DEPARTMENT OF
HUMAN
RESOURCES
CITY & COUNTY OF SAN FRANCISCO

HEALTH SERVICE SYSTEM DIVISION

2003-2004 BENEFITS ENROLLMENT GUIDE

Municipal Executives Association
Management Cafeteria Plan

PLAN YEAR
JULY 1, 2003 – JUNE 30, 2004

DEPARTMENT OF
HUMAN
RESOURCES
CITY & COUNTY OF SAN FRANCISCO

April 2003

Dear Member or Prospective Member:

We are pleased to provide with the Benefit Information booklet for the Municipal Executives Association Management Cafeteria Plan for the Plan Year beginning July 1, 2003 and ending June 30, 2004. The Management Cafeteria Plan is administered by Employee Benefit Specialists (EBS).

Please take a few moments to review this important information. Members represented by MEA and certain unrepresented managers and elected officials are eligible to participate in this plan. Included in this booklet is information regarding the benefit programs available to you and your eligible dependents.

Benefit counselors from EBS will be available by appointment to assist you with your enrollment during the annual Open Enrollment period. **Please contact EBS at 800-229-7683 to schedule your enrollment appointment.**

The staff of the Health Service System are committed to providing courteous, timely and responsive customer service to all members. If you have suggestions on how we might improve our service, please send them to:

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

Very truly yours,

Health Service Board

Claire Zvanski, President
Melissa Welch, M.D. MPH, Vice President
Karen Breslin, Commissioner
Chris Daly, Supervisor
James M. Deignan, Commissioner
Scott Heldfond, Commissioner
Aleeta Van Runkle, Commissioner

Department of Human Resources

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

Employee Benefit Specialists, Inc.

Joan Rhodes, President

CONTACT INFORMATION

Health Service System Membership Division

1145 Market Street, Suite 200
San Francisco, CA 94103
(415) 554-1750; (800) 541-2266 (outside 415 area code)
Email: HSS_ Membership@ci.sf.ca.us
website: www.ci.sf.ca.us/hss/

MEDICAL PLANS

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

For a list of participating providers:

website: www.beechstreet.com or 800-937-2277

For Mental Health/Substance Abuse Treatment contact UBH:
website: www.unitedbehavioralhealth.com or 800-888-2998

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

Health Net
155 Grand Avenue
Oakland, CA 94612
(800) 522-0088
Group No. 61515

website: www.healthnet.com

Managed Health Network (MHN) - (800) 977-7591

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

website: www.mylifepath.com

DENTAL PLANS

Delta Dental
P.O. Box 7736
San Francisco, CA 94120
(888) 335-8227
(800) 4-AREA-DR (referrals to Delta dentists)
Group No. 9502-0003

website: www.deltadentalca.org

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

website: www.deltadentalca.org

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

VISION PLAN

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

COBRA ADMINISTRATOR

SHPS, Inc. (Sykes Health Plan Services, Inc.)
P. O. Box 34640
Louisville, KY 40232-4640
(800) 636-0400

website: www.shps.com

HEALTH CARE AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

Fringe Benefits Management Co.
3101 Sessions Road
Tallahassee, FL 32303
(800) 342-8017 Customer Service
(800) 865-3262 Automated Interactive Benefits

website: www.fbmc-benefits.com

ALL OTHER MANAGEMENT CAFETERIA PLAN BENEFITS

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

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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. Health care operations 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 sfgov.org/site/dhr

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

This notice is effective April 14, 2003.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT HSS PRIVACY OFFICERS, ANTOINETTE CANDELARIA AT (415) 554-1708 OR JEFFREY HILDEBRANT AT (415) 554-2477.

IMPORTANT INFORMATION -- READ THIS FIRST!

This Booklet Provides Only an Overview -- Consult the Individual Health and Dental Plan Booklets for Details

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

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

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

You Need to Submit Social Security Numbers for Your Enrolled Dependents Even if You Make No Other Changes

HSS requires the social security number of each of your enrolled dependents. If you are making changes to your benefits, please list the social security numbers of all of your dependents (even if they are already enrolled) on your enrollment application. If you are not making any changes to your benefits, and have not reported this information in the past, you must fill-out the Dependent Information Form and return it to HSS.

Only Eligible Dependents May Be Enrolled In HSS

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

Enroll New Dependents Within 30 Days

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

No Plan Can Guarantee the Continued Participation Of Any Particular Provider

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

If you choose Kaiser, Health Net, Blue Shield, PMI Dental and/or Pacific Union Dental, this means that you may not be able to see a particular doctor or dentist if that provider chooses to drop out of the plan.

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

List Your Primary Care Physician/Dentist on The Enrollment Form

If you enroll in the Health Net or Blue Shield health plans, or the PMI or Pacific Union dental plans, you can avoid delays in obtaining services by listing your primary care physician or dentist on the enrollment form. If you need assistance in selecting a physician/dentist, contact the plan directly or consult with a representative at the open enrollment site.

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

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

WE SUGGEST THAT YOU KEEP THESE MATERIALS HANDY THROUGHOUT THE YEAR SINCE THEY CONTAIN VALUABLE INFORMATION ABOUT YOUR BENEFITS.

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

How Open Enrollment Works

You are required to make an active enrollment elections during each annual open enrollment period to avoid forfeiture of your flex credits. If you fail to make an active enrollment election, the Health Service System will apply your available flexible credits to your medical plan premium only. Any unused flexible credits will be deemed forfeited for the plan year.

Changes You May Make During Open Enrollment

During the annual Open Enrollment period you may do any of the following:

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

  You must complete a Health Service System Enrollment Form to make the changes indicated above
- Enroll or re-enroll in the Flexible Spending Accounts (Health Care and Dependent Care). You must re-enroll in the Flexible Spending Accounts each year.

Your new coverage begins July 1st of each year and continues through June 30th of the following year, provided you and your dependents remain eligible. The benefit plans you select (except Delta Dental) will send you and your dependents membership/identification cards directly to your home. Until you receive those cards, you should use the group identification numbers listed in the Contact Information in this booklet.

