$63.04	$5,831
65	$99.46	$11,683
70	$132.12	$12,726

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

UNIVERSAL LIFE INSURANCE

Horizon Universal Life Insurance for Dependent Children and Grandchildren*

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

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	Bi-Weekly Premium	Cash value at age 65 Non-Guar. 5.4%*
	$25,000 Standard Rates	
0	$4.02	$0
1	$4.10	$827
2	$4.20	$2,315
3	$4.28	$3,666
4	$4.36	$4,432
5	$4.46	$5,244
6	$4.56	$4,809
7	$4.64	$4,248
8	$4.76	$3,827
9	$4.84	$3,280
10	$4.96	$2,874
11	$5.04	$2,641
12	$5.14	$2,359
13	$5.24	$2,353
14	$5.34	$2,103
15	$5.44	$2,149
16	$5.50	$2,210
17	$5.56	$2,451

	$25,000 No Tobacco	$25,000 Tobacco	$25,000 No Tobacco	$25,000 Tobacco
18	$4.95	$6.28	$9,164	$5,673
19	$5.14	$6.50	$9,178	$6,446
20	$5.32	$6.74	$9,241	$7,346
21	$5.50	$6.98	$9,236	$8,154
22	$5.70	$7.24	$9,282	$8,847
23	$5.90	$7.50	$9,173	$9,429
24	$6.12	$7.78	$9,193	$10,064

Horizon Universal Life Insurance for Available Dependent Rider

Children's Term Insurance Rider

Insurance Amount	Bi-Weekly Premium
$5,000	$1.40
$7,000	$1.96
$9,000	$2.52
$10,000	$2.80

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.

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.

During your initial enrollment period, 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 $3,000 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 25 percent 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.

SHORT TERM DISABILITY INSURANCE

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 health care provider.

Important: This proceeding is provided for informational purposes only and is not a statement of coverage. If any differences exist between the information provided here and your actual policy, the actual policy information will apply.

ING Short Term Disability Insurance Rates

Rates listed are per $100 of Benefit

Benefit Duration	Issue Age	Bi-Weekly Rate/$100
3 months	18-49	$0.81
3 months	50-59	$1.10
3 months	60-64	$1.14

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: $60,000 ÷ 12 months = $5000 monthly income

STEP 2: $5,000 x 40% = $2000 maximum monthly benefit eligible to receive

STEP 3: $2000 benefit elected ÷ $100 = 20

STEP 4: 20 x $0.81 = $16.20 bi-weekly 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 ÷ 12 months = $5800 monthly income

STEP 2: $5,800 x 40% = $2,300 maximum monthly benefit eligible to receive

STEP 3: $2300 benefit elected ÷ 100 = 23

STEP 4: 23 x $1.10 = $25.30 bi-weekly 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 bi-weekly premium.
$_____Line 4

Long Term Disability Insurance

Administered by UNUM

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

Permanent employees will be eligible on the first day of the bi-weekly pay period following their first day of work. Temporary employees will be eligible on the first day of the bi-weekly pay period following six months of employment.

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.

LONG TERM DISABILITY INSURANCE

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.

Maximum Benefit Period

Age at Disability	Max. Period of Payment
Less than age 60	To age 65, 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.

This plan highlight summary is provided to help you understand the coverage available from UNUM. If the terms of this plan highlight summary and the policy differ, the policy will govern.

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 .0057 =
$_____Estimated Monthly Cost

Example A:
Employee annual salary $30,000 ($2,500/month)

Your Monthly Salary $2500 x .0057 = $14.25
Estimated Monthly Cost

Example B: Employee annual salary $150,000 ($12,500/month)

Your Monthly Salary $11,250 x .0057 = $64.13
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.

Accident Insurance

Administered by Allstate Workforce Division (AWD)

Why Accident Insurance?

On average, there are 11 unintentional-injury deaths and about 2,340 disabling injuries every hour during the course of a year. Nearly one in five people sought medical attention or suffered at least one day of activity restriction because of an injury. (Source: National Safety Council, Injury Facts 2001.)

Policy Features

- Guaranteed renewable until age 70
- 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.

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 *(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.

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.

ACCIDENT INSURANCE

Sickness Disability Income Rider

Benefits 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, 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.

	Basic	Enhanced	Premier
Individual	$9.96	$18.94	$27.94
Family	$17.26	$33.52	$33.52

Sickness Disability Income Rider

	Basic	Enhanced	Premier
Individual	$13.52	$26.06	$38.58
Family	$20.80	$40.64	$60.46

Outpatient Physician's Treatment Benefit Rider

	Basic	Enhanced	Premier
Individual	$17.20	$33.44	$49.66
Family	$28.46	$55.96	$83.44

Issue Ages 18-64 *(Above rates are bi-weekly)*

ACCIDENT INSURANCE POLICY LIMITATIONS AND EXCLUSIONS

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 prorate 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.