No Changes Allowed after Open Enrollment Closes

You cannot make any changes to your benefits after the close of Open Enrollment each year unless the change is on account of and consistent with a qualifying change in family status (marriage, divorce, birth of a child, etc.).

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

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

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

Flexible Credit Allocation Guidelines

Initial Enrollment

Eligible MEA members 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. Allocations made toward medical premiums must be done to cover the entire cost of the applicable plan or in increments of $25. 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 the Status Change. For example, for the birth of a child, the member may elect to allocate credits to the Dependent Daycare Program and reduce or cancel credits applied to other benefits options.

Open Enrollment

Any member who does not 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. All credits remaining, if any, will be deemed forfeited. Any additional amount required to cover the actual cost of the Medical Plan option, will be covered by payroll deduction.

Transfers from MEA to Another Bargaining Unit

Members who become ineligible for MEA Management Cafeteria Plan participation due to a change in bargaining unit will only be allowed to continue the following benefits subject to the stated limitations:

***Medical Plan*:** Participation will continue in the same plan and at the same level of coverage as was in effect under the MEA Plan on the last day of eligibility. If the employee was using available flexible credits to cover all or a portion of the cost of this coverage, the entire cost of coverage will be converted to a payroll deduction.

Dependent Care Reimbursement Account: Participation will continue at the same bi-weekly deduction as was in effect under the MEA Plan on the last day of eligibility. If the employee was using available flexible credits to fund all or a portion of their DCAP account, the entire bi-weekly contribution amount will be converted to a payroll deduction.

Healthcare Reimbursement Account: Participation will continue at the same bi-weekly deduction as was in effect under the MEA Plan on the last day of eligibility. If the employee was using available flexible credits to fund all or a portion of their healthcare reimbursement account, the entire bi-weekly contribution amount will be converted to a payroll deduction.

Benefit Plans Offered by the Health Service System

Medical Plans

The following health plans are available:

- City Health Plan
- Kaiser*
- Health Net*
- Blue Shield*

Dental Plans

The following dental plans are available:

- Delta Dental
- PMI Dental*
- Pacific Union Dental*

Vision Care Plan

A vision care plan is provided automatically to all employees and eligible dependents that elect health coverage. Kaiser members receive this benefit through Kaiser and should contact Kaiser if they need assistance. Members of other health plans receive this benefit through Vision Service Plan whose contact information is listed in the front of this booklet. Please refer to page 23 for details.

Flexible Spending Accounts

Health Care and Dependent Care Flexible Spending Accounts are offered through Fringe Benefit Management Co. Please refer to page 25 for details.

* YOU MUST LIVE IN THE PLAN'S SERVICE AREA. SEE THE SERVICE AREA CHARTS IN THIS BOOKLET.

FREQUENTLY ASKED QUESTIONS

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

What benefits are available to me?

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

What is an Open Enrollment period?

An Open Enrollment is a period of time during which employees may change benefit plans and/or add or delete eligible dependents. The effective date of all Open Enrollment changes is July 1st.

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

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

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

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

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

If you do not enroll during the Open Enrollment period, the Health Service System will apply your available flex credits toward your health insurance premium only. Any credits not used will be lost for the duration of the plan year July 1, 2003 through June 30, 2004.

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

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

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

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

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

Yes. You may maintain coverage by contacting HSS and making arrangements to pay any premium contributions due directly to HSS. For information regarding continuation of the other voluntary benefits contact EBS at (800) 229-7683.

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

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

- You return to work
  HSS needs to be notified of your return to work and request for reinstatement; OR

- Open Enrollment
  You need to fill out and submit an Enrollment Application Form to enroll yourself and your dependents into the plan desired.

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

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

- Your legal spouse or domestic partner. A spouse from whom you have been granted a final dissolution of marriage, or from whom you are legally separated, shall not be eligible.
- Unmarried children from birth to twenty-five (25) years of age who meet all of the following conditions:

  1) Dependent is not married; 2) does not work full time; 3) continue to reside in the home, except for full-time students and children living with a divorced spouse; and 4) is eligible to be declared as a dependent child on your income tax return.
- Children shall include your natural child, stepchild so long as you are married to the natural parent, a legally adopted child, a child under legal guardianship, and a natural or legally adopted child of an enrolled domestic partner.
- A child living with you in a parent-child relationship and economically dependent upon you, 18 or under, is also an eligible dependent provided you declare the child as an exemption on your income tax. Documentation of dependency may be required.
- A child who is incapable of self-support because of a physical or mental incapacity that existed prior to the child's nineteenth (19th) birthday and who is a dependent in a health plan of the Health Service System on a continuous basis and was enrolled prior to child's nineteenth (19^{th}) birthday may be continued as a dependent in this Health Service System, as long as the child remains so incapacitated, by the filing of acceptable medical evidence with the HSS at least sixty (60) days prior to the attainment of age twenty-three (23).

When may I enroll an eligible dependent?

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

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

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

What is imputed income?

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

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

It is your responsibility to make additions, cancellations or changes in your enrollment. You are, in most cases, the only person who is aware of any changes that occur in your family status requiring or permitting such additions, cancellation or changes. HSS has no obligation to provide coverage for an ineligible dependent or to make a refund of contributions made on account of an ineligible dependent.

What is a qualifying change in family status?

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

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

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

When may I cancel coverage for a dependent?

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

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

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 a divorce, legal separation, or loss of eligibility under HSS's eligibility guidelines. See page 68 for COBRA explanation.

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

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

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

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

When you leave City employment, except for retirement, your coverage and your dependents' coverage will cease on the last day of the pay period in which your termination occurs. You can elect to continue coverage of your health/dental plans pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). SHPS, Inc. (Sykes Health Plan Services, Inc) is the third party administrator for COBRA.

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

The Health Service System will notify SHPS, Inc. of the termination. SHPS, Inc will send the COBRA notification to terminated members or dependents.

COBRA coverage will end at the earliest occurrence of:

- Coverage under another group plan
- Failure to pay the contribution required under the benefit plan within thirty (30) days
- The end of the applicable COBRA period.

COBRA Coverage must begin the day after your coverage with the City terminates.

All COBRA related matters should be referred to:

SHPS, Inc.
P.O. Box 34640
Louisville, KY 40232-464
Tel. (800) 636-0400

What happens to my coverage when I retire?

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

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

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

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

MEDICAL PLANS

Indemnity/Preferred Provider Plan -- City Health Plan.

Health Service System offers one indemnity plan – the City Health Plan. In the City Health Plan, you may receive health care services from any licensed medical provider you choose. If you use a non-preferred provider, you may be required to pay for services directly to the provider and submit the claim for reimbursement to the City Health Plan. You must meet a plan year deductible for most services before this plan pays. Some services or procedures also require that you obtain pre-authorization.

The amount this plan will pay depends on whether you use a preferred provider and where the member resides. A preferred provider is a medical provider who has an agreement with our provider certification organization, Beech Street Corporation, to provide health care to our plan members at a contract rate. When you use preferred providers, they will submit the claim for reimbursement and the plan pays a higher percentage of the charges to the provider. However, you still need to pay the applicable deductible and co-payment.

If you live outside of the preferred provider area and you do not use a preferred provider, the City Health Plan will pay a higher percentage of your medical costs than if you live in one of the nine Bay Area counties. If you use a preferred provider, your costs are paid at the higher percentage rate. The nine Bay Area counties are: Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano and Sonoma.

Health Maintenance Organizations - Kaiser, Health Net, Blue Shield

A Health Maintenance Organization (HMO) is an organized system of health care providers who offer a wide range of medical services (for example; pediatrics, internal medicine, surgery, obstetrics, etc.) to the HMO members. Medical services are provided by a primary care physician who treats you or, when necessary, refers you to other doctors within the HMO network. Generally, you pay only a low co-pay for services. HSS offers three HMOs -- Kaiser, Health Net and Blue Shield.

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

A network model HMO, such as Health Net and Blue Shield, contracts with independent multi-specialty medical groups and independent physician associations to provide services at fixed rates to HMO members. If you enroll in a network HMO, you must select a medical group and a primary care physician within the medical group. The primary care physician will coordinate any care or treatment you need. If you do not elect a primary care physician, one will be assigned to you by the health plan.

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

Medical Plan Service Areas

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

* VERIFY YOUR ZIP CODE WITH THE PLAN

DENTAL PLANS

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

Delta Dental Plan

Delta Premier Plan is an indemnity dental plan. You may see the dentist of your choice. However, if you use a Delta Premier dentist, they will submit a claim for reimbursement to Delta, and you may have to pay a percentage of the bill (ranging from no cost for preventive and diagnostic services, to 20% for basic services such as fillings and extractions, to 50% for major services such as dentures or bridges.) There is an annual dollar limit on benefits ($2,500 per plan year).

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

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

Delta PMI and Pacific Union Dental Plans

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

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

Dental Plan Comparison

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

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

Type of Service	DELTA	DELTA PMI	PACIFIC UNION
Provider of Service	Any licensed dentist. Generally higher benefits if you use Delta dentists.	Service is provided by PMI dentists only. You must live in the service area and you must choose your dentist from dentists contracting with the plan.	Service is provided by Pacific Union dentists only. You must live in the service area and you must choose your dentist from dentists contracting with the plan.
Cleanings and Exams	No charge. Limit once every six months.	No charge. Limit once every six months.	No charge. Limit once every six months.
X-rays	100%	No charge.	No charge.
Extractions	80%	No charge.	No charge.
Fillings	80%	No charge.	No charge.
Crowns	80%	No charge.	No charge.
Dentures, Pontics and Bridges	50%. Dentures are covered at 50% of maximum fee allowance.	No charge. Full and partial dentures once every 5 years. Fixed bridgework; certain limitations apply.	No charge. Full dentures, upper or lower, once every 5 years. Fixed bridge work; certain limitations apply.
Root Canals	80%	No charge.	No charge.
Orthodontia	Covered for adults and children at 50%, up to a maximum of $2,500 lifetime.	$1,600 charge per case for dependents to age 23. $1,800 charge per case for adults $350 start-up fee. Other limitations apply.	$1,660 charge per case for dependents age 10-19. $1,880 charge per case age 20 or older. $350 start-up fee. Other limitations apply.
Annual Maximum	$2,500 per person per benefit year, excluding orthodontic benefits.	None.	None.
Waiting Period	Six months for dentures, pontics, bridges and orthodontia for new enrollees.	None.	None.

DENTAL PLAN SERVICE AREAS

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

VISION PLAN

The City & County of San Francisco offers all members and their eligible dependents who enroll in the City Health Plan, Blue Shield HMO or Health Net HMO a vision plan that is administered by Vision Service Plan (VSP). Members and their eligible dependents who are enrolled in the Kaiser HMO receive their vision benefits through Kaiser. If you are enrolled in the Kaiser HMO, contact them directly for vision benefit details. If you do not enroll in an available health plan, you will not have vision plan coverage.

Under the Vision Plan, you have the choice of using a VSP network doctor or an out-of-network provider. It is to your advantage to use a VSP doctor because covered services are provided to you at the higher benefit and you will have lower out-of-pocket costs. You can find a VSP doctor in your area by accessing **www.vsp.com** or contacting the VSP Member Services Department at (800) 877-7195. When you wish to receive services from a VSP 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.**

The Plan provides you and your eligible dependents with one eye exam every 12 months when using a VSP doctor. The Vision Plan also helps you and your eligible dependents to cover the cost of eyewear, such as glasses or contact lenses.