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 you 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).

Allstate Financial Workplace Division is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, Florida), a wholly owned subsidiary of the Allstate Corporation. The Accident benefits are provided by policy AP2 and riders APDIr1 and APHCR1 or state variations thereof. The policies and riders are underwritten by American Heritage Life Insurance Company.

Cancer Insurance

Administered by Allstate Workforce Division (AWD)

No one likes to think about getting cancer. But it will still affect 1 in 2 men and 1 in 3 women. Cancer may not be preventable, but you can protect yourself from some of the costs. 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.

Cancer insurance from AWD pays you benefits that can be used for non-medical cancer-related expenses that health insurance might not cover.

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

Important: In addition to cancer the policy also covers; 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.

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.

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. CER1Pays 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.

New or Experimental Treatment
Actual charges up to $10,000 for a 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 $10,0000 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.

At Home Nursing
Actual charges up to the amount shown each day for private nursing care and attendance by a nurse at home. Must be required and authorized by the attending physician and must begin within 14 days after confinement as an inpatient in a hospital. Limited to the number of days of the previous continuous hospital confinement.

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 confinement.

Hospice Care
Actual charges up to $100 per day per visit for home care.

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.

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 (traveled distance of a 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.

CANCER INSURANCE

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 charges for baseline mammography; mammography every 2 years, or more frequently upon a physician's recommendation; and annual mammography (depending on age).

Cervical Cancer Screening Test
Greater of $50 or charges 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 30-day waiting period.

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.

Premiums for Allstate Cancer Insurance

Premiums for Basic		
	Base Plan	Base Plan Adding ICR2
Individual	$10.20	$12.98
Family	$17.14	$22.68

Premiums for Enhanced		
	Base Plan	Base Plan Adding ICR2
Individual	$13.00	$15.76
Family	$22.20	$27.74

Premiums for Premier		
	Base Plan	Base Plan Adding ICR2
Individual	$16.82	$19.60
Family	$29.20	$34.72

Issue Ages: 18-64 Rates are Bi-weekly (Per Pay Period)

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.

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. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Financial Workplace Division.

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.

Allstate Financial ~ Benefits are provided by Cancer/Specified Disease Insurance policy CP10B, or state variations thereof. Cancer Initial Diagnosis Level Benefit Rider provided by rider CLR1, or state variations thereof. Cancer Enhancement rider provided by rider CER1, or state variations thereof. Intensive Care Rider provided by rider ICR2 or state variations thereof. The policy and rider are underwritten by American Heritage Life Insurance Company. This brochure is for use in California. 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.

Heart & Stroke Insurance

Why Heart & Stroke Insurance?

Knowing how to help protect yourself and your family against the high cost of medical treatment in the event of heart disease can help you maintain your lifestyle.

58,800,000 Americans have one or more types of cardiovascular diseases; 4,400,000 Americans suffered a stroke in 1998; 4,600,000 Americans suffered from congestive heart failure in 1998; 28% of Americans who suffer a stroke or heart attack are under age 65. (source: American Heart Association – Heart Attack and Stroke, 1999).

POLICY FEATURES

This program pays benefits 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
- Impatient 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 paid in addition to other insurance coverage.

Premiums for Heart & Stroke Insurance

Base Plan				
	1/2 Unit		1 Unit	
	Weekly	Monthly	Weekly	Monthly
Individual	$2.08	$4.16	$4.15	$8.30
Family	$4.00	$8.00	$8.00	$16.00
Base Plan—Adding ICR90 - $300 A Day				
	1/2 Unit		1 Unit	
	Weekly	Monthly	Weekly	Monthly
Individual	$2.84	$5.68	$4.91	$9.82
Family	$5.53	$11.06	$5.52	$19.04
Base Plan—Adding ICR90 - $600 A Day				
	1/2 Unit		1 Unit	
	Weekly	Monthly	Weekly	Monthly
Individual	$3.60	$7.20	$5.67	$11.34
Family	$7.05	$14.10	$11.04	$22.08

Issue age 18 to 64

Renew ability

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.).

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.

Long Term Care Insurance

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, stepparents-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 health care.
- 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 health care 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)

LONG TERM CARE INSURANCE

- 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.