Type of Service	**Amount of Benefit if Using a VSP Doctor**	**Amount of Benefit if Using Out-of-Network Provider**
Vision Exam	Covered in full every 12 months[1] after the $10 copayment Blue Shield and Health Net enrollees pay a $5 copayment	Reimbursed up to $40 every 12 months[1] after the $10 copayment
Single Vision Lenses	Covered in full once every 24 months[1] after the $25 copayment	Reimbursed up to $40 once every 24 months[1] after $25 copayment
Lined Bifocal Lenses	Covered in full once every 24 months[1] after the $25 copayment	Reimbursed up to $60 once every 24 months[1] after $25 copayment
Lined Trifocal Lenses	Covered in full once every 24 months [1]after the $25 copayment	Reimbursed up to $80 once every 24 months[1] after $25 copayment
Frames Note: Single copayment of $25 applies if frames and lenses are purchased together	A wide selection of frames are covered in full once every 24 months[1] after the $25 copayment; subject to plan limitations	Reimbursed up to $45 once every 24 months[1] after the $25 copayment
Contact Lenses		
Medically Necessary[2]	Covered at 75% once every 24 months[1], in lieu of frames/lenses, after the $25 copayment	Reimbursement up to $250 once every 24 months[1] in lieu of frames/lenses, after the $25 copayment
Elective	Covered up to $100[3] once every 24 months[1], in lieu of frames/lenses; no copayment	Reimbursement up to $100[3] once every 24 months[1], in lieu of frames/lenses; no copayment

[1]Based on your last date of service

[2]Medically necessary contact lenses must be prescribed by a VSP doctor for certain conditions. Your VSP doctor must get prior approval from VSP for medically necessary contact lenses

[3]The allowance will apply toward the standard eye exam, contact lens evaluation exam, fitting costs and materials.

Benefit Authorization

When you make an appointment with a VSP 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 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 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. A claim form can be obtained by accessing the VSP website.

Plan Limits and Exclusions

- The Vision Care Plan covers one set of contact or eyeglass lenses every 24 months.
- If you elect contact lenses, you will be eligible for a frame 24 months after the last date of obtaining the contact lenses. This rule also applies to your eligible dependents.
- Cosmetic extras such as designer frames, lens coating or tinted lenses will cost you extra. If you use a VSP doctor, you will pay the VSP discounted price for these cosmetic extras. If you are using an out-of-network provider, you will pay the retail price.
- This 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 will 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 lenses; tinted lenses except Pink #1 and Pink #2
- Progressive multifocal lenses
- The coating of the lens or lenses
- 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 lenses or two pairs of glasses in lieu of bifocals
- Replacement of lenses and a frame 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.

FLEXIBLE SPENDING ACCOUNTS

How the Flexible Spending Accounts Work

Flexible Spending Accounts are a way to be reimbursed for certain health care and dependent care expenses using tax-free dollars. You may open a Health Care Flexible Spending Account or a Dependent Care Flexible Spending Account, or both. You may use the Health Care Flexible Spending Account to be reimbursed for medical, dental, and vision expenses incurred by you and your dependents if they are not covered by a health plan and are not for cosmetic purposes. You may use the Dependent Care Flexible Spending Account to be reimbursed for custodial child care or care for other dependent family members provided during the plan year so that you and your spouse, if married, can work.

Important Note: If **you do not use the money in your account(s) within the Plan Year (July 1 thru June 30), you will forfeit any remaining balance in your account(s) per IRS regulations.**

How Money Is Put Into Flexible Spending Accounts

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

How You Get Reimbursed From Your Flexible Spending Accounts

You will be reimbursed from your account when you submit claims for eligible expenses to Fringe Benefits Management Company (FBMC), the Plan Administrator. Claim forms for reimbursement are available from HSS or FBMC. Although your expenses must be for services incurred from July 1 through June 30, you may file plan year claims until the following September 30. Any claims postmarked after September 30 **will not** be processed.

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

IMPORTANT RULES ABOUT FLEXIBLE SPENDING ACCOUNTS

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

Health Care Flexible Spending Account

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

Eligible expenses are defined by the IRS

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

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

* Restrictions may apply

For more information about eligible Health Care Flexible Spending Account expenses, contact Fringe Benefits Management Co. using the contact information on the first page of this booklet.

Health Care Flexible Spending Account Worksheet

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

Example:

Total estimated uninsured eligible health care expenses for July 1, 2003 through June 30, 2004, assuming you are enrolling in the account during Open Enrollment.	$_____	(Line 1)
Enter either $5,000 or the amount on line 1, whichever is lower.	$_____	(Line 2)
Divide the number on line 2 by 26. This is the amount you should have deducted from each paycheck for your health care account.	$_____	

Dependent Care Flexible Spending Account.

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

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

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

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

- Children 12 years or younger who reside in your household, and
- Adults/children physically or mentally incapable of self-care, who spend at least eight hours a day in your home

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

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

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

Dependent Care Flexible Spending Account Worksheet

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

Example:

Total estimated eligible dependent care expenses for July 1, 2003 through June 30, 2004, assuming you are enrolling in the account during Open Enrollment.	$_____	(Line 1)
Enter the appropriate amount from the chart below or the amount on line 1, whichever is lower.	$_____	(Line 2)
Divide the number on line 2 by 26. This is the amount you should have deducted from each paycheck to cover your dependent care expenses.	$_____	

If you are:	Enter on Line 2:
Single, and head of household	$5,000
Married, file a joint tax return	The lowest of $5,000, your income, or your spouse's income.
Married, file separate tax returns	The lowest of $2,500, your income, or your spouse's income
Married, spouse is disabled or a full-time student and has no earned income	$2,400 for 1 dependent $4,800 for 2 or more dependents

Dependent Care Credit

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

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 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 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.

ING 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 Flexible Benefit Plan. One type plan provides a group term life insurance benefit in the amount of $50,000 that is fully paid for by the City and County of San Francisco. 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/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 the City and County and purchase for yourself under a group term plan. Any coverage you purchase over this amount, or purchase on an individual basis, or that is not part of a group term plan, must be paid for with after tax dollars.

Beneficiary Designation

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

Basic Term Life Insurance Coverage

All employees who are eligible to participate in the Flexible Benefit Program 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.

ING Supplemental Group Term Life Insurance Rates*

Age	Bi-weekly pay period cost per $10,000
< 30	.32
30-34	.37
35-39	.47
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 monthly premium you will pay on an after tax basis by following the steps shown in the example below:

Sally is 40 years old and earns $65,000 per year. She chooses to purchase two times her annual salary. (Remember Sally has $50,000 of coverage provided to her by the City and County at no cost.)

Step 1: $65,00 x 2 = $130,000

Step 2: $130,000 ÷ $10,000 = 13

Step 3: 13 x $.65= $8.45 per month

***IMPORTANT NOTE:** **Rates are subject to change. Your actual rate will be quoted at the time of your enrollment**

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 some 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. Since your premium is paid through 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 leave the company, 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.

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 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 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?

*Grandchildren who are residents of New York & are under 14 years of age are not eligible

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.

Face Amount Increase Rider (FAIR)

Allows an employee, under the age of 66, to automatically purchase additional insurance (without evidence of insurability) for $1.00 or $2.00 a week at the employee's attained age on the option date for five consecutive years. Spouses under the age of 61 are eligible to select the rider for $1.00 a week for three consecutive years.

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

Note: 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 $10 per week.

Issue Age	Insurance Amount	Cash value at age 65 Non-Guar. 6.8%*
25	$91,319	$48,736
30	$71,596	$26,131
35	$53,957	$22,425
40	$41,868	$15,963
45	$31,695	$10,752
50	$24,163	$5,568
55	$17,422	$2,303
60	$15,096	$1,873
65	$10,000	$2,493
70	$10,000	$2,750

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

Issue Age	Weekly Premium	Cash value at age 65 Non-Guar. 6.8%*
25	$5.78	$26,352
30	$7.19	$18,118
35	$9.32	$20,772
40	$11.80	$19,067
45	$15.37	$17,012
50	$19.95	$11,591
55	$27.40	$6,676
60	$31.52	$6,293
65	$49.73	$12,634
70	$66.08	$13,934

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

Horizon Universal Life Insurance for Dependent Children and Grandchildren*

*Grandchildren who are under the age of 14½ and are residents of New York state are not eligible.

Issue Age	Weekly Premium	Cash value Non-Guar. 6.8%
$25,000 Standard Rates		
0	$2.01	$0
1	$2.05	$5,829
2	$2.10	$8,503
3	$2.14	$10,829
4	$2.18	$12,013
5	$2.23	$13,231
6	$2.28	$12,124
7	$2.32	$10,815
8	$2.38	$9,775
9	$2.42	$8,545
10	$2.48	$7,568
11	$2.52	$0
12	$2.57	$0
13	$2.62	$0
14	$2.67	$0
15	$2.72	$0
16	$2.75	$0
17	$2.78	$0

	$25,000 No Tobacco	$25,000 Tobacco	$25,000 No Tobacco	$25,000 Tobacco
18	$2.49	$3.14	$15,951	$10,749
19	$2.57	$3.25	$15,723	$11,770
20	$2.66	$3.37	$15,580	$12,964
21	$2.75	$3.49	$15,334	$13,990
22	$2.85	$3.62	$15,171	$14,817
23	$2.95	$3.75	$14,775	$15,455
24	$3.06	$3.89	$14,580	$16,157

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).

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

Horizon Universal Life Insurance for Available Dependent Rider

Children's Term Insurance Rider	
Insurance Amount	**Weekly Premium**
$5,000	$0.70
$7,000	$0.98
$9,000	$1.26
$10,000	$1.40

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.

ING SHORT TERM DISABILITY INSURANCE

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 selected. The benefit duration options available for this plan are 3 months or 2 years.

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.

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 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 Note: This proceeding is provided for informational purposes only and is not a statement of coverage. Any differences 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	Monthly Rate/$100
3 months	18-49	$1.76
3 months	50-59	$2.38
3 months	60-64	$2.46
2 years	18-49	$3.71
2 years	50-59	$5.97
2 years	60-64	$6.18

Rate Calculation Examples

Stan is 45 years old and earns $65,000 per year and participates in SDI so is eligible for a 40% benefit maximum, and selects a 3 month benefit.

Step 1: $65,000 ÷ 12 months = $5400 monthly income
Step 2: $5,400 x 40% = $2160 maximum monthly benefit eligible to receive
Step 3: $2100 benefit elected ÷ $100* = 21 - rates are quoted per $100 of benefit.
Step 4: 21 x $1.76(rate per $100 of benefit) = $36.96 monthly premium.

Cheryl is 50 years old and earns $70,000 per year and participates in SDI so is eligible for a 40% benefit maximum and selects a 3 month benefit.

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 $2.38 = $54.74 cost per month

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. **Select the Benefit Duration (3 months or 2 years)**

   Based on your age and the benefit duration you have selected, determine your premium rate per one hundred dollars of coverage

   $_____ Line 3

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

   $_____ Line 4

5. **Multiply Line 3 by Line 4 and you will have your monthly premium.**

   $_____ Line 5

   To determine your pay period amount, multiply the monthly premium by 12 and divide by 26.

UNUM LONG TERM DISABILITY

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 this definition of disability and have satisfied the elimination period, you can return to work on a part-time basis and still receive a 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 2/3 % of your basic monthly earnings
- To a maximum of $7,500

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.

Instances when Benefits would Not be Paid

Benefits would not be paid for disabilities caused by, contributed 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 figured in Item 4 is your monthly payment.

This plan highlight summary is provided to help you understand your insurance coverage 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 monthly cost 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 .0051 = $_____Estimated Monthly Cost

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

Your Monthly Salary $2500 x .0051 = $12.75 Estimated Monthly Cost

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

Your Monthly Salary $11,250 x .0051 = $57.38 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

Why Accident Insurance?