	Gold Coast Advantage Partnership
Nursing Home Daily Benefit	100%
Residential Care Facility Benefit	100%
Home Health Care Benefit	100%
Elimination Period	90 Days
Benefit Period	3 Years
Daily Benefit	$130.00
Payment Type	Life-Pay
Underwriting Class	Standard

SAMPLE: Long Term Care Insurance Rates

Age	Bi-Weekly Cost
18-30	$29.73
35	$33.62
40	$36.72
45	$40.10
50	$43.31
55	$46.76
60	$58.24
65	$78.53
69	$108.12

Note: The rates listed at left are subject to change and should be used as samples only. This illustration is a general description of coverage and is not a contract. For a rate quote please see 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.

Pet Care Insurance

Easy, affordable accident & illness protection for the life of your pet!

PetCare Pet Insurance Programs eliminate the financial stress of providing unexpected medical attention.

CANINE/FELINE PLANS

QuickCare Gold

The most Comprehensive Coverage. Accident and illness coverage that protects your cat or dog in virtually any situation. Choose between 70% or 100% coverage.

Coverage Amounts and Description:

70% or 100% of payable claims are paid after any applicable deductible up to policy limits for all pets up to age 8 (afe 6 for "select" dog breeds.)*

- 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 care for your pet.
- Recovery Costs - $150 (No deductible) – To pay for advertising or to offer a reward should your pet become lost or missing.

Deductible	$50 (100% Coverage) $75 (70% Coverage)

QuickCare Gold Advantages:

- Unlimited number of accidents covered
- No maximum annual illness benefit restrictions
- Eligible enrollment age 8 wks – 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 Bi-Weekly Premiums

Plan	Cat	Dog
70% Coverage	$7.87	$10.36
100% Coverage	$11.19	$19.50

For QuickCare Gold, medical records will be requested at the time of enrollment. (Shar Pei breed is eligible for Accident coverage only.)

PET CARE INSURANCE

Want extra coverage with QuickCare Gold?

Choose a double coverage endorsement and receive double the lifetime illness protection: Cat - $60,000 Dog - $72,000 – split equally into 12 illness categories

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.**

QuickCare Gold Bi-Weekly Premiums

Plan	Dog
70% Coverage	$14.93
100% Coverage	$24.90

QuickCare

Selected accident only coverage designed for cats and dogs of all ages.

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 Advantages

- Unlimited number of (listed) accidents covered
- No 30 day waiting period
- No age limitations for enrollment
- Enrollment as early as 9 weeks of age
- No "select" breed surcharges

QuickCare Bi-Weekly Premiums

Cat $4.59

Dog $5.05

QuickCare for Indoor Cats

Selected Accident and Illness Coverage tailored for kittens and cats that live primarily indoors.

Coverage Amounts and Description:

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

- 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 Syndrom - $1,500 – Medical treatment for injuries resulting from accidentally falling from an elevated dwelling
- Bite Wounds and Bite Wound Abscesses - $500
- Burns - $500

PET CARE INSURANCE

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 Bi-Weekly Premiums for Indoor Cats

Cat $4.55

QuickCare Senior

Selected Accident and Illness Coverage specially tailored for senior cats and dogs (with no age limitations).

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.

- 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 dyspasia.
- No Itemized Restrictive Schedule of Benefits
- Benefit from PetCare's Maximum Discount

QuickCare Senior Bi-weekly Premiums

Cat $9.12

Dog $13.68

You will need to bring the following information with you to enroll your pet:

- Veterinarian Provider's name
- Address
- Phone
- Date of most recent physical exam & vaccinations

Enrolled pets must have an annual physical exam. Routine care and preventative care are not covered. Anything pre-existing or symptomatic is not covered. Policy renews annually. Your pets medical records will be requested on all applications.

Management Cafeteria Plan 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 (i.e. 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 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 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.

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.

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.

Unlimited Phone Consultations

You have unlimited toll-free access to your Provider Attorney for personal or business related legal matters immediately after you enroll. Just 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.

Minor Legal Expenses

Your Provider Attorney will represent you or your covered family members against moving traffic violations at 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.

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.

Important Note: 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.

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. 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.

*Hourly rates for referral attorneys and court appearances may vary.

Pre-Paid Legal Rates

Bi-Weekly Rate

Family Plan $6.90

Family Plan $7.36

(w/ optional Legal Shield benefit)

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.

Important Note: The information contained in this material is for illustrative purposes only and is not a contract. It is intended to provide a general overview of the coverage available to you should you decide to enroll. Please remember that only the plan contract can give actual terms, coverage, amounts, and exclusions.

Additional Benefits Offered under The Management Cafeteria Plan

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 $100 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 flex 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 Employee Benefits Specialists, 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 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.

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