Every 10 minutes, 2 people will be killed and 370 people will suffer a disabling injury. Accidents are the leading killer of persons age 1 to 33. Over 19.4 million disabling injuries occurred in the United States during 1998. Accidents cost Americans over $480.5 billion each year. (source: Injury Facts, 1999, Published by the National Safety Council.)

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 (180days 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.

The following examples represent the benefits available under the 1 Unit Base Policy:

Accidental Death and Dismemberment

Up to $20,000 maximum for primary insured; up to $10,000 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

$100 per day. Maximum of 90 days per injury. Hospital must be located in the United States or its territories.

Ambulance (needed as a result of accidental injury)

$100 Regular Ambulance or $200 Air Ambulance

Disability

$600 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. $1/30^{th}$ of the monthly disability is paid for each day of total disability.

Medical Expenses

Medical fees up to $250. 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.

Optional Riders

Sickness Disability Income Rider

Benefits provided if the insured is totally disabled as a result of sickness not resulting from injury.

Sickness Hospital Confinement Rider

When a covered person is confined as an inpatient in a hospital, pays $100 per day per unit of coverage for hospital confinement due exclusively to sickness not resulting from injury.

BASE PLAN				SICKNESS DISABILITY INCOME RIDER				SICKNESS HOSPITAL CONFINEMENT RIDER			
	½ Unit	1 Unit	1 ½ Unit		½ Unit	1 Unit	1 ½ Unit		½ Unit	1 Unit	1 ½ Unit
Individual	$11.83	$21.56	$31.30	Individual	$3.85	$7.70	$11.55	Individual	$2.30	$4.60	$6.90
Family	$19.73	$37.36	$54.99	Family	N/A	N/A	N/A	Family	$5.30	$10.60	$15.90

Issue Ages 18-64

All riders are available in ½, 1, or 1 ½ units. Number of units selected for riders need not match number of units selected for the policy. The riders are available on an individual and family basis (Disability Income Rider #APDIR1) or state variations thereof available for individual coverage only) and are guaranteed renewable to age 70. Premiums are subject to change on a class basis.

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 Coporation. 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.

HERITAGE SERIES CANCER INSURANCE

It's probably crossed your mind that you could get cancer. And you may have thought about the ways it would affect your life and your loved ones. But have you considered how cancer would impact your financial security?

An average of 65% of cancer-related expenses are considered non-medical, which means your health insurance may not pay[1]. Indirect costs can be twice as much as your medical[2]. This is where cancer insurance can help out.

Cancer insurance pays you benefits that can be used for non-medical, cancer-related expenses that health insurance might not cover. Benefits are paid as you go and cover the actual costs of specific treatments and expenses as they happen. You can use this insurance to fill the gap in your other policies.

Important Note: In addition to cancer the policy also covers; Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Typhoid Fever, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Epidemic Cerebrospinal Meningitis, Undulant Fever, Sickle Cell Anemia, Rocky Mountain Spotted Fever, Smallpox, Addison's Disease, Hansen's Disease, Tularemia and Bubonic Plague.

Hospital Confinement

The policy CP10B and the CER1 rider each pay $200/day of continuous hospital confinement up to 70 days. After the 70th day, we pay $30 for each day thereafter of continuous hospital confinement.

- $400/day <70 days
- $30/day >70 days

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.

Second Surgical Opinion

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

Anesthesia

Actual charges up to 25% of surgical or maximum of $100 if skin cancer

Ambulatory Surgical Center

- Actual charges up to $250 a day.

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

The policy pays charges up to $10,000 per 12-month period for covered treatment. The CER1 rider increases the benefit by $10,000 and pays after the $10,000 per 12-month limit in the policy is reached.

1 All cancer statistics in this brochure are from the American Cancer Society

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

The policy pays charges up to $10,000 per 12-month period for blood, plasma, platelets and transfusions, processing and procurement costs and cross matching. The CER1 rider increases the benefit by $10,000 and pays after the $10,000 per 12-month limit in the policy is reached.

Physician's Attendance

Actual charges up to $30 a day

Private Duty Nursing Services

- Actual charges up to $100 per day, while hospital confined

At Home Nursing

- Actual charges up to $100 a day

Skin Cancer

- Actual charges up to $120 for the first removal; actual charges up to $60 for each additional removal.

Prosthesis

- Actual charges up to $2,000 each prosthetic device. Limited to $2,000 per covered person per 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

- $100 per day in lieu of all other benefits in the policy when confined to a hospital operated by the U.S. Government or a hospital that does not charge for the services it provides.

Non-Local Transportation

1) Actual cost of round trip coach fare; or 2) $0.40 a mile up to 700 miles round trip (traveled distance of a 70 mile minimum round trip).

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.

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 (CLR1-4units)

- Pays a one-time benefit of amount shown 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 (Rider ICR2)

$300 per day or $600 per day (reduces to 50% at age 70) *. No benefits are paid if confinement is due to an attempted suicide or intentional self-inflicted injury; or intoxicants or controlled substances; we are not liable for loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician. Benefits are not paid under this rider for continuous hospital intensive care unit confinements that occur during hospitalization that begins before the rider date. Children born within 10 months of the rider date are not covered for any continuous hospital intensive care unit confinement benefit that occurs or begins during the first 30 days of such child's life.

Premiums for Heritage Series Cancer Insurance

BASE PLAN CP10B CLR1 (10 UNITS), CER 1 (2 UNITS)			BASE PLAN ADDING ICR2 (3 UNITS) $300 A DAY		BASE PLAN ADDING ICR2 (6 UNITS) $600 A DAY	
	Weekly	Monthly	Weekly	Monthly	Weekly	Monthly
Individual	$8.15	$35.32	$8.85	$38.32	$9.54	$41.31
Family	$14.15	$61.31	$15.53	$67.30	$16.92	$73.30

Issue Ages: 18-64

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.

HEARTCARE PLUS INSURANCE

Why HeartCare Plus 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 HeartCare Plus 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 HeartCare Plus Insurance

	BASE PLAN				BASE PLAN ADDING ICR90 - $300 A DAY				BASE PLAN ADDING ICR90 - $600 A DAY			
	½ Unit		1 Unit		½ Unit		1 Unit		½ Unit		1 Unit	
	Weekly	Monthly	Weekly	Monthly	Weekly	Monthly	Weekly	Monthly	Weekly	Monthly	Weekly	Monthly
Individual	$2.08	$8.98	$4.15	$17.96	$2.84	$12.28	$4.91	$21.26	$3.60	$15.58	$5.67	$24.56
Family	$4.00	$17.32	$8.00	$34.64	$5.53	$23.92	$5.52	$41.24	$7.05	$30.52	$11.04	$47.84

Coverage is available to eligible individuals age 18 to 64

Renewability

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

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

Termination of Insurance

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

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.

Note: 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.

JOHN HANCOCK LONG TERM CARE

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 retirees, spouses, parents, parents-in-law, stepparents, step-parents-in-law, children and stepchildren (ages 18-84) are eligible for coverage.

Why Long Term Care?

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

- Consider that: 48.6% of people age 65 and older may spend time in a nursing home.
- 71.8% of people over the age of 65 may use some form of home 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)
- 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 counselor will be able to assist you with your questions and provide you with quotes.

Plan	**Gold Coast Advantage Partnership**
Nursing Home Daily Benefit	100%
Residential Care Facility Percentage	100%
Home Health Care Percentage	100%
Elimination Period	90 Days
Benefit Period	3 Years
Payment Mode	Payroll/Credit Contribution
Payment Type	Life-pay
Underwriting Class	Standard

SAMPLE Long Term Care Insurance Rates

Age	**Monthly Cost**
18-30	$55.58
35	$59.00
40	$63.27
45	$68.40
50	$75.24
55	$89.78
60	$114.57
65	$157.32
70	$230.85

Note: The rates listed above are samples only. This illustration is a general description of coverage and is not a contract. For a rate quote please see an enrollment counselor. Any differences in premiums between this illustration and those quoted at the time of enrollment will be determined in favor of the quoted rates. Please review your policy for all terms and conditions.

VETERINARY PET INSURANCE

For minor problems to life-threatening situations, whether it's a recurring ear infection, being injured in an accident or contracting a serious illness, there may come a time when your pet needs medical attention.

Veterinary Pet Insurance allows you to provide medical care for your pet without having to worry about the cost. And you can use any licensed veterinarian in the world.

Canine/Feline Plans

Veterinary Pet Insurance policies cover more than 6,4000 medical problems and conditions related to accidental injuries, poisonings, and illnesses (including cancer).

Coverage helps pay for:

- Diagnostic tests
- Treatments
- Office Visits
- Lab Fees
- Prescriptions
- Hospitalization
- X-rays
- Surgeries

Premiums start at less than $10 per month and are based on the species, age of your pet and the plan you select. Visit perinsurance.com for more information.

VPI Superior Plan

The Superior Plan is the most popular plan for dogs and cats and provides the highest payouts available.

- Annual Benefit Maximum of $14,000
- A low deductible of $50 per incident

VPI Standard Plan

- Annual Benefit Maximum of $9,000
- A low deductible of $50 per incident

The required premium, annual benefit maximum and amount each plan pays for approved claims are the only differences between the plans. The VPI Superior Plan reimburses nearly double that of the VPI Standard Plan. Here are just a few examples of benefit allowances available for each plan.

Type of Service	VPI Superior Plan	VPI Standard Plan
Medical Problem	Benefit Allowance	Benefit Allowance
Intestinal Foreign Body	$855.00	$464.00
Lymphosarcoma (cancer)	$1,748.00	$1,004.00
Fractured Leg (plate)	$1,301.00	$733.00
Gastric Upset	$418.00	$205.00

Benefits include diagnosis, diagnostics and anesthesia allowances.

Avian/Exotic Pet Plan

Major medical coverage is also available for avians, rabbits ferrets, reptiles and other exotic pets with premiums starting at just $7.00 per month. Optional Supplemental and Routine Care Coverage for birds can be added for $8.25 per month to help pay for blood testing, nail and wing trims and more. Please call 1-800-USAPETS for details and availability of avian and exotic pet coverage.

Vaccination and Routine Care Coverage

Just as annual visits to the doctor are important for you and your family, regular veterinary care is critical to the long-term health of your pets.

Vaccination and Routine Care coverage provides benefits for:

- Vaccinations
- Heartworm Protection
- Prescription Flea Control
- A Choice of Spaying/Neutering, Routine Teeth Cleaning or Comprehensive Health Screen

This coverage can be added to your primary plan for only $8.25 a month, so for just $99 per year, you can receive up to $213 in annual benefits. No deductible applies to these routine care benefits.

To apply for dog or cat coverage, your pet must be 6 weeks of age or older, there is no upper age limit. Your premium is based on the age of your pet, the species and the plan you select.

Your pet's coverage will begin 14 days after your application and premium are received and approved. You will receive a complete packet that includes your policy, benefit schedule, claim form, wallet sized ID card and your pet's VPI Lost & Found ID tag inscribed with your pet's policy number and VPI's toll free number. If your pet becomes lost, the finder will be able to contact VPI. If your pet is sick or injured the finder will be more likely to seek veterinary help knowing your pet is insured.

Veterinary Pet Insurance Rates - Canine

	Superior Plan Major Medical Only	Superior Plan with vaccination and routine care coverage
Pet Age	**Monthly**	**Monthly**
Puppy (6 wks – 11 mos)	$18.00	$26.25
1 – 4 Years	$20.83	$29.08
5 – 7 Years	$26.58	$34.83
8 and older	Call for rates	Call for rates
	Standard Plan Major Medical Only	Standard Plan with vaccination and routine care coverage
Pet Age	**Monthly**	**Monthly**
Puppy(6 wks – 11 mos)	$10.25	$18.50
1 – 4 Years	$12.25	$20.50
5 – 7 Years	$14.75	$23.00
8 and older	Call for rates	Call for rates

Veterinary Pet Insurance Rates - Feline

	Superior Plan Major Medical Only	Superior Plan with vaccination and routine care coverage
Pet Age	**Monthly**	**Monthly**
Kitten (6 wks – 11 mos)	$15.17	$23.42
1 – 4 Years	$18.42	$26.67
5 – 7 Years	$23.42	$31.67
8 and older	Call for rates	Call for rates
	Standard Plan Major Medical Only	Standard Plan with vaccination and routine care coverage
Pet Age	**Monthly**	**Monthly**
Kitten (6 wks–11 mos)	$9.08	$17.33
1 – 4 Years	$10.83	$19.08
5 – 7 Years	$13.08	$21.33
8 and older	Call for rates	Call for rates

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 will be required to submit a claim for reimbursement and for most 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.

Note: No receipt is required for this expense and you may submit an annual receipt one time for this expense and be reimbursed automatically.

Health Club and Fitness

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

Auto and Homeowners Insurance

You may elect to be reimbursed for your auto and/or homeowners or renters insurance bills. 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 a bona fide coaching professional.

State Disability Insurance

If you are in a position that requires a contribution through payroll deduction to the California State Disability plan, you can sign up to be reimbursed some or all of that cost.

Note: No receipt is required for this expense and you may submit an annual receipt one time for this expense and be reimbursed automatically.

Prior Service Buy Back

If you are having an SF retirement service withholding from paycheck to purchase "prior service" you may choose to be reimbursed from the Management Cafeteria Plan. 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 on a post tax basis 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.

MISCELLANEOUS REIMBURSEMENT FORM

EBS

☐ Health Club	☐ Association Dues	☐ PERS Long Term Care
☐ Cultural Arts	☐ Professional Coaching	☐ SDI Reimbursement
☐ Excess Tuition Insurance	☐ Retirement Buy Back Plan	☐ Auto/Homeowners

To file a claim for expenses, please request a copy of a receipt for services from the service provider. The receipt must include the following information:

- The name of the person for whom the expense was incurred (you, your spouse, your dependents).
- The date of the service provider.
- The name of the service provider.
- A description of the service, or expense.
- The amount or cost of the item, or service provided.

Attach a copy of the receipt(s) for eligible expenses/dues to this form and mail to:

Employee Benefit Specialists, Inc. (or EBS)
P. O. Box 11657
Pleasanton, CA 94588

Be sure to keep a copy of your receipts and claim forms for your personal records. These will not be provided to you from the Recordkeeper.

Reimbursement Request Information

EMPLOYER NAME: _____

EMPLOYEE NAME: _____

Name of person for whom the service was provided	*Relationship to Employee*	*Type of Expense*	*Amount requested to be reimbursed*
Total Requested Reimbursement:			

I certify that the charges for which I am requesting reimbursement have been incurred by me, my spouse, and/or eligible dependents. Furthermore I declare that I am requesting reimbursement only for expenses that have not and will not be paid under any other benefit plan or program; and that I am solely responsible for the accuracy and veracity of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my Direct Reimbursement Plan.

Employee Signature: _____ Date: _____

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.

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.

Unlimited Phone Consultations

You have unlimited toll-free access to your Provider Attorney firm for personal or business related legal matters immediately after you enroll. Just call your provider'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 changes to your benefit 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 membership year, 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 Firm 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

	Monthly Cost	Bi-weekly Cost
Family Plan	$14.95	$6.90
Family Plan (w/ optional Legal Shield benefit)	$15.95	$7.36

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.

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 counseling session.

Commuter Check

The City and County of San Francisco offers a pre-tax commuter benefit for all benefit eligible employees. This pre-tax program allows you to have up to $100 per month deducted from your paycheck for qualified commuting expenses.

Qualified commuting expenses are those incurred by you to commute to work on mass transit and/or a qualified vanpool.

The benefit of this program is that you are saving tax dollars on expenses you are already incurring. Your tax savings depend on the deduction you sign up for and your tax bracket. Most people save between 20% and 35% on every dollar they put through the program.

In addition to the citywide pre-tax program, eligible members may also sign up for a post-tax commuter benefit using their employer 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 dollars in addition to any pre-tax payroll deductions you have signed up for.

Employees that participate in either part of this benefit elect the amount they need for transit expenses. Payroll deductions are taken 24 times per year, and the employer flex credits are contributed every pay period. Once a month Commuter Check vouchers are sent to participants to use to buy transit tickets. Commuter checks come in different denominations and are accepted by all Bay Area transit operators. The employees receive their Commuter checks at the end of each month in time to purchase the following month's transit tickets.

Group Legal

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

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^3.

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

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

- Visit your local Gateway® store and identify yourself as MEA and provide your program code, which is **BEPU20236**.
- Call 1 (877) 485-1462 to order by phone. Please make sure you identify yourself as MEA and provide your program code, which is **BEPU20236**.
- Click on the MEA Employee Purchase website 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.

VOLUNTARY BENEFIT PROGRAMS

As an employee of the City & County of San Francisco, you are eligible to elect coverage under one or more of the following voluntary employee-paid post-tax benefit programs offered by Colonial Life and Accident Insurance Company:

- Short-Term Disability Insurance
- Accident Insurance
- Life Insurance
- Long-Term Care Insurance
- Supplemental Health Plans
  - Critical Illness
  - Hospital Confinement
  - Intensive Care
  - Cancer Insurance

For information regarding any of these programs, contact Colonial Life and Accident Insurance Company at 1-800-650-5433.

Continuation Coverage for Separated Employees and Dependents (COBRA)

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

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

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

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

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

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

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

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